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OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206-AK48

Federal Employees Health Benefits Program: Modification of Two-Option Limitation for Health Benefits Plans and Continuation of Coverage for Annuitants Whose Plan Terminates an Option

AGENCY: Office of Personnel Management.

ACTION: Final rule.

SUMMARY: The Office of Personnel Management (OPM) is issuing a final rule modifying the prohibition against Federal Employees Health Benefits (FEHB) plans offering more than 2 options and also modifying what happens when an annuitant's health plan terminates an option, and the annuitant doesn't make a health benefits change.

DATES: Effective December 30, 2004.

FOR FURTHER INFORMATION CONTACT: Karen Leibach, (202) 606-0004.

SUPPLEMENTARY INFORMATION: On June 7, 2004, OPM published an interim rule in the **Federal Register** (69 FR 31721) modifying the 2-option limitation on health plans to allow FEHB plans to offer 2 options plus a high deductible plan. The regulation also modified what happens when an annuitant whose plan terminates an option doesn't make a health benefits change. Such an annuitant will only be transferred to the plan's remaining option if that option reasonably approximates the terminating option; otherwise, the annuitant will be transferred to the standard option of the Blue Cross and Blue Shield Service Benefit Plan.

We received comments from 1 employee union, 1 Federal agency, and 1 FEHB carrier.

One commenter opposed allowing high deductible plans and health savings accounts (HSAs) in the FEHB Program. This commenter believes that a high deductible/HSA plan will attract younger healthier enrollees, leaving older, less healthy people in traditional health plans, which will drive up premiums. The commenter also believes that people will move back and forth, moving into traditional plans in years when they anticipate more medical expenses and moving back into the high deductible plan after they've had their treatment, again increasing premiums in the traditional plans. We believe that offering high deductible/HSA plans is consistent with OPM's overall goal of providing FEHB enrollees with benefit options that allow greater personal decision-making and flexibility when choosing health coverage for themselves and their families. OPM's experience with consumer-driven health plans has not shown any negative impact on the FEHB premiums. We believe that people will use the coverage as intended: spending the accounts for routine health care costs, banking the difference for future needs, and relying on the insurance portion for a catastrophic event.

One commenter said agencies would have problems programming their computer systems to accept an enrollment code ending in something other than a 1, 2, 4, or 5; the commenter suggested assigning a completely new enrollment code to any high deductible/HSA plans. The commenter also suggested that to avoid confusion these plans should be treated as separate plans, rather than options of existing plans, and should have separate brochures. These are operational issues outside the scope of the regulations. We have forwarded the suggestions to the contracting offices.

One commenter expressed concern that the term "reasonably approximate" wasn't defined, in relation to determining whether an annuitant in a terminating option should be transferred into a plan's remaining option or transferred into the standard option of the Blue Cross and Blue Shield Service Benefit Plan. Whenever a plan terminates—whether it's the whole plan, an option, or a service area enrollment code—OPM notifies agencies and retirement systems of the actions they should take regarding the

plan's enrollees. This regulatory change will not require retirement systems (or agencies) to make a determination on their own regarding whether a plan's remaining option reasonably approximates the terminating option. OPM will continue to provide specific instructions regarding terminations.

One commenter requested that OPM make it clear whether the regulatory change applies to all plans, including the Blue Cross and Blue Shield Service Benefit Plan. The commenter believes that the Service Benefit should be allowed to offer more than 2 options. The regulation as written could indeed apply to all plans. However, OPM disagrees with the commenter's interpretation of the FEHB statute regarding the Service Benefit Plan. Our interpretation is that the statute limits the Service Benefit Plan to no more than 2 options; the regulatory change does not negate the statutory provision. If at some point the language in the law is changed to allow the Service Benefit Plan to offer more than 2 options, there would be nothing in the regulatory language to preclude them from doing so.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation only affects health benefits plans and annuitants participating in the Federal Employees Health Benefits Program.

Executive Order 12866, Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Order 12866.

List of Subjects in 5 CFR Part 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance, Health professionals, Hostages, Iraq, Kuwait, Lebanon, Reporting and recordkeeping requirements, Retirement.

■ Accordingly, under the authority of 5 U.S.C. 8913, OPM is adopting its interim regulations under 5 CFR part 890 as published on June 7, 2004 (69 FR 31721), as a final rule without change.

U.S. Office of Personnel Management.

Kay Coles James,

Director.

[FR Doc. 04-28545 Filed 12-29-04; 8:45 am]

BILLING CODE 6325-39-P

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 959

[Docket No. FV05-959-1 IFR]

Onions Grown in South Texas; Decreased Assessment Rate

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Interim final rule with request for comments.

SUMMARY: This rule decreases the assessment rate established for the South Texas Onion Committee (Committee) for the 2004-05 and subsequent fiscal periods from \$0.03 to \$0.02 per 50-pound equivalent of onions handled. The Committee locally administers the marketing order which regulates the handling of onions grown in South Texas. Authorization to assess onion handlers enables the Committee to incur expenses that are reasonable and necessary to administer the program. The fiscal period began August 1 and ends July 31. The assessment rate will remain in effect indefinitely unless modified, suspended, or terminated.

DATES: Effective January 3, 2005. Comments received by February 28, 2005, will be considered prior to issuance of a final rule.

ADDRESSES: Interested persons are invited to submit written comments concerning this rule. Comments must be sent to the Docket Clerk, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1400 Independence Avenue, SW., STOP 0237, Washington, DC 20250-0237; fax: (202) 720-8938; e-mail: moab.docketclerk@usda.gov; or Internet: <http://www.regulations.gov>. Comments should reference the docket number and the date and page number of this issue of the **Federal Register** and will be available for public inspection in the Office of the Docket Clerk during regular business hours, or can be viewed at: <http://www.ams.usda.gov/fv/moab.html>.

FOR FURTHER INFORMATION CONTACT:

Belinda G. Garza, Regional Manager, Texas Marketing Field Office, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1313 E. Hackberry; McAllen, Texas 78501; telephone: (956) 682-2833, fax: (956)

682-5942; or George Kelhart, Technical Advisor, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1400 Independence Avenue, SW., STOP 0237, Washington, DC 20250-0237; telephone: (202) 720-2491, fax: (202) 720-8938.

Small businesses may request information on complying with this regulation by contacting Jay Guerber, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1400 Independence Avenue, SW., STOP 0237, Washington, DC 20250-0237; telephone: (202) 720-2491, fax: (202) 720-8938, or e-mail: Jay.Guerber@usda.gov.

SUPPLEMENTARY INFORMATION: This rule is issued under Marketing Agreement No. 143 and Order No. 959, both as amended (7 CFR part 959), regulating the handling of onions grown in South Texas, hereinafter referred to as the "order." The order is effective under the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601-674), hereinafter referred to as the "Act."

The Department of Agriculture (USDA) is issuing this rule in conformance with Executive Order 12866.

This rule has been reviewed under Executive Order 12988, Civil Justice Reform. Under the marketing order now in effect, South Texas onion handlers are subject to assessments. Funds to administer the order are derived from such assessments. It is intended that the assessment rate as issued herein will be applicable to all assessable onions beginning August 1, 2004, and continue until amended, suspended, or terminated. This rule will not preempt any State or local laws, regulations, or policies, unless they present an irreconcilable conflict with this rule.

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

20 days after the date of the entry of the ruling.

This rule decreases the assessment rate established for the Committee for the 2004-05 and subsequent fiscal periods from \$0.03 to \$0.02 per 50-pound equivalent of onions handled.

The South Texas onion marketing order provides authority for the Committee, with the approval of USDA, to formulate an annual budget of expenses and collect assessments from handlers to administer the program. The members of the Committee are producers and handlers of South Texas onions. They are familiar with the Committee's needs and with the costs for goods and services in their local area and are thus in a position to formulate an appropriate budget and assessment rate. The assessment rate is formulated and discussed in a public meeting. Thus, all directly affected persons have an opportunity to participate and provide input.

For the 2003-04 and subsequent fiscal periods, the Committee recommended, and USDA approved, an assessment rate that would continue in effect from fiscal period to fiscal period unless modified, suspended, or terminated by USDA upon recommendation and information submitted by the Committee or other information available to USDA.

The Committee met on June 3, 2004, and unanimously recommended 2004-05 fiscal period expenditures of \$145,291 and an assessment rate of \$0.03 per 50-pound equivalent of onions. The Committee subsequently met on October 28, 2004, and unanimously recommended a revised budget of \$141,819 and a reduced assessment rate of \$0.02 per 50-pound equivalent of onions. In comparison, last year's budgeted expenditures were \$139,661. The recommended assessment rate is \$0.01 lower than the rate currently in effect. The decrease in the assessment rate is primarily due to the 2005 onion crop expected to be larger than previously estimated (5 million 50-pound equivalents vs. 4 million 50-pound equivalents). The reduced assessment rate and budget will lower handler costs by about \$50,000 and will keep the Committee's reserves at an acceptable level. At the current rate of assessment, assessment and interest income would exceed anticipated expenses by about \$11,000, and the projected reserve on July 31, 2005, would exceed the level authorized by the order.

The major expenditures recommended by the Committee for the 2004-05 fiscal period include \$76,819 for personnel and office expenses, \$30,000 for compliance, and \$35,000 for

promotion expenses. Budgeted expenses for these items in 2003–04 were \$74,661, \$30,000, and \$35,000, respectively.

The assessment rate recommended by the Committee was derived by considering anticipated expenses and production levels of South Texas onions, and additional pertinent factors. In its recommendation, the Committee utilized an estimate of 5 million 50-pound equivalents of assessable onions for the 2004–05 fiscal period. If realized, this will provide estimated assessment revenue of \$100,000 from all handlers. In addition, it is anticipated that \$41,819 will be provided by interest income and reserve funds. When combined, revenue from these sources will be adequate to cover budgeted expenses. Funds in the reserve (currently \$277,746) will be kept within the maximum of approximately two fiscal periods' expenses as required by § 959.43 of the order.

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

Although this assessment rate is effective for an indefinite period, the Committee will continue to meet prior to or during each fiscal period to recommend a budget of expenses and consider recommendations for modification of the assessment rate. The dates and times of Committee meetings are available from the Committee or USDA. Committee meetings are open to the public and interested persons may express their views at these meetings. USDA will evaluate Committee recommendations and other available information to determine whether modification of the assessment rate is needed. Further rulemaking will be undertaken as necessary. The Committee's 2004–05 budget and those for subsequent fiscal periods will be reviewed and, as appropriate, approved by USDA.

Initial Regulatory Flexibility Analysis

Pursuant to requirements set forth in the Regulatory Flexibility Act (RFA), the Agricultural Marketing Service (AMS) has considered the economic impact of this rule on small entities. Accordingly, AMS has prepared this initial regulatory flexibility analysis.

The purpose of the RFA is to fit regulatory actions to the scale of business subject to such actions in order that small businesses will not be unduly or disproportionately burdened. Marketing orders issued pursuant to the

Act, and the rules issued thereunder, are unique in that they are brought about through group action of essentially small entities acting on their own behalf. Thus, both statutes have small entity orientation and compatibility.

There are approximately 113 producers of onions in the production area and approximately 37 handlers subject to regulation under the marketing order. Small agricultural producers are defined by the Small Business Administration (SBA) (13 CFR 121.201) as those having annual receipts less than \$750,000, and small agricultural service firms are defined as those whose annual receipts are less than \$5,000,000.

Most of the handlers are vertically integrated corporations involved in producing, shipping, and marketing onions. For the 2003–04 marketing year, the industry's 37 handlers shipped onions produced on 14,436 acres with the average and median volume handled being 137,530 and 111,545 fifty-pound equivalents, respectively. In terms of production value, total revenues for the 37 handlers were estimated to be \$42.5 million, with average and median revenues being \$1.14 million and \$931,400, respectively.

The South Texas onion industry is characterized by producers and handlers whose farming operations generally involve more than one commodity, and whose income from farming operations is not exclusively dependent on the production of onions. Alternative crops provide an opportunity to utilize many of the same facilities and equipment not in use when the onion production season is complete. For this reason, typical onion producers and handlers either produce multiple crops or alternate crops within a single year.

Based on the SBA's definition of small entities, the Committee estimates that all of the 37 handlers regulated by the order would be considered small entities if only their spring onion revenues are considered. However, revenues from other productive enterprises would likely push a large number of these handlers above the \$5,000,000 annual receipt threshold. All of the 113 producers may be classified as small entities based on the SBA definition if only their revenue from spring onions is considered. When revenues from all sources are considered, a majority of the producers would not be considered small entities because receipts would exceed \$750,000.

This rule decreases the assessment rate established for the Committee and collected from handlers for the 2004–05

and subsequent fiscal periods from \$0.03 to \$0.02 per 50-pound equivalent of onions handled. The Committee unanimously recommended 2004–05 expenditures of \$141,819 and an assessment rate of \$0.02 per 50-pound equivalent of onions handled. The recommended assessment rate is \$0.01 lower than the rate currently in effect. The quantity of assessable onions for the 2004–05 fiscal period is estimated at 5 million 50-pound equivalents. Thus, the \$0.02 rate should provide \$100,000 in assessment income. Income derived from handler assessments, along with interest income and funds from the Committee's authorized reserve, will be adequate to cover budgeted expenses.

The major expenditures recommended by the Committee for the 2004–05 fiscal period include \$76,819 for personnel and office expenses, \$30,000 for compliance, and \$35,000 for promotion expenses. Budgeted expenses for these items in 2003–04 were \$74,661, \$30,000, and \$35,000, respectively.

The Committee reviewed and unanimously recommended 2004–05 expenditures of \$141,819, which include a decrease in administrative expenses. The assessment rate of \$0.02 per 50-pound equivalent of assessable onions recommended by the Committee was determined by considering anticipated expenses and production levels of South Texas onions. The Committee utilized an estimate of 5 million 50-pound equivalents of assessable onions for the 2004–05 fiscal period, which, if realized, will provide estimated assessment revenue of \$100,000 from all handlers. In addition, it is anticipated that \$41,819 will be provided by interest income and reserve funds. When combined, revenue from these sources will be adequate to cover budgeted expenses.

The Committee discussed alternative expenditure levels, but determined that the recommended expenses were reasonable and necessary to adequately cover program operations. Other assessment rates were not considered because the Committee had substantially lowered its assessment rate the previous fiscal year.

A review of historical information and preliminary information pertaining to the upcoming fiscal period indicates that the season average f.o.b. price for the 2004–05 fiscal period could range between \$9.25 and \$19.05 per 50-pound equivalent of onions (range of Texas f.o.b. onion prices for 2001 through 2003). Therefore, the estimated assessment revenue for the 2004–05 fiscal period as a percentage of total

f.o.b. revenue could range between .10 and .22 percent.

This action decreases the assessment obligation imposed on handlers. Assessments are applied uniformly on all handlers, and some of the costs may be passed on to producers. However, decreasing the assessment rate reduces the burden on handlers, and may reduce the burden on producers. In addition, the Committee's meeting was widely publicized throughout the South Texas onion industry and all interested persons were invited to attend the meeting and participate in Committee deliberations on all issues. Like all Committee meetings, the October 28, 2004, meeting was a public meeting and all entities, both large and small, were able to express views on this issue. Finally, interested persons are invited to submit information on the regulatory and informational impacts of this action on small businesses.

This action imposes no additional reporting or recordkeeping requirements on either small or large South Texas onion handlers. As with all Federal marketing order programs, reports and forms are periodically reviewed to reduce information requirements and duplication by industry and public sector agencies.

USDA has not identified any relevant Federal rules that duplicate, overlap, or conflict with this rule.

A small business guide on complying with fruit, vegetable, and specialty crop marketing agreements and orders may be viewed at: <http://www.ams.usda.gov/fv/moab.html>. Any questions about the compliance guide should be sent to Jay Guerber at the previously mentioned address in the **FOR FURTHER INFORMATION CONTACT** section.

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

Pursuant to 5 U.S.C. 553, it is also found and determined upon good cause that it is impracticable, unnecessary, and contrary to the public interest to give preliminary notice prior to putting this rule into effect, and that good cause exists for not postponing the effective date of this rule until 30 days after publication in the **Federal Register** because: (1) The 2004–05 fiscal period began on August 1, 2004, and the marketing order requires that the rate of assessment for each fiscal period apply to all assessable onions handled during such fiscal period; (2) this action decreases the assessment rate for

assessable onions beginning with the 2004–05 fiscal period; (3) handlers are aware of this action which was unanimously recommended by the Committee at a public meeting and is similar to other assessment rate actions issued in past years; and (4) this interim final rule provides a 60-day comment period, and all comments timely received will be considered prior to finalization of this rule.

List of Subjects in 7 CFR Part 959

Marketing agreements, Onions, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, 7 CFR part 959 is amended as follows:

PART 959—ONIONS GROWN IN SOUTH TEXAS

■ 1. The authority citation for 7 CFR part 959 continues to read as follows:

Authority: 7 U.S.C. 601–674.

■ 2. Section 959.237 is revised to read as follows:

§ 959.237 Assessment rate.

On and after August 1, 2004, an assessment rate of \$0.02 per 50-pound equivalent is established for South Texas onions.

Dated: December 23, 2004.

A.J. Yates,
Administrator, Agricultural Marketing Service.

[FR Doc. 04–28631 Filed 12–29–04; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 25

[Docket No. NM296; Special Conditions No. 25–278–SC]

Special Conditions: Dassault Aviation Model Falcon Fan Jet, Falcon Fan Jet Series D, –Series E, –Series F airplanes; and Mystere-Falcon Model 20–C5, –20–D5, –20–E5, –20–F5, and –200 Series Airplanes; High Intensity Radiated Fields (HIRF)

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special conditions; request for comments.

SUMMARY: These special conditions are issued for Dassault Aviation Model Falcon Fan Jet, Falcon Fan Jet series D, –series E, –series F airplanes; and Mystere-Falcon Model 20–C5, –20–D5,

–20–E5, –20–F5, and –200 series airplanes modified by Premier Air Center. These airplanes will have novel and unusual design features when compared to the state of technology envisioned in the airworthiness standards for transport category airplanes. The modification incorporates the installation of a Universal EFI–890 Electronic Flight Display System, the Collins Attitude-Heading Reference System, and a Computer Instruments Corporation (CIC) Air Data System. The applicable airworthiness regulations do not contain adequate or appropriate safety standards for the protection of these systems from the effects of high-intensity-radiated fields (HIRF). These special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

DATES: The effective date of these special conditions is December 20, 2004. Comments must be received on or before January 31, 2005.

ADDRESSES: Comments on these special conditions may be mailed in duplicate to: Federal Aviation Administration, Transport Airplane Directorate, Attn: Rules Docket (ANM–113), Docket No. NM296, 1601 Lind Avenue SW., Renton, Washington, 98055–4056; or delivered in duplicate to the Transport Airplane Directorate at the above address. Comments must be marked: Docket No. NM296.

FOR FURTHER INFORMATION CONTACT: Greg Dunn, FAA, Airplane and Flight Crew Interface Branch, ANM–111, Transport Airplane Directorate, Aircraft Certification Service, 1601 Lind Avenue SW., Renton, Washington, 98055–4056; telephone (425) 227–2799; facsimile (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA has determined that notice and opportunity for prior public comment is impracticable because these procedures would significantly delay certification of the airplanes and thus delivery of the affected aircraft. In addition, the substance of these special conditions has been subject to the public comment process in several prior instances with no substantive comments received. The FAA therefore finds that good cause exists for making these special conditions effective upon issuance; however, we invite interested persons to participate in this rulemaking by submitting written comments, data, or views. The most helpful comments reference a specific portion of the

special conditions, explain the reason for any recommended change, and include supporting data. We ask that you send us two copies of written comments.

We will file in the docket all comments we receive, as well as a report summarizing each substantive public contact with FAA personnel concerning these special conditions. The docket is available for public inspection before and after the comment closing date. If you wish to review the docket in person, go to the address in the **ADDRESSES** section of this preamble between 7:30 a.m. and 4 p.m. Monday through Friday, except Federal holidays.

We will consider all comments we receive on or before the closing date for comments. We will consider comments filed late if it is possible to do so without incurring expense or delay. We may change these special conditions in light of the comments received.

If you want the FAA to acknowledge receipt of your comments on these special conditions, include with your comments a pre-addressed, stamped postcard on which the docket number appears. We will stamp the date on the postcard and mail it back to you.

Background

On May 13, 2004, Premier Air Center, 18 Terminal Drive, East Alton, Illinois, 62024, applied for a supplemental type certificate (STC) to modify Dassault Aviation Model Falcon Fan Jet, Falcon Fan Jet series D, -series E, -series F airplanes; and Mystere-Falcon Model 20-C5, -20-D5, -20-E5, -20-F5, and -200 series airplanes. These models are currently approved under Type Certificate No. A7EU. These Dassault airplane models are transport category airplanes powered by two turbofan engines with maximum takeoff weights of up to 29,000 pounds. These airplanes operate with a 2-pilot crew and can seat up to 10 passengers. The modification incorporates the installation of a Universal EFI-890 Electronic Flight Display System, the Collins Attitude-Heading Reference System, and a Computer Instruments Corporation (CIC) Air Data System. The avionics/electronics and electrical systems installed in these airplanes have the potential to be vulnerable to high-intensity radiated fields (HIRF) external to the airplanes.

Type Certification Basis

Under the provisions of 14 CFR 21.101, Premier Air Center must show that the Dassault Aviation Model Falcon Fan Jet, Falcon Fan Jet series D, -series E, -series F airplanes; and Mystere-Falcon Model 20-C5, -20-D5, -20-E5,

-20-F5, and -200 series airplanes, as changed, continue to meet the applicable provisions of the regulations incorporated by reference in Type Certificate No. A7EU, or the applicable regulations in effect on the date of application for the change. The regulations incorporated by reference in the type certificate are commonly referred to as the "original type certification basis." The certification basis for the Dassault Aviation Model Falcon Fan Jet, Falcon Fan Jet series D, -series E, -series F airplanes includes the applicable paragraphs of CAR 4b, as amended by Amendments 4b-1 through 4b-12, Special Regulation SR-422B, and 14 CFR part 25 as amended by Amendments 25-1 through 25-4, in lieu of CAR 4b.350(e) and (f). The certification basis for the Dassault Aviation Mystere-Falcon Model 200 series airplanes includes the applicable paragraphs of CAR 4b, as amended by Amendments 4b-1 through 4b-12, Special Regulation SR-422B and 14 CFR part 25 as amended by Amendments 25-1 through 25-46. The certification basis for the Dassault Aviation Mystere-Falcon Model 20-C5, -20-D5, -20-E5, -20-F5 series airplanes includes the applicable paragraphs of CAR 4b, as amended by Amendments 4b-1 through 4b-12, Special Regulation SR-422B, and 14 CFR part 25 as amended by Amendments 25-1 through 25-56; § 25.904 and Appendix 1 as amended by Amendment 25-62; SFAR 27 as amended by Amendments 27-1 through 27-6; and 14 CFR part 36 as amended by Amendments 36-1 through 36-15. In addition, the certification basis includes certain later amended sections of the applicable part 25 regulations that are not relevant to these special conditions.

If the Administrator finds that the applicable airworthiness regulations (*i.e.*, part 25, as amended) do not contain adequate or appropriate safety standards for modified Model Falcon Fan Jet, Falcon Fan Jet series D, -series E, -series F airplanes; and Mystere-Falcon Model 20-C5, -20-D5, -20-E5, -20-F5, and -200 series airplanes, because of a novel or unusual design feature, special conditions are prescribed under the provisions of § 21.16.

In addition to the applicable airworthiness regulations and special conditions, the Dassault Aviation Model Falcon Fan Jet, Falcon Fan Jet series D, -series E, -series F airplanes; and Mystere-Falcon Model 20-C5, -20-D5, -20-E5, -20-F5, and -200 series airplanes must comply with the fuel vent and exhaust emission requirements of 14 CFR part 34 and the noise

certification requirements of 14 CFR part 36.

Special conditions, as defined in 14 CFR 11.19, are issued in accordance with § 11.38, and become part of the type certification basis in accordance with § 21.101.

Special conditions are initially applicable to the model for which they are issued. Should Premier Air Center apply at a later date for a supplemental type certificate to modify any other model included on Type Certificate No. A7EU to incorporate the same novel or unusual design feature, these special conditions would also apply to the other model under the provisions of § 21.101.

Novel or Unusual Design Features

As noted earlier, the Dassault Model Falcon Fan Jet, Falcon Fan Jet series D, -series E, -series F airplanes; and Mystere-Falcon Model 20-C5, -20-D5, -20-E5, -20-F5, and -200 series airplanes modified by Premier Air Center will incorporate electronic displays and advanced heading reference systems that will perform critical functions. These systems may be vulnerable to high-intensity radiated fields external to the airplane. The current airworthiness standards of part 25 do not contain adequate or appropriate safety standards for the protection of this equipment from the adverse effects of HIRF. Accordingly, this system is considered to be a novel or unusual design feature.

Discussion

There is no specific regulation that addresses protection requirements for electronic and electrical systems from HIRF. Increased power levels from ground-based radio transmitters and the growing use of sensitive avionics/electronics and electrical systems to command and control airplanes have made it necessary to provide adequate protection.

To ensure that a level of safety is achieved equivalent to that intended by the regulations incorporated by reference, special conditions are needed for the Model Falcon Fan Jet, Falcon Fan Jet series D, -series E, -series F airplanes; and Mystere-Falcon Model 20-C5, -20-D5, -20-E5, -20-F5, and -200 series airplanes modified by Premier Air Center. These special conditions require that new avionics/electronics and electrical systems that perform critical functions be designed and installed to preclude component damage and interruption of function due to both the direct and indirect effects of HIRF.

High-Intensity Radiated Fields (HIRF)

With the trend toward increased power levels from ground-based transmitters, and the advent of space and satellite communications, coupled with electronic command and control of the airplane, the immunity of critical digital avionics/electronics and electrical systems to HIRF must be established.

It is not possible to precisely define the HIRF to which the airplane will be exposed in service. There is also uncertainty concerning the effectiveness of airframe shielding for HIRF. Furthermore, coupling of electromagnetic energy to cockpit-installed equipment through the cockpit window apertures is undefined. Based on surveys and analysis of existing HIRF emitters, an adequate level of protection exists when compliance is shown with either HIRF protection special condition paragraph 1 or 2 below:

1. A minimum threat of 100 volts rms (root-mean-square) per meter electric field strength from 10 KHz to 18 GHz.

a. The threat must be applied to the system elements and their associated wiring harnesses without the benefit of airframe shielding.

b. Demonstration of this level of protection is established through system tests and analysis.

2. A threat external to the airframe of the field strengths identified in the table below for the frequency ranges indicated. Both peak and average field strength components from the table are to be demonstrated.

Frequency	Field strength (volts per meter)	
	Peak	Average
10 kHz–100 kHz	50	50
100 kHz–500 kHz	50	50
500 kHz–2 MHz	50	50
2 MHz–30 MHz	100	100
30 MHz–70 MHz	50	50
70 MHz–100 MHz	50	50
100 MHz–200 MHz	100	100
200 MHz–400 MHz	100	100
400 MHz–700 MHz	700	50
700 MHz–1 GHz	700	100
1 GHz–2 GHz	2000	200
2 GHz–4 GHz	3000	200
4 GHz–6 GHz	3000	200
6 GHz–8 GHz	1000	200
8 GHz–12 GHz	3000	300
12 GHz–18 GHz	2000	200
18 GHz–40 GHz	600	200

The field strengths are expressed in terms of peak of the root-mean-square (rms) over the complete modulation period.

The threat levels identified above are the result of an FAA review of existing studies on the subject of HIRF, in light of the ongoing work of the

Electromagnetic Effects Harmonization Working Group of the Aviation Rulemaking Advisory Committee.

Applicability

As discussed above, these special conditions are applicable to the Dassault Aviation Model Falcon Fan Jet, Falcon Fan Jet series D, –series E, –series F airplanes; and Mystere-Falcon Model 20–C5, –20–D5, –20–E5, –20–F5, and –200 series airplanes. Should Premier Air Center apply at a later date for a supplemental type certificate to modify any other model included on Type Certificate No. A7EU to incorporate the same or similar novel or unusual design feature, these special conditions would apply to that model as well under the provisions of § 21.101.

Conclusion

This action affects only certain novel or unusual design features on the Dassault Aviation Model Falcon Fan Jet, Falcon Fan Jet series D, –series E, –series F airplanes; and Mystere-Falcon Model –20–C5, –20–D5, –20–E5, –20–F5, and –200 series airplanes modified by Premier Air Center. It is not a rule of general applicability and affects only the applicant who applied to the FAA for approval of these features on the airplane.

The substance of the special conditions for these airplanes has been subjected to the notice and comment procedure in several prior instances and has been derived without substantive change from those previously issued. Because a delay would significantly affect the certification of the airplane, which is imminent, the FAA has determined that prior public notice and comment are unnecessary and impracticable, and good cause exists for adopting these special conditions upon issuance. The FAA is requesting comments to allow interested persons to submit views that may not have been submitted in response to the prior opportunities for comment described above.

List of Subjects in 14 CFR Part 25

Aircraft, Aviation safety, Reporting and recordkeeping requirements.

■ The authority citation for these special conditions is as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701, 44702, 44704.

The Special Conditions

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the following special conditions are issued as part of the supplemental type certification basis for the Dassault Model

Falcon Fan Jet, Falcon Fan Jet series D, –series E, –series F airplanes; and Mystere-Falcon Model 20–C5, –20–D5, –20–E5, –20–F5, and –200 series airplanes modified by Premier Air Center.

1. *Protection from Unwanted Effects of High-Intensity Radiated Fields (HIRF).* Each electronic and electrical system that performs critical functions must be designed and installed to ensure that the operation and operational capability of these systems to perform critical functions are not adversely affected when the airplane is exposed to high intensity radiated fields.

2. For the purpose of these special conditions, the following definition applies: *Critical Functions:* Functions whose failure would contribute to or cause a failure condition that would prevent the continued safe flight and landing of the airplane.

Issued in Renton, Washington, on December 20, 2004.

Kevin Mullin,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–28556 Filed 12–29–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION**Federal Aviation Administration****14 CFR Part 39**

[Docket No. FAA–2004–19972; Directorate Identifier 2004–NM–273–AD; Amendment 39–13924; AD 2004–26–12]

RIN 2120–AA64

Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model ERJ 170 Series Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; request for comments.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for all EMBRAER Model ERJ 170 series airplanes. This AD requires revising the airplane flight manual (AFM) to include certain operational instructions and prohibit dispatch of any flight with the integrated electronic standby system (IESS) inoperative, even though it is allowed by the current version of the Master Minimum Equipment List; and performing a test to determine proper operation of the network interface card (NIC) communications and repairing if necessary. This AD also requires

installing a certain software version of the PRIMUS EPIC system, after which the AFM revision must be removed from the AFM. This AD is prompted by reports of temporary loss of all cockpit display units (DU). We are issuing this AD to prevent temporary or possible sustained loss of all modular avionics units (MAU), which triggers a cascade of failures in systems dependent on MAUs functionalities. Such failures could reduce the flightcrew's situational awareness and increase workload and consequently reduce the ability of the flightcrew to maintain the safe flight and landing of the airplane.

DATES: Effective December 30, 2004.

The incorporation by reference of certain publications listed in the AD is approved by the Director of the Federal Register as of December 30, 2004.

We must receive comments on this AD by February 28, 2005.

ADDRESSES: Use one of the following addresses to submit comments on this AD.

- DOT Docket Web site: Go to <http://dms.dot.gov> and follow the instructions for sending your comments electronically.

- Government-wide rulemaking Web site: Go to <http://www.regulations.gov> and follow the instructions for sending your comments electronically.

- Mail: Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, room PL-401, Washington, DC 20590.

- Fax: (202) 493-2251.

- Hand Delivery: Room PL-401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this AD, contact Empresa Brasileira de Aeronautica S.A. (EMBRAER), P.O. Box 343-CEP 12.225, Sao Jose dos Campos—SP, Brazil. You can examine this information at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

You can examine the contents of this AD docket on the Internet at <http://dms.dot.gov>, or in person at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., room PL-401, on the plaza level of the Nassif Building, Washington, DC. This docket number is FAA-2004-19972; the directorate identifier for this docket is 2004-NM-273-AD.

Examining the Docket

You can examine the AD docket on the Internet at <http://dms.dot.gov>, or in person at the Docket Management Facility office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Management Facility office (telephone (800) 647-5227) is located on the plaza level of the Nassif Building at the DOT street address stated in the **ADDRESSES** section. Comments will be available in the AD docket shortly after the DMS receives them.

FOR FURTHER INFORMATION CONTACT: Tom Groves, Aerospace Engineer, International Branch, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055-4056; telephone (425) 227-1503; fax (425) 227-1149.

SUPPLEMENTARY INFORMATION: The Departamento de Aviacao Civil (DAC), which is the airworthiness authority for Brazil, notified the FAA that an unsafe condition may exist on all Empresa Brasileira de Aeronautica S.A. (EMBRAER) ERJ 170 series airplanes. The DAC advises that, during some flight tests performed by the manufacturer on Model ERJ 170 prototype airplanes, a temporary loss of all display units (DU) occurred. Post-incident investigation showed that this failure could be traced to a failure on the master timer network interface card (NIC)/network interface integrated module (NIM) synchronizer, which provides timing signals for the avionics standard communication bus (ASCB). In that scenario, for approximately 4 seconds, the pilots were left with only the integrated electronic standby system (IESS) for basic flying, with only a very high frequency (VHF) radio for voice communication. In all reported cases, the system recovered without any specific pilot action. However, further investigation showed the theoretical possibility of a sustained loss of all modular avionics units (MAU), which triggers a cascade of failures in systems dependent on MAU functionalities. These functionalities include DUs, flight control system normal mode, autopilot, and autothrottle.

Temporary or possible sustained loss of all MAUs, if not corrected, could trigger a cascade of failures in systems dependent on MAU functionalities. Such failures could reduce the flightcrew's situational awareness and increase workload and consequently reduce the ability of the flightcrew to maintain the safe flight and landing of the airplane.

Other Relevant Rulemaking

We have determined that Gulfstream Model GV-SP series airplanes may be subject to an unsafe condition similar to that addressed in this AD. Therefore, we are considering additional rulemaking to address that unsafe condition on that airplane model.

Relevant Service Information

EMBRAER has issued Operational Bulletin 170-011/04, Revision 1, dated December 23, 2004. The operational bulletin informs operators of the possibility of loss of all MAUs, and provides procedures for operation in the event that this type of failure occurs. The operational bulletin also prohibits operators from dispatch with the IESS inoperative, even though it is allowed by the current version of the Master Minimum Equipment List.

EMBRAER has issued Service Bulletin 170-31-0003, dated December 23, 2004. This service bulletin describes procedures for performing a test to assess the general conditions of the NIC communications, and making repairs if necessary.

EMBRAER has issued Service Bulletin 170-31-0002, dated December 23, 2004. This service bulletin describes procedures for installing the software version of the PRIMUS EPIC system identified as "load 15.3" or higher, after which the AFM revision described previously may be removed.

Accomplishing the actions specified in the service information is intended to adequately address the unsafe condition. The DAC mandated the service information and issued Brazilian emergency airworthiness directive 2004-12-04, effective December 27, 2004, to ensure the continued airworthiness of these airplanes in Brazil.

FAA's Determination and Requirements of This AD

This airplane model is manufactured in Brazil and is type certificated for operation in the United States under the provisions of section 21.29 of the Federal Aviation Regulations (14 CFR 21.29) and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the DAC has kept the FAA informed of the situation described above. We have examined the DAC's findings, evaluated all pertinent information, and determined that we need to issue an AD for products of this type design that are certificated for operation in the United States.

Therefore, we are issuing this AD to prevent temporary or possible sustained

loss of all MAUs, which triggers a cascade of failures in systems dependent on MAUs functionalities. Such failures could reduce the flightcrew's situational awareness and increase workload and consequently reduce the ability of the flightcrew to maintain the safe flight and landing of the airplane. This AD requires accomplishing the actions specified in the service information described previously, except as discussed under "Differences Between This AD and the Service Information."

Differences Between This AD and the Service Information

EMBRAER Service Bulletin 170-31-0003 specifies that you may contact the manufacturer for instructions on how to repair certain conditions, but this AD requires you to repair those conditions using a method that we or the DAC (or its delegated agent) approve. In light of the type of repair that is required to address the unsafe condition, and consistent with existing bilateral airworthiness agreements, we have determined that, for this AD, a repair we or the DAC approve is acceptable for compliance with this AD.

Although the Accomplishment Instructions of EMBRAER Service Bulletin 170-31-0003 specify submitting test results to the airplane manufacturer, this AD does not require that action.

Differences Between This AD and the Brazilian AD

Although the Brazilian AD requires operators to revise the Emergency and Abnormal Procedures Sections of the AFM, this AD requires that the Limitations Section of the AFM be revised. The Limitations Section of the AFM is the only mandatory AFM section.

FAA's Determination of the Effective Date

An unsafe condition exists that requires the immediate adoption of this AD; therefore, providing notice and opportunity for public comment before the AD is issued is impracticable, and good cause exists to make this AD effective in less than 30 days.

Comments Invited

This AD is a final rule that involves requirements that affect flight safety and was not preceded by notice and an opportunity for public comment; however, we invite you to submit any relevant written data, views, or arguments regarding this AD. Send your comments to an address listed under **ADDRESSES**. Include "Docket No. FAA-

2004-19972; Directorate Identifier 2004-NM-273-AD" at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of the AD. We will consider all comments received by the closing date and may amend the AD in light of those comments.

We will post all comments we receive, without change, to <http://dms.dot.gov>, including any personal information you provide. We will also post a report summarizing each substantive verbal contact with FAA personnel concerning this AD. Using the search function of our docket web site, anyone can find and read the comments in any of our dockets, including the name of the individual who sent the comment (or signed the comment on behalf of an association, business, labor union, etc.). You can review the DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477-78), or you can visit <http://dms.dot.gov>.

Authority for This Rulemaking

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

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

Regulatory Findings

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

For the reasons discussed above, I certify that the regulation:

1. Is not a "significant regulatory action" under Executive Order 12866;

2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

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

We prepared a regulatory evaluation of the estimated costs to comply with this AD. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

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

Adoption of the Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

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

2004-26-12 Empresa Brasileira de Aeronautica S.A. (EMBRAER);

Amendment 39-13924. Docket No. FAA-2004-19972; Directorate Identifier 2004-NM-273-AD.

Effective Date

(a) This AD becomes effective December 30, 2004.

Affected ADs

(b) None.

Applicability

(c) This AD applies to all EMBRAER Model ERJ 170 series airplanes, certificated in any category.

Unsafe Condition

(d) This AD was prompted by reports of temporary loss of all cockpit display units (DU). The Federal Aviation Administration is issuing this AD to prevent temporary or possible sustained loss of all MAUs, which triggers a cascade of failures in systems dependent on MAUs functionalities. Such failures could reduce the flightcrew's situational awareness and increase workload and consequently reduce the ability of the flightcrew to maintain the safe flight and landing of the airplane.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Airplane Flight Manual (AFM) Revision

(f) Within 72 hours after the effective date of this AD: Revise the Limitations Section of the EMBRAER ERJ 170 AFM by inserting a copy of EMBRAER Operational Bulletin 170–011/04, Revision 1, dated December 23, 2004, into the AFM.

Network Interface Card (NIC) Test

(g) Within 30 days after the effective date of this AD, or before or concurrently with doing the software installation required by paragraph (h) of this AD, whichever occurs first: Do a test to determine proper operation of the NIC communications in accordance with the Accomplishment Instructions of EMBRAER Service Bulletin 170–31–0003, dated December 23, 2004. If any failure is detected, before further flight, repair the airplane in accordance with a method approved by either the Manager, International Branch, ANM–116, FAA, Transport Airplane Directorate; or the Departamento de Aviação Civil (DAC) (or its delegated agent).

Software Installation

(h) Within 40 days or 300 flight hours after the effective date of this AD, whichever

occurs first: Install the software version of the PRIMUS EPIC system identified as “load 15.3” or higher, in accordance with the Accomplishment Instructions of EMBRAER Service Bulletin 170–31–0002, dated December 23, 2004. After installation of this software, remove the AFM revision required by paragraph (f) of this AD.

Submission of Test Results Not Required

(i) Although EMBRAER Service Bulletin 170–31–0003 specifies to submit certain information to the airplane manufacturer, this AD does not include that requirement.

Alternative Methods of Compliance (AMOCs)

(j) The Manager, International Branch, ANM–116, FAA, Transport Airplane Directorate, has the authority to approve AMOCs for this AD, if requested in accordance with the procedures found in 14 CFR 39.19.

Related Information

(k) Brazilian emergency airworthiness directive 2004–12–04, effective December 27, 2004, also addresses the subject of this AD.

Material Incorporated by Reference

(l) You must use the service information that is specified in Table 1 of this AD to perform the actions that are required by this AD, unless the AD specifies otherwise. (Only the first pages of EMBRAER Service Bulletins 170–31–0002 and Service Bulletin 170–31–0003 contain the issue date of those documents; no other page of those documents is dated.) The Director of the Federal Register approves the incorporation by reference of those documents in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. For copies of the service information, contact Empresa Brasileira de Aeronautica S.A. (EMBRAER), P.O. Box 343—CEP 12.225, Sao Jose dos Campos—SP, Brazil. You can review copies at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street SW, room PL–401, Nassif Building, Washington, DC; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

TABLE 1.—MATERIAL INCORPORATED BY REFERENCE

EMBRAER Service Document	Revision level	Date
Operational Bulletin 170–011/04	1	December 23, 2004.
Service Bulletin 170–31–0002	Original	December 23, 2004.
Service Bulletin 170–31–0003	Original	December 23, 2004.

Issued in Renton, Washington, on December 23, 2004.

Kevin M. Mullin,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–28707 Filed 12–29–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Food and Drug Administration****21 CFR Part 173**

[Docket No. 2003F–0128]

Secondary Direct Food Additives Permitted in Food for Human Consumption

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the food additive regulations to provide for the safe use of acidified sodium chlorite solutions as an antimicrobial agent on finfish and crustaceans. This action is in response to a petition filed by Alcide Corp.

DATES: The regulation is effective December 30, 2004. Submit written or electronic objections and requests for a hearing by January 31, 2005. See section VI of this document for information on the filing of objections.

ADDRESSES: You may submit written objections and requests for a hearing identified by Docket No. 2003F–0128, by any of the following methods:

- Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.
- Agency Web site: <http://www.fda.gov/dockets/ecomments>. Follow the instructions for submitting comments on the agency Web site.
- E-mail: fdadockets@oc.fda.gov.

Include Docket No. 2003F–0128 in the subject line of your e-mail message.

- FAX: 301–827–6870.
- Mail/Hand delivery/Courier [For paper, disk, 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 number for this rulemaking. All objections received will be posted without change to <http://www.fda.gov/ohrms/dockets/default.htm>, including

any personal information provided. For detailed instructions on submitting objections, see the “Objections” 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.fda.gov/ohrms/dockets/default.htm> and insert the docket number, found in brackets in the heading of this document, into the “Search” box and follow the prompts and/or go to the Division of Dockets Management, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT:

Mical E. Honigfort, Center for Food Safety and Applied Nutrition (HFS–265), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD 20740, 301–436–1278.

SUPPLEMENTARY INFORMATION:**I. Background**

In a notice published in the **Federal Register** of April 10, 2003 (68 FR 17656), FDA announced that a food additive petition (FAP 3A4743) had been filed by Alcide Corp., 8561 154th Ave. NE., Redmond, WA 98052–3557. The petition proposed to amend the food additive regulations in § 173.325

Acidified sodium chlorite solutions (21 CFR 173.325) to expand the permitted use concentration and to expand the pH range for acidified sodium chlorite solutions as an antimicrobial agent in water and ice intended for use on seafood (fresh or saltwater).

Under the Antimicrobial Regulation Technical Corrections Act of 1998 (ARTCA) (Public Law 105–324), the use of acidified sodium chlorite solutions as an antimicrobial agent on seafood is subject to regulation by FDA as a food additive. Such solutions are to be used on food in the preparing, packing, or holding of the food for commercial purposes, and therefore, such use is exempt from the definition of the term “pesticide chemical” (21 U.S.C. 321(q)(1)(B)(i)). Moreover, in the “Legal and Policy Interpretation of the Jurisdiction Under the Federal Food, Drug, and Cosmetic Act of the Food and Drug Administration and the Environmental Protection Agency Over the Use of Certain Antimicrobial Substances” (63 FR 54532 at 54541, October 9, 1998), FDA discussed, in the context of its jurisdiction over antimicrobial substances, what constitutes “processing” of seafood; this interpretation is unchanged by ARTCA. FDA stated that fish that is harvested is “processed.” Consequently, activities done postharvest to seafood, such as handling, storing, preparing, heading, eviscerating, shucking, or holding, would be activities done to “processed food,” not raw agricultural commodities. Therefore, under ARTCA, fish processing operations and commercial fishing vessels would not be considered a “field” or a “treatment facility where raw agricultural commodities are the only food treated” (21 U.S.C. 321(q)(1)(B)(i)), and thus, an antimicrobial applied to seafood at such locations would not be subject to regulation as a “pesticide chemical,” but instead would be subject to regulation as a “food additive” under the Federal Food, Drug, and Cosmetic Act (the act).

Although the use of acidified sodium chlorite solutions as an antimicrobial agent on seafood is regulated under section 409 of the act (21 U.S.C. 348) as a food additive, this intended use may nevertheless be subject to regulation as a pesticide under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA). Therefore, manufacturers intending to market acidified sodium chlorite solutions for such use should contact the Environmental Protection Agency to determine whether this use requires a pesticide registration under FIFRA.

II. Conclusion

In consultation with the agency, the petitioner agreed to limit the proposed use of the additive to a concentration of 1,200 parts per million (ppm) and pH ranging from 2.3 to 2.9 as an antimicrobial agent to reduce pathogenic bacteria on finfish and crustaceans. FDA has evaluated data in the petition and other relevant material. Based on this information, the agency concludes that the proposed use of the additive is safe and the additive will achieve its intended technical effect. Therefore, 21 CFR part 173 is amended as set forth in this document.

The agency is including as a condition of use that seafood treated with acidified sodium chlorite solutions at a concentration of 1,200 ppm must be cooked prior to consumption to ensure that there are no detectable residues on the treated products (Ref. 1).

III. Public Disclosure

In accordance with § 171.1(h) (21 CFR 171.1(h)), the petition and the documents that FDA considered and relied upon in reaching its decision to approve the petition are available for inspection at the Center for Food Safety and Applied Nutrition by appointment with the contact person listed in this document. As provided in § 171.1(h), the agency will delete from the documents any materials that are not available for public disclosure before making the documents available for inspection.

IV. Environmental Impact

In the notice of filing, FDA gave interested parties an opportunity to submit comments on the petitioner’s environmental assessment. FDA received no comments in response to that notice.

The agency has carefully considered the potential environmental effects of this action. FDA has concluded that the action will not have a significant impact on the human environment, and that an environmental impact statement is not required. The agency’s finding of no significant impact and the evidence supporting that finding, contained in an environmental assessment, may be seen in the Division of Dockets Management (see ADDRESSES) between 9 a.m. and 4 p.m., Monday through Friday.

V. Paperwork Reduction Act of 1995

This final rule contains no collection of information. Therefore, clearance by the Office of Management and Budget under the Paperwork Reduction Act of 1995 is not required.

VI. Objections and Hearing Requests

Any person who will be adversely affected by this regulation may file with the Division of Dockets Management (see ADDRESSES) written or electronic objections. Each objection shall be separately numbered, and each numbered objection shall specify with particularity the provisions of the regulation to which objection is made and the grounds for the objection. Each numbered objection on which a hearing is requested shall specifically so state. Failure to request a hearing for any particular objection shall constitute a waiver of the right to a hearing on that objection. Each numbered objection for which a hearing is requested shall include a detailed description and analysis of the specific factual information intended to be presented in support of the objection in the event that a hearing is held. Failure to include such a description and analysis for any particular objection shall constitute a waiver of the right to a hearing on the objection. Three copies of all documents are to be submitted and are to be identified with the docket number found in brackets in the heading of this document. Any objections received in response to the regulation may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

VII. Reference

The following reference has been placed on display in the Division of Dockets Management (see ADDRESSES) and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday.

1. Memorandum from the Chemistry Review Group to the Regulatory Review Group II, “Acidified solutions of sodium chlorite in processing waters intended for use on seafood or freshwater fish,” June 21, 2004.

List of Subjects in 21 CFR Part 173

Food additives.

- Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, and redelegated to the Director, Center for Food Safety and Applied Nutrition, 21 CFR part 173 is amended as follows:

PART 173—SECONDARY DIRECT FOOD ADDITIVES PERMITTED IN FOOD FOR HUMAN CONSUMPTION

- 1. The authority citation for 21 CFR part 173 continues to read as follows:

Authority: 21 U.S.C. 321, 342, 348.

- 2. Section 173.325 is amended by redesignating paragraph (d) as paragraph

(d)(1) and by adding new paragraph (d)(2) to read as follows:

§ 173.325 Acidified sodium chlorite solutions.

* * * * *

(d)(1) * * *

(2) The additive is used as a single application in processing facilities as an antimicrobial agent to reduce pathogenic bacteria due to cross-contamination during the harvesting, handling, heading, evisceration, butchering, storing, holding, packing, or packaging of finfish and crustaceans; or following the filleting of finfish; in accordance with current industry standards of good manufacturing practice. Applied as a dip or spray, the additive is used at levels that result in a sodium chlorite concentration of 1,200 ppm, in combination with any GRAS acid at levels sufficient to achieve a pH of 2.3 to 2.9. Treated seafood shall be cooked prior to consumption.

* * * * *

Dated: December 21, 2004.

Leslye M. Fraser,

*Director, Office of Regulations and Policy,
Center for Food Safety and Applied Nutrition.*
[FR Doc. 04-28577 Filed 12-29-04; 8:45 am]

BILLING CODE 4160-01-S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 558

New Animal Drugs for Use in Animal Feeds; Chlortetracycline

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule, technical amendment.

SUMMARY: The Food and Drug Administration (FDA) is amending the animal drug regulations to add the approved withdrawal time to the limitations to conditions of use for chlortetracycline Type C medicated feeds for chickens when fed at the 500 gram per ton level. This change is being made to improve the accuracy of the regulations.

DATES: This rule is effective December 30, 2004.

FOR FURTHER INFORMATION CONTACT:

George K. Haibel, Center for Veterinary Medicine (HFV-6), Food and Drug Administration, 7519 Standish Pl., Rockville, MD 20855, 301-827-4567, e-mail: george.haibel@fda.gov.

SUPPLEMENTARY INFORMATION: FDA has found that the April 1, 2004, edition of Title 21, Parts 500 to 599 of the Code of Federal Regulations (CFR) does not reflect the approved withdrawal time for chlortetracycline in Type C medicated feeds for chickens when fed at the 500 gram per ton level. The approved 24-hour withdrawal time at this dose level

was inadvertently removed for all sponsors at the time of a supplemental approval of a zero-day withdrawal time for AUREOMYCIN Type C medicated chicken feeds under NADA 48-761 (63 FR 57245 at 57247, October 27, 1998). At this time, FDA is amending the regulations to correct this error in 21 CFR 558.128. This action is being taken to improve the accuracy of the regulations.

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.

List of Subjects in 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 part 558 is amended as follows:

PART 558—NEW ANIMAL DRUGS FOR USE IN ANIMAL FEEDS

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

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

■ 2. Section 558.128 is amended by revising paragraph (e)(1)(iv) to read as follows:

§ 558.128 Chlortetracycline.

* * * * *

(e) * * *

(1) * * *

Chlortetracycline amount	Indications for use	Limitations	Sponsor
* * * * *	* * * * *	* * * * *	* * * * *
(iv) 500 g/ton	Chickens: For the reduction of mortality due to <i>E. coli</i> infections susceptible to chlortetracycline.	1. Feed for 5 d; 0-day withdrawal time when formulated from AUREOMYCIN Type A medicated articles or Type B medicated feeds under NADA 48-761. 2. Feed for 5 d; withdraw 24 h prior to slaughter; do not feed to chickens producing eggs for human consumption.	046573 017519, 046573, 048164, 066104
* * * * *	* * * * *	* * * * *	* * * * *

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Dated: December 16, 2004.

Steven D. Vaughn,*Director, Office of New Animal Drug
Evaluation, Center for Veterinary Medicine.*

[FR Doc. 04-28578 Filed 12-29-04; 8:45 am]

BILLING CODE 4160-01-S

**DEPARTMENT OF HEALTH AND
HUMAN SERVICES****Food and Drug Administration****21 CFR Part 558****New Animal Drugs for Use in Animal
Feeds; Tilimicosin****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 of a supplemental new animal drug application (NADA) filed by Elanco Animal Health which provides for revised reproductive safety labeling of tilimicosin Type A medicated article used in medicated swine feeds.

DATES: This rule is effective December 30, 2004.

FOR FURTHER INFORMATION CONTACT: Joan C. Gotthardt, Center for Veterinary Medicine (HFV-130), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855, 301-827-7571, e-mail: joan.gotthardt@fda.gov.

SUPPLEMENTARY INFORMATION: Elanco Animal Health, A Division of Eli Lilly & Co., Lilly Corporate Center, Indianapolis, IN 46285, filed a supplement to NADA 141-064 that provides for the use of PULMOTIL 90 (tilimicosin phosphate) Type A medicated article in swine feed for the control of swine respiratory disease associated with certain bacterial organisms. The supplemental NADA provides for revised reproductive safety labeling. The supplemental NADA is approved as of November 24, 2004, and 21 CFR 558.618 is amended to reflect the approval. The basis of approval is discussed in the freedom of information summary.

In accordance with the freedom of information provisions of 21 CFR part 20 and 21 CFR 514.11(e)(2)(ii), a summary of safety and effectiveness data and information submitted to support approval of this application 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.

Under section 512(c)(2)(F)(iii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360b(c)(2)(F)(iii)), this supplemental approval qualifies for 3 years of marketing exclusivity beginning November 24, 2004.

The agency has determined under 21 CFR 25.33(a)(1) 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.

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.

List of Subjects in 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 part 558 is amended as follows:

**PART 558—NEW ANIMAL DRUGS FOR
USE IN ANIMAL FEEDS**

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

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

§ 558.618 [Amended]

■ 2. Section 558.618 is amended in paragraph (e)(3) in the third sentence by removing "pregnant swine or" and by adding in its place "male".

Dated: December 20, 2004.

Steven D. Vaughn,*Director, Office of New Animal Drug
Evaluation, Center for Veterinary Medicine.*

[FR Doc. 04-28576 Filed 12-29-04; 8:45 am]

BILLING CODE 4160-01-S

**DEPARTMENT OF HOMELAND
SECURITY****Coast Guard****33 CFR Part 117****[CGD01-04-148]****Drawbridge Operation Regulations:
Newtown Creek, Dutch Kills, English
Kills, and Their Tributaries, NY****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 drawbridge operation regulations for the Metropolitan Avenue Bridge, mile 3.4, across English Kills at New York City, New York. Under this temporary deviation the bridge may remain closed 6 a.m. to midnight from December 27, 2004 through December 29, 2004 and January 3, 2005 through January 5, 2005. This temporary deviation is necessary to facilitate bridge maintenance.

DATES: This deviation is effective from December 27, 2004 through January 5, 2005.

FOR FURTHER INFORMATION CONTACT: Judy Leung-Yee, Project Officer, First Coast Guard District, at (212) 668-7195.

SUPPLEMENTARY INFORMATION: The Metropolitan Avenue Bridge has a vertical clearance in the closed position of 10 feet at mean high water and 15 feet at mean low water. The existing drawbridge operation regulations are listed at 33 CFR 117.801(e).

The owner of the bridge, New York City Department of Transportation (NYCDOT), requested a temporary deviation from the drawbridge operation regulations to facilitate rehabilitation repairs at the bridge. The bridge must remain in the closed position to perform these repairs.

Under this temporary deviation the NYCDOT Metropolitan Avenue Bridge may remain in the closed position 6 a.m. through midnight from December 27, 2004 through December 29, 2004 and January 3, 2005 through January 5, 2005.

This deviation from the operating regulations is authorized under 33 CFR 117.35, and will be performed with all due speed in order to return the bridge to normal operation as soon as possible.

Dated: December 20, 2004.

David P. Pekoske,*Rear Admiral, U.S. Coast Guard, Commander,
First Coast Guard District.*

[FR Doc. 04-28547 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-15-P

**DEPARTMENT OF HOMELAND
SECURITY****Coast Guard****33 CFR Part 117****[CGD01-04-151]****Drawbridge Operation Regulations:
Connecticut River, CT****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 drawbridge operation regulations for the Amtrak Old Saybrook-Old Lyme Bridge, mile 3.4, across the Connecticut River, Connecticut. Under this temporary deviation, effective from February 21, 2005 through March 31, 2005, the bridge shall open on signal on a fixed schedule at 8 a.m., 12 p.m., 4 p.m., and 8 p.m. From 8 p.m. to 8 a.m. the draw shall open on signal after at least a four-hour advance notice is given. This deviation is necessary in order to facilitate necessary repairs at the bridge.

DATES: This deviation is effective from February 21, 2005 through March 31, 2005.

FOR FURTHER INFORMATION CONTACT: Judy Leung-Yee, Project Officer, First Coast Guard District, at (212) 668-7195.

SUPPLEMENTARY INFORMATION: The Old Saybrook-Old Lyme Bridge, at mile 3.4 across the Connecticut River has a vertical clearance in the closed position of 19 feet at mean high water and 22 feet at mean low water. The existing drawbridge operating regulations are listed at 33 CFR 117.205(b).

The owner of the bridge, Amtrak, requested a temporary deviation from the drawbridge operating regulations to facilitate structural repairs at the bridge.

This deviation to the operating regulations allows the Old Saybrook-Old Lyme Bridge to operate on a fixed opening schedule from February 21, 2005 through March 31, 2005. The bridge shall open only at 8 a.m., 12 p.m., 4 p.m., and 8 p.m. and from 8 p.m. through 8 a.m., the draw shall open on signal after at least a four-hour advance notice is given.

In accordance with 33 CFR 117.35(c), this work will be performed with all due speed in order to return the bridge to normal operation as soon as possible. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: December 14, 2004.

John L. Grenier,

*Captain, U.S. Coast Guard, Acting
Commander, First Coast Guard District.*

[FR Doc. 04-28553 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-15-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[CGD01-04-152]

RIN 1625-AA11

Regulated Navigation Area; East Rockaway Inlet to Atlantic Beach Bridge, Nassau County, Long Island, NY

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule with request for comments.

SUMMARY: The Coast Guard is re-establishing a temporary regulated navigation area (RNA) that was in effect from 6 December to 10 December, until 10 March 2005. The area of this RNA covers the entrance of East Rockaway Inlet to the Atlantic Beach Bridge, Nassau County, New York. This rule restricts the passage of commercial vessels carrying petroleum products with a loaded draft in excess of five feet. Significant shoaling in this area has reduced the depths of the navigable channel making the area unsafe for passage of vessels with drafts of greater than five feet carrying petroleum products as cargo. Operators of such vessels may request transit of the area on a trip-by-trip basis to the Captain of the Port, Long Island Sound, New Haven, Connecticut.

DATES: This rule is effective from 12:01 a.m. on December 11, 2004 until 11:59 p.m. on March 10, 2005. Comments must be received on or before January 10, 2005.

ADDRESSES: Comments should be mailed to the Waterways Management Officer, Coast Guard Group/Marine Safety Office Long Island Sound, 120 Woodward Ave., New Haven, CT 06512. Comments received, along with documents indicated in this preamble as being available in the docket, are part of docket CGD01-04-152 and will be available for inspection or copying at Group/MSO Long Island Sound, New Haven, CT, at the address above, between 9 a.m. and 3 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Lieutenant A. Logman, Waterways Management Officer, Coast Guard Group/Marine Safety Office Long Island Sound at (203) 468-4429.

SUPPLEMENTARY INFORMATION:

Request for Comments and Public Meeting

Interested persons are invited to participate in this rulemaking by submitting written views, comments, data, or arguments. Persons submitting comments should include their names and addresses, identify this rulemaking (CGD01-04-152), the specific section of this rule to which each comment applies, and give reasons for each comment. The Coast Guard requests that all comments and attachments be submitted in an 8½" x 11" unbound format suitable for copying and electronic filing. If that is not practical, a second copy of any bound material is requested. Persons desiring acknowledgment that their comments have been received should enclose a stamped, self-addressed post card or envelope.

The Coast Guard will consider all comments received during the comment period, and may modify this temporary final rule in light of comments received. The Coast Guard plans no public hearing. Persons may request a public hearing by writing to Waterways Management Officer, Group/Marine Safety Office Long Island Sound at the address listed under **ADDRESSES** above. The request should include reasons why a hearing would be beneficial. If it determines that the opportunity for oral presentations will aid this rulemaking, the Coast Guard will hold a public hearing at a time and place announced by a later notice in the **Federal Register**.

In accordance with 5 U.S.C. 553(d)(3) good cause exists for publishing a temporary final rule without a prior comment period. Due to the immediate need for the protection of the maritime public, it is impracticable to publish a NPRM in advance. Delaying this rule to provide for a notice and comment period would be impracticable, unnecessary and contrary to the public interest. Any delay in implementing this rule would be contrary to public interest as immediate action is needed to prevent vessels, carrying petroleum products as cargo with a loaded draft of greater than five feet, from transiting the area so as to avoid the potential hazards associated with a grounding of a vessel carrying petroleum products as cargo.

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(3)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. Due to the immediate need for the protection of the maritime public, it is impracticable to publish a NPRM in

advance. Thus, 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**. Any delay in implementing this rule would be contrary to public interest as immediate action is needed to prevent vessels, carrying petroleum products as cargo with a loaded draft of greater than five feet, from transiting the area so as to avoid the potential hazards associated with a grounding of a vessel carrying petroleum products as cargo.

On December 3, 2004, the M/V KRISTIN POLING, a small coastal tanker, ran aground at high tide south of East Rockaway Inlet, Nassau County, New York. East Rockaway Inlet has experienced significant shoaling causing the channel to migrate towards the west. The shoaling in this area has reduced depths to a point where transit for vessels drawing greater than five feet presents a danger of grounding. The delay inherent in the NPRM process is contrary to the public interest and impracticable, as immediate action is needed to minimize the potential danger posed by the possibility of further groundings of tankers and the potential resultant oil spills in and around this regulated navigation area.

On 4 December 2004, the First Coast Guard District Commander implemented a temporary RNA (CGD01-04-150), effective from 6 p.m. on December 4, 2004 to 11:59 p.m. on December 10, 2004. Since the establishment of that area, we have determined that the continued application of these restrictions is prudent to protect the maritime public.

Background and Purpose

On Friday December 3, 2004, the M/V KRISTIN POLING, a small coastal tanker carrying approximately 18,000 barrels of home heating oil, ran aground at high tide south of East Rockaway Inlet, approximately ¼ mile west of Silver Point at the end of Atlantic Beach. This grounding presented the potential for a major oil spill. The M/V KRISTIN POLING was en route to Sprague Energy Oceanside terminal, a home heating oil distributor located in Oceanside, Long Island, New York, a major supplier of home heating oil for western Long Island. The M/V KRISTIN POLING conducted lightering operations on scene until the vessel was re-floated. No product was discharged into the water as a result of this grounding. East Rockaway Inlet has experienced significant shoaling causing the channel to shift towards the west. The shoaling in this area has reduced depths to a point where transit for

vessels drawing greater than five feet presents a danger of grounding, and the potential for a significant oil spill. East Rockaway Inlet is scheduled to be dredged by contractors for the U.S. Army Corps of Engineers beginning December 11, 2004. Once completed, vessels will be able to safely transit the inlet. Although the dredge project is expected to require 45 days to complete, delays can be expected due to inclement weather, warranting a longer effective period for this rulemaking to ensure adequate protections for the marine community and environment for the entire dredging period. Once the dredge project is complete, the RNA established herein will be cancelled.

Discussion of Rule

This rule will provide for the safety of vessel traffic in and around East Rockaway Inlet, Long Island, New York. This regulation establishes a temporary RNA on the navigable waters of the East Rockaway Inlet in an area bounded by lines drawn from the approximate position of the Silver Point breakwater buoy (LLN 31500) at 40°34' 56" N, 073°45' 19" W, running north to a point of land on the northwest side of the inlet at position 40°35' 28" N, 073°46' 12" W, thence easterly along the shore to the east side of the Atlantic Beach Bridge, State Route 878, over East Rockaway Inlet, thence across said bridge to the south side of East Rockaway Inlet, thence westerly along the shore and across the water to the beginning. This rule prohibits the transit of vessels carrying petroleum products as cargo with a loaded draft greater than five feet through the regulated navigation area. Operators of such vessels wishing to transit the regulated navigation area may submit a request to the Captain of the Port, Long Island Sound on a trip-by-trip basis. The request must include the proposed under-keel-clearance, taking into account the predicted tide. This RNA is in effect from 12:01 a.m. on December 11, 2004 until 11:59 p.m. on March 10, 2005.

Any violation of the regulated navigation area described herein, is punishable by, among others, civil and criminal penalties, *in rem* liability against the offending vessel, and license sanctions.

The Captain of the Port Long Island Sound will notify the maritime community of the periods during which the regulated navigation area will be enforced. Broadcast notifications will be made to the maritime community advising them of the boundaries of the regulated navigation area.

Regulatory Evaluation

This rule is not a "significant regulatory action" under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not "significant" under the regulatory policies and procedures of the Department of Homeland Security (DHS).

We expect the economic impact of this rule will be so minimal that a full Regulatory Evaluation under the regulatory policies and procedures of DHS is unnecessary. This regulation may have some impact on the public, but the potential impact will be minimized for the following reasons: The RNA limits only vessels carrying petroleum products as cargo with a loaded draft of greater than five feet; operators of vessels with a loaded draft of greater than five feet may request permission to transit the regulated navigation area from the Captain of the Port, Long Island Sound. COTP Long Island Sound is working with the U.S. Army Corps of Engineers to have an accurate survey of East Rockaway Inlet conducted to determine whether there is adequate water for vessels to transit this inlet prior to dredging being completed. This survey will enable the COTP to quickly and appropriately assess requests to transit East Rockaway Inlet for the effective period of this RNA. Recreational and other maritime traffic is not prohibited from transiting this area.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601-612), we have considered whether this rule will have a significant economic impact on a substantial number of small entities. 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 may affect the following entities, some of which may be small entities: the owners or operators of vessels carrying petroleum products intending to transit or anchor in those portions of the East Rockaway Inlet covered by the regulated navigation area; and Sprague Energy Oceanside, located in Oceanside, Long Island, New

York, a supplier of home heating oil, and Keyspan E.S. Barrett, an electrical power generation facility, located in Island Park, Long Island, New York, which receive the vessels affected by this regulated navigation area. For the reasons outlined in the Regulatory Evaluation section above, this rule will not have a significant impact on a substantial number of small entities.

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.

Assistance for Small Entities

Under subsection 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 [Pub. L. 104–121], the Coast Guard wants 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 this rule will affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please call Lieutenant A. Logman, Waterways Management Officer, Group/Marine Safety Office Long Island Sound, at (203) 468–4429.

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).

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).

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.

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 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.

Taking of Private Property

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

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.

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 will not concern an environmental risk to health or risk to safety that may disproportionately affect children.

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it will 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.

To help the Coast Guard establish regular and meaningful consultation and collaboration with Indian and Alaskan Native tribes, we published a notice in the **Federal Register** (66 FR 36361, July 11, 2001) requesting comments on how to best carry out the Order. We invite your comments on how this rule might impact tribal governments, even if that impact may not constitute a “tribal implication” under the Order.

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. It has not been designated by the Administrator of the Office of Information and Regulatory Affairs as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

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.

Environment

The Coast Guard considered the environmental impact of this rule and concluded that, under figure 2–1, paragraph 34(g), of Commandant Instruction M16475.1D, this rule is categorically excluded from further environmental documentation. A Categorical Exclusion Determination is available in the docket where indicated under **ADDRESSES**.

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. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 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. From 12:01 a.m. on December 11, 2004 until 11:59 p.m. on March 10, 2004, add temporary § 165.T01–152 to read as follows:

§ 165.T01–152 Regulated Navigation Area, East Rockaway Inlet to Atlantic Beach Bridge, Nassau County, Long Island, New York

(a) *Location.* The following area is established as a Regulated Navigation Area: All waters of East Rockaway Inlet in an area bounded by lines drawn from the approximate position of the Silver Point breakwater buoy (LLN 31500) at 40°34'56" N, 073°45'19" W, running north to a point of land on the northwest side of the inlet at position 40°35'28" N, 073°46'12" W, thence easterly along the shore to the east side of the Atlantic Beach Bridge, State Route 878, over East Rockaway Inlet, thence across the bridge to the south side of East Rockaway Inlet, thence westerly along the shore and across the water to the beginning.

(b) *Regulations.* (1) Vessels carrying petroleum products as cargo, with a loaded draft greater than five feet, are prohibited from transiting within the regulated navigation area.

(2) Operators of vessels carrying petroleum products as cargo with a loaded draft greater than five feet may submit a request to transit the regulated navigation area, on a trip-by trip basis, to the Captain of the Port, Long Island Sound. The request must include the proposed under keel clearance for the transit, taking into account the predicted tide.

(c) *Effective period.* This temporary final rule is effective from 12:01 a.m. on December 11, 2004 until 11:59 p.m. on March 10, 2004.

Dated: December 10, 2004.

David P. Pekoske,

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

[FR Doc. 04–28549 Filed 12–29–04; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[CGD09–04–149]

RIN 1625–AA00

Safety Zone; Chicago River Main Branch, Chicago, IL

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone for the demolition of the Chicago Sun-Times Building. This safety zone is necessary to protect vessels and persons from potential falling debris during the demolition phase of the Chicago Sun-Times Building along the Chicago River Main Branch, Chicago, Illinois.

DATES: This rule is effective from December 20, 2004 through March 19, 2005.

ADDRESSES: Documents indicated in this preamble as being available in the docket, are part of docket [CGD09–04–149] and are available for inspection or copying at Marine Safety Office Chicago, 215 W. 83rd Street, Suite D, Burr Ridge, Illinois 60527, between 7:30 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: LTJG Cameron Land, U.S. Coast Guard Marine Safety Office Chicago, at (630) 986–2155.

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. Notification of this event and the permit application was not received in time to publish an NPRM followed by a final rule before the effective date. Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying this rule would be contrary to the public interest of ensuring the safety of persons and vessels during this event and immediate action is necessary to prevent possible loss of life or property. During the enforcement of this safety zone, comments will be accepted and reviewed and may result in a modification to the rule.

Background and Purpose

This temporary safety zone is necessary to ensure the safety of vessels and persons during the planned demolition of the Chicago Sun-Times Building. During the demolition phase, it is possible for falling debris to fall into the Chicago River. The Captain of the Port Chicago has determined that demolition in close proximity of the waterway may pose a significant risk and hazard to persons and vessels.

Establishing a safety zone to control vessel movement around the location of the Chicago Sun-Times Building will help ensure the safety and reduce the risks of persons and vessels during the demolition phase.

Discussion of Rule

The safety zone will be established on the north side of the Chicago River Main Branch, from the east side of the Wabash Ave Bridge at position 41°53.296' N and 087°37.611' W extending 515 feet along the shoreline to the east side of the Chicago Sun-Times Building, at position 41°53.347' N and 087°37.539' W extending 40 feet perpendicular to the shoreline to position 41°53.342' N and 087°37.534' W extending parallel to the shoreline to position 41°53.290' N and 087°37.607' W then back to the point of origin.

All persons shall comply with the instructions of the Coast Guard Captain of the Port or the designated on scene representative. Entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the Captain of the Port Chicago, or his designated on scene representative.

Regulatory Information

This rule is not a “significant regulatory action” under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. It is not “significant” under the regulatory policies and procedures of the Department of Homeland Security (DHS).

We expect the economic impact of this rule to be so minimal that a full Regulatory Evaluation under the regulatory policies and procedures of DHS is unnecessary.

This determination is based on the consideration that the zone is an area where the Coast Guard expects insignificant adverse impact to mariners from the zones’ activation.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule would have a significant impact on a substantial number of small entities. 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: the owners or operators of vessels intending to transit or anchor in a portion of the Chicago River Main Branch from December 20, 2004 through March 19, 2005. This regulation will not have a significant economic impact for the following reasons. The reduction in width of the navigation channel by 40 feet will still allow commercial and recreation vessels to transit around the area. The designated area is being established to allow barges to be moored against the seawall to catch falling debris and to protect persons and vessels utilizing the waterway. The Coast Guard will give notice to the public via a Broadcast to Mariners that the regulation is in effect.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Public Law 104–121), we offered to assist small entities in understanding the rule so that they could better evaluate its effects on them and participate in the rulemaking process. 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).

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).

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 cost of compliance on them. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

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

Taking of Private Property

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

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.

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.

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.

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. It has not been designated by the Administrator of the Office of Information and Regulatory Affairs as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

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 procedure; and related management system 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.

Environment

We have analyzed this rule under Commandant Instruction M16475.1D, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA)(42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the instruction. Therefore, this rule is categorically excluded, under figure 2–1, paragraph (34)(g) of the Commandant Instruction M16475.1D from further environmental documentation.

An “Environmental Analysis checklist” and “Categorical Exclusion Determination” are required under the Instruction and the results of these determinations will be provided in the docket where indicated under **ADDRESSES**. This action is not expected to result in any significant adverse environmental impact as described in the National Environmental Protection Act.

List of Subjects in 33 CFR Part 165

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

■ For the reasons set out 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. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 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. A new temporary § 165.T09–149 is added to read as follows:

§ 165.T09–149 Safety Zone; Chicago River Main Branch, Chicago, IL.

(a) *Location.* The safety zone will be established on the north side of the Chicago River Main Branch, from the east side of the Wabash Ave Bridge at position 41°53.296' N and 087°37.611' W extending 515 feet along the shoreline to the east side of the Chicago Sun-Times Building, at position 41°53.347' N and 087°37.539' W extending 40 feet perpendicular to the shoreline to position 41°53.342' N and 087°37.534' W extending parallel to the shoreline to position 41°53.290' N and 087°37.607' W then back to the point of origin.

(b) *Effective period.* This regulation is effective from December 20, 2004 through March 19, 2005.

(c) *Regulations.* In accordance with the general regulations in 165.23 of this part, entry into this zone is prohibited unless authorized by the Coast Guard Captain of the Port, Chicago, or the designated on scene representative.

Dated: December 20, 2004.

T. W. Carter,

Captain, U.S. Coast Guard, Captain of the Port Chicago.

[FR Doc. 04–28550 Filed 12–29–04; 8:45 am]

BILLING CODE 4910–15–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[NM–44–1–7603a; FRL–7856–3]

Approval and Promulgation of Air Quality Implementation Plans; New Mexico; Recodification and SIP Renumbering of the New Mexico Administrative Code for Albuquerque/Bernalillo County

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: The EPA is approving a State Implementation Plan (SIP) revision submitted by the Governor of New Mexico on May 2, 2003. The submittal revises the numbering and format of New Mexico's Albuquerque/Bernalillo County SIP and contains no substantive changes to the regulations. We are approving these revisions in accordance with the requirements of the Federal Clean Air Act (the Act).

DATES: This rule is effective on February 28, 2005 without further notice, unless EPA receives relevant adverse comment by January 31, 2005. If EPA receives such comment, EPA will publish a timely withdrawal in the **Federal**

Register informing the public that this rule will not take effect.

ADDRESSES: Submit your comments, identified by File ID No. NM–44–1–7603a, by one of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the on-line instructions for submitting comments.

US EPA Region 6 “Contact Us” Web site: <http://epa.gov/region6/r6comment.htm>. Please click on “6PD” (Multimedia) and select “Air” before submitting comments.

E-mail: Mr. Thomas Diggs at diggs.thomas@epa.gov. Please also cc the person listed in the **FOR FURTHER INFORMATION CONTACT** section below.

Fax: Mr. Thomas Diggs, Chief, Air Planning Section (6PD–L), at 214–665–7263.

Mail: Mr. Thomas Diggs, Chief, Air Planning Section (6PD–L), Environmental Protection Agency, 1445 Ross Avenue, Suite 1200, Dallas, Texas 75202–2733.

Hand or Courier Delivery: Mr. Thomas Diggs, Chief, Air Planning Section (6PD–L), Environmental Protection Agency, 1445 Ross Avenue, Suite 1200, Dallas, Texas 75202–2733. Such deliveries are accepted only between the hours of 8 a.m. and 4 p.m. weekdays, except for legal holidays. Special arrangements should be made for deliveries of boxed information.

Instructions: Please include the text “Public comment on File ID No. NM–44–1–7603a” in the subject line of the first page of your comments. EPA’s policy is that all comments received will be included in the public file without change, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information the disclosure of which is restricted by statute. Do not submit information through regulations.gov or e-mail if you believe that it is CBI or otherwise protected from disclosure. [Regulations.gov](http://regulations.gov) is an “anonymous access” system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through regulations.gov, your e-mail address will be automatically captured and included as part of the comment that is placed in the public file and made available on the Internet. If you submit an electronic comment, 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 EPA cannot read your comment due to

technical difficulties and cannot contact you for clarification, EPA 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.

Official File: Copies of the documents relevant to this action are in the official file which is available at the Air Planning Section (6PD–L), Environmental Protection Agency, 1445 Ross Avenue, Suite 700, Dallas, Texas 75202–2733. The file will be made available by appointment for public inspection in the Region 6 FOIA Review Room between the hours of 8:30 a.m. and 4:30 p.m. weekdays except for legal holidays. Contact the person listed in the **FOR FURTHER INFORMATION CONTACT** paragraph below or Mr. Bill Deese at 214–665–7253 to make an appointment. If possible, please make the appointment at least two working days in advance of your visit. There will be a 15 cent per page fee for making photocopies of documents. On the day of the visit, please check in at the EPA Region 6 reception area at 1445 Ross Avenue, Suite 700, Dallas, Texas.

Copies of any State submittals and EPA’s technical support document are also available for public inspection at the State Air Agency listed below during official business hours by appointment: Albuquerque Environmental Health Department, Air Pollution Control Division, One Civic Plaza, Albuquerque, New Mexico 87103.

FOR FURTHER INFORMATION CONTACT: Carrie Paige, Air Planning Section (6PD–L), EPA Region 6, 1445 Ross Avenue, Dallas, Texas 75202–2733, telephone (214) 665–6521; fax number 214–665–7263; e-mail address paige.carrie@epa.gov.

SUPPLEMENTARY INFORMATION: Throughout this document, “we,” “us,” and “our” refer to EPA.

Outline

- I. The State’s Submittal
 - A. What Revision Did the State Submit?
 - B. What is a SIP?
- II. EPA’s Evaluation
 - A. What is the Federal approval process for a SIP?
 - B. What does Federal approval of a SIP mean to me?
 - C. How is EPA Evaluating this Revision?
- III. Final Action
- IV. Statutory and Executive Order Reviews

I. The State’s Submittal

A. What Revision Did the State Submit?

On May 2, 2003, the State of New Mexico submitted revisions to the New Mexico—Albuquerque/Bernalillo County SIP. These revisions apply to

sections of the New Mexico Administrative Code (NMAC) for Albuquerque/Bernalillo County that have been reformatted and renumbered.

B. What Is a SIP?

Section 110 of the Act requires states to develop air pollution regulations and control strategies to ensure that state air quality meets the National Ambient Air Quality Standards (NAAQS) that EPA has established.

Each state must submit these regulations and control strategies to us for approval and incorporation into the federally enforceable SIP. Each federally approved SIP is designed to protect air quality. These SIPs can be extensive, containing state regulations or other enforceable documents and supporting information such as emission inventories, monitoring networks, and modeling demonstrations.

II. EPA's Evaluation

A. What Is the Federal Approval Process for a SIP?

When a state wants to incorporate its regulations into the federally enforceable SIP, the state must formally adopt the regulations and control strategies consistent with state and Federal requirements. This process includes a public notice, a public hearing, a public comment period, and a formal adoption by a state-authorized rulemaking body.

Once a state adopts a rule, regulation, or control strategy, the state may submit the adopted provisions to us and request that we include these provisions in the federally enforceable SIP. We must then decide on an appropriate Federal action, provide public notice on this action, and seek additional public comment regarding this action. If we receive relevant adverse comments, we must address them prior to taking a final action.

Under section 110 of the Act, when we approve all state regulations and supporting information, those state regulations and supporting information become a part of the federally approved SIP. You can find records of these SIP actions in the Code of Federal Regulations (CFR) at Title 40, part 52, entitled "Approval and Promulgation of Implementation Plans." The actual state regulations that we approved are not reproduced in their entirety in the CFR but are "incorporated by reference," which means that we have approved a given state regulation with a specific effective date.

B. What Does Federal Approval of a SIP Mean to Me?

A state may enforce state regulations before and after we incorporate those regulations into a federally approved SIP. After we incorporate those regulations into a federally approved SIP, both EPA and the public may also take enforcement action against violators of these regulations.

C. How Is EPA Evaluating This Revision?

The Technical Support Document (TSD) prepared for this rule provides two tables that show the current and newly reformatted versions of the NMAC. These tables allow the reviewer to cross-reference the renumbering of the NMAC. After thorough evaluation and comparison with the current SIP, we have confirmed that all sections are accounted for, the revisions are administrative in nature, limited to renumbering of existing sections and parts, and do not weaken the existing SIP.

III. Final Action

The EPA is approving the aforementioned changes to New Mexico's Albuquerque/Bernalillo County SIP because the revisions are consistent with the Act and EPA regulatory requirements. The EPA is publishing this rule without prior proposal because the EPA views this as a non-controversial submittal and anticipates no adverse comments. However, in the proposed rules section of this **Federal Register** publication, EPA is publishing a separate document that will serve as the proposal to approve the SIP revision should adverse comments be filed. This rule will be effective February 28, 2005 without further notice, unless EPA receives relevant adverse comment by January 31, 2005.

If the EPA receives such comments, then EPA will publish a document withdrawing the final rule and informing the public that the rule will not take effect. All public comments received will then be addressed in a subsequent final rule based on the proposed rule. The EPA will not institute a second comment period. Parties interested in commenting should do so at this time. If no such comments are received, the public is advised that this rule will be effective on February 28, 2005, and no further action will be taken on the proposed rule.

IV. Statutory and Executive Order Reviews

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is

not a "significant regulatory action" and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, "Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use" (66 FR 28355, May 22, 2001). This action merely approves state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104-4).

This rule also does not have tribal implications because it will 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, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does not 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, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 "Protection of Children from Environmental Health Risks and Safety Risks" (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission,

to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

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 rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. 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 Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by February 28, 2005. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule 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 40 CFR Part 52

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

Dated: December 16, 2004.

Richard E. Greene,

Regional Administrator, Region 6.

■ 40 CFR part 52 is amended as follows:

PART 52—[AMENDED]

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

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

Subpart GG—New Mexico

■ 2. In § 52.1620(c), the two tables are amended as follows:

■ a. In the first table entitled "EPA Approved New Mexico Regulations," by removing the centered heading, "New Mexico Administrative Code (NMAC) Title 20—Environment Protection Chapter 11—Albuquerque/Bernalillo County Air Quality Control Board (AQCB)," and by removing the entry for Part 03, Transportation Conformity.

■ b. By revising the second table entitled "EPA Approved Albuquerque/Bernalillo County, NN Regulations," to read as follows:

§ 52.1620 Identification of plan.

*	*	*	*	*
(c)	*	*	*	
*	*	*	*	*

EPA APPROVED ALBUQUERQUE/BERNALILLO COUNTY, NN REGULATIONS

State citation	Title/subject	State approval/ effective date	EPA approval date	Explanation
Albuquerque/Bernalillo County, Air Quality Control Regulations				
Regulation No. 8	Airborne Particulate Matter.	02/17/83	02/23/93, 58 FR 10970	Only Section 8.03, Soil Disturbance, in SIP.
Section 21	Permit Fees	01/23/79	04/10/80, 45 FR 24460.	

New Mexico Administrative Code (NMAC) Title 20—Environment Protection, Chapter 11—Albuquerque/Bernalillo County Air Quality Control Board

Part 1 (20.11.1 NMAC)	General Provisions	10/01/02	12/30/04 [Insert FR page where document begins].	No action taken on Sections I.2.3, II.2.4, II.7.3–7.6, II.16.5, II.18.1.B, II.19.1.A, and II.22.2.
Part 3 (20.11.3 NMAC)	Transportation Conformity.	07/01/98	07/08/99, 64 FR 36786	
Part 4 (20.11.4 NMAC)	General Conformity ...	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 5 (20.11.5 NMAC)	Visible Air Contaminants.	01/01/03	12/30/04 [Insert FR page where document begins].	
Part 6 (20.11.6 NMAC)	Emergency Action Plan.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 7 (20.11.7 NMAC)	Variance Procedure ...	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 21 (20.11.21 NMAC)	Open Burning	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 22 (20.11.22 NMAC)	Woodburning	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 40 (20.11.40 NMAC)	Source Registration ...	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 41 (20.11.41 NMAC)	Authority to Construct	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 43 (20.11.43 NMAC)	Stack Height Requirements.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 60 (20.11.60 NMAC)	Permitting in Non-attainment Areas.	10/01/02	12/30/04 [Insert FR page where document begins].	

EPA APPROVED ALBUQUERQUE/BERNALILLO COUNTY, NN REGULATIONS—Continued

State citation	Title/subject	State approval/ effective date	EPA approval date	Explanation
Part 61 (20.11.61 NMAC)	Prevention of Significant Deterioration.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 63 (20.11.63 NMAC)	New Source Performance Standards for Stationary Sources.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 64 (20.11.64 NMAC)	Emission Standards for Hazardous Air Pollutants for Stationary Sources.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 65 (20.11.65 NMAC)	Volatile Organic Compounds.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 66 (20.11.66 NMAC)	Process Equipment ...	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 67 (20.11.67 NMAC)	Equipment, Emissions, Limitations.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 68 (20.11.68 NMAC)	Incinerators and Crematories.	04/01/02	12/30/04 [Insert FR page where document begins].	
Part 90 (20.11.90 NMAC)	Administration, Enforcement, and Inspection.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 100 (20.11.100 NMAC)	Motor Vehicle Inspection—Decentralized.	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 102 (20.11.102 NMAC)	Oxygenated Fuels	10/01/02	12/30/04 [Insert FR page where document begins].	
Part 103 (20.11.103 NMAC)	Motor Vehicle Visible Emissions.	10/01/02	12/30/04 [Insert FR page where document begins].	

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[FR Doc. 04–28501 Filed 12–29–04; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Part 419****[CMS–1427–CN]****RIN 0938–AM75****Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates; Wage Index Tables and Corrections****AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Correction of final rule with comment period.

SUMMARY: This document corrects technical errors that appear in the final rule with comment period published in the **Federal Register** on November 15, 2004 entitled “Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates.” In addition, it provides additional information about the calendar year 2005 wage indices for this payment system that was not published in that final rule with comment period.

DATES: *Effective Date:* This document is effective on January 1, 2005.

FOR FURTHER INFORMATION CONTACT: Dana Burley, (410) 786–0378.

SUPPLEMENTARY INFORMATION:**I. Background***A. Corrections*

In FR Doc. 04–24759 of November 15, 2004 (69 FR 65681), there were a few inadvertent technical and typographical errors that we are correcting and identifying in the “Correction of Errors” section below. The provisions in this correction are effective as if they had been included in the document published in the **Federal Register** on November 15, 2004, that is, as of January 1, 2005.

B. Wage Index

Section 1833(t)(2)(D) of the Social Security Act (the Act) requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the Hospital Outpatient Prospective Payment System (OPPS) payment rate and the copayment standardized amount attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. As we have done in prior years, we adopted the Hospital Inpatient Prospective Payment System (IPPS) wage indices and applied them to Tax Equality and Fiscal Responsibility Act (TEFRA)

hospitals that participate in the OPPS but not the IPPS.

In determining the OPPS payment rate and the copayment standardized amount, we standardize 60 percent of estimated costs (the labor-related portion of costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels.

As published in the original OPPS April 7, 2000 final rule (65 FR 18545), the OPPS has consistently adopted the final IPPS wage indices for adjusting the OPPS standard payment amounts for labor market differences. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In the August 16, 2004 OPPS proposed rule (69 FR 50541), we proposed to use the corrected proposed fiscal year (FY) 2005 hospital IPPS wage index for urban areas published in the **Federal Register** on June 25, 2004 (69 FR 35919) and the proposed FY 2005 hospital IPPS wage index for rural areas published in the **Federal Register** on May 18, 2004 (69 FR 28580) to determine the wage adjustments for the OPPS payment rates and the copayment standardized amount for calendar year (CY) 2005.

On November 15, 2004, we published the final rule with comment period for the OPPS and CY 2005 payment rates (69 FR 65681). In that final rule (69 FR

65842), we specified that, while we customarily publish the wage index tables in the final rule for the OPPS update, we were not including them as we were in the process of reviewing the wage indices for IPPS. We added that we would publish the finalized tables in a later **Federal Register** document.

II. Correction of Errors

In FR Doc. 04-24759 (69 FR 65681) make the following corrections:

1. On page 65697, line 38 of the center column, the code “73428” is corrected to read “74328.”
2. On page 65771, line 39 of the first column “January 1, 2006” is corrected to read, “January 1, 2007.”
3. On page 65778, Table 23 incorrectly lists C9218. Table 23 is corrected to exclude C9218.
4. On page 65841, line 22 of the third column, the payment rate for APC 375 is incorrectly identified as “\$3,214.22.” The payment rate is corrected to read “\$3,217.47.”
5. On page 65848, line 13 of the center column, the coinsurance amount for the partial hospitalization APC is incorrectly identified as “\$56.33.” The coinsurance amount is corrected to read “\$56.27.”
6. On page 65885, APC 9218 incorrectly notes status indicator “G.” The status indicator for APC 9218 is corrected to read “K.”
7. On page 66104, C9218 incorrectly notes status indicator “G.” The status

indicator for C9218 is corrected to read “K.”

III. Wage Index Tables and Additional Information

As stated above, we adopted the final IPPS wage indices for adjusting the OPPS standard payment amounts for labor market differences. Accordingly, the final wage index tables for the IPPS and OPPS are included in the IPPS correction notice (CMS-1428-F2) published elsewhere in this issue. The applicable wage index tables published in the IPPS correction notice that we will adopt for OPPS calculations are referenced in the following chart:

BILLING CODE 4120-01-P

IPPS TABLES APPLICABLE FOR OPPTS CALCULATIONS

Reference and Title Under IPPS	Reference and Title Under OPPTS
TABLE 4A ₁ — WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA	ADDENDUM H ₁ .— WAGE INDEX FOR URBAN AREAS BY MSA
TABLE 4A ₂ .— WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA	ADDENDUM H ₂ .— WAGE INDEX FOR URBAN AREAS BY CBSA
TABLE 4B ₁ — WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS BY MSA	ADDENDUM I ₁ .— WAGE INDEX FOR RURAL AREAS BY MSA
TABLE 4B ₂ .— WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS BY CBSA	ADDENDUM I ₂ .— WAGE INDEX FOR RURAL AREAS BY CBSA
TABLE 4C ₁ — WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY MSA	ADDENDUM J ₁ .— WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY MSA
TABLE 4C ₂ .— WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA	ADDENDUM J ₂ .— WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA
TABLE 4G.— PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS	ADDENDUM L.— PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS
TABLE 4H.— PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS	ADDENDUM M.— PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS
TABLE 9B.— HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 of PUB.L.108-173 AND SPECIAL EXCEPTIONS WAGE INDEX ASSIGNMENTS— FY 2005	ADDENDUM N.— HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 of PUB.L. 108-173

In addition, as also noted above, we adopted the IPPS wage indices and applied them to TEFRA hospitals that participate in the OPPS but not the IPPS. For CY 2005, we will also implement an adjustment to the wage index to reflect the "out-migration" of hospital employees who reside in one county but commute to work in a different county with a higher wage index, in accordance with section 505 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173 (August 11, 2004 IPPS final rule (69 FR 49061 through

49067), as revised and corrected on October 7, 2004 (69 FR 60242)). Hospitals paid under the IPPS located in the qualifying section 505 "out-migration" counties received a wage index increase. We are applying the same criterion to TEFRA hospitals paid under the OPPS but not paid under the IPPS. Therefore, TEFRA hospitals located in qualifying section 505 counties will also receive increases to their wage indices under OPPS. In the OPPS proposed rule (69 FR 50916), those TEFRA hospitals were included in Addendum K. Accordingly, in this

notice, we are providing the finalized Addendum K below. This addendum includes the wage index adjustment for commuting hospital employees (out-migration) in qualifying counties under IPPS (Table 4J under IPPS) as well as information regarding TEFRA hospitals that are paid under the OPPS and that are located in qualifying section 505 counties and for which an adjustment will be made to their wage indices for CY 2005. Column 4 identifies the TEFRA hospitals by triple asterisks (* * *).

**Addendum K--Section 505 "Out-Migration" Adjustment for IPPS Hospitals and
TEFRA Hospitals Participating in the OPPTS**

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
010005*	0.0259	Marshall	
010008*	0.0212	Crenshaw	
010010	0.0259	Marshall	
010012	0.0205	De Kalb	
010022*	0.0714	Cherokee	
010029*	0.0107	Lee	
010035*	0.0375	Cullman	
010038	0.0062	Calhoun	
010045*	0.0160	Fayette	
010047	0.0155	Butler	
010061	0.0506	Jackson	
010072*	0.0310	Talladega	
010078	0.0062	Calhoun	
010083	0.0121	Baldwin	
010100	0.0121	Baldwin	
010101*	0.0310	Talladega	
010115	0.0093	Franklin	
010129	0.0121	Baldwin	
010143*	0.0375	Cullman	
010146	0.0062	Calhoun	
010150*	0.0155	Butler	
010158*	0.0093	Franklin	
013027	0.0121	Baldwin	***
040014*	0.0159	White	
040019*	0.0697	St. Francis	
040047*	0.0090	Randolph	
040066*	0.0382	Clark	
040069*	0.0140	Mississippi	
040070*	0.0140	Mississippi	
040071	0.0026	Jefferson	
040076	0.1075	Hot Spring	
040100	0.0159	White	
040143	0.0026	Jefferson	
050009	0.0478	Napa	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
050013	0.0478	Napa	
050014*	0.0131	Amador	
050042*	0.0219	Tehama	
050046*	0.0156	Ventura	
050065	0.0029	Orange	
050069	0.0029	Orange	
050073*	0.0269	Solano	
050082*	0.0156	Ventura	
050084	0.0555	San Joaquin	
050089	0.0152	San Bernardino	
050090	0.0308	Sonoma	
050099	0.0152	San Bernardino	
050101	0.0269	Solano	
050117	0.0463	Merced	
050118	0.0555	San Joaquin	
050122	0.0555	San Joaquin	
050129	0.0152	San Bernardino	
050133	0.0170	Yuba	
050136	0.0308	Sonoma	
050140	0.0152	San Bernardino	
050150*	0.0316	Nevada	
050159*	0.0156	Ventura	
050167	0.0555	San Joaquin	
050168	0.0029	Orange	
050173	0.0029	Orange	
050174*	0.0308	Sonoma	
050177*	0.0156	Ventura	
050193	0.0029	Orange	
050224	0.0029	Orange	
050226	0.0029	Orange	
050230	0.0029	Orange	
050236*	0.0156	Ventura	
050245	0.0152	San Bernardino	
050253	0.0029	Orange	
050272	0.0152	San Bernardino	
050279	0.0152	San Bernardino	
050291	0.0308	Sonoma	
050298	0.0152	San Bernardino	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
050300	0.0152	San Bernardino	
050313	0.0555	San Joaquin	
050325*	0.0176	Tuolumne	
050327	0.0152	San Bernardino	
050331	0.0308	Sonoma	
050335	0.0176	Tuolumne	
050336	0.0555	San Joaquin	
050348	0.0029	Orange	
050367	0.0269	Solano	
050377	0.0062	Madera	***
050385	0.0308	Sonoma	
050394*	0.0156	Ventura	
050426	0.0029	Orange	
050444	0.0463	Merced	
050469*	0.0152	San Bernardino	
050476	0.0257	Lake	
050491	0.0029	Orange	
050494*	0.0316	Nevada	
050497	0.0463	Merced	***
050517	0.0152	San Bernardino	
050526	0.0029	Orange	
050528*	0.0463	Merced	
050535	0.0029	Orange	
050539	0.0257	Lake	
050543	0.0029	Orange	
050547	0.0308	Sonoma	
050548	0.0029	Orange	
050549*	0.0156	Ventura	
050550	0.0029	Orange	
050551	0.0029	Orange	
050567	0.0029	Orange	
050568	0.0062	Madera	
050570	0.0029	Orange	
050580	0.0029	Orange	
050584	0.0152	San Bernardino	
050585	0.0029	Orange	
050586	0.0152	San Bernardino	
050589	0.0029	Orange	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
050592	0.0029	Orange	
050594	0.0029	Orange	
050603	0.0029	Orange	
050609*	0.0029	Orange	
050616*	0.0156	Ventura	
050618*	0.0152	San Bernardino	
050667	0.0478	Napa	
050678	0.0029	Orange	
050680	0.0269	Solano	
050690*	0.0308	Sonoma	
050693	0.0029	Orange	
050695	0.0555	San Joaquin	
050720	0.0029	Orange	
050728	0.0308	Sonoma	
052035	0.0029	Orange	***
052037	0.0152	San Bernardino	***
052039	0.0029	Orange	***
053034	0.0029	Orange	***
053037	0.0152	San Bernardino	***
053304	0.0029	Orange	***
054074	0.0269	Solano	***
054077	0.0156	Ventura	***
054093	0.0152	San Bernardino	***
054111	0.0152	San Bernardino	***
054122	0.0478	Napa	***
054123	0.0555	San Joaquin	***
054141	0.0269	Solano	***
060001*	0.0294	Weld	
060003*	0.0203	Boulder	
060027*	0.0203	Boulder	
060103*	0.0203	Boulder	
070003*	0.0009	Windham	
070006*	0.0047	Fairfield	
070010*	0.0047	Fairfield	
070018*	0.0047	Fairfield	
070020	0.0073	Middlesex	
070021*	0.0009	Windham	
070028*	0.0047	Fairfield	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
070033*	0.0047	Fairfield	
070034*	0.0047	Fairfield	
074000	0.0047	Fairfield	***
074007	0.0073	Middlesex	***
074008	0.0009	Windham	***
074014	0.0047	Fairfield	***
100014	0.0118	Volusia	
100017	0.0118	Volusia	
100045*	0.0118	Volusia	
100047	0.0021	Charlotte	
100062	0.0060	Marion	
100068	0.0118	Volusia	
100072	0.0118	Volusia	
100077	0.0021	Charlotte	
100118	0.0398	Flagler	
100175	0.0231	De Soto	
100212	0.0060	Marion	
100232	0.0347	Putnam	
100236	0.0021	Charlotte	
100252	0.0233	Okeechobee	
110023*	0.0500	Gordon	
110027	0.0387	Franklin	
110029*	0.0063	Hall	
110041*	0.0777	Habersham	
110063	0.0290	Liberty	
110069	0.0474	Houston	
110120*	0.0873	Polk	
110124	0.0428	Wayne	
110136	0.0261	Baldwin	
110150*	0.0261	Baldwin	
110153	0.0474	Houston	
110187*	0.1172	Lumpkin	
110189*	0.0031	Fannin	
110190	0.0182	Macon	
110205*	0.0779	Gilmer	
130003*	0.0095	Nez Perce	
130011	0.0218	Latah	
130024	0.0275	Bonner	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
130049*	0.0349	Kootenai	
140012*	0.0220	Lee	
140026	0.0346	La Salle	
140033	0.0147	Lake	
140043*	0.0046	Whiteside	
140058*	0.0081	Morgan	
140084	0.0147	Lake	
140100	0.0147	Lake	
140110*	0.0346	La Salle	
140129*	0.0096	Wabash	
140130	0.0147	Lake	
140155*	0.0027	Kankakee	
140160*	0.0286	Stephenson	
140161*	0.0138	Livingston	
140173*	0.0046	Whiteside	
140186*	0.0027	Kankakee	
140202	0.0147	Lake	
140205	0.0163	Boone	
140234*	0.0346	La Salle	
140291	0.0147	Lake	
150022	0.0249	Montgomery	
150030*	0.0201	Henry	
150035	0.0083	Porter	
150045	0.0416	De Kalb	
150062	0.0153	Decatur	
150065*	0.0139	Jackson	
150076*	0.0189	Marshall	
150088	0.0196	Madison	
150091	0.0573	Huntington	
150102*	0.0160	Starke	
150113	0.0196	Madison	
150122	0.0199	Ripley	
160013	0.0218	Muscatine	
160026*	0.0496	Boone	
160032	0.0272	Jasper	
160080*	0.0049	Clinton	
160140	0.0364	Plymouth	
180012*	0.0083	Hardin	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
180066*	0.0567	Logan	
180127*	0.0352	Franklin	
180128	0.0282	Lawrence	
183028	0.0083	Hardin	***
190001*	0.0645	Washington	
190003*	0.0107	Iberia	
190010	0.0401	Tangipahoa	
190015*	0.0401	Tangipahoa	
190017	0.0235	St. Landry	
190049	0.0645	Washington	
190054*	0.0107	Iberia	
190078	0.0235	St. Landry	
190088	0.0705	Webster	
190099*	0.0390	Avoyelles	
190106*	0.0238	Allen	
190133	0.0238	Allen	
190144	0.0705	Webster	
190147*	0.0401	Tangipahoa	
190148*	0.0390	Avoyelles	
190191	0.0235	St. Landry	
193044	0.0401	Tangipahoa	***
200002*	0.0129	Lincoln	
200013	0.0186	Waldo	
200024*	0.0071	Androscoggin	
200034*	0.0071	Androscoggin	
200050*	0.0140	Hancock	
210001	0.0129	Washington	
210004	0.0040	Montgomery	
210016	0.0040	Montgomery	
210018	0.0040	Montgomery	
210022	0.0040	Montgomery	
210023	0.0209	Anne Arundel	
210043	0.0209	Anne Arundel	
210048	0.0287	Howard	
210057	0.0040	Montgomery	
220001	0.0056	Worcester	
220002	0.0249	Middlesex	
220003	0.0056	Worcester	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
220006	0.0306	Essex	
220010	0.0306	Essex	
220011	0.0249	Middlesex	
220019	0.0056	Worcester	
220025	0.0056	Worcester	
220028	0.0056	Worcester	
220029	0.0306	Essex	
220033	0.0306	Essex	
220035	0.0306	Essex	
220049	0.0249	Middlesex	
220058	0.0056	Worcester	
220062	0.0056	Worcester	
220063	0.0249	Middlesex	
220070	0.0249	Middlesex	
220076	0.0249	Middlesex	
220080	0.0306	Essex	
220082	0.0249	Middlesex	
220084	0.0249	Middlesex	
220089	0.0249	Middlesex	
220090	0.0056	Worcester	
220095	0.0056	Worcester	
220098	0.0249	Middlesex	
220101	0.0249	Middlesex	
220105	0.0249	Middlesex	
220163	0.0056	Worcester	
220171	0.0249	Middlesex	
220174	0.0306	Essex	
222000	0.0249	Middlesex	***
222026	0.0306	Essex	***
222044	0.0306	Essex	***
223026	0.0249	Middlesex	***
223028	0.0306	Essex	***
223029	0.0056	Worcester	***
223033	0.0056	Worcester	***
224007	0.0249	Middlesex	***
224022	0.0249	Middlesex	***
230003*	0.0035	Ottawa	
230013*	0.0091	Oakland	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
230015	0.0359	St. Joseph	
230019*	0.0091	Oakland	
230021	0.0136	Berrien	
230022*	0.0113	Branch	
230029*	0.0091	Oakland	
230037*	0.0178	Hillsdale	
230041	0.0099	Bay	
230042*	0.0685	Allegan	
230047	0.0082	Macomb	
230069	0.0487	Livingston	
230071*	0.0091	Oakland	
230072*	0.0035	Ottawa	
230075	0.0145	Calhoun	
230078*	0.0136	Berrien	
230092	0.0389	Jackson	
230093*	0.0079	Mecosta	
230096*	0.0359	St. Joseph	
230099	0.0339	Monroe	
230106*	0.0030	Newaygo	
230121*	0.0691	Shiawassee	
230130*	0.0091	Oakland	
230151*	0.0091	Oakland	
230174*	0.0035	Ottawa	
230184	0.0389	Jackson	
230195	0.0082	Macomb	
230204	0.0082	Macomb	
230207*	0.0091	Oakland	
230217	0.0145	Calhoun	
230222	0.0228	Midland	
230223*	0.0091	Oakland	
230227	0.0082	Macomb	
230254*	0.0091	Oakland	
230257	0.0082	Macomb	
230264	0.0082	Macomb	
230269*	0.0091	Oakland	
230277*	0.0091	Oakland	
230279	0.0487	Livingston	
230295	0.0685	Allegan	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
232025	0.0136	Berrien	***
232028	0.0145	Calhoun	***
233025	0.0145	Calhoun	***
233028	0.0091	Oakland	***
234011	0.0091	Oakland	***
234021	0.0082	Macomb	***
234023	0.0091	Oakland	***
240011*	0.0506	Mc Leod	
240013*	0.0226	Morrison	
240014	0.0454	Rice	
240018*	0.1196	Goodhue	
240044	0.0868	Winona	
240064*	0.0138	Itasca	
240069*	0.0419	Steele	
240071*	0.0454	Rice	
240089*	0.1196	Goodhue	
240133	0.0319	Meeker	
240152*	0.0735	Kanabec	
240154	0.0138	Itasca	
240187*	0.0506	Mc Leod	
240205	0.0138	Itasca	
240211*	0.0705	Pine	
250030*	0.0318	Leake	
250040	0.0294	Jackson	
250045	0.0042	Hancock	
250088*	0.0122	Wilkinson	
250154*	0.0318	Leake	
260011*	0.0007	Cole	
260047*	0.0007	Cole	
260074	0.0158	Randolph	
260097	0.0425	Johnson	
260127	0.0158	Pike	
280054*	0.0137	Gage	
280077*	0.0089	Dodge	
280123	0.0137	Gage	
290019*	0.0026	Carson City	
293029	0.0026	Carson City	***
300017	0.0361	Rockingham	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
300023	0.0361	Rockingham	
300029	0.0361	Rockingham	
303026	0.0361	Rockingham	***
310002*	0.0351	Essex	
310009	0.0351	Essex	
310013	0.0351	Essex	
310018	0.0351	Essex	
310038*	0.0350	Middlesex	
310039	0.0350	Middlesex	
310054	0.0351	Essex	
310070*	0.0350	Middlesex	
310076*	0.0351	Essex	
310078	0.0351	Essex	
310083	0.0351	Essex	
310093	0.0351	Essex	
310096	0.0351	Essex	
310108	0.0350	Middlesex	
310119*	0.0351	Essex	
313025	0.0351	Essex	***
314011	0.0350	Middlesex	***
320018	0.0063	Dona Ana	
320085	0.0063	Dona Ana	
330001	0.0560	Orange	
330004*	0.0959	Ulster	
330008*	0.0470	Wyoming	
330027*	0.0137	Nassau	
330094**	0.0778	Columbia	
330106*	0.0137	Nassau	
330126*	0.0560	Orange	
330135*	0.0560	Orange	
330167	0.0137	Nassau	
330181*	0.0137	Nassau	
330182*	0.0137	Nassau	
330191	0.0026	Warren	
330198	0.0137	Nassau	
330205*	0.0560	Orange	
330209	0.0560	Orange	
330224*	0.0959	Ulster	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
330225	0.0137	Nassau	
330235*	0.0270	Cayuga	
330259	0.0137	Nassau	
330264*	0.0560	Orange	
330276	0.0063	Fulton	
330331	0.0137	Nassau	
330332	0.0137	Nassau	
330333	0.0137	Nassau	
330372	0.0137	Nassau	
330386*	0.1139	Sullivan	
330402	0.0959	Ulster	
340015	0.0267	Rowan	
340020	0.0207	Lee	
340021*	0.0216	Cleveland	
340037	0.0216	Cleveland	
340039*	0.0144	Iredell	
340069	0.0053	Wake	
340070	0.0448	Alamance	
340073	0.0053	Wake	
340085	0.0377	Davidson	
340088*	0.0115	Transylvania	
340096	0.0377	Davidson	
340104	0.0216	Cleveland	
340114	0.0053	Wake	
340126*	0.0161	Wilson	
340127*	0.0961	Granville	
340129*	0.0144	Iredell	
340138	0.0053	Wake	
340144*	0.0144	Iredell	
340145*	0.0563	Lincoln	
340173	0.0053	Wake	
344014	0.0053	Wake	***
360013	0.0166	Shelby	
360025*	0.0087	Erie	
360034	0.0263	Wayne	
360036*	0.0263	Wayne	
360065*	0.0141	Huron	
360070	0.0028	Stark	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
360078*	0.0159	Portage	
360084	0.0028	Stark	
360086	0.0168	Clark	
360093	0.0120	Defiance	
360095*	0.0087	Hancock	
360099*	0.0087	Hancock	
360100	0.0028	Stark	
360107*	0.0213	Sandusky	
360131	0.0028	Stark	
360151	0.0028	Stark	
360156	0.0213	Sandusky	
360175*	0.0159	Clinton	
360187	0.0168	Clark	
360197*	0.0092	Logan	
362007	0.0213	Sandusky	***
370004*	0.0193	Ottawa	
370014*	0.0831	Bryan	
370015*	0.0463	Mayes	
370023	0.0084	Stephens	
370043*	0.0294	Marshall	
370065	0.0121	Craig	
370113*	0.0205	Delaware	
370149	0.0356	Pottawatomie	
370179	0.0314	Okfuskee	
380002	0.0130	Josephine	
380008*	0.0201	Linn	
380022*	0.0201	Linn	
390011	0.0012	Cambria	
390044	0.0200	Berks	
390046	0.0098	York	
390056	0.0042	Huntingdon	
390065*	0.0501	Adams	
390066	0.0259	Lebanon	
390096	0.0200	Berks	
390101	0.0098	York	
390110*	0.0012	Cambria	
390130	0.0012	Cambria	
390138*	0.0325	Franklin	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
390146	0.0053	Warren	
390150*	0.0206	Greene	
390151*	0.0325	Franklin	
390201*	0.1127	Monroe	
390233	0.0098	York	
393026	0.0200	Berks	***
393037	0.0098	York	***
394020	0.0259	Lebanon	***
420007	0.0001	Spartanburg	
420020*	0.0035	Georgetown	
420027	0.0210	Anderson	
420030*	0.0103	Colleton	
420043	0.0177	Cherokee	
420068*	0.0097	Orangeburg	
420070*	0.0101	Sumter	
420083	0.0001	Spartanburg	
420093	0.0001	Spartanburg	
420098	0.0035	Georgetown	
440008*	0.0663	Henderson	
440024	0.0387	Bradley	
440035	0.0441	Montgomery	
440047	0.0499	Gibson	
440056	0.0321	Jefferson	
440060*	0.0499	Gibson	
440063	0.0011	Washington	
440073*	0.0513	Maury	
440105	0.0011	Washington	
440114	0.0523	Lauderdale	
440115	0.0499	Gibson	
440143	0.0448	Marshall	
440148*	0.0568	De Kalb	
440174	0.0372	Haywood	
440181	0.0407	Hardeman	
440184	0.0011	Washington	
440185*	0.0387	Bradley	
450032*	0.0416	Harrison	
450039	0.0097	Tarrant	
450050	0.0750	Ward	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
450059	0.0073	Comal	
450064	0.0097	Tarrant	
450087	0.0097	Tarrant	
450099*	0.0180	Gray	
450113	0.0195	Anderson	
450121	0.0097	Tarrant	
450135	0.0097	Tarrant	
450137	0.0097	Tarrant	
450144*	0.0573	Andrews	
450163	0.0134	Kleberg	
450187*	0.0264	Washington	
450194*	0.0328	Cherokee	
450214*	0.0368	Wharton	
450224*	0.0411	Wood	
450347*	0.0427	Walker	
450362	0.0486	Burnet	
450370	0.0258	Colorado	
450389*	0.0881	Henderson	
450395	0.0484	Polk	
450419	0.0097	Tarrant	
450438	0.0258	Colorado	
450447*	0.0358	Navarro	
450451*	0.0551	Somervell	
450465	0.0435	Matagorda	
450547*	0.0411	Wood	
450563*	0.0097	Tarrant	
450596	0.0808	Hood	
450597	0.0077	De Witt	
450623*	0.0492	Fannin	
450626	0.0294	Jackson	
450639	0.0097	Tarrant	
450672	0.0097	Tarrant	
450675	0.0097	Tarrant	
450677	0.0097	Tarrant	
450694*	0.0368	Wharton	
450747*	0.0195	Anderson	
450755*	0.0484	Hockley	
450763	0.0236	Hutchinson	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
450779	0.0097	Tarrant	
450813	0.0195	Anderson	
450858	0.0097	Tarrant	
452018	0.0097	Tarrant	***
452019	0.0097	Tarrant	***
452028	0.0097	Tarrant	***
453040	0.0097	Tarrant	***
453041	0.0097	Tarrant	***
453042	0.0097	Tarrant	***
453300	0.0097	Tarrant	***
454012	0.0097	Tarrant	***
460017	0.0392	Box Elder	
460036*	0.0700	Wasatch	
460039*	0.0392	Box Elder	
470018	0.0287	Windsor	
470023	0.0118	Caledonia	
490019	0.1240	Culpepper	
490038	0.0022	Smyth	
490047*	0.0198	Page	
490084	0.0167	Essex	
490105	0.0022	Smyth	
490110	0.0082	Montgomery	
500003*	0.0208	Skagit	
500007	0.0208	Skagit	
500019	0.0213	Lewis	
500021	0.0055	Pierce	
500024	0.0023	Thurston	
500039*	0.0174	Kitsap	
500041*	0.0118	Cowlitz	
500079	0.0055	Pierce	
500108	0.0055	Pierce	
500118*	0.0548	Mason	
500122*	0.0459	Island	
500129	0.0055	Pierce	
500139	0.0023	Thurston	
500143	0.0023	Thurston	
510018*	0.0209	Jackson	
510028*	0.0141	Fayette	

1 Provider Number	2 Out-Migration Adjustment	3 Qualifying County Name	4 TEFRA
510039	0.0112	Ohio	
510047*	0.0275	Marion	
510050	0.0112	Ohio	
510088	0.0141	Fayette	
513025	0.0112	Ohio	***
520028*	0.0157	Green	
520035	0.0077	Sheboygan	
520042	0.0118	Sauk	
520044	0.0077	Sheboygan	
520057	0.0118	Sauk	
520059*	0.0200	Racine	
520071*	0.0239	Jefferson	
520094*	0.0200	Racine	
520095	0.0118	Sauk	
520096*	0.0200	Racine	
520102*	0.0298	Walworth	
520116*	0.0239	Jefferson	
520132	0.0077	Sheboygan	
522005	0.0200	Racine	***

BILLING CODE 4210-01-C

IV. Waiver of Proposed Rulemaking and Delayed Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice such as this are effective in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). We also ordinarily provide a 30-day delay in the effective date of the provisions of a notice in accordance with section 553(d) of the APA (5 U.S.C. 553(d)). However, we can waive both the notice-and-comment procedure and the 30-day delay in effective date if the Secretary finds, for good cause, that it is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the notice.

We find it unnecessary to undertake notice-and-comment rulemaking because this correction notice merely provides minor technical and typographical corrections and does not make any substantive changes to the regulations. In addition, while we are presenting information regarding the wage index tables, we are not changing our payment methodology. We are

adopting the IPPS wage indices and applying the methodology that has already been subject to public comment and subsequently finalized. As we stated in the OPPS final rule, we are now presenting the information regarding the wage index tables that was not available when the final rule was published. Thus, because the corrections are technical and typographical in nature, and the public has already been given the opportunity to comment on our method for calculating the wage adjustment factor and was informed earlier that the finalized wage index tables would be provided in a subsequent **Federal Register** document, we believe additional comment would be unnecessary.

Further, we believe a delayed effective date is unnecessary because this notice merely corrects inadvertent technical errors and provides the tables that display the wage index values applicable for the OPPS as explained in the OPPS final rule (69 FR 65842). There is no significant effect on the payment rates for any provider. Further, we believe imposing a 30-day delay in the effective date would be contrary to the public interest for outpatient providers. To the extent that any

provider's rates are affected, we believe that it is imperative that appropriate wage index values are applied in as timely a manner as possible, and that any delay in applying the appropriate wage index values would be contrary to the public interest. Therefore, we find good cause to waive notice-and-comment procedures, as well as the 30-day delay in effective date.

Authority: Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)). (Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 21, 2004.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 04-28253 Filed 12-22-04; 1:00 pm]

BILLING CODE 4210-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Part 422****[CMS-4041-IFC]****RIN 0938-AK71****Medicare Program; Modifications to Managed Care Rules****AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Interim final rule with comment period.

SUMMARY: This interim final rule with comment period corrects a technical error made in the August 22, 2003 final rule "Modifications to Medicare Rules" (68 FR 50840).

DATES: This interim final rule with comment period is effective January 31, 2005.

Comment date: To ensure consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on February 28, 2005.

ADDRESSES: In commenting, please refer to file code CMS-4041-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments to <http://www.cms.hhs.gov/regulations/ecomments> or to www.regulations.gov (attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-4041-IFC, P.O. Box 8010, Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7197 in advance to schedule your arrival with one of our staff members. Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue,

SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Tony Hausner, (410) 786-1093.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS-4041-IFC and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public website. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786-7197.

I. Background

[If you choose to comment on issues in this section, please include the caption "BACKGROUND" at the beginning of your comments.]

On August 22, 2003, we published a final rule titled, "Modifications to Managed Care Rules" (68 FR 50840), which implemented the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), which included certain

changes to the intermediate sanctions regulations at 42 CFR 422.758.

In that final rule, we made limited organizational changes to the intermediate sanctions regulations (68 FR 50841); however, when making those organizational changes, we made technical errors in § 422.752 and § 422.758. Specifically, the \$25,000 Civil Money Penalty (CMP) that had been described at § 422.758(a) was inadvertently omitted in the revised version of the intermediate sanctions regulation. We note that these CMPs are set forth at section 1857(g)(3)(A) of the Social Security Act (Act) and provide authority for the Secretary to apply up to a \$25,000 penalty for each determination under section 1857(c)(2) that a deficiency not otherwise described in section 1857(g)(1) of the Act exists and has directly and adversely affected (or has the substantial likelihood of adversely affecting) one or more Medicare Advantage (MA) enrollees.

The omission of the \$25,000 CMP from § 422.758(a) occurred because we included language in § 422.758(a) that was intended to replace the first two sentences of § 422.752(a). This language clarifies that CMS does not have CMP authority in the case of the violations set forth in § 422.752(a). The OIG has CMP authority in the case of these violations. In the preamble to our August 22, 2003 final rule, we noted that we were changing § 422.752(a) for this purpose (68 FR 50851). However, the regulatory text was inadvertently placed at § 422.758(a).

We also have determined that the reference to § 422.756(f)(3) in existing § 422.758(b) more appropriately belongs in the introductory text of § 422.758 because our authority to impose CMPs in the amounts set forth in all of § 422.758 is described in § 422.756(f)(3). Section § 422.758(b) also contains a redundant reference to § 422.752(b), which we are eliminating, in this interim final rule with comment period, to avoid confusion.

Section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final

regulation except under exceptional circumstances.

This interim final rule finalizes provisions set forth in the August 22, 2003 final rule. We will publish the final rule within the 3-year time limit imposed by section 902 of the MMA. Therefore, we believe that the interim final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

II. Provisions of the Interim Final Rule

[If you choose to comment on issues in this section, please include the caption "PROVISIONS OF THE INTERIM FINAL RULE" at the beginning of your comments.]

To ensure that the Medicare regulations are an accurate reflection of our current statutory authority to impose CMPs, in this interim final rule with comment period, we are correcting § 422.758 to state that if we make a determination under § 422.752(b), based on any determination under § 422.510(a) except a determination under § 422.510(a)(4), we may impose civil money penalties, pursuant to § 422.756(f)(3), in the following amounts:

- If the deficiency on which the determination is based has directly adversely affected (or has the substantial likelihood of adversely affecting) one or more MA enrollees—up to \$25,000 for each determination.
- For each week that a deficiency remains uncorrected after the week in which the MA organization receives CMS' notice of the determination—up to \$10,000.
- If we make a determination, based on a determination under § 422.510(a)(1), that an MA organization has terminated its contract with us in a manner other than as described under § 422.512—\$250 per Medicare enrollee from the terminated MA plan or plans at the time the MA organization terminated its contract, or \$100,000, whichever is greater.

In addition, we are correcting § 422.752(a) to incorporate the changes that we intended to make in the August 22, 2003 final rule (and which currently appear at § 422.758(a)) to provide that for the violations listed in § 422.752(a), we may impose the sanctions specified in § 422.750(a)(2), (a)(3), or (a)(4) on any MA organization that has a contract in effect. The MA organization may also be subject to other applicable remedies available under law.

III. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them

individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We find for good cause that it is unnecessary to undertake notice and comment procedures because this correcting amendment does not make any substantive policy changes. This correcting amendment sets forth self-implementing provisions of the Act (as described above) with respect to the imposition of CMPs. Because the rule directly conforms to the statute and does not articulate new requirements, we believe that pursuing notice and comment is unnecessary. Moreover, because that process could introduce confusion regarding our current authority to impose CMPs, we find that pursuing that process would be both impracticable and contrary to the public interest. Therefore, for good cause, we waive notice and comment procedures under 5 U.S.C. 553(b)(B).

With respect to the requirement of a 60-day delay in the effective date of any final rule under the Congressional Review Act (CRA) (see U.S.C. section 801), the CRA provides that the 60-day delayed effective date shall not apply to any rule "which an agency for good cause finds that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest." (See 5 U.S.C. section 808(2).) For the reasons set forth above, we believe that additional notice and comment rulemaking on this subject would be impracticable, unnecessary, or contrary to the public interest. Therefore, we do not believe that the CRA requires a 60-day delay in the effective date of this final rule.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Regulatory Impact

[If you choose to comment on issues in this section, please include the caption "REGULATORY IMPACT" at the beginning of your comments.]

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 million to \$29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 for final rules 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 we have determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This interim final rule with comment period does not have any costs associated with this requirement and will not approach the Unfunded Mandates Reform Act threshold.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 422

Administrative practice and procedure, Health facilities, Health Maintenance Organizations (HMO), Medicare+Choice, Penalties, Privacy, Provider-sponsored organizations (PSO), Reporting and recordkeeping requirements.

■ Accordingly, 42 CFR chapter IV is corrected by making the following correcting amendments:

PART 422—MEDICARE ADVANTAGE PROGRAM

■ 1. The authority citation for part 422 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 422.752(a) introductory text is revised to read as follows:

§ 422.752 Basis for imposing sanctions.

(a) All intermediate sanctions. For the violations listed in this paragraph (a), we may impose the sanctions specified in § 422.750(a)(2), (a)(3), or (a)(4) on any MA organization that has a contract in effect. The MA organization may also be

subject to other applicable remedies available under law.

* * * * *

■ 3. Section 422.758 is revised to read as follows:

§ 422.758 Maximum amount of civil money penalties imposed by CMS.

If CMS makes a determination under § 422.752(b), based on any determination under § 422.510(a) except a determination under § 422.510(a)(4), CMS may impose civil money penalties, pursuant to § 422.756(f)(3), in the following amounts:

(a) If the deficiency on which the determination is based has directly adversely affected (or has the substantial likelihood of adversely affecting) one or more Medicare Advantage enrollees—up to \$25,000 for each determination.

(b) For each week that a deficiency remains uncorrected after the week in which the Medicare Advantage organization receives CMS' notice of the determination—up to \$10,000.

(c) If CMS makes a determination, based on a determination under § 422.510(a)(1) that a Medicare Advantage organization has terminated its contract with CMS in a manner other than as described under § 422.512—\$250 per Medicare enrollee from the terminated Medicare Advantage plan or plans at the time the Medicare Advantage organization terminated its contract, or \$100,000, whichever is greater.

Dated: June 23, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: September 8, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04-28155 Filed 12-29-04; 8:45 am]

BILLING CODE 4120-01-P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 0, 4 and 63

[ET Docket No. 04-35; FCC 04-188]

Disruptions to Communications

AGENCY: Federal Communications Commission.

ACTION: Final rule; announcement of effective date.

SUMMARY: The Federal Communications Commission announces the effective date for Part 4, Disruptions to Communications, and the amendments to § 63.100, Notification of service outage, which also contain information

collection requirements subject to approval by OMB. Furthermore, the Federal Communications Commission has received approval from the Office of Management and Budget (OMB) for the new and/or revised information collection requirements contained in the information collection 3060-0484, "New Part 4 of the Commission's Rules Concerning Disruptions to Communications."

DATES: Part 4 and the amendments to § 63.100, published at 69 FR 70316 (December 3, 2004), and the information collection requirements contained therein are effective January 3, 2005.

FOR FURTHER INFORMATION CONTACT: Charles Iseman at (202) 418-2444, charles.iseман@fcc.gov, Office of Engineering and Technology, TTY (202) 418-2989.

SUPPLEMENTARY INFORMATION: The FCC published a document in the **Federal Register** of December 3, 2004 (69 FR 70316) that set forth an effective date of January 3, 2005, except for part 4 and the amendments to § 63.100, which contain information collection requirements that had not been approved by the Office of Management and Budget. The document stated that the Commission will publish a document in the **Federal Register** announcing the effective date for part 4 and the amendments to § 63.100, and the information collection requirements contained therein. On December 21, 2004, OMB approved the information collection requirements for 3060-0484, "Part 4 of the Commission's Rules Concerning Disruptions to Communications." Therefore, by this Notice, the Commission announces that the effective date for part 4 and the amendments to § 63.100, and the information collection requirements contained therein (3060-0484), will be January 3, 2005. The expiration date for the information collection requirements will be December 31, 2007.

Under OMB's terms of clearance, OMB's approval of the information collection is based on the Commission's Order Granting Partial Stay, FCC 04-291, adopted December 20, 2004 and released December 22, 2004. That Order grants an immediate partial stay of the provisions of paragraph 134 of the Report and Order (summarized as 69 FR 70316, December 3, 2004) insofar as it requires the reporting as outages of DS3 simplex events that are not corrected within five days of their discovery. At this time, the duration of the partial stay is unknown and the Commission continues discussions with both homeland security officials and impacted industry representatives. The

Commission has committed to seek public comment on this matter.

Pursuant to the Paperwork Reduction Act of 1995, Public Law 104-13, an agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. Notwithstanding any other provisions of law, no person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Questions concerning this information collection, 3060-0484, should be directed to Leslie F. Smith, Federal Communications Commission, (202) 418-0217 or via the Internet at Leslie.Smith@fcc.gov.

Federal Communications Commission.

Marlene H. Dortch,
Secretary.

[FR Doc. 04-28504 Filed 12-29-04; 8:45 am]

BILLING CODE 6712-01-P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[CG Docket No. 02-278; FCC 04-204]

Rules and Regulations Implementing the Telephone Consumer Protection Act of 1991

AGENCY: Federal Communications Commission.

ACTION: Final rule; announcement of effective date.

SUMMARY: In this document, the Commission announces that the Office of Management and Budget (OMB) has approved for three years the information collections contained in the Commission's amended telemarketing rule at 47 CFR 64.1200(c)(2)(i)(D). FCC

announces the effective date for § 64.1200(c)(2)(i)(D).

DATES: 47 CFR 64.1200(c)(2)(i)(D), published at 69 FR 60311, October 8, 2004, is effective January 1, 2005.

ADDRESSES: Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT:

Erica H. McMahon at 202-418-2512, Consumer & Governmental Affairs Bureau, Erica.McMahon@fcc.gov.

SUPPLEMENTARY INFORMATION: On July 3, 2003, the Commission released a *Report and Order, In the Matter of Rules and Regulations Implementing the Telephone Consumer Protection Act of 1991*, published at 68 FR 44144, July 25, 2003. On September 29, 2003, OMB approved for three years the information collections contained in the Commission's telemarketing rules at section 64.1200. On September 21, 2004, the Commission released an *Order, In the Matter of Rules and Regulations Implementing the Telephone Consumer Protection Act of 1991*, published at 69 FR 60311, October 8, 2004, in which the Commission revised one of its telemarketing rules, 47 CFR 64.1200(c)(2)(i)(D), to require telemarketers to access the national registry every 31 days, rather than every 3 months in order to qualify for the safe harbor protections. The Commission publishes this notice of the effective date of the information collection requirement contained in 47 CFR 64.1200(c)(2)(i)(D). The information collection requirement was approved by OMB on December 21, 2004. OMB Control No. 3060-0519. If you have any comments on the burden estimates, or how we can improve the collection(s) and reduce the burden(s) they cause you, please write to Les Smith, Federal Communications Commission, Room 1-A804, 445 12th Street, SW.,

Washington, DC 20554. Please include the OMB Control Number, 3060-0519, in your correspondence. We will also accept your comments regarding the Paperwork Reduction Act aspects of the collections via the Internet, if you send them to Leslie.Smith@fcc.gov or call (202) 418-0217.

Synopsis

As required by the Paperwork Reduction Act of 1995 (44 U.S.C. 3507), the FCC is notifying the public that it received approval for three years from OMB on December 21, 2004 for the collection(s) of information contained in the Commission's amended telemarketing rule at 47 CFR 64.1200(c)(2)(i)(D). Due to the modification to 47 CFR 64.1200(c)(2)(i)(D), the revised annual reporting burden for this collection(s) of information, including the time for gathering and maintaining the collection of information, is estimated to be: 144,497 responses, a total annual hour burden of 1,851,600 hours, and \$4,361,000 in total annual costs. Under 5 CFR 1320, an agency may not conduct or sponsor a collection of information unless it displays a current valid OMB Control Number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid OMB Control Number. The OMB Control Number is 3060-0519.

The foregoing notice is required by the Paperwork Reduction Act of 1995, Public Law 104-13, October 1, 1995, 44 U.S.C. 3507.

Federal Communications Commission.

Marlene H. Dortch,
Secretary.

[FR Doc. 04-28505 Filed 12-29-04; 8:45 am]

BILLING CODE 6712-01-P

Proposed Rules

Federal Register

Vol. 69, No. 250

Thursday, December 30, 2004

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

7 CFR Parts 210, 215 and 220

RIN 0584-AD38

Procurement Requirements for the National School Lunch, School Breakfast and Special Milk Programs

AGENCY: Food and Nutrition Service, USDA.

ACTION: Proposed rule.

SUMMARY: This rule proposes to amend the regulations governing procedures related to the procurement of goods and services in the National School Lunch Program, School Breakfast Program and Special Milk Program to remedy deficiencies identified in audits and program reviews. This proposal makes changes in three areas: the school food authority's responsibility for proper procurement procedures and contracts; prohibitions on the school food authority's use of nonprofit school food service account funds for costs resulting from improper procurements and contracts; and the State agency's review and approval of school food authority procurement procedures and contracts. The proposed rule also makes technical amendments to the Special Milk Program and School Breakfast Program regulations to make the procurement and contract requirements and consequences for failing to take corrective action in these regulations consistent with the National School Lunch Program regulations and adds the definitions of contractor and nonprofit school food service account to the National School Lunch Program, Special Milk Program and School Breakfast Program regulations. These changes are intended to promote free and open competition in school food authority procurements, clarify State agency rights and ensure that only allowable contract costs are paid with nonprofit school food service account funds.

DATES: To be assured of consideration, comments must be received on or before February 28, 2005.

ADDRESSES: The Food and Nutrition Service invites interested persons to submit comments on this proposed rule. Comments may be submitted by any of the following methods:

- E-Mail: Send comments to CNDPROPOSAL@FNS.USDA.GOV, (In the subject line of the message, identify that the comments are for the CND proposed procurement rule.
- Fax: Submit comments by facsimile transmission to: (703) 305-2879, attention Terry Hallberg.
- Mail: Comments should be addressed to Mr. Terry Hallberg, Chief, Program Analysis and Monitoring Branch, Food and Nutrition Service, Department of Agriculture, 3101 Park Center Drive, Room 640, Alexandria, Virginia 22302-1594. All written submissions will be available for public inspection at this location Monday through Friday, 8:30 a.m. to 5 p.m.
- Hand Delivery or Courier: Deliver comments to 3101 Park Center Drive, Room 640, Alexandria, Virginia 22302-1594, during normal business hours of 8:30 a.m. to 5 p.m.
- Federal eRulemaking Portal: Go to <http://www.regulations.gov>. Follow the online instructions for submitting comments.

FOR FURTHER INFORMATION CONTACT: Denise Londos or Todd J. Barrett at the above address or by telephone at 703-305-2590.

SUPPLEMENTARY INFORMATION:

I. Background

Generally, schools manage the school meals programs under the Department's Child Nutrition Programs—the National School Lunch Program, School Breakfast Program and Special Milk Program, on their own. School food service activities are self-managed by local school food authority officials. In conducting these activities, school food authorities manage the school meals programs but contract with vendors for goods and services related to the school food service operation, using either fixed price or cost reimbursable contracts. Under a fixed price award, the resulting contract has a firm fixed price, with or without adjustments. In a cost-reimbursable contract or contract with cost-reimbursable provisions, the school food authority pays the

contractor for certain costs incurred by the contractor, with or without a fixed fee for services. The vast majority of these contractors are commercial enterprises.

In other situations, school food authorities operating the National School Lunch Program and/or the School Breakfast Program contract with a commercial enterprise or nonprofit organization to manage the school meal programs. These companies are collectively known as food service management companies. These contracts may be either fixed price or cost-reimbursable. The vast majority of these contractors are commercial enterprises.

School food authorities use funds from the nonprofit school food service account to pay for costs incurred under both self-managed and food service management company contracted programs. The funds in the nonprofit school food service account come from federal and nonfederal sources. The federal funds are provided as reimbursements through the Department's Child Nutrition Programs for meals and milk meeting the requirements in 7 CFR 210.10, 215.7 and 220.8 that are served to eligible children. The primary sources of nonfederal revenue are student payments, adult payments and a la carte sales revenue. Additional funding sources include State and local funds and sales revenue from vending and catering activities. Regardless of the source, the school food authority must retain all of these revenues in the restricted nonprofit school food service account and may only expend these revenues for the allowable costs of the school food authority's nonprofit school food service program. The allowability of the expenditures is determined using the applicable program and departmental regulations (7 CFR Parts 210, 215, 220, 3016 and 3019, as applicable) and Office of Management and Budget Cost Circulars (A-87 Cost Principles for State, Local Governments and Indian Tribal Governments or A-122 Cost Principles for Non-profit Organizations, as applicable).

A school food authority is permitted to engage in other activities that are outside of the scope of the nonprofit school food service; however the school food authority must ensure none of the resources of its nonprofit school food

service subsidize the costs of such activities. Some examples of these nonprogram activities include food service catering to the community and individuals, providing food and nonfood supplies for school functions such as graduation ceremonies, sports banquets and school club meetings, etc., sales of meals to school non-student visitors, and allowing school food service facilities and equipment to be used by other school or community groups. The direct and indirect costs of these activities are not Child Nutrition Program charges to the nonprofit school food service account. As a result, these costs must be fully funded by the revenues received from such activities or from sources outside the nonprofit school food service account.

II. Discussion of the Rule's Provisions

A. Procurement Procedures

Regardless of the requested goods or services or the procurement method used, all procurements must be conducted in a manner that provides full and open competition. When conducting a procurement, a public school food authority must follow its own procurement procedures that reflect applicable State and local laws, provided that the procurement complies with the standards set forth in Department regulation 7 CFR 3016.36(b) through (i) and 3016.60(b) through (c). Similarly, a State agency conducting a procurement on behalf of one or more school food authority or other Child Nutrition Program participant would follow those same Department regulations. A not for profit school food authority may opt to follow its own organizational procedures for procurements made with nonprofit school food service account funds provided the procedures comply with the standards set forth in 7 CFR 3019.40 through 3019.48.

The procurement procedures used by school food authorities are either formal or informal. Formal procurement procedures use either sealed bids or competitive proposals and must be used when the proposed purchase will exceed the small purchase threshold. Formal procurement procedures require public advertising and direct solicitation of potential suppliers with written responses from the potential suppliers. Formal procurements also require the use of specific forms and processes that must be followed depending upon the formal procurement procedure chosen. The informal or small purchase procurement procedure is used for purchases that are

not expected to exceed the small purchase threshold.

In a small purchase procurement, an adequate number of suppliers are contacted to obtain price quotations. While obtaining written price quotations and contacting at least three suppliers is recommended, the number of suppliers that should be contacted depends on the marketplace. This means in some areas with a large number of suppliers, more than three suppliers should be contacted, while in other areas, less than three suppliers may exist.

Full and open competition provides a "level playing field" so that all potential contractors have the opportunity to win the contract award. The outcome of a properly conducted procurement results in the school food authority obtaining the best product at the best price. When competition is impaired, the school food authority loses the fundamental benefit of an open marketplace. The loss of this benefit can needlessly diminish the resources of the nonprofit school food service account and inhibit the school food authority from providing high quality, nutritious meals to children and implementing needed improvements to its food service operations.

B. Goals of This Proposed Rule

We are proposing to amend the National School Lunch Program regulations, 7 CFR Part 210, Special Milk Program regulations, 7 CFR Part 215, and School Breakfast Program regulations, 7 CFR Part 220 to remedy deficiencies in school food authority procurement practices that have been identified in audits conducted by the U.S. Department of Agriculture's Office of Inspector General, Report Numbers 27010-3-AT, February 2002 and 27601-0027-CH, April 2002. These identified deficiencies are undermining free and open competition and resulting in unallowable uses of nonprofit school food service account funds.

C. Audit Results—Cooperative Buying Groups

In February 2002, the Department's Office of Inspector General (OIG) released Audit Report 27010-3-AT. The audit outlined problems in school food authority cooperative buying arrangements. Under these arrangements, school food authorities in a single jurisdiction or multiple, often geographically related, jurisdictions, pool purchasing needs and solicit a single service provider to provide goods and services. School food authorities, as a cooperative buying group, expect the service provider to perform a number of different functions. These functions

generally include selling food and nonfood supplies to the school food authorities from the service provider's inventory, conducting procurements with manufacturers and food processors on behalf of the member school food authorities, and storing, distributing and managing the school food authorities' inventories of USDA donated foods and purchased foods and nonfood supplies. The OIG's audit identified a number of instances where the cooperative buying group, using nonprofit school food service account funds, failed to conduct procurement transactions in a manner that provided for full and open competition. For example, one cooperative buying group failed to include all items to be purchased in its bid solicitation and instead, purchased items directly from the service provider outside of the terms of the contract. In another instance, the service provider was permitted to make a material change to the contract resulting in an unallowable cost-plus-percentage-of-cost pricing structure. As a result, unallowable costs were paid by school food authorities with funds from the nonprofit school food service account.

D. Audit Results—Procurement Procedures and Allowable Costs

In April 2002, OIG released Audit Report 207601-0027-CH which revealed problems in several cost-reimbursable contracts between school food authorities and food service management companies. Some contracts between school food authorities and food service management companies lacked controls as to exactly how the company would determine the allowability of costs charged to the school food authority, including how the company would provide the school food authority with the benefits of purchase discounts and rebates in the determination of net costs. In some cases, this resulted from the school food authority's failure to inform potential contractors of how costs should be charged to the school food authority under the resulting contract award. In other cases, even though the school food authority's procurement documents required return of such discounts and rebates, some school food authorities permitted a material change to the food service management company contract that specifically allowed the food service management company to keep discounts and rebates earned through purchases billed to the school food authority.

The failure of a school food authority to fully describe its cost reporting requirements in its solicitation document undermines full and open

competition by placing unreasonable burdens on potential contractors. Without adequate details on how it must report costs to the school food authority, a potential contractor lacks the information needed to properly establish the fixed price component (management fee) of its offer. For example, one potential contractor, assuming that no discounts, rebates and credits will be returned to the school food authority, could provide an offer with a low management fee, knowing that its fixed costs and profit margin would actually be funded, in part, through the retained discounts, rebates and credits. A second potential contractor, recognizing the discounts, rebates and credits as being due to the school food authority might provide an offer with a higher management fee that included all its fixed costs and profit margin. Since school food authorities only evaluate the fixed fee component when determining the most cost effective offer under a cost reimbursable contract, the failure of a school food authority to address its cost reporting requirements in its solicitation documents creates unacceptable risks to full and open competition. Further, failure to adequately address issues regarding allowable costs in solicitation documents and contracts can result in unallowable cost charges to the school food authority that are paid with nonprofit school food service account funds.

As the OIG found, the absence of a specific contract requirement limiting food service management company charges to allowable costs has resulted in food service management companies charging school food authorities for administrative costs that were already included as part of the fixed fee, billing for the same expense twice, and charging the school food authority for the food service management company's administrative cost overruns. Without adequate guidance from the school food authority on how costs must be billed, a contractor lacks the information needed to properly identify allowable and unallowable costs submitted for payment to the school food authority. In turn, the school food authority cannot determine whether nonprofit school food service account funds can be used to pay all or only part of the costs billed by the contractor. Either result is untenable.

This proposed rule would clarify that only costs resulting from cost reimbursable contracts or cost reimbursable contract provisions that meet applicable cost allowability requirements are allowable nonprofit school food service account

expenditures. The proposed rule does not interfere in the right of a school food authority to enter into a contract, including a contract with terms that result in unallowable costs. The proposed rule, does, however, prohibit the school food authority from using nonprofit school food service account funds to pay for those unallowable costs.

In addition this proposed rule would prohibit contract terms that allow payments from the nonprofit school food service account in excess of the contractor's actual net allowable costs. Such net allowable costs must be computed by deducting certain discounts, rebates and other applicable credits. Contractors, using applicable department and program regulations and OMB cost circulars, would be required to provide sufficient information to permit the school food authority to identify allowable and unallowable costs and the amount of all such discounts and rebates on invoices and bills presented for payment to school food authorities. The school food authority would use this contractor supplied information to calculate the amount of net allowable costs that can be paid from the nonprofit school food service account. In making this calculation, the school food authority would apply the applicable program and department regulations and OMB cost circulars to identify the allowable costs, net of applicable credits, that may be paid from the nonprofit school food service account and unallowable contract costs that must be paid from other funding sources.

Further, the proposed rule would require that upon request, contractors would be required to provide documentation of discounts, rebates and other applicable credits as well as costs billed to the school food authorities. As defined by the applicable OMB cost circulars, discounts, rebates and other applicable credits include, but are not limited to, price reductions due to: product promotion, volume purchasing, on-line ordering or other electronic ordering systems, prompt payments or advance payments and use of certain suppliers. This proposed rule would apply to all discounts, rebates and credits accruing to or received by the contractor, including any assignee under the contract to the extent those amounts are allocable to the allowable costs for which the contractor will be reimbursed by the school food authority. For reference purposes, this proposed rule clarifies the applicability of the definition of applicable credits is the respective OMB cost circulars.

School food authorities that fail to comply with proper procurement procedures or permit a contractor to make a material change to a contract after contract award compromise the integrity of the entire procurement process. A material change to a contract after it has been awarded alters the terms and conditions of that contract to the extent that had other bidders known of these changes in advance, they could have bid differently and more competitively. This means that when a school food authority agrees to or allows a winning bidder to make changes to contract terms that are materially inconsistent with the underlying solicitation document, the school food authority has subverted full and open competition by denying all bidders the opportunity to compete under the same terms and conditions. While all school food authorities must have procedures to respond to bid protests, when a material change occurs to the contract after the bid has been awarded, the only way a disadvantaged bidder will learn of the change is through obtaining and reviewing the executed contract. This is inherently unfair given that the school food authority has undermined open and free competition by providing an unwarranted advantage to the successful bidder to the detriment of the other bidders.

This proposed rule would prohibit school food authorities from using nonprofit school food service account funds for any cost resulting from a procurement that failed to meet program requirements.

E. State Agency Review of Contracts

Under current regulations, State agencies generally do not review school food authority contracts until after the contracts have been executed (signed by the school food authority and contractor). Except for school food authority/food service management company contracts, State agencies do not receive copies of other school food authority contracts and generally only review these contracts during the normal on-site review process. In some States, a pre-approved prototype contract or contract terms are provided to the school food authority by the State agency. In the case of a pre-approved prototype contract, State agency officials generally do not review the executed contract since the State agency expects all school food authorities to use the approved prototype as it was drafted. In other cases, a State agency may limit its review only to discretionary contract terms and conditions because the State agency expects the school food authority has incorporated, verbatim,

the pre-approved contract terms the State agency provided.

The OIG found that some food service management companies required material changes to contracts that operated to the disadvantage of the school food authorities. These included changes that were made after the State agency's review and approval of executed contracts, changes to pre-approved prototype contracts and changes to required contract terms. Many of the changes circumvented regulatory requirements. State agencies and school food authorities have indicated that food service management companies were able to accomplish these changes by requiring the school food authority sign a food service management company prepared contract or refusing to sign the school food authority's approved contract until the changes were made. While the school food authorities should have conducted a new procurement in response to these demands, the delay incident to such actions would have prevented some school food authorities from providing meals to students. Some State agencies have expressed concerns with their ability to obtain copies of contracts prior to their execution and have further expressed concerns that they do not have the ability or authority to mandate changes to contract terms and obtain required corrective actions.

When the State agency finds problems with the terms of an already executed contract, it may be too late to remedy the problems for the current contract, except when State or local laws and procedures permit contract nullification. Since the school food authority is bound to fulfill its contract terms, in the most serious cases, the State agency's only recourse is to disallow all costs resulting from the contract. In the majority of cases, the State agency's required corrective action results in the school food authority initiating a new procurement process at the end of the current contract year, eliminating the option for contract renewals. None of these approaches provide timely corrective action. To reduce the number of contract disallowances and re-bid situations, this rule proposes that when a school food authority contracts with a food service management company, the contract must be reviewed and approved by the State agency prior to the contract being executed. The proposed rule also clarifies that for all other contracts, State agencies have authority to obtain copies of the contracts prior to execution and are encouraged to do so for all contracts. Further, this rule proposes that the school food authority obtain written

State agency approval of any change to a prototype solicitation document or prototype contract before the revised solicitation is issued or the revised contract is executed. This provision does not interfere with the school food authority or potential contractor's right to negotiate, pursuant to Department regulations, 7 CFR parts 3016 and 3019, contract terms and conditions under a competitive proposal procurement. In this type of procurement, the pre-approved prototype contract or contract terms only address the nonnegotiable aspects of the contract. Contract terms for areas subject to negotiation are not prepared until after the negotiations have been completed.

To ensure that school food authorities understand the scope of the authority granted to State agencies to properly administer the school meals programs, the proposed rule would clarify the right of the State agency to obtain procurement documents prior to issuance of the school food authority's solicitation as well as prior to the execution of the resulting contract. State agencies are encouraged to obtain these procurement documents prior to the school food authority's issuance (publication, direct mailing, internet posting, etc.) of the solicitation. Through this review, the State agency can provide technical assistance to the school food authority by identifying deficiencies in the procurement documents and processes before the solicitation is released. State agencies are also encouraged to obtain the school food authority's procurement documents when reviewing contracts to determine the adequacy of the contract terms and identify instances where the integrity of the procurement process may have been compromised.

Further, this proposed regulation would prohibit school food authorities from using nonprofit school food service account funds to pay for unallowable contract costs, including costs that result from improperly procured contracts and from a school food authority's failure to initiate corrective actions to procurement and contract documents as required by the State agency. Currently, 7 CFR 210.24 requires State agencies withhold program payments when a school food authority fails to comply with program requirements. This withholding would stay in effect until the school food authority took corrective action satisfactory to the State agency. At that point, the withheld funds are released to the school food authority. However, the school food authority would still be prohibited from using its nonprofit school food service account funds to

pay for unallowable costs. Therefore, whether or not the State agency withheld program payments, costs incurred under an improperly procured contract as well as costs incurred during the period the school food authority fails to take State agency required corrective action would be unallowable costs.

This proposed regulation does not absolve a school food authority from fulfilling its contractual obligations, even in those cases where the school food authority has failed to comply with required procurement practices. Additionally, this proposed regulation does not impair a school food authority's right to contract, including the right to contract for goods or services that represent unallowable nonprofit school food service account costs as long as the procurement and contract terms require adequate reporting and disclosure of such costs. Such costs could include catering school board luncheons or operating concession stands at school sporting events. While this proposed regulation would not impair a school food authority's right to contract for goods and services that represent unallowable costs, such unallowable costs cannot be paid with nonprofit school food service account funds.

F. Ethics and Integrity in the Procurement Process

While not specifically identified as a deficiency in the OIG audits, the Department is aware of instances in which full and open competition has been undermined by a lack of ethical conduct on the part of potential contractors and school food authorities. When State agencies or others determine such conduct is intentional, the matter should be referred to the appropriate legal authorities. However, in some cases, the unethical conduct results from school food authorities failing to fulfill their responsibilities under applicable code of conduct rules. All public and nonprofit school food authorities must have a written code of conduct governing the performance of its employees engaged in the award and administration of contracts. The code of conduct must prohibit any employee, officer or agent of the school food authority from participating in the selection, award or administration of the contract if a conflict of interest, whether real or apparent, exists. The Department regulations at 7 CFR 3016.36(b)(3) and 3019.42 define the minimum standards for determining when a conflict of interest exists and the actions that must be taken if a conflict occurs. The information indicates that school food

authorities appear to know that an individual is prohibited from personally soliciting or accepting cash as an inducement to award a contract. However, we have been concerned that these same school food authorities seem unaware that soliciting or personally accepting noncash gratuities (gifts) or accepting cash or noncash gifts in the name of the school is also prohibited. This lack of awareness may stem from the various forms such inducements can take. Inducements to contract in any form are not acceptable under Departmental regulations.

The Department is aware of situations in which school officials, in exchange for requiring the school food authority to purchase products from a specified contractor, have requested or accepted tickets to professional sporting events, contractor paid vacations, funds for student scholarships, and school building and athletic venue improvements. These situations have occurred primarily in two settings: First, in long term beverage contracting and second, in food service management company procurements.

G. Long Term Beverage Contracting

A number of schools have entered into long term beverage contracts, particularly for the acquisition of carbonated soft drinks and bottled water. Generally, these contracts provide financial incentives to the school, either in the form of cash payments or improvements to school facilities, in exchange for the contractor's right to sell its beverages to the school on an exclusive, long-term basis. These contracts are usually obtained outside of the nonprofit school food service operation and school officials may or may not have followed competitive procurement requirements.

While these incentives may represent improper inducements under applicable Department regulations, as long as nonprofit school food service resources *i.e.*, cash, labor or other assets are not used to support, directly or indirectly, any purchase made under the contract, and the school observes the regulatory prohibitions on competitive food sales and the sale of foods of minimal nutritional value, the Department has no authority over the procurement or operation of these contracts.

However, in some cases, the incentives offered by a potential contractor are contingent on the nonprofit school food service purchasing beverages under the contract. In these cases, a conflict of interest has arisen, applicable procurement requirements have been violated and the Department does have

an interest in the contract. While the nonprofit school food service may be bound by the terms of the contract, all direct and indirect costs resulting from the contract would be unallowable nonprofit school food service account expenses. On the other hand, if the nonprofit school food service is included in a properly procured long term beverage contract that includes incentives, cost allowability is generally not an issue; however, these incentives represent program income. The full value of all incentives (cash and noncash) would be used to determine the amount of program income resulting from the contract. This full value of these incentives is used to compute the amount of the program income that is allocated and deposited into the nonprofit school food service account. Failure to provide the nonprofit school food service with its allocated share of noncash incentives (*i.e.*, athletic equipment, classroom improvements, score boards, etc.) would circumvent the proper allocation of program income to the nonprofit school food service and would be a violation of existing Department regulations, 7 CFR 3016.25 and 3019.24.

H. Food Service Management Companies and Procurement

In the area of food service management company procurements, we are aware of situations in which potential bidders have offered gifts to school officials or cash payments to the school upon execution of the contract. In some cases these payments were never requested, while in other cases, some school officials have required payment at the start of the contract in exchange for contract award; and in still others, the payment is offered as an advance on a guaranteed return provision of the contract. In all of these cases, whether or not the receipt of funds is a factor in awarding the contract, the payment creates the appearance of a prohibited conflict of interest.

The Department is not proposing to add regulatory requirements to address these issues since existing regulations already require compliance with ethics and integrity requirements. However, the Department is seeking public comments to determine if there is a need for us to publish a rule on ethics and integrity for these situations.

I. Regulatory Consistency

The procurement and contract requirements and consequences for failure to comply with program regulations are not consistently addressed in the National School

Lunch, School Breakfast and Special Milk Program regulations. This proposed rule makes changes to School Breakfast Program and the Special Milk Program regulations to make the procurement and contracting requirements and the consequences for failure to comply with program regulations consistent with the National School Lunch program regulations.

J. Definition of Nonprofit School Food Service Account

The phrase "nonprofit school food service account" is used by school food authorities, State agencies and the Department to describe the books and records maintained for the nonprofit school food service pursuant to §§ 210.19(a)(2) and 220.13(i). We are proposing to add a definition of nonprofit school food service account to codify this commonly used term. This new definition does not create any new requirements and does not require creation of a separate bank account. In the Special Milk Program, the phrase "nonprofit milk program" is used instead of nonprofit school food service. For the Special Milk Program, the proposed definition of nonprofit school food service account is modified accordingly.

III. Procedural Matters

A. Executive Order 12866

This proposed rule has been determined to be not significant and therefore was not reviewed by the Office of Management and Budget (OMB) under Executive Order 12866.

B. Regulatory Flexibility Act

This proposed rule has been reviewed with regard to the requirements of the Regulatory Flexibility Act (5 U.S.C. 601–612). Roberto Salazar, Administrator for the Food and Nutrition Service, has certified that this proposed rule would not have a significant economic impact on a substantial number of small entities. This proposed rule would simplify school food authority administrative procedures by clarifying procurement requirements so that all cost reimbursable contracts or cost reimbursable provisions of contracts are bid in a consistent manner. The U.S. Department of Agriculture does not anticipate any significant fiscal impact that would result from implementation of this proposed rulemaking.

C. Public Law 104–4

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 Food and Nutrition Service generally prepares a written statement, including a cost-benefit analysis, for proposed and final rules with "Federal mandates" that may result in expenditures to State, local, or tribal governments, in the aggregate, or to the private sector, of \$100 million or more in any one year. When such a statement is needed for a rule, section 205 of the UMRA generally requires the Food and Nutrition Service to identify and consider a reasonable number of regulatory alternatives and adopt the least costly, more cost-effective or least burdensome alternative that achieves the objectives of the rule.

This proposed rule contains no Federal mandates (under regulatory provisions of Title II of the UMRA) for State, local, and tribal governments or the private sector of \$100 million or more in any one year. Thus, this proposed rule is not subject to the requirements of sections 202 and 205 of the UMRA.

D. Executive Order 12372

The National School Lunch Program, Special Milk Program and the School Breakfast Program, which are listed in the Catalog of Federal Domestic Assistance under Nos. 10.555, 10.556, and 10.553, respectively, are subject to the provisions of Executive Order 12372, which requires intergovernmental consultation with State and local officials. (See 7 CFR part 3015, subpart V, and final rule related notice published at 48 FR 29114, June 24, 1983.)

E. Executive Order 13132

Executive Order 13132 requires Federal agencies to consider the impact of their regulatory actions on State and local governments. Where such actions have federalism implications, agencies are directed to provide a statement for inclusion in the preamble to the regulations describing the agency's considerations in terms of the three categories called for under section 6(b)(2)(B) of Executive Order 13132. The Food and Nutrition Service (FNS) has considered the impact of this rule on State and local governments and has determined that this rule would not have federalism implications. This proposed rule would not impose substantial or direct compliance costs on State and local governments. Therefore, under section 6(b) of the Executive Order, a federalism summary impact statement is not required.

F. Executive Order 12988

This proposed rule has been reviewed under Executive Order 12988, Civil Justice Reform. This proposed rule, when finalized, would have preemptive effect with respect to any State or local laws, regulations or policies which conflict with its provisions or which would otherwise impede its full implementation. This proposed rule would not have retroactive effect unless so specified in the **DATES** section of the final rule preamble. Prior to any judicial challenge to the provisions of this rule or the application of the provisions, all applicable administrative procedures must be exhausted. In the National School Lunch Program and the School Breakfast Program, the administrative procedures are set forth under the following regulations: (1) School food authority appeals of State agency findings as a result of an administrative review must follow State agency hearing procedures as established pursuant to 7 CFR 210.18(q), 215.13(g) and 220.14(e); (2) school food authority appeals of FNS findings as a result of an administrative review must follow FNS hearing procedures as established pursuant to 7 CFR 210.30(d)(3) and 220.14(g); and (3) State agency appeals of State Administrative Expense fund sanctions (7 CFR 235.11(b)) must follow the FNS administrative review process as established pursuant to 7 CFR 235.11(f).

G. Civil Rights Impact Analysis

Under Department Regulation 4300-4, Civil Rights Impact Analysis, FNS has reviewed this proposed rule to identify and address any major civil rights impacts the proposed rule might have on minorities, women, and persons with disabilities. After a careful review of the rule's intent and provisions, FNS has determined that this rule would not in any way limit or reduce participants' ability to participate in the Child Nutrition Programs on the basis of an individual's or group's race, color national origin, sex, age or disability. FNS found no factors that would negatively and disproportionately affect any group of individuals.

H. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. Chap. 35; see 5 CFR part 1320) requires that the Office of Management and Budget (OMB) approve all collections of information by a Federal agency from the public before they can be implemented. Respondents are not required to respond to any collection of information unless it displays a current valid OMB control number. This proposed rule contains

information collections that are subject to review and approval by OMB; therefore, in accordance with the Paperwork Reduction Act of 1995, this notice invites the general public and other agencies to comment on the proposed information collection. Written comments on this proposed information collection must be received on or before February 28, 2005.

Comments concerning the information collection aspects of this proposed rule should be sent to the Office of Information and Regulatory Affairs, OMB, Room 10235, New Executive Office Building, Washington, DC 20503, Attention: Desk Officer for the Food and Nutrition Service. A copy of these comments may also be sent to Mr. Terry Hallberg at the address listed in the **ADDRESSES** section of this preamble. Commenters are asked to separate their comments on the information collection requirements from their comments on the remainder of the proposed rule.

OMB is required to make a decision concerning the collection of information contained in this proposed regulation between 30 to 60 days after the publication of this document in the **Federal Register**. Therefore, a comment to OMB is best assured of having full consideration if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment to the Department on the proposed regulation.

Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information, 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 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.

The title, description, and respondent description of the information collections are shown below with an estimate of the annual reporting and recordkeeping burdens. Included in the estimate is the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The chart below identifies only the burden hours associated with those

sections of 7 CFR Part 210, National School Lunch Program, 7 CFR Part 215, Special Milk Program and 7 CFR Part 220, School Breakfast Program. These burden hours represent proposed changes to the current reporting and recordkeeping requirements and incorporate additional proposed requirements.

Title: 7 CFR Part 210 National School Lunch Program.

OMB Number: 0584-0006.

Expiration Date: 07/31/2006.

Type of Request: Revision of existing collection.

Abstract: This proposed rule would update the National School Lunch Program regulations, 7 CFR Part 210 (OMB Number: 0584-0006) regarding the use of federal funds for the provision of meals and milk for school children under these programs.

This proposed rule would prohibit a school food authority from using funds in the nonprofit school food service account for expenditures made under an improperly procured contract, including any cost reimbursable provision of a contract that permits the contractor to receive payments in excess of the

contractor's actual net allowable costs. State agencies would also be responsible for reviewing and approving contracts between school food authorities and food service management companies prior to their execution.

The expected result is that regulatory language will ensure optimum utilization of funds in the nonprofit school food service account. The burden associated with the proposed rules will only affect schools participating in the National School Lunch or School Breakfast Programs that contract with food service management companies.

ESTIMATED ANNUAL RECORDKEEPING AND REPORTING BURDEN

	Section	Annual number of respondents	Annual frequency	Average burden per response	Annual burden hours
National School Lunch Program State agency review and approve procurements between school food authority and contractor:					
Total existing State agencies	7 CFR 210.19(a)	57	22	.167	207
Total proposed State agencies	7 CFR 210.19(a)	57	30	4	6,840
School food authority provide procurement materials to State agency for approval:					
Total existing school food authorities	7 CFR 210.16(c)	1,648	1	.25	412
Total proposed school food authorities	7 CFR 210.16(a)	1,648	1	1.5	2,487
School Breakfast Program*					

*The vast majority of schools participating in the SBP also participate in the NSLP. Therefore, the burden associated with state agencies and school food authorities contracting for goods and services to operate the School Breakfast Program is carried in the NSLP information collection budget:

Total Existing: 619
Total Proposed: 9,327
Change: +8,708

Title: 7 CFR Part 215 Special Milk Program.

OMB Number: 0584-0005.

Expiration Date: 01/31/06.

Type of Request: Revision of existing collection.

Abstract: This proposed rule would update the Special Milk Program regulations, 7 CFR Part 215 (OMB Number: 0584-0005) regarding the use of federal funds for the provision of meals and milk for school children under these programs. This proposed rule would prohibit a school food authority from using funds in the nonprofit school food service account for expenditures made under an improperly procured contract, including any cost reimbursable provision of a contract that permits the contractor to receive payments in excess of the contractor's actual net allowable costs. State agencies would also be responsible for reviewing and approving contracts between school food authorities and food service management companies prior to their execution. The expected result is that regulatory language will ensure optimum utilization of funds in the nonprofit school food service account. The burden associated with

contract review in the proposed rule will only affect schools participating in the National School Lunch or School Breakfast Programs that contract with food service management companies. The burden associated with schools participating in the Special Milk Program would be minimal because milk is often the sole procured item and the procurement is generally handled at the school food authority level. Therefore this burden is also carried in the NSLP information collection budget.

Title: 7 CFR 220 School Breakfast Program.

OMB Number: 0584-0012.

Expiration Date: 08/31/07.

Type of Request: Revision of existing collection.

Abstract: This proposed rule would update the School Breakfast Program Regulations, 7 CFR Part 220, (OMB Number: 0584-0012) regarding the use of federal funds for the provision of meals and milk for school children under these programs. This proposed rule would prohibit a school food authority from using funds in the nonprofit school food service account for expenditures made under an improperly procured contract, including

any cost reimbursable provision of a contract that permits the contractor to receive payments in excess of the contractor's actual net allowable costs. State agencies would also be responsible for reviewing and approving contracts between school food authorities and food service management companies prior to their execution. The expected result is that regulatory language will ensure optimum utilization of funds in the nonprofit school food service account. The burden associated with the proposed rules will only affect schools participating in the National School Lunch or School Breakfast Programs that contract with food service management companies. The vast majority of schools participating in the SBP also participate in the NSLP. Therefore, the burden associated with state agencies and school food authorities contracting for goods and services to operate the School Breakfast Program is carried in the NSLP information collection budget.

I. Government Paperwork Elimination Act Compliance

FNS is committed to compliance with the Government Paperwork Elimination

Act, which requires Government agencies to provide the public with the option of submitting information or transacting business electronically to the maximum extent possible.

List of Subjects

7 CFR Part 210

Children, Commodity School Program, Food assistance programs, Grants programs-social programs, National School Lunch Program, Nutrition, Reporting and recordkeeping requirements, Surplus agricultural commodities.

7 CFR Part 215

Food assistance programs, Grant programs-education, Grant programs-health, Infants and children, Milk, Reporting and recordkeeping requirements.

7 CFR Part 220

Children, Food assistance programs, Grant programs-social programs, Nutrition, Reporting and recordkeeping requirements, School Breakfast Program.

Accordingly, 7 CFR Parts 210, 215 and 220 are proposed to be amended as follows:

PART 210—NATIONAL SCHOOL LUNCH PROGRAM

1. The authority citation for Part 210 continues to read as follows:

Authority: 42 U.S.C. 1751–1760, 1779.

2. In § 210.2, add, in alphabetical order, the definitions of “*Applicable credits*”, “*Contractor*”, and “*Nonprofit school food service account*” to read as follows:

§ 210.2 Definitions.

* * * * *

Applicable credits shall have the meaning established in Office of Management and Budget Circulars, A–87, C(4) and A–122, Attachment A, A(5), respectively. For availability of OMB circulars referenced in this definition see 5 CFR 1310.3.

* * * * *

Contractor means a commercial enterprise, public or nonprofit private organization or individual that enters into a contract with a school food authority.

* * * * *

Nonprofit school food service account means the restricted account in which all of the revenue from all food service operations conducted by the school food authority principally for the benefit of school children is retained and used

only for the operation or improvement of the nonprofit school food service.

* * * * *

3. In § 210.16:

a. Amend paragraph (a)(7) by removing the word “and” at the end of the paragraph;

b. Amend paragraph (a)(8) by removing the period at the end of the paragraph and adding a semicolon in its place;

c. Add paragraphs (a)(9) and (a)(10) at the end; and

d. Amend paragraph (b)(1) by removing the second sentence and adding a new sentence in its place.

The additions read as follows:

§ 210.16 Food service management companies.

(a) * * *

(9) Obtain written approval of invitations for bids and requests for proposals prior to their issuance when required by the State agency. The school food authority must incorporate all State agency required changes to its solicitation documents prior to issuance of those documents; and

(10) Ensure that, prior to the execution of any contract or amendment to an existing food service management company contract, the State agency has reviewed and approved the contract terms and the school food authority has incorporated all State agency required changes into the contract or amendment. Any changes made by the school food authority or a food service management company to a State agency pre-approved prototype contract or State agency approved contract term must be approved in writing by the State agency prior to execution of the contract. To obtain approval of any proposed contract or contract modification, the school food authority must submit all procurement documents, including responses submitted by potential contractors, if requested by the State agency.

(b) * * *

(1) * * * A school food authority with no capability to prepare a cycle menu may, with State agency approval, require that each food service management company include a 21-day cycle menu, developed in accordance with the provisions of § 210.10, with its bid or proposal. * * *

* * * * *

4. In § 210.19:

a. Amend paragraph (a)(2) by adding two new sentences between sentences two and three; and

b. Amend paragraph (a)(6) by removing the first sentence and adding two sentences in its place.

The additions read as follows:

§ 210.19 Additional responsibilities.

(a) * * *

(2) * * * All costs resulting from contracts that do not meet the requirements of this part are unallowable nonprofit school food service account expenses. When the school food authority fails to incorporate State agency required changes to solicitation or contract documents, all costs resulting from the subsequent contract award are unallowable charges to the nonprofit school food service account. * * *

* * * * *

(6) * * * Each State agency shall annually review each contract between any school food authority and food service management company to ensure compliance with all the provisions and standards set forth in this part prior to the execution of the contract by either party. Each State agency shall review each contract amendment between a school food authority and food service management company to ensure compliance with all the provisions and standards set forth in this part prior to the execution of the amended contract by either party. * * *

* * * * *

5. In § 210.21:

a. Revise paragraph (a);

b. Amend paragraph (b) by removing the words “7 CFR part 3015” and adding, in their place, the words “this part and parts 3015, 3016 and 3019 of this title, as applicable,”;

c. Revise paragraph (c); and

d. Add a new paragraph (e).

The revisions and addition read as follows:

§ 210.21 Procurement.

(a) *General.* State agencies and school food authorities shall comply with the requirements of this part and parts 3015, 3016 and 3019 of this title, as applicable, and applicable Office of Management and Budget Circulars, concerning the procurement of all goods and services with nonprofit school food service account funds.

* * * * *

(c) *Procedures.* The State agency or school food authority may use its own procurement procedures which reflect applicable State and local laws and regulations, provided that procurements made with nonprofit school food service account funds adhere to the standards set forth in this part and §§ 3016.36(b) through 3016.36(i), 3016.60 and 3019.40 through 3019.48 of this title, as applicable, and in the applicable Office of Management and Budget Circulars. These requirements are adopted by FNS to ensure that all supplies, food,

equipment and services are obtained for the program in compliance with applicable laws and executive orders.

(1) *Pre-issuance review requirement.* The State agency may impose a pre-issuance review requirement on a school food authority's proposed procurement. The school food authority must make available, upon request of the State agency, its procurement documents, including but not limited to solicitation documents, specifications, evaluation criteria, procurement procedures, proposed contracts and contract terms. School food authorities shall comply with State agency requests for changes to procurement procedures and solicitation and contract documents to ensure that to the State agency's satisfaction, such procedures and documents reflect applicable procurement and contract requirements and the requirements of this part.

(2) *Prototype solicitation documents and contacts.* The school food authority must obtain the State agency's prior written approval for any change made to prototype solicitation or contract documents prior to issuance of the revised solicitation documents or execution of the revised contract.

(3) *Prohibited expenditures.* No expenditure may be made from the nonprofit school food service account for any cost resulting from a procurement failing to meet the requirements of this part.

(e) *Cost reimbursable contracts.* (1) *Required provisions.* The school food authority must include the following provisions in all cost reimbursable contracts, including contracts with cost reimbursable provisions, and in solicitation documents prepared to obtain offers for such contracts:

(i) Allowable costs will be paid to the contractor net of all discounts, rebates and other applicable credits accruing to or received by the contractor or any assignee under the contract, to the extent those credits are allocable to the allowable portion of the costs billed to the school food authority;

(ii) The contractor must separately identify for each cost submitted for payment to the school food authority the amount of that cost that is allowable (can be paid from the nonprofit school food service account) and the amount that is unallowable (cannot be paid from the nonprofit school food service account);

(iii) The contractor's determination of its allowable costs must be made in compliance with the applicable Departmental and Program regulations and Office of Management and Budget cost circulars;

(iv) The contractor must individually identify discounts, rebates and other applicable credits on all bills and invoices presented to the school food authority for payment; and

(v) The contractor must maintain documentation of costs and discounts, rebates and other applicable credits, and must furnish such documentation upon request to the school food authority, the State agency, or the Department.

(2) *Prohibited expenditures.* No expenditure may be made from the nonprofit school food service account for any cost resulting from a cost reimbursable contract that fails to include the requirements of this section, nor may any expenditure be made from the nonprofit school food service account that permits or results in the contractor receiving payments in excess of the contractor's actual, net allowable costs.

6. In § 210.24, amend the first sentence by removing the word “§ 3015.103” and adding in its place the words “Departmental regulations at §§ 3016.43 and 3019.62 of this title”.

* * * * *

PART 215—SPECIAL MILK PROGRAM

1. The authority citation for Part 215 continues to read as follows:

Authority: 42 U.S.C. 1772 and 1779.

2. In § 215.2, add paragraph (c), previously reserved, and paragraphs (e-3) and (r-1) to read as follows:

§ 215.2 Definitions.

* * * * *

(c) *Applicable credits* shall have the meaning established in Office of Management and Budget Circulars, A-87, C(4) and A-122, Attachment A A(5), respectively. For availability of OMB circulars referenced in this definition, see 5 CFR 1310.3.

* * * * *

(e-3) *Contractor* means a commercial enterprise, public or nonprofit private organization or individual that enters into a contract with a school food authority.

* * * * *

(r-1) *Nonprofit school food service account* means the restricted account in which all of the revenue from the nonprofit milk service maintained for the benefit of children is retained and used only for the operation or improvement of the nonprofit milk service.

* * * * *

3. In § 215.14a;

a. Revise paragraph (a);

b. Amend paragraph (b) by removing the words “OMB Circular A-102 and 7

CFR part 3015,” and adding, in their place, the words “this part and parts 3015, 3016 and 3019 of this title, as applicable,”;

c. Revise paragraph (c); and

d. Add a new paragraph (d).

The revisions and addition read as follows:

§ 215.14a Procurement standards.

(a) *General.* State agencies and school food authorities shall comply with the requirements of this part and parts 3015, 3016 and 3019 of this title, as applicable, and applicable Office of Management and Budget Circulars, concerning the procurement of all goods and services with nonprofit school food service account funds.

* * * * *

(c) *Procedures.* The State agency or school food authority may use its own procurement procedures which reflect applicable State or local laws and regulations, provided that procurements made with nonprofit school food service account funds adhere to the standards set forth in this part and §§ 3016.36(b) through 3016.36(i), 3016.60 and 3019.40 through 3019.48 of this title, as applicable, and in the applicable Office of Management and Budget Circulars.

These requirements are adopted by FNS to ensure that all supplies, food, equipment and services are obtained for the program in compliance with applicable laws and executive orders.

(1) *Pre-issuance review requirement.* The State agency may impose a pre-issuance review requirement on a school food authority's proposed procurement. The school food authority must make available, upon request of the State agency, its procurement documents, including but not limited to solicitation documents, specifications, evaluation criteria, procurement procedures, proposed contracts and contract terms. School food authorities shall comply with State agency requests for changes to procurement procedures and solicitation and contract documents to ensure to the State agency's satisfaction, such procedures and documents reflect applicable procurement and contract requirements and the requirements of this part.

(2) *Prototype solicitation documents and contacts.* The school food authority must obtain the State agency's prior written approval for any change made to prototype solicitation or contract documents prior to issuance of the revised solicitation documents or execution of the revised contract.

(3) *Prohibited expenditures.* No expenditure may be made from the nonprofit school food service account for any cost resulting from a

procurement failing to meet the requirements of this part.

(d) *Cost reimbursable contracts.* (1) *Required provisions.* The school food authority must include the following provisions in all cost reimbursable contracts, including contracts with cost reimbursable provisions, and in solicitation documents prepared to obtain offers for such contracts:

(i) Allowable costs will be paid to the contractor net of all discounts, rebates and other applicable credits accruing to or received by the contractor or any assignee under the contract, to the extent those credits are allocable to the allowable portion of the costs billed to the school food authority;

(ii) The contractor must separately identify for each cost submitted for payment to the school food authority the amount of that cost that is allowable (can be paid from the nonprofit school food service account) and the amount that is unallowable (cannot be paid from the nonprofit school food service account);

(iii) The contractor's determination of its allowable costs must be made in compliance with the applicable Departmental and Program regulations and Office of Management and Budget cost circulars;

(iv) The contractor must individually identify all discounts, rebates and other applicable credits on all bills and invoices presented to the school food authority for payment; and

(v) The contractor must maintain documentation of costs and discounts, rebates and other applicable credits, and must furnish such documentation upon request to the school food authority, the State agency, or the Department.

(2) *Prohibited expenditures.* No expenditure may be made from the nonprofit school food service account for any cost resulting from a cost reimbursable contract that fails to include the requirements of this section, nor may any expenditure be made from the nonprofit school food service account that permits or results in the contractor receiving payments in excess of the contractor's actual, net allowable costs.

4. Redesignate §§ 215.15 through 215.17 as §§ 215.16 through 215.18, respectively; and add a new § 215.15 to read as follows:

§ 215.15 Withholding payments.

In accordance with Departmental regulations at §§ 3016.43 and 3019.62 of this title, the State agency shall withhold Program payments in whole or in part, to any school food authority which has failed to comply with the provisions of this part. Programs

payments shall be withheld until the school food authority takes corrective action satisfactory to the State agency, or gives evidence that such corrective actions will be taken, or until the State agency terminates the grant in accordance with §§ 215.16. Subsequent to the State agency's acceptance of the corrective actions, payments will be released for any milk served in accordance with the provisions of this part during the period the payments were withheld.

PART 220—SCHOOL BREAKFAST PROGRAM

1. The authority citation for Part 220 continues to read as follows:

Authority: 42 U.S.C. 1773, 1779, unless otherwise noted.

2. In § 220.2, add paragraphs (a–1), (d–1) and (o–3) to read as follows:

§ 220.2 Definitions.

* * * * *

(a–1) *Applicable credits* shall have the meaning established in Office of Management and Budget Circulars, A–87, C(4) and A–122, Attachment A, A(5), respectively. For availability of OMB circulars referenced in this definition see 5 CFR 1310.3.

* * * * *

(d–1) *Contractor* means a commercial enterprise, public or nonprofit private organization or individual that enters into a contract with a school food authority.

* * * * *

(o–3) *Nonprofit school food service account* means the restricted account in which all of the revenue from all food service operations conducted by the school food authority principally for the benefit of school children is retained and used only for the operation or improvement of the nonprofit school food service.

* * * * *

3. In § 220.7, revise paragraph (d) to read as follows:

§ 220.7 Requirements for participation.

* * * * *

(d)(1) Any school food authority (including a State agency acting in the capacity of a school food authority) may contract with a food service management company to manage its food service operation in one or more of its schools. However, no school or school food authority may contract with a food service management company to operate an a la carte food service unless the company agrees to offer free, reduced price and paid reimbursable breakfasts to all eligible children. Any

school food authority that employs a food service management company in the operation of its nonprofit school food service shall:

(i) Adhere to the procurement standards specified in § 220.16 when contracting with the food service management company;

(ii) Ensure that the food service operation is in conformance with the school food authority's agreement under the Program;

(iii) Monitor the food service operation through periodic on-site visits;

(iv) Retain control of the quality, extent, and general nature of its food service, and the prices to be charged the children for meals;

(v) Retain signature authority on the State agency-school food authority agreement, free and reduced price policy statement and claims;

(vi) Ensure that all federally donated foods received by the school food authority and made available to the food service management company accrue only to the benefit of the school food authority's nonprofit school food service and are fully utilized therein;

(vii) Maintain applicable health certification and assure that all State and local regulations are being met by a food service management company preparing or serving meals at a school food authority facility;

(viii) Obtain written approval of invitations for bids and requests for proposals prior to their issuance when required by the State agency. The school food authority must incorporate all State agency required changes to its solicitation documents prior to issuance of those documents; and

(ix) Ensure that, prior to the execution of any contract or amendment to an existing food service management company contract, the State agency has reviewed and approved the contract terms and the school food authority has incorporated all State agency required changes into the contract or amendment. Any changes made by the school food authority or a food service management company to a State agency pre-approved prototype contract or State agency approved contract term must be approved in writing by the State agency prior to execution of the contract. To obtain approval of any proposed contract or contract modification, the school food authority must submit all procurement documents, including responses submitted by potential contractors, if requested by the State agency.

(2) In addition to adhering to the procurement standards under this part, school food authorities contracting with

food service management companies shall ensure that:

(i) The invitation to bid or request for proposal contains a 21-day cycle menu developed in accordance with the provisions of § 220.8, to be used as a standard for the purpose of basing bids or estimating average cost per meal. A school food authority with no capability to prepare a cycle menu may, with State agency approval, require that each food service management company include a 21-day cycle menu, developed in accordance with the provisions of § 220.8, with its bid or proposal. The food service management company must adhere to the cycle for the first 21 days of meal service. Changes thereafter may be made with the approval of the school food authority; and

(ii) Any invitation to bid or request for proposal indicate that nonperformance subjects the food service management company to specified sanctions in instances where the food service management company violates or breaches contract terms. The school food authority shall indicate these sanctions in accordance with the procurement provisions stated in § 220.16.

(3) Contracts that permit all income and expenses to accrue to the food service management company and "cost-plus-a-percentage-of-cost" and "cost-plus-a-percentage-of-income" contracts are prohibited. Contracts that provide for fixed fees such as those that provide for management fees established on a per meal basis are allowed. Contractual agreements with food service management companies shall include provisions which ensure that the requirements of this section are met. Such agreements shall also include the following requirements:

(i) The food service management company shall maintain such records as the school food authority will need to support its Claim for Reimbursement under this part, and shall, at minimum, report claim information to the school food authority promptly at the end of each month. Such records shall be made available to the school food authority, upon request, and shall be available for a period of 3 years from the date of the submission of the final Financial Status Report, for inspection and audit by representatives of the State agency, of the Department, and of the Government Accountability Office at any reasonable time and place. If audit findings have not been resolved, the records shall be retained beyond the three-year period (as long as required for the resolution of the issues raised by the audit);

(ii) The food service management company shall have State or local health

certification for any facility outside the school in which it proposes to prepare meals and the food service management company shall maintain this health certification for the duration of the contract; and

(iii) No payment is to be made for meals that are spoiled or unwholesome at time of delivery, do not meet detailed specifications as developed by the school food authority for each food component specified in § 220.8, or do not otherwise meet the requirements of the contract. Specifications shall cover items such as grade, purchase units, style, condition, weight, ingredients, formulations, and delivery time.

(4) The contract between a school food authority and food service management company shall be of a duration of no longer than 1 year and options for the yearly renewal of the contract shall not exceed 4 additional years. All contracts shall include a termination clause whereby either party may cancel for cause with 60-day notification.

* * * * *

4. In § 220.16,

a. Revise paragraph (a);

b. Amend paragraph (b) by removing the words "OMB Circular A-102 and 7 CFR 3015" and adding in their place the words "this part and parts 3015, 3016 and 3019 of this title, as applicable";

c. Revise paragraph (c); and

d. Add paragraph (e).

The revisions and addition read as follows:

§ 220.16 Procurement standards.

(a) *General.* State agencies and school food authorities shall comply with the requirements of this part and parts 3015, 3016 and 3019 of this title, as applicable, and applicable Office of Management and Budget Circulars, concerning the procurement of all goods and services with nonprofit school food service account funds.

* * * * *

(c) *Procedures.* The State agency or school food authority may use its own procurement procedures which reflect applicable State and local laws and regulations, provided that procurements made with nonprofit school food service account funds adhere to the standards set forth in this part and §§ 3016.36(b) through 3016.36(i), 3016.60 and 3019.40 through 3019.48 of this title, as applicable, and the applicable Office of Management and Budget Circulars. These requirements are adopted by FNS to ensure that all supplies, food, equipment and services are obtained for the program in compliance with applicable laws and executive orders.

(1) *Pre-issuance review requirement.* The State agency may impose a pre-issuance review requirement on a school food authority's proposed procurement. The school food authority must make available, upon request of the State agency, its procurement documents, including but not limited to solicitation documents, specifications, evaluation criteria, procurement procedures, proposed contracts and contract terms. School food authorities shall comply with State agency requests for changes to procurement procedures and solicitation and contract documents to ensure that to the State agency's satisfaction, such procedures and documents reflect applicable procurement and contract requirements and the requirements of this part.

(2) *Prototype solicitation documents and contracts.* The school food authority must obtain the State agency's prior written approval for any change made to prototype solicitation or contract documents prior to issuance of the revised solicitation documents or execution of the revised contract.

(3) *Prohibited expenditures.* No expenditure may be made from the nonprofit school food service account for any cost resulting from a procurement failing to meet the requirements of this part.

* * * * *

(e) *Cost reimbursable contracts.* (1) *Required provisions.* The school food authority must include the following provisions in all cost reimbursable contracts, including contracts with cost reimbursable provisions, and in solicitation documents prepared to obtain offers for such contracts:

(i) Allowable costs will be paid to the contractor net of all discounts, rebates and other applicable credits accruing to or received by the contractor or any assignee under the contract, to the extent those credits are allocable to the allowable portion of the costs billed to the school food authority;

(ii) The contractor must separately identify for each cost submitted for payment to the school food authority the amount of that cost that is allowable (can be paid from the nonprofit school food service account) and the amount that is unallowable (cannot be paid from the nonprofit school food service account);

(iii) The contractor's determination of its allowable costs must be made in compliance with the applicable Departmental and Program regulations and Office of Management and Budget cost circulars;

(iv) The contractor must individually identify all discounts, rebates and other

applicable credits on all bills and invoices presented to the school food authority for payment; and

(v) The contractor must maintain documentation of costs and discounts, rebates, and other applicable credits, and must furnish such documentation upon request to the school food authority, the State agency, or the Department.

(2) *Prohibited expenditures.* No expenditure may be made from the nonprofit school food service account for any cost resulting from a cost reimbursable contract that fails to include the requirements of this section, nor may any expenditure be made from the nonprofit school food service account that permits or results in the contractor receiving payments in excess of the contractor's actual, net allowable costs.

4. Redesignate §§ 220.18 through 220.21 as §§ 220.19 through 220.22, respectively; and add a new § 220.18 to read as follows:

§ 220.18 Withholding payments.

In accordance with Departmental regulations at §§ 3016.43 and 3019.62 of this title, the State agency shall withhold Program payments, in whole or in part, to any school food authority which has failed to comply with the provisions of this part. Programs payments shall be withheld until the school food authority takes corrective action satisfactory to the State agency, or gives evidence that such corrective actions will be taken, or until the State agency terminates the grant in accordance with § 220.19. Subsequent to the State agency's acceptance of the corrective actions, payments will be released for any breakfasts served in accordance with the provisions of this part during the period the payments were withheld.

Dated: December 21, 2004.

Roberto Salazar,
Administrator, Food and Nutrition Service.
[FR Doc. 04-28532 Filed 12-29-04; 8:45 am]
BILLING CODE 3410-30-P

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 1124

[Docket No. AO-368-A30; DA-01-08-PNW]

Milk in the Pacific Northwest Marketing Area; Decision on Proposed Amendments to Marketing Agreement and to Order

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Proposed rule.

SUMMARY: This document proposes to adopt as a final rule, order language contained in the interim final rule published in the **Federal Register** on January 12, 2004, concerning pooling provisions of the Pacific Northwest Federal milk order. This document also sets forth the final decision of the Department and is subject to approval by producers. Specifically, the final decision adopts an amendment that would continue to amend the *Producer milk* provision which will eliminate the ability to simultaneously pool the same milk on the order and on a State-operated order that provides for marketwide pooling.

FOR FURTHER INFORMATION CONTACT:

Gino M. Tosi, Marketing Specialist, USDA/AMS/Dairy Programs, Order Formulation and Enforcement Branch, Room 2968, 1400 Independence Avenue, SW., STOP 0231, Washington, DC 20250-0231, (202) 690-1366, e-mail address gino.tosi@usda.gov.

SUPPLEMENTARY INFORMATION: This administrative action is governed by the provisions of sections 556 and 557 of Title 5 of the United States Code and therefore is excluded from the requirements of Executive Order 12866.

These proposed amendments have been reviewed under Executive Order 12988, Civil Justice Reform. This proposed rule is not intended to have a retroactive effect. If adopted, this proposed rule will not preempt any state or local laws, regulations, or policies, unless they present an irreconcilable conflict with this rule.

The Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601-674), provides that administrative proceedings must be exhausted before parties may file suit in court. Under Section 608c(15)(A) of the Act, any handler subject to an order may request modification or exemption from such order by filing with the Secretary a petition stating that the order, any provision of the order, or any obligation imposed in connection with the order is not in accordance with the law. A handler is afforded the opportunity for a hearing on the petition. After a hearing, the Secretary would rule on the petition. The Act provides that the district court of the United States in any district in which the handler is an inhabitant, or has its principal place of business, has jurisdiction in equity to review the Secretary's ruling on the petition, provided a bill in equity is filed not later than 20 days after the date of the entry of the ruling.

Regulatory Flexibility Act and Paperwork Reduction Act

In accordance with the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), the Agricultural Marketing Service has considered the economic impact of this action on small entities and has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities. For the purpose of the Regulatory Flexibility Act, a dairy farm is considered a "small business" if it has an annual gross revenue of less than \$750,000, and a dairy products manufacturer is a "small business" if it has fewer than 500 employees. For the purposes of determining which dairy farms are "small businesses," the \$750,000 per year criterion was used to establish a production guideline of 500,000 pounds per month. Although this guideline does not factor in additional monies that may be received by dairy producers, it should be an inclusive standard for most "small" dairy farmers. For purposes of determining a handler's size, if the plant is part of a larger company operating multiple plants that collectively exceed the 500-employee limit, the plant will be considered a large business even if the local plant has fewer than 500 employees.

In the Pacific Northwest Federal milk order, 805 of the 1,164 dairy producers (farmers), or about 69 percent, whose milk was pooled under the Pacific Northwest Federal milk order at the time of the hearing (April 2002), would meet the definition of small businesses. On the processing side, 9 of the 20 milk plants associated with the Pacific Northwest milk order during April 2002 would qualify as "small businesses," constituting about 45 percent of the total.

The adoption of the proposed pooling standard serves to revise established criteria that determine the producer milk that has a reasonable association with—and consistently serves the fluid needs of—the Pacific Northwest milk marketing area and is not associated with other marketwide pools concerning the same milk. Criteria for pooling are established on the basis of performance levels that are considered adequate to meet the Class I fluid needs and by doing so determine those that are eligible to share in the revenue that arises from the classified pricing of milk. Criteria for pooling are established without regard to the size of any dairy industry organization or entity. The established criteria are applied in an identical fashion to both large and small businesses and do not have any different economic impact on small

entities as opposed to large entities. Therefore, the proposed amendment will not have a significant economic impact on a substantial number of small entities.

A review of reporting requirements was completed under the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). It was determined that these proposed amendments would have no impact on reporting, recordkeeping, or other compliance requirements because they would remain identical to the current requirements. No new forms are proposed and no additional reporting requirements would be necessary.

This notice does not require additional information collection that requires clearance by the Office of Management and Budget (OMB) beyond currently approved information collection. The primary sources of data used to complete the forms are routinely used in most business transactions. Forms require only a minimal amount of information which can be supplied without data processing equipment or a trained statistical staff. Thus, the information collection and reporting burden is relatively small. Requiring the same reports for all handlers does not significantly disadvantage any handler that is smaller than the industry average.

Prior Documents in This Proceeding:

Notice of Hearing: Issued February 26, 2002; published March 4, 2002 (67 FR 9622).

Correction to Notice of Hearing: Issued March 14, 2002; published March 19, 2002 (67 FR 12488)

Tentative Final Decision: Issued August 8, 2003; published August 18, 2003 (68 FR 49375).

Interim Final Rule: Issued January 5, 2004; published January 12, 2004 (69 FR 1654).

Preliminary Statement

A public hearing was held upon proposed amendments to the marketing agreement and the order regulating the handling of milk in the Pacific Northwest marketing area. The hearing was held, pursuant to the provisions of the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674), and the applicable rules of practice (7 CFR part 900), at Salt Lake City, Utah, on April 16–19, 2002, pursuant to a Notice of Hearing issued February 26, 2002; published March 4, 2002 (67 FR 9622).

Upon the basis of the evidence introduced at the hearing and the record thereof, the Administrator, on August 8, 2003, issued a Tentative Final Decision

containing notice of the opportunity to file written exceptions thereto.

The material issues, findings and conclusions, rulings, and general findings of the Recommended Decision are hereby approved and adopted and are set forth herein. The material issue on the record of the hearing relate to:

1. Simultaneous pooling of milk on the order and on a State-operated milk order providing for marketwide pooling.

Findings and Conclusions

The following findings and conclusions on the material issues are based on evidence presented at the hearing and the record thereof:

1. Simultaneous Pooling on a Federal and State-Operated Milk Order

Two proposals, published in the hearing notice as Proposals 1 and 10, seeking to exclude the same milk from being simultaneously pooled on either the Pacific Northwest or the Western orders and any State-operated order which provides for marketwide pooling, should be adopted on a permanent basis. The practice of pooling milk on a Federal order and simultaneously pooling the same milk on a State-operated order has come to be referred to as “double dipping”. The Pacific Northwest order does not currently prohibit milk to be simultaneously pooled on the order and a State-operated order that provides for marketwide pooling. Proposals 1 and 10 were offered by Northwest Dairy Association (NDA), a cooperative association that markets the milk of their dairy-farmer members in the Pacific Northwest and Western milk marketing areas. The Western order was terminated on April 1, 2004 (69 FR 1958). Accordingly, proposal 10, applicable to the Western order, is no longer considered.

A witness appearing on behalf of NDA, testified that “double dipping” not only creates disorderly conditions in California, it also results in competitive inequities in Federal milk order areas. The NDA witness explained that once minimal pool qualification standards are met, milk pooled via this manner rarely is delivered to a Federal order marketing area.

The NDA witness provided evidence indicating that in 2001, over \$4.5 million was diverted from the Western Order pool and the producer blend price was reduced by an average of 10 cents per hundredweight (cwt) through “double dipping”. The witness was of the opinion that milk pooled through “double dipping” provided no service or delivery of milk from California yet

the California milk receives the benefit of the Western order’s blend price.

The NDA witness testified that there was no evidence of “double dipping” presently occurring on the Pacific Northwest order. However, the witness was of the opinion that the Pacific Northwest order would be targeted. The witness drew this conclusion on the premise that as soon as the “double dipping” loophole is closed in other orders, California milk will be pooled on orders that do not yet prohibit the practice.

Two witnesses, one representing Gossner Foods, Inc. (Gossner), an ultra high temperature (UHT) fluid milk processor located in Utah, and the second, Utah Dairymen’s Association (UDA), a cooperative located in Utah, also provided testimony in support of eliminating “double dipping”. The witnesses concurred that by eliminating “double dipping”, producers pooled on the order would benefit financially and enhance their ability to stay in business.

A witness representing River Valley Milk Producers Inc. (River Valley), a dairy farmer cooperative located in Southwestern Idaho, testified in support of eliminating “double dipping”. The witness was of the opinion that producers from outside of the marketing area should meet pooling standards by demonstrating actual performance in supplying the Western marketing area as a condition for pooling their milk and receiving the blend price. However, the witness stressed that producer milk which already participates in a State marketwide pool should be prohibited from participating in a Federal order pool.

The Commissioner of the Utah Department of Agriculture and Food testified in support of eliminating “double dipping” on the Western milk order. The witness testified that increasing volumes of California milk are diluting the Class I utilization of the market and lowering the blend price paid to producers. The witness found this to be patently unfair and stressed that “double dipping” lowers the income of Utah dairy farmers.

Three dairy farmers from Utah testified in support of prohibiting “double dipping”. These witnesses stated that “double dipping” on the Western order has had a significant negative impact on their pay prices. They maintained that it is unfair and wrong for dairy farmers to have their milk price reduced as a result of California milk being pooled on the order. One dairy farmer witness also added that the loose pooling provisions of the Western Order have resulted in unwarranted financial gain to those who

do not supply the Class I milk market of the Western marketing area. This witness indicated that this contributed to the financial ruin of a quarter of Western Order dairy farmers over the past 4 years.

There was no direct opposition to eliminating or preventing "double dipping". However, a witness testifying on behalf of the Dairy Farmers of America (DFA), a dairy farmer cooperative that markets the milk of their members in the Pacific Northwest and in most other Federal milk orders offered their own proposals. These proposals were published in the hearing notice as Proposals 2, 3, 4, 5, 6, 7, 8, and 9, and are offered, said the witness, to address broader pooling standards and concerns rather than focusing on the single pooling issue of "double dipping".

For nearly 70 years, the Federal Government has operated the milk marketing order program. The law authorizing the use of milk marketing orders, the Agricultural Marketing Agreement Act of 1937 (AMAA), as amended, provides authority for milk marketing orders as an instrument which dairy farmers may voluntarily opt to use to achieve objectives consistent with the AMAA and that are in the public interest. An objective of the AMAA, as it relates to milk, was the stabilization of market conditions in the dairy industry. The declaration of the AMAA is specific: "The disruption of the orderly exchange of commodities in interstate commerce impairs the purchasing power of farmers and destroys the value of agricultural assets which support the national credit structure and that these conditions affect transactions in agricultural commodities with a national public interest, and burden and obstruct the normal channels of interstate commerce."

The AMAA provides authority for employing several methods to achieve more stable marketing conditions. Among these is classified pricing which entails pricing milk according to its use by charging processors differing prices on the basis of form and use. In addition, the AMAA provides for specifying when and how processors are to account for and make payments to dairy farmers. Plus, the AMAA requires that milk prices established by an order be uniform to all processors and that the price charged can be adjusted by, among other things, the location at which milk is delivered by producers (section 608c(5)).

As these features and constraints provided for in the AMAA were employed in establishing prices under

Federal milk orders, some important market stabilization goals were achieved. The most often recognized goal was the near elimination of ruinous pricing practices of handlers competing with each other on the basis of the price they paid dairy farmers for milk and in price concessions made by dairy farmers. The need for processors to compete with each other on the price they paid for milk was significantly reduced because all processors are charged the same minimum amount for milk, and processors had assurance that their competitors were paying the same value-adjusted minimum price.

The AMAA also authorizes the establishment of uniform prices to producers as a method to achieve stable marketing conditions. Marketwide pooling has been adopted in all Federal orders because of its superior features of providing equity to both processors and producers, thereby helping to prevent disorderly marketing conditions. A marketwide pool, using the mechanism of a producer settlement fund to equalize on the use-value of milk pooled on an order, meets that objective of the AMAA of ensuring uniform prices to producers supplying a market.

The California State milk order program clearly has objectives similar to those of the AMAA. Exhibits presented at the hearing indicate that the California State order program has a long history in the development and evolution of a classified pricing plan and in providing equity in pricing to handlers and producers. Important as classified pricing has been in setting minimum prices, the issue of equitable returns to producers for milk could not be satisfied by only the use of a classified pricing plan. Some California plants had higher Class I fluid milk use than did others and some plants processed little or no fluid milk products. As with the Federal order system, producers who were fortunate enough to be located nearer Class I processors had been receiving a much larger return for their milk than producers shipping to plants with lower Class I use or to plants whose main business was the manufacturing of dairy products. Over time, disparate price differences grew between producers located in the same production area of the state which, in turn, led to disorderly marketing conditions and practices. These included producers who became increasingly willing to make price concessions with handlers by accepting lower prices and in paying higher charges for services such as hauling. Contracts between producers and handlers were the norm, but the contracts were not long-term (rarely

more than a single month) and could not provide a stable marketing relationship from which the dairy farmers could plan their operations.

In 1967, the California State legislature passed and enacted the Gonsalves Milk Pooling Act. The law provided the authority for the California Agriculture Secretary to develop and implement a pooling plan, which was implemented in 1968. The California pooling plan provides for the operation of a State-wide pool for all milk that is produced in the State and delivered to California pool plants. It uses an equalization fund that equalizes prices among all handlers and sets minimum prices to be paid to all producers pooled on the State order. While the pooling plan details vary somewhat from pooling details under the Federal order program, the California pooling objectives are basically identical to those of the Federal program.

It is clear from this review of the Federal and California State programs that the orderly marketing of milk is intended in both systems. Both plans provide a stable marketing relationship between handlers and dairy farmers and both serve the public interest. It would be incorrect to conclude that the Federal and California milk order programs have differing purposes when the means, mechanisms, and goals are so nearly identical. In fact, the Federal order program has precedent in recognizing that the California State milk order program has marketwide pooling. Under milk order provisions in effect prior to milk order reform, and under § 1000.76(c), a provision currently applicable to all Federal milk marketing orders, the Department has consistently recognized California as a State government program with marketwide pooling.

Since the 1960's the Federal milk order program recognized the harm and disorder that resulted to both producers and handlers when the same milk of a producer was simultaneously pooled on more than one Federal order. When this occurs, producers do not receive uniform minimum prices, and handlers receive unfair competitive advantages. The need to prevent "double pooling" became critically important as distribution areas expanded and orders merged. The issue of California milk, already pooled under its State-operated program and able to simultaneously be pooled under a Federal order, has essentially the same undesirable outcomes that Federal orders once experienced and subsequently corrected. It is clear that the Pacific Northwest order should be amended to prevent the ability of milk to be pooled

on more than one order when both orders employ marketwide pooling.

There are other State-operated milk order programs that provide for marketwide pooling. For example, New York operates a milk order program for the western region of that State. A key feature explaining why this State-operated program has operated for years alongside the Federal milk order program is the exclusion of milk from the State pool when the same milk is already pooled under a Federal order. Because of the impossibility of the same milk being pooled simultaneously, the Federal order program has had no reason to specifically address "double dipping" or "double pooling" issues, the disorderly marketing conditions that arise from such practice, or the primacy of one regulatory program over another. The other States with marketwide pooling similarly do not double-pool Federal order milk.

The record supports that the Pacific Northwest order should be similarly amended to preclude the ability to simultaneously pool the same milk on the order if the same milk is already pooled on a State-operated order that provides for marketwide pooling.

California milk should only be eligible for pooling on the Pacific Northwest order when it is not pooled on the California State order and when it meets the Pacific Northwest order's pooling standards. It is the ability of milk from California to "double dip" that is a source of disorderly marketing conditions and should be preempted in the case of the Pacific Northwest order.

Proposal 1 offers a reasonable solution for prohibiting the same milk to draw pool funds from Federal and State marketwide pools simultaneously. It is consistent with the current prohibition against the same milk pooling simultaneously in more than one Federal order pool. Adoption of Proposal 1 will not establish any barrier to the pooling of milk from any source that actually demonstrates performance in supplying the Pacific Northwest market's Class I needs. Adoption of Proposal 1 will specifically prohibit the practice of "double dipping".

The amendatory language provided below had been modified by the Department in the interim final rule but nevertheless accomplishes the intent of Proposal 1. The amendment adopted in this final decision to prohibit "double dipping" had been made in the order's *Producer milk* definition. This change was made because milk marketing orders do not regulate producers in their capacity as producers. Additionally, the amendatory language adopted on a permanent basis is consistent with that

adopted in other milk orders where the practice of "double dipping" has been eliminated.

Rulings on Proposed Findings and Conclusions

Briefs and proposed findings and conclusions were filed on behalf of certain interested parties. These briefs, proposed findings and conclusions and the evidence in the record were considered in making the findings and conclusions set forth above. To the extent that the suggested findings and conclusions filed by interested parties are inconsistent with the findings and conclusions set forth herein, the requests to make such findings or reach such conclusions are denied for the reasons previously stated in this decision.

General Findings

The findings and determinations hereinafter set forth supplement those that were made when the Pacific Northwest order was first issued. The previous findings and determinations are hereby ratified and confirmed, except where they may conflict with those set forth herein.

(a) The tentative marketing agreement and the order, as hereby proposed to be amended, and all of the terms and conditions thereof, will tend to effectuate the declared policy of the Act;

(b) The parity prices of milk as determined pursuant to section 2 of the Act are not reasonable in view of the price of feeds, available supplies of feeds, and other economic conditions which affect market supply and demand for milk in the marketing area, and the minimum prices specified in the tentative marketing agreement and the order, as hereby proposed to be amended, are such prices as will reflect the aforesaid factors, insure a sufficient quantity of pure and wholesome milk, and be in the public interest; and

(c) The tentative marketing agreement and the order, as hereby proposed to be amended, will regulate the handling of milk in the same manner as, and will be applicable only to persons in the respective classes of industrial and commercial activity specified in, (a) marketing agreement(s) upon which a hearing has been held.

Rulings on Exceptions

No exceptions to the tentative final decision were received.

Marketing Agreement and Order

Annexed hereto and made a part hereof are two documents, a Marketing Agreement regulating the handling of milk, and an Order amending the order

regulating the handling of milk in the Pacific Northwest marketing area. An interim amended order was approved by producers and published in the **Federal Register** on January 12, 2004 (69 FR 1654), as an Interim Final Rule. Both of these documents have been decided upon as the detailed and appropriate means of effectuating the foregoing conclusions.

It is hereby ordered, that this entire decision and the two documents annexed hereto be published in the **Federal Register**.

Determination of Producer Approval and Representative Period

February 2004 is hereby determined to be the representative period for the purpose of ascertaining whether the issuance of the order, as amended in the Interim Rule published in the **Federal Register** on January 12, 2004 (69 FR 1654), regulating the handling of milk in the Pacific Northwest marketing area is approved or favored by producers, as defined under the terms of the order as amended and as hereby proposed to be amended on a permanent basis who during such representative period were engaged in the production of milk for sale within the aforesaid marketing area.

List of Subjects in 7 CFR Part 1124

Milk marketing orders.

Dated: December 23, 2004.

A. J. Yates,

Administrator, Agricultural Marketing Service.

Order Amending the Order Regulating the Handling of Milk in the Pacific Northwest Marketing Area(s)

This order shall not become effective unless and until the requirements of § 900.14 of the rules of practice and procedure governing proceedings to formulate marketing agreements and marketing orders have been met.

Findings and Determinations

The findings and determinations hereinafter set forth supplement those that were made when the order was first issued and when it was amended. The previous findings and determinations are hereby ratified and confirmed, except where they may conflict with those set forth herein.

(a) Findings. A public hearing was held upon the proposed amendment to the tentative marketing agreement and to the order regulating the handling of milk in the Pacific Northwest marketing area. The hearing was held pursuant to the provisions of the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674), and the

applicable rules of practice and procedure (7 CFR part 900).

Upon the basis of the evidence introduced at such hearing and the record thereof, it is found that:

(1) The said order as hereby amended, and all of the terms and conditions thereof, will tend to effectuate the declared policy of the Act;

(2) The parity prices of milk, as determined pursuant to Section 2 of the Act, are not reasonable in view of the price of feeds, available supplies of feeds, and other economic conditions which affect market supply and demand for milk in the aforesaid marketing area. The minimum prices specified in the order as hereby amended are such prices as will reflect the aforesaid factors, insure a sufficient quantity of pure and wholesome milk, and be in the public interest; and

(3) The said order as hereby amended regulates the handling of milk in the same manner as, and is applicable only to persons in the respective classes of industrial or commercial activity specified in, (a) marketing agreement(s) upon which a hearing has been held.

Order Relative to Handling

It is therefore ordered, that on and after the effective date hereof, the handling of milk in the Pacific Northwest marketing area shall be in conformity to and in compliance with the terms and conditions of the order, as amended, and as hereby amended, as follows:

The provisions of the order amending the order contained in the interim amendment of the order issued by the Administrator, Agricultural Marketing Service, on January 5, 2004, and published in the **Federal Register** on January 12, 2004 (69 FR 1654), shall be and are the terms and provisions of this order.

[This marketing agreement will not appear in the Code of Federal Regulations.]

Marketing Agreement Regulating the Handling of Milk in Pacific Northwest Marketing Area

The parties hereto, in order to effectuate the declared policy of the Act, and in accordance with the rules of practice and procedure effective thereunder (7 CFR Part 900), desire to enter into this marketing agreement and do hereby agree that the provisions referred to in paragraph I hereof as augmented by the provisions specified in paragraph II hereof, shall be and are the provisions of this marketing agreement as if set out in full herein.

I. The findings and determinations, order relative to handling, and the provisions of §§ 1124.1 to 1124.86, all inclusive, of the order regulating the handling of milk in the Pacific Northwest marketing area (7 CFR part 1124 which is annexed hereto); and

II. The following provisions: Record of milk handled and authorization to correct typographical errors.

(a) *Record of milk handled.* The undersigned certifies that he/she handled during the month of _____ 2004, _____ hundredweight of milk covered by this marketing agreement.

(b) *Authorization to correct typographical errors.* The undersigned hereby authorizes the Deputy Administrator, or Acting Deputy Administrator, Dairy Programs, Agricultural Marketing Service, to correct any typographical errors which may have been made in this marketing agreement.

Effective date. This marketing agreement shall become effective upon the execution of a counterpart hereof by the Secretary in accordance with Section 900.14(a) of the aforesaid rules of practice and procedure.

In Witness Whereof, The contracting handlers, acting under the provisions of the Act, for the purposes and subject to the limitations herein contained and not otherwise, have hereunto set their respective hands and seals.

Signature

By (Name)

(Title)

(Address)

(Seal)

Attest

[FR Doc. 04-28629 Filed 12-29-04; 8:45 am]

BILLING CODE 3410-02-P

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 1131

[Docket No. AO-271-837; DA-03-04-A]

Milk in the Arizona-Las Vegas Marketing Area; Tentative Partial Decision on Proposed Amendment and Opportunity To File Written Exceptions to Tentative Marketing Agreement and to Order

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Proposed rule.

SUMMARY: This tentative partial decision adopts on an interim final and emergency basis, a proposal that would eliminate the ability to simultaneously pool the same milk on the Arizona-Las Vegas milk order and any State-operated milk order that has marketwide pooling. This decision requires determining if producers approve the issuance of the amended order on an interim basis. Other proposals considered at the public hearing regarding producer-handlers will be addressed in a separate decision.

DATES: Comments should be submitted on or before February 28, 2005.

ADDRESSES: Comments (6 copies) should be filed with the Hearing Clerk, Room 1083-STOP 9200, United States Department of Agriculture, 1400 Independence Avenue, SW., Washington, DC 20250-9200, and you may also send your comments by the electronic process available at Federal eRulemaking portal at <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT: Jack Rower, Marketing Specialist, Order Formulation and Enforcement Branch, USDA/AMS/Dairy Programs, Room 2971-STOP 0231, 1400 Independence Avenue, SW., Washington, DC 20250-0231, (202) 720-2357, e-mail address: jack.rower@usda.gov.

SUPPLEMENTARY INFORMATION: This administrative action is governed by the provisions of sections 556 and 557 of Title 5 of the United States Code and, therefore, is excluded from the requirements of Executive Order 12866.

The amendment to the rules proposed herein has been reviewed under Executive Order 12988, Civil Justice Reform. It is not intended to have a retroactive effect. If adopted, the proposed rule would not preempt any state or local laws, regulations, or policies, unless they present an irreconcilable conflict with this rule.

The Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601-674), provides that administrative proceedings must be exhausted before parties may file suit in court. Under Section 608c(15)(A) of the Act, any handler subject to an order may request modification or exemption from such order by filing with the Department of Agriculture (Department) a petition stating that the order, any provision of the order, or any obligation imposed in connection with the order is not in accordance with the law. A handler is afforded the opportunity for a hearing on the petition. After a hearing, the Department would rule on the petition. The Act provides that the district court of the United States in any district in which the handler is an inhabitant, or has its principal place of business, has jurisdiction in equity to review the Department's ruling on the petition, provided a bill in equity is filed not later than 20 days after the date of the entry of the ruling.

Regulatory Flexibility Act and Paperwork Reduction Act

In accordance with the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), the Agricultural Marketing Service has considered the economic impact of this

action on small entities and has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities. For the purpose of the Regulatory Flexibility Act, a dairy farm is considered a "small business" if it has an annual gross revenue of less than \$750,000, and a dairy products manufacturer is a "small business" if it has fewer than 500 employees. For the purposes of determining which dairy farms are "small businesses," the \$750,000 per year criterion was used to establish a milk marketing guideline of 500,000 pounds per month. Although this guideline does not factor in additional monies that may be received by dairy producers, it should be an inclusive standard for most "small" dairy farmers. For purposes of determining a handler's size, if the plant is part of a larger company operating multiple plants that collectively exceed the 500-employee limit, the plant will be considered a large business even if the local plant has fewer than 500 employees.

During September 2003, the month during which the hearing began, there were 106 dairy producers pooled on, and 22 handlers regulated by, the Arizona-Las Vegas order. Approximately 18 producers, or 17 percent, were small businesses based on the above criteria. On the handler side, 7, or 32 percent were "small businesses".

The adoption of the proposed producer milk provision, a part of the order's pooling standards, serves to revise established criteria that determine the producer milk that has a reasonable association with the Arizona-Las Vegas milk marketing area and is not associated with other marketwide pools concerning the same milk. Criteria for pooling milk are also established on the basis of performance standards that are considered adequate to meet the Class I fluid needs of the market and determine those that are eligible to share in the revenue arising from the classified pricing of milk. Criteria for pooling are established without regard to the size of any dairy industry organization or entity. The criteria established are applied in an equal fashion to both large and small businesses and do not have any different economic impact on small entities as opposed to large entities. Therefore, the proposed amendment will not have a significant economic impact on a substantial number of small entities.

A review of reporting requirements was completed under the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). It was determined that the

proposed amendment would have no impact on reporting, record keeping, or other compliance requirements because they would remain identical to the current requirements. No new forms are proposed and no additional reporting requirements would be necessary.

This tentative partial decision does not require additional information collection that requires clearance by the Office of Management and Budget (OMB) beyond currently approved information collection. The primary sources of data used to complete the forms are routinely used in most business transactions. Forms require only a minimal amount of information, which can be supplied without data processing equipment or a trained statistical staff. Thus, the information collection and reporting burden is relatively small. Requiring the same reports from all handlers does not significantly disadvantage any handler that is smaller than the industry average.

No other burdens are expected to fall on the dairy industry as a result of overlapping Federal rules. The rulemaking proceeding does not duplicate, overlap, or conflict with any existing Federal rules.

Interested parties are invited to submit comments on the probable regulatory and informational impact of this proposed rule on small entities. Also, parties may suggest modifications of this proposal for the purpose of tailoring their applicability to small businesses.

Prior Document in This Proceeding

Notice of Hearing: Issued July 31, 2003; published August 6, 2003 (68 FR 46505).

Correction to Notice of Hearing: August 20, 2003; published August 26, 2003 (68 FR 51202).

Notice of Reconvened Hearing: Issued October 27, 2003; published October 31, 2003 (68 FR 62027).

Notice of Reconvened Hearing: Issued December 18, 2003; published December 29, 2003 (68 FR 74874).

Preliminary Statement

Notice is hereby given of the filing with the Hearing Clerk of this tentative partial decision with respect to the proposed amendment to the tentative marketing agreement and the order regulating the handling of milk in the Arizona-Las Vegas marketing area. This notice is issued pursuant to the provisions of the Agricultural Marketing Agreement Act and the applicable rules of practice and procedure governing the formulation of marketing agreements and marketing orders (7 CFR part 900).

Interested parties may file written exceptions to this decision with the Hearing Clerk, U.S. Department of Agriculture, Room 1083-STOP 9200, 1400 Independence Avenue, SW., Washington, DC 20250-9200, by February 28, 2005. Six (6) copies of the exceptions should be filed. All written submissions made pursuant to this notice will be made available for public inspection at the office of the Hearing Clerk during regular business hours (7 CFR 1.27(b)).

The hearing notice specifically invited interested persons to present evidence concerning the probable regulatory and informational impact of proposals on small businesses. While no evidence was received that specifically addressed this issue, some of the evidence encompassed entities of various size.

The proposed amendment set forth below is based on the record of a public hearing held at Tempe, Arizona, on September 23-25, 2003, pursuant to a notice of hearing issued July 31, 2003, and published August 6, 2003 (68 FR 46505); reconvened at Seattle, Washington, on November 17-21, 2003, pursuant to a notice of reconvened hearing issued October 27, 2003, and published October 31, 2003 (68 FR 62027); and reconvened at Alexandria, Virginia, on January 20-22, 2004, pursuant to a notice of reconvened hearing issued December 18, 2003, and published December 29, 2003 (68 FR 74874).

The material issues on the record of the hearing relate to:

1. Simultaneous pooling of milk on the order and on a State-operated milk order providing for marketwide pooling.
2. Determination as to whether emergency marketing conditions exist that would warrant the omission of a recommended decision and the opportunity to file written exceptions.

Finding and Conclusions

The following findings and conclusions on the material issues are based on evidence presented at the hearing and the record thereof:

1. Simultaneous Pooling on a Federal and State-Operated Milk Order

A proposal, published in the hearing notice as Proposal 4, seeking to exclude the same milk from being simultaneously pooled on the Arizona-Las Vegas order and any State-operated order which provides for marketwide pooling, should be adopted immediately. The practice of pooling milk on a Federal order and simultaneously pooling the same milk on a State-operated order has come to be

referred to as double-dipping. The Arizona-Las Vegas order does not currently prohibit milk from being simultaneously pooled on the order and a State-operated order that provides for marketwide pooling. Proposal 4 was offered by United Dairymen of Arizona, a cooperative association that markets the milk of their members in the Arizona-Las Vegas marketing area.

A witness appearing on behalf of the Alliance of Western Milk Producers, testified in support of Proposal 4. The witness testified that double-dipping creates a competitive advantage in both procuring milk and competing for markets for milk.

A witness appearing on behalf of Northwest Dairy Association (NDA), testified in support of Proposal 4, saying that double-dipping not only creates disorderly conditions in California, it also results in competitive inequities in Federal milk order areas. The NDA witness explained that once minimal pool qualification standards are met, milk pooled in this manner rarely is delivered to a Federal order marketing area. The witness noted that the implementation of similar provisions in Orders 30, 32, and 124, which effectively prevents the simultaneous pooling of milk in the California State-wide pool and in the Federal order, should also be adopted for the Arizona-Las Vegas order.

A witness testifying on behalf of Dairy Farmers of America (DFA), a dairy farmer cooperative that markets the milk of their members in Arizona-Las Vegas and in most of the other Federal milk orders, supported adoption of Proposal 4. The witness indicated that the regulatory language for this proposal is identical to what has been adopted for Orders 30, 32, 33, and 124. A witness representing Sarah Farms, a producer-handler located in Arizona, testified in opposition to adopting Proposal 4. The witness was of the opinion that the adoption of Proposal 4 would be a trade restriction and that Sarah Farms preferred freer trade rather than more restricted trade. The witness concluded by hypothesizing that Proposal 4 was proposed to hurt Sarah Farms.

A witness representing Edaleen Dairy, a producer-handler located in Lynden, Washington, also testified in opposition to adopting Proposal 4. The witness indicated that since Sarah Farms was opposed to Proposal 4, they would also be opposed to it.

The witness explained that California operates a quota and overbase payment system. Under this system, all producers receive a uniform blend price in the form of the overbase. Other producers are entitled to an additional payment of

\$1.70 per hundredweight for their "quota" milk. The witness noted that producers who have moved California milk into the Arizona market have lost their quota and if they were to participate in California again they would only be entitled to the overbase price. The witness indicated that the California Department of Food and Agriculture had issued a decision that required a producer participating in the state order to do so for a period of twelve months at a time, preventing participation in the Federal order program because California does not permit dual participation. As a result, the witness noted that benefits can not be obtained by double-dipping.

In post hearing briefs, Edaleen Dairy, Mallorie's Dairy, Smith Brothers Farm, and Sarah Farms concurred that a producer located in California, pooling milk in Arizona, would not be considered double-dipping.

For nearly 70 years, the Federal government has operated the milk marketing order program. The law authorizing the use of milk marketing orders, the Agricultural Marketing Agreement Act of 1937 (AMAA), as amended, provides authority for milk marketing orders as an instrument which dairy farmers may voluntarily use to achieve objectives consistent with the AMAA and that are in the public interest. An objective of the AMAA, as it relates to milk, was the stabilization of market conditions in the dairy industry. The declaration of the AMAA is specific: "the disruption of the orderly exchange of commodities in interstate commerce impairs the purchasing power of farmers and destroys the value of agricultural assets which support the national credit structure and that these conditions affect transactions in agricultural commodities with a national public interest, and burden and obstruct the normal channels of interstate commerce."

The AMAA provides authority for employing several methods to achieve more stable marketing conditions. Among these is classified pricing, which entails pricing milk according to its use by charging processors differing prices on the basis of form and use. In addition, the AMAA provides for specifying when and how processors are to account for and make payments to dairy farmers. Plus, the AMAA requires that milk prices established by an order be uniform to all processors and that the price charged can be adjusted by, among other things, the location at which milk is delivered by producers (section 608c(5)).

As these features and constraints provided for in the AMAA were employed in establishing prices under Federal milk orders, some important market stabilization goals were achieved. The most often recognized goal was the near elimination of ruinous pricing practices of handlers competing with each other on the basis of the price they paid dairy farmers for milk and in price concessions made by dairy farmers. The need for processors to compete with each other on the price they paid for milk was significantly reduced because all processors are charged the same minimum amount for milk, and processors had assurance that their competitors were paying the same value-adjusted minimum price.

The AMAA also authorizes the establishment of uniform prices to producers as a method to achieve stable marketing conditions. Marketwide pooling has been adopted in all Federal orders because it provides equity to both processors and producers, thereby helping to prevent disorderly marketing conditions. A marketwide pool, using the mechanism of a producer settlement fund to equalize the use-value of milk pooled on an order, meets that objective of the AMAA, ensuring uniform prices to producers supplying a market.

Since the 1960's the Federal milk order program has recognized the harm and disorder that resulted to both producers and handlers when the same milk of a producer was simultaneously pooled on more than one Federal order. When this occurs, producers do not receive uniform minimum prices, and handlers receive unfair competitive advantages. The need to prevent "double pooling" became critically important as distribution areas expanded and orders merged. Milk already pooled under a State-operated program and able to simultaneously be pooled under a Federal order has essentially the same undesirable outcomes that Federal orders once experienced and subsequently corrected.

There are other State-operated milk order programs that provide for marketwide pooling. For example, New York operates a milk order program for the western region of that State. A key feature explaining why this State-operated program has operated for years alongside the Federal milk order program is the exclusion of milk from the State pool when the same milk is already pooled under a Federal order. Because of the impossibility of the same milk being pooled simultaneously, the Federal order program has had no reason to specifically address "double dipping" or "double pooling" issues,

the disorderly marketing conditions that arise from such practice, or the primacy of one regulatory program over another. The other States with marketwide pooling similarly do not allow double-pooling of Federal order milk.

The record supports that the Arizona-Las Vegas order should be amended to preclude the ability to simultaneously pool the same milk on the order if the same milk is already pooled on a State-operated order that provides for marketwide pooling.

Proposal 4 offers a reasonable solution for prohibiting the same milk to draw pool funds from Federal and State marketwide pools simultaneously. It is consistent with the current prohibition against allowing the same milk to participate simultaneously in more than one Federal order pool. Adoption of Proposal 4 will not establish any barrier to the pooling of milk from any source that actually demonstrates performance in supplying the Arizona-Las Vegas market's Class I needs.

2. Determination of Emergency Marketing Conditions

Evidence presented at the hearing establishes that California milk that can be pooled simultaneously on a State-operated order and a Federal order, a practice commonly referred to as double-dipping, would render the Arizona-Las Vegas milk order unable to establish prices that are uniform to producers and to handlers. This shortcoming of the pooling provisions could allow milk not providing a reasonable or consistent service to meeting the needs of the Class I market to be pooled on the Arizona-Las Vegas order.

In view of these findings, an interim final rule amending the order will be issued as soon as the procedures are completed to determine the approval of producers whose milk is pooled in the Arizona-Las Vegas order. Consequently, it is determined that emergency marketing conditions exist and the issuance of a recommended decision is therefore being omitted. The record clearly establishes a basis as noted above for amending the order on an interim basis. Other proposals considered at the public hearing regarding producer-handlers will be issued in a separate decision.

Rulings on Proposed Findings and Conclusions

Briefs, proposed findings and conclusions were filed on behalf of certain interested parties. These briefs, proposed findings and conclusions, and the evidence in the record were considered in making the findings and

conclusions set forth above. To the extent that the suggested findings and conclusions filed by interested parties are inconsistent with the findings and conclusions set forth herein, the requests to make such findings or reach such conclusions are denied for the reasons previously stated in this decision.

General Findings

The findings and determinations hereinafter set forth supplement those that were made when the Arizona-Las Vegas order was first issued and when it was amended. The previous findings and determinations are hereby ratified and confirmed, except where they may conflict with those set forth herein.

The following findings are hereby made with respect to the aforesaid marketing agreement and order:

(a) The interim marketing agreement and the order, as hereby proposed to be amended, and all of the terms and conditions thereof, will tend to effectuate the declared policy of the Act;

(b) The parity prices of milk as determined pursuant to section 2 of the Act are not reasonable with respect to the price of feeds, available supplies of feeds, and other economic conditions which affect market supply and demand for milk in the marketing area, and the minimum prices specified in the interim marketing agreement and the order, as hereby proposed to be amended, are such prices as will reflect the aforesaid factors, insure a sufficient quantity of pure and wholesome milk, and be in the public interest; and

(c) The interim marketing agreement and the order, as hereby proposed to be amended, will regulate the handling of milk in the same manner as, and will be applicable only to persons in the respective classes of industrial and commercial activity specified in, the marketing agreement upon which a hearing has been held.

Interim Marketing Agreement and Interim Order Amending the Order

Annexed hereto and made a part hereof are two documents: an Interim Marketing Agreement regulating the handling of milk, and an Interim Order amending the order regulating the handling of milk in the Arizona-Las Vegas marketing area, which have been decided upon as the detailed and appropriate means of effectuating the foregoing conclusions.

It is hereby ordered, that this entire tentative partial decision and the interim order and the interim marketing agreement annexed hereto be published in the **Federal Register**.

Determination of Producer Approval and Representative Period

The month of May 2004 is hereby determined to be the representative period for the purpose of ascertaining whether the issuance of the order, as amended and as hereby proposed to be amended, regulating the handling of milk in the Arizona-Las Vegas marketing area is approved or favored by producers, as defined under the terms of the order as hereby proposed to be amended, who during such representative period were engaged in the production of milk for sale within the aforesaid marketing area.

List of Subjects in 7 CFR Part 1131

Milk marketing orders.

Dated: December 23, 2004.

A.J. Yates,

Administrator, Agricultural Marketing Service.

Interim Order Amending the Order Regulating the Handling of Milk in the Arizona-Las Vegas Marketing Area

This interim order shall not become effective unless and until the requirements of § 900.14 of the rules of practice and procedure governing proceedings to formulate marketing agreements and marketing orders have been met.

Findings and Determinations

The findings and determinations hereinafter set forth supplement those that were made when the order was first issued and when it was amended. The previous findings and determinations are hereby ratified and confirmed, except where they may conflict with those set forth herein.

(a) *Findings.* A public hearing was held upon certain proposed amendments to the tentative marketing agreement and to the order regulating the handling of milk in the Arizona-Las Vegas marketing area. The hearing was held pursuant to the provisions of the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674), and the applicable rules of practice and procedure (7 CFR part 900).

Upon the basis of the evidence introduced at such hearing and the record thereof, it is found that:

(1) The said order as hereby amended, and all of the terms and conditions thereof, will tend to effectuate the declared policy of the Act;

(2) The parity prices of milk, as determined pursuant to section 2 of the Act, are not reasonable in view of the price of feeds, available supplies of feeds, and other economic conditions which affect market supply and demand

for milk in the aforesaid marketing area. The minimum prices specified in the order as hereby amended are such prices as will reflect the aforesaid factors, insure a sufficient quantity of pure and wholesome milk, and be in the public interest; and

(3) The said order as hereby amended regulates the handling of milk in the same manner as, and is applicable only to persons in the respective classes of industrial or commercial activity specified in, a marketing agreement upon which a hearing has been held.

Order Relative to Handling

It is therefore ordered, that on and after the effective date hereof, the handling of milk in the Arizona-Las Vegas marketing area shall be in conformity to and in compliance with the terms and conditions of the order, as amended, and as hereby amended, as follows:

The authority citation for 7 CFR part 1131 continues to read as follows:

Authority: 7 U.S.C. 601–674.

PART 1131—MILK IN THE ARIZONA—LAS VEGAS MARKETING AREA

1. Section 1131.13 is amended by adding a new paragraph (e) to read as follows:

§ 1131.13 Producer milk.

* * * * *

(e) Producer milk shall not include milk of a producer that is subject to a marketwide equalization pool under a milk classification and pricing plan under the authority of a State government.

[This marketing agreement will not appear in the Code of Federal Regulations.]

Marketing Agreement Regulating the Handling of Milk in Certain Marketing Areas

The parties hereto, in order to effectuate the declared policy of the Act, and in accordance with the rules of practice and procedure effective thereunder (7 CFR part 900), desire to enter into this marketing agreement and do hereby agree that the provisions referred to in paragraph I hereof as augmented by the provisions specified in paragraph II hereof, shall be and are the provisions of this marketing agreement as if set out in full herein.

I. The findings and determinations, order relative to handling, and the provisions of §§ 1131.1 to 1131.86 all inclusive, of the order regulating the handling of milk in the Arizona-Las Vegas marketing area (7 CFR part 1131) which is annexed hereto; and

II. The following provisions: Record of milk handled and authorization to correct typographical errors.

(a) *Record of milk handled.* The undersigned certifies that he/she handled during the month of _____ 2004,

_____ hundredweight of milk covered by this marketing agreement.

(b) *Authorization to correct typographical errors.* The undersigned hereby authorizes the Deputy Administrator, or Acting Deputy Administrator, Dairy Programs, Agricultural Marketing Service, to correct any typographical errors which may have been made in this marketing agreement.

Effective date. This marketing agreement shall become effective upon the execution of a counterpart hereof by the Department in accordance with Section 900.14(a) of the aforesaid rules of practice and procedure.

In witness whereof, The contracting handlers, acting under the provisions of the Act, for the purposes and subject to the limitations herein contained and not otherwise, have hereunto set their respective hands and seals.

Signature _____

By (Name) _____

(Title) _____

(Address) _____

(Seal) _____

Attest _____

[FR Doc. 04–28630 Filed 12–29–04; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2004–19929; Directorate Identifier 2004–NE–15–AD]

RIN 2120–AA64

Airworthiness Directives; Pratt & Whitney JT8D–1, –1A, –1B, –7, –7A, –7B, –9, –9A, –11, –15, –15A, –17, –17A, –17R, –17AR, –209, –217, –217A, –217C, and –219 Turbofan Engines

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to adopt a new airworthiness directive (AD) for Pratt & Whitney (PW) JT8D–1, –1A, –1B, –7, –7A, –7B, –9, –9A, –11, –15, –15A, –17, –17A, –17R, –17AR, –209, –217, –217A, –217C, and –219 turbofan engines. This proposed AD would require removing affected rotating parts overhauled by a certain repair vendor, and inspecting or replacing the parts as applicable. This proposed AD results from reports that certain JT8D critical life-limited rotating parts have been returned to service with cracks, corrosion pitting, or dimensions outside of manual limits. We are proposing this AD to prevent failure of critical life-limited rotating engine parts which could result in an uncontained engine failure and damage to the airplane.

DATES: We must receive any comments on this proposed AD by February 28, 2005.

ADDRESSES: Use one of the following addresses to submit comments on this proposed AD.

- DOT Docket Web site: Go to <http://dms.dot.gov> and follow the instructions for sending your comments electronically.

- Government-wide rulemaking Web site: Go to <http://www.regulations.gov> and follow the instructions for sending your comments electronically.

- Mail: Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–001.

- Fax: (202) 493–2251.

- Hand Delivery: Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

You can get the service information identified in this proposed AD from Pratt & Whitney, 400 Main St., East Hartford, CT 06108; telephone (860) 565–7700; fax (860) 565–1605.

You may examine the comments on this proposed AD in the AD docket on the Internet at <http://dms.dot.gov>.

FOR FURTHER INFORMATION CONTACT:

Keith Lardie, Aerospace Engineer, Engine Certification Office, FAA, Engine and Propeller Directorate, 12 New England Executive Park, Burlington, MA 01803–5299; telephone (781) 238–7189; fax (781) 238–7199.

SUPPLEMENTARY INFORMATION:

Docket Management System (DMS)

We have implemented new procedures for maintaining AD dockets electronically. As of May 17, 2004, we post new AD actions on the DMS and assign a DMS docket number. We track each action and assign a corresponding Directorate identifier. The DMS docket No. is in the form “Docket No. FAA–200X–XXXXX.” Each DMS docket also lists the Directorate identifier (“Old Docket Number”) as a cross-reference for searching purposes.

Comments Invited

We invite you to submit any written relevant data, views, or arguments regarding this proposal. Send your comments to an address listed under **ADDRESSES**. Include “Docket No. FAA–2004–19929; Directorate Identifier 2004–NE–15–AD” in the subject line of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of the proposed AD. We will

consider all comments received by the closing date and may amend the proposed AD in light of those comments.

We will post all comments we receive, without change, to <http://dms.dot.gov>, including any personal information you provide. We will also post a report summarizing each substantive verbal contact with FAA personnel concerning this proposed AD. Using the search function of the DMS Web site, anyone can find and read the comments in any of our dockets, including the name of the individual who sent the comment (or signed the comment on behalf of an association, business, labor union, etc.). You may review the DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477-78) or you may visit <http://dms.dot.gov>.

Examining the AD Docket

You may examine the docket that contains the proposal, any comments received and any final disposition in person at the DMS Docket Offices between 9:00 a.m. and 5:00 p.m., Monday through Friday, except Federal holidays. The Docket Office (telephone (800) 647-5227) is located on the plaza level of the Department of Transportation Nassif Building at the street address stated in **ADDRESSES**. Comments will be available in the AD docket shortly after the DMS receives them.

Discussion

During an investigation of two high pressure compressor disks from a repair vendor, PW found chips in the disks' protective coating. When PW removed the remainder of the coating, PW found cracks and corrosion pitting. Upon further investigation, PW found approximately 85% of the parts PW looked at from the same repair vendor were either cracked, had cracks emanating from bolt holes, were pitted, or improperly blended or machined. As a result, we issued Special Airworthiness Information Bulletin (SAIB) No. NE-02-08 on December 20, 2001 to provide additional information about this subject. SAIB No. NE-02-08 does not provide compliance time information. This condition, if not corrected, could result in an uncontained engine failure and damage to the airplane.

Relevant Service Information

We have reviewed and approved the technical contents of PW Alert Service Bulletin (ASB) No. JT8D A6442, dated April 4, 2003, that describes procedures

for removing the affected rotating parts, inspecting, overhauling, and returning the parts to service as applicable.

FAA's Determination and Requirements of the Proposed AD

We have evaluated all pertinent information and identified an unsafe condition that is likely to exist or develop on other products of this same type design. We are proposing this AD, which would require removing affected rotating parts overhauled by CADMAR Aerospace, Inc. and inspecting or replacing the parts as applicable. The proposed AD would require you to use the service information described previously to perform these actions.

Costs of Compliance

We estimate that about 632 JT8D engines installed on airplanes of U.S. registry would be affected by this proposed AD. We estimate that 158 engines will require access to the high pressure compressor outside of regularly scheduled maintenance, and will require 66 work hours per engine. The high pressure compressor section of the remaining 474 engines will be inspected during regularly scheduled maintenance, and will therefore not require additional labor costs to inspect. The average labor rate is \$65 per work hour. We estimate that half of the parts presently installed will require replacement, at a cost of approximately \$6,730,750. Based on this information, we estimate the total cost of the proposed AD to U.S. operators to be \$8,086,390.

Authority for This Rulemaking

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

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

Regulatory Findings

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

For the reasons discussed above, I certify that the proposed regulation:

1. Is not a "significant regulatory action" under Executive Order 12866;
2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and
3. Would not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a summary of the costs to comply with this proposal and placed it in the AD Docket. You may get a copy of this summary at the address listed under **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. The Federal Aviation Administration amends § 39.13 by adding the following new airworthiness directive (AD):

Pratt & Whitney: Docket No. FAA-2004-19929; Directorate Identifier 2004-NE-15-AD.

Comments Due Date

- (a) The FAA must receive comments on this AD action by February 28, 2005.

Affected ADs

- (b) None.

Applicability

- (c) This AD applies to Pratt & Whitney (PW) JT8D-1, -1A, -1B, -7, -7A, -7B, -9, -9A, -11, -15, -15A, -17, -17A, -17R, -17AR, -209, -217, -217A, -217C, and -219 turbofan engines. These engines are installed on, but not limited to, Boeing 727 and 737 series, and McDonnell Douglas DC-9 series and MD-80 series airplanes.

Unsafe Condition

(d) This AD results from reports that certain JT8D critical life-limited rotating parts have been returned to service with cracks, corrosion pitting, or dimensions outside of manual limits. We are issuing this AD to prevent failure of critical life-limited rotating engine parts, which could result in an uncontained engine failure and damage to the airplane.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified unless the actions have already been done, and no later than March 31, 2008.

Disks and Hubs Installed in Engines

(f) At the next shop visit after the effective date of this AD, remove all coating from the

disks and hubs identified in Tables 1 and 2 of this AD and visually, dimensionally, and nondestructively inspect the parts using the inspection criteria listed in the Accomplishment Instructions portion of PW Alert Service Bulletin (ASB) No. JT8D A6442, dated April 4, 2003.

TABLE 1.—AFFECTED 7TH, 8TH, 9TH, 10TH, 11TH, AND 12TH STAGE COMPRESSOR DISKS

SN	P/N *	Description *
B207AA0072	774407	DISK—COMPRESSOR, 7TH STAGE.
B207AA0185	774407	DISK—COMPRESSOR, 7TH STAGE.
B207AA0265	774407	DISK—COMPRESSOR, 7TH STAGE.
B207AA0307	774407	DISK—COMPRESSOR, 7TH STAGE.
B207AA0390	774407	DISK—COMPRESSOR, 7TH STAGE.
B207AA0602	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAH2848	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAJ5251	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAJ8447	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAJ8508	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAK1906	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAK5073	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAK6015	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAK6588	774407	DISK—COMPRESSOR, 7TH STAGE.
G83339	774407	DISK—COMPRESSOR, 7TH STAGE.
H29725	774407	DISK—COMPRESSOR, 7TH STAGE.
J39323	774407	DISK—COMPRESSOR, 7TH STAGE.
J66757	774407	DISK—COMPRESSOR, 7TH STAGE.
J93566	774407	DISK—COMPRESSOR, 7TH STAGE.
K72131	774407	DISK—COMPRESSOR, 7TH STAGE.
L24089	774407	DISK—COMPRESSOR, 7TH STAGE.
M15351	774407	DISK—COMPRESSOR, 7TH STAGE.
M78744	774407	DISK—COMPRESSOR, 7TH STAGE.
M88080	774407	DISK—COMPRESSOR, 7TH STAGE.
N04693	774407	DISK—COMPRESSOR, 7TH STAGE.
N24126	774407	DISK—COMPRESSOR, 7TH STAGE.
N37768	774407	DISK—COMPRESSOR, 7TH STAGE.
N70373	774407	DISK—COMPRESSOR, 7TH STAGE.
N88332	774407	DISK—COMPRESSOR, 7TH STAGE.
P14777	774407	DISK—COMPRESSOR, 7TH STAGE.
P14853	774407	DISK—COMPRESSOR, 7TH STAGE.
P54407	774407	DISK—COMPRESSOR, 7TH STAGE.
P60411	774407	DISK—COMPRESSOR, 7TH STAGE.
R02963	774407	DISK—COMPRESSOR, 7TH STAGE.
R02983	774407	DISK—COMPRESSOR, 7TH STAGE.
R03090	774407	DISK—COMPRESSOR, 7TH STAGE.
R12397	774407	DISK—COMPRESSOR, 7TH STAGE.
R12398	774407	DISK—COMPRESSOR, 7TH STAGE.
R12414	774407	DISK—COMPRESSOR, 7TH STAGE.
R12506	774407	DISK—COMPRESSOR, 7TH STAGE.
R12527	774407	DISK—COMPRESSOR, 7TH STAGE.
R19285	774407	DISK—COMPRESSOR, 7TH STAGE.
R19423	774407	DISK—COMPRESSOR, 7TH STAGE.
R19466	774407	DISK—COMPRESSOR, 7TH STAGE.
R31288	774407	DISK—COMPRESSOR, 7TH STAGE.
R31356	774407	DISK—COMPRESSOR, 7TH STAGE.
R37429	774407	DISK—COMPRESSOR, 7TH STAGE.
R57637	774407	DISK—COMPRESSOR, 7TH STAGE.
R57707	774407	DISK—COMPRESSOR, 7TH STAGE.
R72163	774407	DISK—COMPRESSOR, 7TH STAGE.
R81448	774407	DISK—COMPRESSOR, 7TH STAGE.
R81455	774407	DISK—COMPRESSOR, 7TH STAGE.
R90915	774407	DISK—COMPRESSOR, 7TH STAGE.
S05602	774407	DISK—COMPRESSOR, 7TH STAGE.
S13909	774407	DISK—COMPRESSOR, 7TH STAGE.
S13945	774407	DISK—COMPRESSOR, 7TH STAGE.
S14021	774407	DISK—COMPRESSOR, 7TH STAGE.
S14057	774407	DISK—COMPRESSOR, 7TH STAGE.
S14083	774407	DISK—COMPRESSOR, 7TH STAGE.
S14112	774407	DISK—COMPRESSOR, 7TH STAGE.
S36685	774407	DISK—COMPRESSOR, 7TH STAGE.

TABLE 1.—AFFECTED 7TH, 8TH, 9TH, 10TH, 11TH, AND 12TH STAGE COMPRESSOR DISKS—Continued

SN	P/N *	Description *
S36696	774407	DISK—COMPRESSOR, 7TH STAGE.
S36760	774407	DISK—COMPRESSOR, 7TH STAGE.
S36882	774407	DISK—COMPRESSOR, 7TH STAGE.
S37210	774407	DISK—COMPRESSOR, 7TH STAGE.
S37330	774407	DISK—COMPRESSOR, 7TH STAGE.
S37334	774407	DISK—COMPRESSOR, 7TH STAGE.
S37351	774407	DISK—COMPRESSOR, 7TH STAGE.
S37384	774407	DISK—COMPRESSOR, 7TH STAGE.
T04464	774407	DISK—COMPRESSOR, 7TH STAGE.
T04520	774407	DISK—COMPRESSOR, 7TH STAGE.
T04635	774407	DISK—COMPRESSOR, 7TH STAGE.
T04674	774407	DISK—COMPRESSOR, 7TH STAGE.
T04725	774407	DISK—COMPRESSOR, 7TH STAGE.
T04770	774407	DISK—COMPRESSOR, 7TH STAGE.
T04778	774407	DISK—COMPRESSOR, 7TH STAGE.
T04841	774407	DISK—COMPRESSOR, 7TH STAGE.
T04965	774407	DISK—COMPRESSOR, 7TH STAGE.
T05018	774407	DISK—COMPRESSOR, 7TH STAGE.
BENCAP1838	815607	DISK—COMPRESSOR, 7TH STAGE.
BENCAP5647	815607	DISK—COMPRESSOR, 7TH STAGE.
B207AA0127	5006007-01	DISK—COMPRESSOR, 7TH STAGE.
BENCAK9663	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
BENCAL3896	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
BENCAL5171	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
BENCAM1583	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
BENCAM3953	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
BENCAM8359	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
BENCAM8385	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
BENCAN5764	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
BENCAN5857	5006007-02	DISK—COMPRESSOR, 7TH STAGE.
2B7763	738308	DISK—COMPRESSOR, 8TH STAGE.
B208AA0063	748608	DISK—COMPRESSOR, 8TH STAGE.
B208AA0075	748608	DISK—COMPRESSOR, 8TH STAGE.
BENCAM3705	748608	DISK—COMPRESSOR, 8TH STAGE.
BENCAP0649	748608	DISK—COMPRESSOR, 8TH STAGE.
BENCAP1082	748608	DISK—COMPRESSOR, 8TH STAGE.
G62633	748608	DISK—COMPRESSOR, 8TH STAGE.
H64242	748608	DISK—COMPRESSOR, 8TH STAGE.
H64541	748608	DISK—COMPRESSOR, 8TH STAGE.
J27080	748608	DISK—COMPRESSOR, 8TH STAGE.
M54597	748608	DISK—COMPRESSOR, 8TH STAGE.
N84400	748608	DISK—COMPRESSOR, 8TH STAGE.
P26132	748608	DISK—COMPRESSOR, 8TH STAGE.
P28454	748608	DISK—COMPRESSOR, 8TH STAGE.
P28525	748608	DISK—COMPRESSOR, 8TH STAGE.
P28529	748608	DISK—COMPRESSOR, 8TH STAGE.
P28610	748608	DISK—COMPRESSOR, 8TH STAGE.
R18442	748608	DISK—COMPRESSOR, 8TH STAGE.
R44993	748608	DISK—COMPRESSOR, 8TH STAGE.
R45505	748608	DISK—COMPRESSOR, 8TH STAGE.
R74513	748608	DISK—COMPRESSOR, 8TH STAGE.
S01111	748608	DISK—COMPRESSOR, 8TH STAGE.
S19131	748608	DISK—COMPRESSOR, 8TH STAGE.
S50698	748608	DISK—COMPRESSOR, 8TH STAGE.
S50793	748608	DISK—COMPRESSOR, 8TH STAGE.
S78019	748608	DISK—COMPRESSOR, 8TH STAGE.
BENCAP4498	815608	DISK—COMPRESSOR, 8TH STAGE.
BENCAP4505	815608	DISK—COMPRESSOR, 8TH STAGE.
BENCAR1361	815608	DISK—COMPRESSOR, 8TH STAGE.
BENCAR1363	815608	DISK—COMPRESSOR, 8TH STAGE.
BENCAR1367	815608	DISK—COMPRESSOR, 8TH STAGE.
R91483	5005808-01	DISK—COMPRESSOR, 8TH STAGE.
T03355	5005808-01	DISK—COMPRESSOR, 8TH STAGE.
M33420	787008	HUB—REAR COMPRESSOR, FRONT.
N06209	787008	HUB—REAR COMPRESSOR, FRONT.
N33004	787008	HUB—REAR COMPRESSOR, FRONT.
N33349	787008	HUB—REAR COMPRESSOR, FRONT.
N33420	787008	HUB—REAR COMPRESSOR, FRONT.
N34154	787008	HUB—REAR COMPRESSOR, FRONT.
N90416	787008	HUB—REAR COMPRESSOR, FRONT.
N90658	787008	HUB—REAR COMPRESSOR, FRONT.
B228AA0190	787208	HUB—REAR COMPRESSOR, FRONT.

TABLE 1.—AFFECTED 7TH, 8TH, 9TH, 10TH, 11TH, AND 12TH STAGE COMPRESSOR DISKS—Continued

SN	P/N *	Description *
B228AA0194	787208	HUB—REAR COMPRESSOR, FRONT.
B228AA1021	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAH0967	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAH0969	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAK0069	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAK8767	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAL2504	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAM2701	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAN0012	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAN1226	787208	HUB—REAR COMPRESSOR, FRONT.
BENCAN3008	787208	HUB—REAR COMPRESSOR, FRONT.
P43696	787208	HUB—REAR COMPRESSOR, FRONT.
P43934	787208	HUB—REAR COMPRESSOR, FRONT.
P43948	787208	HUB—REAR COMPRESSOR, FRONT.
P44411	787208	HUB—REAR COMPRESSOR, FRONT.
P45017	787208	HUB—REAR COMPRESSOR, FRONT.
P45277	787208	HUB—REAR COMPRESSOR, FRONT.
P45459	787208	HUB—REAR COMPRESSOR, FRONT.
P45544	787208	HUB—REAR COMPRESSOR, FRONT.
R23166	787208	HUB—REAR COMPRESSOR, FRONT.
R23187	787208	HUB—REAR COMPRESSOR, FRONT.
R23277	787208	HUB—REAR COMPRESSOR, FRONT.
R23628	787208	HUB—REAR COMPRESSOR, FRONT.
R23806	787208	HUB—REAR COMPRESSOR, FRONT.
R24209	787208	HUB—REAR COMPRESSOR, FRONT.
R24598	787208	HUB—REAR COMPRESSOR, FRONT.
R24900	787208	HUB—REAR COMPRESSOR, FRONT.
R91415	787208	HUB—REAR COMPRESSOR, FRONT.
R91746	787208	HUB—REAR COMPRESSOR, FRONT.
R92224	787208	HUB—REAR COMPRESSOR, FRONT.
S07564	787208	HUB—REAR COMPRESSOR, FRONT.
S07655	787208	HUB—REAR COMPRESSOR, FRONT.
S07706	787208	HUB—REAR COMPRESSOR, FRONT.
S39160	787208	HUB—REAR COMPRESSOR, FRONT.
S39199	787208	HUB—REAR COMPRESSOR, FRONT.
S39338	787208	HUB—REAR COMPRESSOR, FRONT.
S39741	787208	HUB—REAR COMPRESSOR, FRONT.
S39839	787208	HUB—REAR COMPRESSOR, FRONT.
S40023	787208	HUB—REAR COMPRESSOR, FRONT.
S40043	787208	HUB—REAR COMPRESSOR, FRONT.
B228AA0261	792038	HUB—REAR COMPRESSOR, 8TH STAGE.
B228AA0566	792038	HUB—REAR COMPRESSOR, 8TH STAGE.
BENCAK8279	792038	HUB—REAR COMPRESSOR, 8TH STAGE.
M41870	792038	HUB—REAR COMPRESSOR, 8TH STAGE.
N89470	797938	HUB—REAR COMPRESSOR, 8TH STAGE.
BENCAP5753	815708	HUB—REAR COMPRESSOR, 8TH STAGE.
BENCAR5454	815708	HUB—REAR COMPRESSOR, 8TH STAGE.
BENCAR5458	815708	HUB—REAR COMPRESSOR, 8TH STAGE.
BENCAR5500	815708	HUB—REAR COMPRESSOR, 8TH STAGE.
BENCAR0387	815808	HUB—REAR COMPRESSOR, 8TH STAGE.
G79931	701509	DISK—COMPRESSOR, 9TH STAGE.
H12008	701509	DISK—COMPRESSOR, 9TH STAGE.
H85014	701509	DISK—COMPRESSOR, 9TH STAGE.
J24173	701509	DISK—COMPRESSOR, 9TH STAGE.
J89012	701509	DISK—COMPRESSOR, 9TH STAGE.
L31210	701509	DISK—COMPRESSOR, 9TH STAGE.
M84244	701509	DISK—COMPRESSOR, 9TH STAGE.
M84648	701509	DISK—COMPRESSOR, 9TH STAGE.
N03018	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0003	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0021	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0108	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0110	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0120	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0251	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0254	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0339	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0465	701509	DISK—COMPRESSOR, 9TH STAGE.
N209AA0613	701509	DISK—COMPRESSOR, 9TH STAGE.
N41318	701509	DISK—COMPRESSOR, 9TH STAGE.
N97641	701509	DISK—COMPRESSOR, 9TH STAGE.
N97777	701509	DISK—COMPRESSOR, 9TH STAGE.

TABLE 1.—AFFECTED 7TH, 8TH, 9TH, 10TH, 11TH, AND 12TH STAGE COMPRESSOR DISKS—Continued

SN	P/N*	Description*
N98300	701509	DISK—COMPRESSOR, 9TH STAGE.
N98342	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH0026	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH0145	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH0196	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH0311	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH0558	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH0686	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH0808	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH1372	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH1462	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH1787	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH2157	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH2310	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH2618	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH2744	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH2754	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH2812	701509	DISK—COMPRESSOR, 9TH STAGE.
NENCAH3172	701509	DISK—COMPRESSOR, 9TH STAGE.
P11727	701509	DISK—COMPRESSOR, 9TH STAGE.
P51543	701509	DISK—COMPRESSOR, 9TH STAGE.
P51573	701509	DISK—COMPRESSOR, 9TH STAGE.
P51959	701509	DISK—COMPRESSOR, 9TH STAGE.
P52941	701509	DISK—COMPRESSOR, 9TH STAGE.
P98658	701509	DISK—COMPRESSOR, 9TH STAGE.
P98768	701509	DISK—COMPRESSOR, 9TH STAGE.
R17612	701509	DISK—COMPRESSOR, 9TH STAGE.
R17753	701509	DISK—COMPRESSOR, 9TH STAGE.
R17770	701509	DISK—COMPRESSOR, 9TH STAGE.
R18740	701509	DISK—COMPRESSOR, 9TH STAGE.
R19009	701509	DISK—COMPRESSOR, 9TH STAGE.
R19013	701509	DISK—COMPRESSOR, 9TH STAGE.
R45437	701509	DISK—COMPRESSOR, 9TH STAGE.
R45449	701509	DISK—COMPRESSOR, 9TH STAGE.
R45875	701509	DISK—COMPRESSOR, 9TH STAGE.
R46726	701509	DISK—COMPRESSOR, 9TH STAGE.
R72945	701509	DISK—COMPRESSOR, 9TH STAGE.
R72960	701509	DISK—COMPRESSOR, 9TH STAGE.
R73803	701509	DISK—COMPRESSOR, 9TH STAGE.
R73835	701509	DISK—COMPRESSOR, 9TH STAGE.
R73941	701509	DISK—COMPRESSOR, 9TH STAGE.
S00757	701509	DISK—COMPRESSOR, 9TH STAGE.
S00963	701509	DISK—COMPRESSOR, 9TH STAGE.
S18823	701509	DISK—COMPRESSOR, 9TH STAGE.
S18838	701509	DISK—COMPRESSOR, 9TH STAGE.
S18955	701509	DISK—COMPRESSOR, 9TH STAGE.
S50282	701509	DISK—COMPRESSOR, 9TH STAGE.
S50317	701509	DISK—COMPRESSOR, 9TH STAGE.
S50434	701509	DISK—COMPRESSOR, 9TH STAGE.
S70079	701509	DISK—COMPRESSOR, 9TH STAGE.
S77569	701509	DISK—COMPRESSOR, 9TH STAGE.
S77744	701509	DISK—COMPRESSOR, 9TH STAGE.
S77764	701509	DISK—COMPRESSOR, 9TH STAGE.
T18831	701509	DISK—COMPRESSOR, 9TH STAGE.
T27504	701509	DISK—COMPRESSOR, 9TH STAGE.
T27506	701509	DISK—COMPRESSOR, 9TH STAGE.
T27542	701509	DISK—COMPRESSOR, 9TH STAGE.
N41854	772509	DISK—COMPRESSOR, 9TH STAGE.
B209AA0643	798509	DISK—COMPRESSOR, 9TH STAGE.
BENCAK4407	798509	DISK—COMPRESSOR, 9TH STAGE.
BENCAK5293	798509	DISK—COMPRESSOR, 9TH STAGE.
BENCAK9176	798509	DISK—COMPRESSOR, 9TH STAGE.
S79381	798509	DISK—COMPRESSOR, 9TH STAGE.
BENCA5919	815609	DISK—COMPRESSOR, 9TH STAGE.
BENCA8126	815609	DISK—COMPRESSOR, 9TH STAGE.
BENCA7181	815709	DISK—COMPRESSOR, 9TH STAGE.
1A9814	701410	DISK—COMPRESSOR, 10TH STAGE.
H18187	701410	DISK—COMPRESSOR, 10TH STAGE.
B210AA0149	772510	DISK—COMPRESSOR, 10TH STAGE.
B210AA0640	772510	DISK—COMPRESSOR, 10TH STAGE.
B210AA0909	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAH0262	772510	DISK—COMPRESSOR, 10TH STAGE.

TABLE 1.—AFFECTED 7TH, 8TH, 9TH, 10TH, 11TH, AND 12TH STAGE COMPRESSOR DISKS—Continued

SN	P/N*	Description*
BENCAH2166	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAH2273	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAH3784	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAH4152	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAH7481	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAJ9921	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAK0265	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAK0436	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAK6513	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAL1628	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAL1639	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAL3371	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAL6369	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAM1250	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAM3804	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAM3921	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAM4098	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAM9868	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAM9908	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAN1150	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAN7151	772510	DISK—COMPRESSOR, 10TH STAGE.
H77954	772510	DISK—COMPRESSOR, 10TH STAGE.
J70438	772510	DISK—COMPRESSOR, 10TH STAGE.
K35562	772510	DISK—COMPRESSOR, 10TH STAGE.
K67440	772510	DISK—COMPRESSOR, 10TH STAGE.
M61663	772510	DISK—COMPRESSOR, 10TH STAGE.
M73696	772510	DISK—COMPRESSOR, 10TH STAGE.
M73717	772510	DISK—COMPRESSOR, 10TH STAGE.
M73921	772510	DISK—COMPRESSOR, 10TH STAGE.
N02011	772510	DISK—COMPRESSOR, 10TH STAGE.
N22418	772510	DISK—COMPRESSOR, 10TH STAGE.
N80149	772510	DISK—COMPRESSOR, 10TH STAGE.
N80717	772510	DISK—COMPRESSOR, 10TH STAGE.
N97525	772510	DISK—COMPRESSOR, 10TH STAGE.
N98121	772510	DISK—COMPRESSOR, 10TH STAGE.
N98502	772510	DISK—COMPRESSOR, 10TH STAGE.
P51840	772510	DISK—COMPRESSOR, 10TH STAGE.
P51884	772510	DISK—COMPRESSOR, 10TH STAGE.
P52230	772510	DISK—COMPRESSOR, 10TH STAGE.
P52692	772510	DISK—COMPRESSOR, 10TH STAGE.
P53030	772510	DISK—COMPRESSOR, 10TH STAGE.
P98173	772510	DISK—COMPRESSOR, 10TH STAGE.
R18125	772510	DISK—COMPRESSOR, 10TH STAGE.
R18126	772510	DISK—COMPRESSOR, 10TH STAGE.
R18219	772510	DISK—COMPRESSOR, 10TH STAGE.
R45551	772510	DISK—COMPRESSOR, 10TH STAGE.
R45884	772510	DISK—COMPRESSOR, 10TH STAGE.
R46585	772510	DISK—COMPRESSOR, 10TH STAGE.
R72889	772510	DISK—COMPRESSOR, 10TH STAGE.
R74037	772510	DISK—COMPRESSOR, 10TH STAGE.
S01333	772510	DISK—COMPRESSOR, 10TH STAGE.
S01381	772510	DISK—COMPRESSOR, 10TH STAGE.
S19348	772510	DISK—COMPRESSOR, 10TH STAGE.
S19418	772510	DISK—COMPRESSOR, 10TH STAGE.
S19446	772510	DISK—COMPRESSOR, 10TH STAGE.
S19563	772510	DISK—COMPRESSOR, 10TH STAGE.
S50885	772510	DISK—COMPRESSOR, 10TH STAGE.
S51060	772510	DISK—COMPRESSOR, 10TH STAGE.
S51077	772510	DISK—COMPRESSOR, 10TH STAGE.
S70198	772510	DISK—COMPRESSOR, 10TH STAGE.
S70221	772510	DISK—COMPRESSOR, 10TH STAGE.
S78390	772510	DISK—COMPRESSOR, 10TH STAGE.
S78774	772510	DISK—COMPRESSOR, 10TH STAGE.
T19111	772510	DISK—COMPRESSOR, 10TH STAGE.
T19185	772510	DISK—COMPRESSOR, 10TH STAGE.
T28090	772510	DISK—COMPRESSOR, 10TH STAGE.
T28130	772510	DISK—COMPRESSOR, 10TH STAGE.
T28230	772510	DISK—COMPRESSOR, 10TH STAGE.
BENCAP3554	815610	DISK—COMPRESSOR, 10TH STAGE.
BENCAP8866	815610	DISK—COMPRESSOR, 10TH STAGE.
BENCAP9500	815610	DISK—COMPRESSOR, 10TH STAGE.
BENCAR3177	815610	DISK—COMPRESSOR, 10TH STAGE.

TABLE 1.—AFFECTED 7TH, 8TH, 9TH, 10TH, 11TH, AND 12TH STAGE COMPRESSOR DISKS—Continued

SN	P/N*	Description*
2A0326	701411	DISK—COMPRESSOR, 11TH STAGE.
8Y2537	701411	DISK—COMPRESSOR, 11TH STAGE.
B211AA0141	772511	DISK—COMPRESSOR, 11TH STAGE.
B211AA0611	772511	DISK—COMPRESSOR, 11TH STAGE.
B211AA0838	772511	DISK—COMPRESSOR, 11TH STAGE.
B211AA0934	772511	DISK—COMPRESSOR, 11TH STAGE.
B211AA1235	772511	DISK—COMPRESSOR, 11TH STAGE.
B211AA1315	772511	DISK—COMPRESSOR, 11TH STAGE.
B211AA1357	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAH0266	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAH8830	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAK0480	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAK7394	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAL2738	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAM2075	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAM7493	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAM7745	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAM7814	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAN3212	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAN7762	772511	DISK—COMPRESSOR, 11TH STAGE.
H58198	772511	DISK—COMPRESSOR, 11TH STAGE.
J24723	772511	DISK—COMPRESSOR, 11TH STAGE.
L55201	772511	DISK—COMPRESSOR, 11TH STAGE.
M10783	772511	DISK—COMPRESSOR, 11TH STAGE.
M40303	772511	DISK—COMPRESSOR, 11TH STAGE.
M61351	772511	DISK—COMPRESSOR, 11TH STAGE.
M61382	772511	DISK—COMPRESSOR, 11TH STAGE.
M62071	772511	DISK—COMPRESSOR, 11TH STAGE.
M73309	772511	DISK—COMPRESSOR, 11TH STAGE.
M87068	772511	DISK—COMPRESSOR, 11TH STAGE.
N03523	772511	DISK—COMPRESSOR, 11TH STAGE.
N41429	772511	DISK—COMPRESSOR, 11TH STAGE.
N97351	772511	DISK—COMPRESSOR, 11TH STAGE.
N97355	772511	DISK—COMPRESSOR, 11TH STAGE.
P03557	772511	DISK—COMPRESSOR, 11TH STAGE.
P11649	772511	DISK—COMPRESSOR, 11TH STAGE.
P51901	772511	DISK—COMPRESSOR, 11TH STAGE.
P52302	772511	DISK—COMPRESSOR, 11TH STAGE.
P52553	772511	DISK—COMPRESSOR, 11TH STAGE.
P53051	772511	DISK—COMPRESSOR, 11TH STAGE.
P66344	772511	DISK—COMPRESSOR, 11TH STAGE.
P66429	772511	DISK—COMPRESSOR, 11TH STAGE.
P76611	772511	DISK—COMPRESSOR, 11TH STAGE.
R05611	772511	DISK—COMPRESSOR, 11TH STAGE.
R18714	772511	DISK—COMPRESSOR, 11TH STAGE.
R29877	772511	DISK—COMPRESSOR, 11TH STAGE.
R29944	772511	DISK—COMPRESSOR, 11TH STAGE.
R29960	772511	DISK—COMPRESSOR, 11TH STAGE.
R30004	772511	DISK—COMPRESSOR, 11TH STAGE.
R30196	772511	DISK—COMPRESSOR, 11TH STAGE.
R30400	772511	DISK—COMPRESSOR, 11TH STAGE.
R30622	772511	DISK—COMPRESSOR, 11TH STAGE.
R30734	772511	DISK—COMPRESSOR, 11TH STAGE.
R30906	772511	DISK—COMPRESSOR, 11TH STAGE.
R44093	772511	DISK—COMPRESSOR, 11TH STAGE.
R44808	772511	DISK—COMPRESSOR, 11TH STAGE.
R45420	772511	DISK—COMPRESSOR, 11TH STAGE.
R45926	772511	DISK—COMPRESSOR, 11TH STAGE.
R46487	772511	DISK—COMPRESSOR, 11TH STAGE.
S04447	772511	DISK—COMPRESSOR, 11TH STAGE.
S04609	772511	DISK—COMPRESSOR, 11TH STAGE.
S80579	772511	DISK—COMPRESSOR, 11TH STAGE.
S80718	772511	DISK—COMPRESSOR, 11TH STAGE.
S80811	772511	DISK—COMPRESSOR, 11TH STAGE.
T22392	772511	DISK—COMPRESSOR, 11TH STAGE.
T23022	772511	DISK—COMPRESSOR, 11TH STAGE.
T23028	772511	DISK—COMPRESSOR, 11TH STAGE.
T23042	772511	DISK—COMPRESSOR, 11TH STAGE.
BENCAM8030	815611	DISK—COMPRESSOR, 11TH STAGE.
BENCAP1478	815611	DISK—COMPRESSOR, 11TH STAGE.
BENCAP1525	815611	DISK—COMPRESSOR, 11TH STAGE.
BENCAP3999	815611	DISK—COMPRESSOR, 11TH STAGE.

TABLE 1.—AFFECTED 7TH, 8TH, 9TH, 10TH, 11TH, AND 12TH STAGE COMPRESSOR DISKS—Continued

SN	P/N*	Description*
3A7566	701412	DISK—COMPRESSOR, 12TH STAGE.
BENCAH0234	772512	DISK—COMPRESSOR, 12TH STAGE.
H58273	772512	DISK—COMPRESSOR, 12TH STAGE.
H76934	772512	DISK—COMPRESSOR, 12TH STAGE.
K04068	772512	DISK—COMPRESSOR, 12TH STAGE.
L85496	772512	DISK—COMPRESSOR, 12TH STAGE.
M09749	772512	DISK—COMPRESSOR, 12TH STAGE.
M10951	772512	DISK—COMPRESSOR, 12TH STAGE.
M49036	772512	DISK—COMPRESSOR, 12TH STAGE.
M61295	772512	DISK—COMPRESSOR, 12TH STAGE.
M84028	772512	DISK—COMPRESSOR, 12TH STAGE.
M84233	772512	DISK—COMPRESSOR, 12TH STAGE.
N57563	772512	DISK—COMPRESSOR, 12TH STAGE.
N58053	772512	DISK—COMPRESSOR, 12TH STAGE.
P11181	772512	DISK—COMPRESSOR, 12TH STAGE.
P11212	772512	DISK—COMPRESSOR, 12TH STAGE.
P51407	772512	DISK—COMPRESSOR, 12TH STAGE.
P51774	772512	DISK—COMPRESSOR, 12TH STAGE.
P52401	772512	DISK—COMPRESSOR, 12TH STAGE.
P77282	772512	DISK—COMPRESSOR, 12TH STAGE.
P97978	772512	DISK—COMPRESSOR, 12TH STAGE.
R17545	772512	DISK—COMPRESSOR, 12TH STAGE.
R18483	772512	DISK—COMPRESSOR, 12TH STAGE.
R18596	772512	DISK—COMPRESSOR, 12TH STAGE.
R45619	772512	DISK—COMPRESSOR, 12TH STAGE.
R45941	772512	DISK—COMPRESSOR, 12TH STAGE.
R72907	772512	DISK—COMPRESSOR, 12TH STAGE.
R73448	772512	DISK—COMPRESSOR, 12TH STAGE.
R73794	772512	DISK—COMPRESSOR, 12TH STAGE.
R74102	772512	DISK—COMPRESSOR, 12TH STAGE.
R74226	772512	DISK—COMPRESSOR, 12TH STAGE.
S01740	772512	DISK—COMPRESSOR, 12TH STAGE.
S01866	772512	DISK—COMPRESSOR, 12TH STAGE.
S01877	772512	DISK—COMPRESSOR, 12TH STAGE.
S01918	772512	DISK—COMPRESSOR, 12TH STAGE.
S02036	772512	DISK—COMPRESSOR, 12TH STAGE.
S19787	772512	DISK—COMPRESSOR, 12TH STAGE.
S51385	772512	DISK—COMPRESSOR, 12TH STAGE.
S51589	772512	DISK—COMPRESSOR, 12TH STAGE.
SO1816	772512	DISK—COMPRESSOR, 12TH STAGE.
B212AA0497	798512	DISK—COMPRESSOR, 12TH STAGE.
B212AA0517	798512	DISK—COMPRESSOR, 12TH STAGE.
B212AA0943	798512	DISK—COMPRESSOR, 12TH STAGE.
B212AA1106	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAJ6163	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAJ9174	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAK2345	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAK2388	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAK5240	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAK9190	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAL2466	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAL5411	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAL6708	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAM3530	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAM3774	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAM5489	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAM6218	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAN0910	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAN6906	798512	DISK—COMPRESSOR, 12TH STAGE.
S94496	798512	DISK—COMPRESSOR, 12TH STAGE.
S94583	798512	DISK—COMPRESSOR, 12TH STAGE.
S94619	798512	DISK—COMPRESSOR, 12TH STAGE.
S94637	798512	DISK—COMPRESSOR, 12TH STAGE.
T28485	798512	DISK—COMPRESSOR, 12TH STAGE.
T43078	798512	DISK—COMPRESSOR, 12TH STAGE.
T43084	798512	DISK—COMPRESSOR, 12TH STAGE.
BENCAP3428	815612	DISK—COMPRESSOR, 12TH STAGE.
BENCAP7698	815612	DISK—COMPRESSOR, 12TH STAGE.
BENCAP7719	815612	DISK—COMPRESSOR, 12TH STAGE.
BENCAP7720	815612	DISK—COMPRESSOR, 12TH STAGE.
BENCAP8481	815612	DISK—COMPRESSOR, 12TH STAGE.

TABLE 1.—AFFECTED 7TH, 8TH, 9TH, 10TH, 11TH, AND 12TH STAGE COMPRESSOR DISKS—Continued

SN	P/N *	Description *
BENCAR2033	815612	DISK—COMPRESSOR, 12TH STAGE.

* The P/N and description for each SN are provided as reference information.

TABLE 2.—AFFECTED REAR COMPRESSOR FRONT HUBS AND REAR COMPRESSOR HUBS

SN	P/N*	Description*
2U4347	521041	HUB—REAR COMPRESSOR, FRONT.
2U4814	521041	HUB—REAR COMPRESSOR, FRONT.
2U5426	521041	HUB—REAR COMPRESSOR, FRONT.
4R1473	521041	HUB—REAR COMPRESSOR, FRONT.
6P7156	521041	HUB—REAR COMPRESSOR, FRONT.
9L9671	521041	HUB—REAR COMPRESSOR, FRONT.
9L9679	521041	HUB—REAR COMPRESSOR, FRONT.
9P3378	521041	HUB—REAR COMPRESSOR, FRONT.
9S4536	521041	HUB—REAR COMPRESSOR, FRONT.
9V7938	521041	HUB—REAR COMPRESSOR, FRONT.
2U4900	650782	HUB—REAR COMPRESSOR, FRONT.
2X6377	650782	HUB—REAR COMPRESSOR, FRONT.
9P4067	650782	HUB—REAR COMPRESSOR, FRONT.
B-21738	650782	HUB—REAR COMPRESSOR, FRONT.
2U5010	698145	HUB—REAR COMPRESSOR, FRONT.
9V8201	698145	HUB—REAR COMPRESSOR, FRONT.
3X3000	717623	HUB—REAR COMPRESSOR, FRONT.
3X6979	717623	HUB—REAR COMPRESSOR, FRONT.
5Z4371	717623	HUB—REAR COMPRESSOR, FRONT.
8X6204	717623	HUB—REAR COMPRESSOR, FRONT.
9V8645	717623	HUB—REAR COMPRESSOR, FRONT.
G23815	717623	HUB—REAR COMPRESSOR, FRONT.
G23817	717623	HUB—REAR COMPRESSOR, FRONT.
H05055	717623	HUB—REAR COMPRESSOR, FRONT.
H05059	717623	HUB—REAR COMPRESSOR, FRONT.
K47148	717623	HUB—REAR COMPRESSOR, FRONT.
N08016	717623	HUB—REAR COMPRESSOR, FRONT.
N08021	717623	HUB—REAR COMPRESSOR, FRONT.
P16923	717623	HUB—REAR COMPRESSOR, FRONT.
R15834	717623	HUB—REAR COMPRESSOR, FRONT.
S61487	717623	HUB—REAR COMPRESSOR, FRONT.
N08020	717623	HUB—REAR COMPRESSOR, FRONT.
2U4331	726222	HUB—REAR COMPRESSOR, FRONT.
4P2249	726222	HUB—REAR COMPRESSOR, FRONT.
4R2166	726222	HUB—REAR COMPRESSOR, FRONT.
9M2324	726222	HUB—REAR COMPRESSOR, FRONT.
9P3757	726222	HUB—REAR COMPRESSOR, FRONT.
9S4223	726222	HUB—REAR COMPRESSOR, FRONT.
9V8146	726222	HUB—REAR COMPRESSOR, FRONT.
2X6391	726227	HUB—REAR COMPRESSOR, FRONT.
3X2998	726227	HUB—REAR COMPRESSOR, FRONT.
4R1190	726227	HUB—REAR COMPRESSOR, FRONT.
6X0015	726227	HUB—REAR COMPRESSOR, FRONT.
6X0071	726227	HUB—REAR COMPRESSOR, FRONT.
9V8100	726227	HUB—REAR COMPRESSOR, FRONT.
9V8331	726227	HUB—REAR COMPRESSOR, FRONT.
4R1272	726230	HUB—REAR COMPRESSOR, FRONT.
9V8024	726230	HUB—REAR COMPRESSOR, FRONT.
9V8107	726230	HUB—REAR COMPRESSOR, FRONT.
9M2176	524857	HUB—REAR COMPRESSOR, REAR.
4R3174	565744	HUB—REAR COMPRESSOR, REAR.
4R3359	565744	HUB—REAR COMPRESSOR, REAR.
4R3432	565744	HUB—REAR COMPRESSOR, REAR.
4R3474	565744	HUB—REAR COMPRESSOR, REAR.
4R3652	565744	HUB—REAR COMPRESSOR, REAR.
4R3774	565744	HUB—REAR COMPRESSOR, REAR.
4R5205	565744	HUB—REAR COMPRESSOR, REAR.
7V1912	565744	HUB—REAR COMPRESSOR, REAR.
9P4228	565744	HUB—REAR COMPRESSOR, REAR.
9T8402	565744	HUB—REAR COMPRESSOR, REAR.
9T8670	565744	HUB—REAR COMPRESSOR, REAR.
9T8888	565744	HUB—REAR COMPRESSOR, REAR.
SR-403	565744	HUB—REAR COMPRESSOR, REAR.
671178	565744-001	HUB ASSY—REAR COMPRESSOR, REAR.

TABLE 2.—AFFECTED REAR COMPRESSOR FRONT HUBS AND REAR COMPRESSOR HUBS—Continued

SN	P/N*	Description*
3S3471	565744-001	HUB ASSY—REAR COMPRESSOR, REAR.
6809	625660	HUB ASSY—REAR COMPRESSOR, REAR.
1Y0069	625660	HUB ASSY—REAR COMPRESSOR, REAR.
1Z2244	625660	HUB ASSY—REAR COMPRESSOR, REAR.
2X6293	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3A1492	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3GV8156	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3V7807	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3V7953	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3V8198	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3V8404	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3V8406	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3V8553	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3V8659	625660	HUB ASSY—REAR COMPRESSOR, REAR.
3Z2149	625660	HUB ASSY—REAR COMPRESSOR, REAR.
4B8465	625660	HUB ASSY—REAR COMPRESSOR, REAR.
4Y5517	625660	HUB ASSY—REAR COMPRESSOR, REAR.
7B5438	625660	HUB ASSY—REAR COMPRESSOR, REAR.
7B5447	625660	HUB ASSY—REAR COMPRESSOR, REAR.
7W7576	625660	HUB ASSY—REAR COMPRESSOR, REAR.
7W7602	625660	HUB ASSY—REAR COMPRESSOR, REAR.
8X6038	625660	HUB ASSY—REAR COMPRESSOR, REAR.
8X6092	625660	HUB ASSY—REAR COMPRESSOR, REAR.
8X6105	625660	HUB ASSY—REAR COMPRESSOR, REAR.
9W6532	625660	HUB ASSY—REAR COMPRESSOR, REAR.
9Y1739	625660	HUB ASSY—REAR COMPRESSOR, REAR.
9Z1690	625660	HUB ASSY—REAR COMPRESSOR, REAR.
G37540	625660	HUB ASSY—REAR COMPRESSOR, REAR.
G37830	625660	HUB ASSY—REAR COMPRESSOR, REAR.
G37838	625660	HUB ASSY—REAR COMPRESSOR, REAR.
G53600	625660	HUB ASSY—REAR COMPRESSOR, REAR.
G53607	625660	HUB ASSY—REAR COMPRESSOR, REAR.
G73739	625660	HUB ASSY—REAR COMPRESSOR, REAR.
G90111	625660	HUB ASSY—REAR COMPRESSOR, REAR.
G90439	625660	HUB ASSY—REAR COMPRESSOR, REAR.
H05137	625660	HUB ASSY—REAR COMPRESSOR, REAR.
H325553	625660	HUB ASSY—REAR COMPRESSOR, REAR.
H32650	625660	HUB ASSY—REAR COMPRESSOR, REAR.
H50340	625660	HUB ASSY—REAR COMPRESSOR, REAR.
HG9804	625660	HUB ASSY—REAR COMPRESSOR, REAR.
IX9575	625660	HUB ASSY—REAR COMPRESSOR, REAR.
J20729	625660	HUB ASSY—REAR COMPRESSOR, REAR.
J21131	625660	HUB ASSY—REAR COMPRESSOR, REAR.
J26334	625660	HUB ASSY—REAR COMPRESSOR, REAR.
J71521	625660	HUB ASSY—REAR COMPRESSOR, REAR.
J71724	625660	HUB ASSY—REAR COMPRESSOR, REAR.
K13732	625660	HUB ASSY—REAR COMPRESSOR, REAR.
OB6809	625660	HUB ASSY—REAR COMPRESSOR, REAR.
1A6622	625660-001	HUB ASSY—REAR COMPRESSOR, REAR.
3V8201	625660-001	HUB ASSY—REAR COMPRESSOR, REAR.
4A1601	625660-001	HUB ASSY—REAR COMPRESSOR, REAR.
G73781	625660-001	HUB ASSY—REAR COMPRESSOR, REAR.
H32570	625660-001	HUB ASSY—REAR COMPRESSOR, REAR.
H89858	625660-001	HUB ASSY—REAR COMPRESSOR, REAR.
2T9662	625665	HUB ASSY—REAR COMPRESSOR, REAR.
4R4959	625665	HUB ASSY—REAR COMPRESSOR, REAR.
6T1172	625665	HUB ASSY—REAR COMPRESSOR, REAR.
9T8549	625665	HUB ASSY—REAR COMPRESSOR, REAR.
GR0491	625665	HUB ASSY—REAR COMPRESSOR, REAR.
G37525	772293	HUB ASSY—REAR COMPRESSOR, REAR.
H32635	772293	HUB ASSY—REAR COMPRESSOR, REAR.
L45221	772293	HUB ASSY—REAR COMPRESSOR, REAR.
3M8156	781028-002	HUB ASSY—REAR COMPRESSOR, REAR.
7V1601	781031	HUB ASSY—REAR COMPRESSOR, REAR.
9T8658	781031	HUB ASSY—REAR COMPRESSOR, REAR.
9T8794	781031	HUB ASSY—REAR COMPRESSOR, REAR.
IUI885	781031	HUB ASSY—REAR COMPRESSOR, REAR.
R39541	804593	HUB ASSY—REAR COMPRESSOR, REAR.
R92677	804593	HUB ASSY—REAR COMPRESSOR, REAR.
S26076	804593	HUB ASSY—REAR COMPRESSOR, REAR.
BENCAM2398	805159	HUB ASSY—REAR COMPRESSOR, REAR.
BENCAP3169	805159	HUB ASSY—REAR COMPRESSOR, REAR.

TABLE 2.—AFFECTED REAR COMPRESSOR FRONT HUBS AND REAR COMPRESSOR HUBS—Continued

SN	P/N*	Description*
BENCAL2074	805163	HUB ASSY—REAR COMPRESSOR, REAR.
T31880	805163	HUB ASSY—REAR COMPRESSOR, REAR.
T31893	805163	HUB ASSY—REAR COMPRESSOR, REAR.

* The P/N and description for each SN are provided as reference information.

Prohibition of Installation of Disks and Hubs Listed in Table 1

(g) After the effective date of this AD, do not install any disk or hub listed in Table 1 of this AD that has zero cycles-in-service since May 14, 2001.

Return to Service Information

(h) Pratt & Whitney issued ASB No. JT8D A6442, dated April 4, 2003, containing additional repair information as to how parts removed as a result of paragraph (f) of this AD may be returned to service.

Definition of Shop Visit

(i) A shop visit is defined as when the engine or module first goes to a maintenance base that can do these procedures regardless of the scheduled maintenance action or the reason for engine removal.

Alternative Methods of Compliance

(j) The Manager, Engine Certification Office, has the authority to approve alternative methods of compliance for this AD if requested using the procedures found in 14 CFR 39.19.

Related Information

(k) None.

Issued in Burlington, Massachusetts, on December 20, 2004.

Francis A. Favara,

Acting Manager, Engine and Propeller Directorate, Aircraft Certification Service.

[FR Doc. 04–28385 Filed 12–29–04; 8:45 am]

BILLING CODE 4910–13–U

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2004–19415; Airspace Docket No. 04–AAL–15]

Proposed Revision of Class E Airspace; Ketchikan, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to revise Class E airspace at Ketchikan, AK. The existing Class E airspace is not sufficient to contain aircraft executing all instrument procedures at Ketchikan Airport. Adoption of this proposal would result in the revision of Class E

airspace upward from 700 feet (ft.) above the surface at Ketchikan, AK.

DATES: Comments must be received on or before February 14, 2005.

ADDRESSES: Send comments on the proposal to the Docket Management System, U.S. Department of Transportation, Room Plaza 401, 400 Seventh Street, SW., Washington, DC 20590–0001. You must identify the docket number FAA–2004–19415/ Airspace Docket No. 04–AAL–15, at the beginning of your comments. You may also submit comments on the Internet at <http://dms.dot.gov>. You may review the public docket containing the proposal, any comments received, and any final disposition in person in the Dockets Office between 9:00 a.m. and 5:00 p.m., Monday through Friday, except Federal holidays. The Docket Office (telephone 1–800–647–5527) is on the plaza level of the Department of Transportation NASSIF Building at the above address.

An informal docket may also be examined during normal business hours at the office of the Manager, Safety, Alaska Flight Services Operations, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587.

FOR FURTHER INFORMATION CONTACT: Jesse Patterson, AAL–538G, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587; telephone number (907) 271–5898; fax: (907) 271–2850; e-mail: Jesse.CTR.Patterson@faa.gov. Internet address: <http://www.alaska.faa.gov/at>.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify both docket numbers and be submitted in triplicate to the address listed above.

Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: “Comments to Docket No. FAA–2004–19415/Airspace Docket No. 04–AAL–15.” The postcard will be date/time stamped and returned to the commenter.

All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of comments received. All comments submitted will be available for examination in the public docket both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of Notice of Proposed Rulemaking’s (NPRM’s)

An electronic copy of this document may be downloaded through the Internet at <http://dms.dot.gov>. Recently published rulemaking documents can also be accessed through the FAA’s web page at <http://www.faa.gov> or the Superintendent of Document’s web page at <http://www.access.gpo.gov/nara>.

Additionally, any person may obtain a copy of this notice by submitting a request to the Federal Aviation Administration, Office of Air Traffic Airspace Management, ATA–400, 800 Independence Avenue, SW., Washington, DC 20591 or by calling (202) 267–8783. Communications must identify both docket numbers for this notice. Persons interested in being placed on a mailing list for future NPRM’s should contact the FAA’s Office of Rulemaking, (202) 267–9677, to request a copy of Advisory Circular No. 11–2A, Notice of Proposed Rulemaking Distribution System, which describes the application procedure.

The Proposal

The FAA is considering an amendment to the Code of Federal Regulations (14 CFR Part 71), which would establish additional Class E airspace at Ketchikan, AK. The intended

effect of this proposal is to revise Class E airspace upward from 700 ft. above the surface to contain Instrument Flight Rules (IFR) operations at Ketchikan, AK.

The Special Instrument Flight Procedures developed for the Ketchikan Airport currently are not contained in Class E airspace. The FAA is proposing to revise Class E airspace at Ketchikan, AK, which would be sufficient to contain aircraft executing instrument procedures. Additional Class E controlled airspace extending upward from 700 ft. above the surface within the Ketchikan Airport area would be created by this action.

The area would be depicted on aeronautical charts for pilot reference. The coordinates for this airspace docket are based on North American Datum 83. The Class E airspace areas designated as 700/1200 foot transition areas are published in paragraph 6005 in FAA Order 7400.9M, *Airspace Designations and Reporting Points*, dated August 30, 2004, and effective September 16, 2004, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore —(1) is not a “significant regulatory action” under Executive Order 12866; (2) is not a “significant rule” under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA’s authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle 1, 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, Subpart 1, Section 40103, Sovereignty and use of airspace. Under that section, the FAA is charged with prescribing regulations to ensure the safe and efficient use of the navigable airspace. This regulation is

within the scope of that authority because it proposes to revise Class E airspace sufficient to contain aircraft executing instrument approaches at Ketchikan Airport and represents the FAA’s continuing effort to safely and efficiently use the navigable airspace.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71— DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9M, *Airspace Designations and Reporting Points*, dated August 30, 2004, and effective September 16, 2004, is to be amended as follows:

* * * * *

Paragraph 6005 Class E airspace extending upward from 700 feet or more above the surface of the earth.

* * * * *

AAL AK E5 Ketchikan, AK [Revised]

Ketchikan International Airport, AK
(Lat. 55°21′20″ N., long. 131°42′50″ W.)
Annette Island VORTAC
(Lat. 55°03′38″ N., long. 131°34′42″ W.)
Ketchikan Localizer
(Lat. 55°20′51″ N., long. 131°42′00″ W.)
Clam Cove NDB
(Lat. 55°20′43″ N., long. 131°41′47″ W.)

That airspace extending upward from 700 feet above the surface within 2.0 miles each side of the Ketchikan Localizer east course extending from the Ketchikan Localizer to 9.0 miles southeast of the Ketchikan International Airport and within 1.8 miles each side of the 353° radial of the Annette Island VORTAC extending from 11 miles north of the VORTAC to the Ketchikan Localizer east course and within 1.9 miles either side of the Ketchikan Localizer west course extending from the localizer to 6.7 miles west of the airport and that airspace bounded by 55°24′49″ N 131°53′23″ W 55°27′30″ N 132°03′10″ W 55°31′20″ N 132°00′30″ W 55°27′27″ N 131°48′35″ W.

* * * * *

Issued in Anchorage, AK, on December 17, 2004.

Anthony M. Wylie,

Acting Area Director, Alaska Flight Services Area Office.

[FR Doc. 04–28554 Filed 12–29–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2004–19696; Airspace Docket No. 04–AAL–24]

Proposed Establishment of Class E Airspace; Beluga, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish new Class E airspace at Beluga, AK. There is no existing Class E airspace to contain aircraft executing instrument approaches at Beluga Airport. Adoption of this proposal would result in the establishment of Class E airspace upward from 700 feet (ft.) above the surface at Beluga, AK.

DATES: Comments must be received on or before February 14, 2005.

ADDRESSES: Send comments on the proposal to the Docket Management System, U.S. Department of Transportation, Room Plaza 401, 400 Seventh Street, SW., Washington, DC 20590–0001. You must identify the docket number FAA–2004–19696/ Airspace Docket No. 04–AAL–24, at the beginning of your comments. You may also submit comments on the Internet at <http://dms.dot.gov>. You may review the public docket containing the proposal, any comments received, and any final disposition in person in the Dockets Office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Office (telephone 1–800–647–5527) is on the plaza level of the Department of Transportation NASSIF Building at the above address.

An informal docket may also be examined during normal business hours at the office of the Manager, Safety, Alaska Flight Services Operations, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587.

FOR FURTHER INFORMATION CONTACT:

Jesse Patterson, AAL–538G, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587; telephone number (907) 271–5898; fax: (907) 271–2850; e-mail:

Jesse.CTR.Patterson@faa.gov. Internet address: <http://www.alaska.faa.gov/at>.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify both docket numbers and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket No. FAA-2004-19696/Airspace Docket No. 04-AAL-24." The postcard will be date/time stamped and returned to the commenter.

All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of comments received. All comments submitted will be available for examination in the public docket both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of Notice of Proposed Rulemaking's (NPRM's)

An electronic copy of this document may be downloaded through the Internet at <http://dms.dot.gov>. Recently published rulemaking documents can also be accessed through the FAA's web page at <http://www.faa.gov> or the Superintendent of Document's web page at <http://www.access.gpo.gov/nara>.

Additionally, any person may obtain a copy of this notice by submitting a request to the Federal Aviation Administration, Office of Air Traffic Airspace Management, ATA-400, 800 Independence Avenue, SW., Washington, DC 20591 or by calling (202) 267-8783. Communications must identify both docket numbers for this notice. Persons interested in being placed on a mailing list for future NPRM's should contact the FAA's Office of Rulemaking, (202) 267-9677,

to request a copy of Advisory Circular No. 11-2A, Notice of Proposed Rulemaking Distribution System, which describes the application procedure.

The Proposal

The FAA is considering an amendment to the Code of Federal Regulations (14 CFR Part 71), which would establish new Class E airspace at Beluga, AK. The intended effect of this proposal is to establish Class E airspace upward from 700 ft. above the surface to contain Instrument Flight Rules (IFR) operations at Beluga, AK.

The Special Instrument Flight Procedures developed for the Beluga Airport currently are not contained in Class E airspace. To improve safety, the FAA is proposing to establish Class E airspace at Beluga, AK, which would be sufficient to contain aircraft executing instrument procedures. New Class E controlled airspace extending upward from 700 ft. above the surface within the Beluga Airport area would be created by this action.

The area would be depicted on aeronautical charts for pilot reference. The coordinates for this airspace docket are based on North American Datum 83. The Class E airspace areas designated as 700/1200 foot transition areas are published in paragraph 6005 in FAA Order 7400.9M, *Airspace Designations and Reporting Points*, dated August 30, 2004, and effective September 16, 2004, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle 1, 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, Subpart 1, Section 40103, Sovereignty and use of airspace. Under that section, the FAA is charged with prescribing regulations to ensure the safe and efficient use of the navigable airspace. This regulation is within the scope of that authority because it proposes to create Class E airspace sufficient to contain aircraft executing instrument approaches at Beluga Airport and represents the FAA's continuing effort to safely and efficiently use the navigable airspace.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9M, *Airspace Designations and Reporting Points*, dated August 30, 2004, and effective September 16, 2004, is to be amended as follows:

* * * * *

Paragraph 6005—Class E airspace extending upward from 700 feet or more above the surface of the earth.

* * * * *

AAL AK E5—Beluga, AK [New]

Beluga Airport, AK

(Lat. 61°10'20" N., long. 151°02'38" W.)

That airspace extending upward from 700 feet above the surface within a 5-mile radius of the Beluga Airport.

* * * * *

Issued in Anchorage, AK, on December 17, 2004.

Anthony M. Wylie,

Acting Area Director, Alaska Flight Services
Area Office.

[FR Doc. 04-28555 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-13-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[CGD05-04-215]

RIN 1625-AA09

Drawbridge Operation Regulations; Chincoteague Channel, Chincoteague, VA

AGENCY: Coast Guard, DHS.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard proposes to change the regulations that govern the operation of the SR 175 Bridge, at mile 3.5, at Chincoteague, Virginia. The proposal would require hourly openings of the draw from 6 a.m. to Midnight year-round; except from 7 a.m. to 5 p.m. on the last consecutive Wednesday and Thursday in July, the draw need not be opened. At all other times, the draw need not open. The proposed change would reduce vehicular traffic congestion to increase public safety and to extend the structural and operational integrity of the movable span while still balancing the needs of marine and vehicular traffic.

DATES: Comments and related material must reach the Coast Guard on or before February 14, 2005.

ADDRESSES: You may mail comments and related material to Commander (obr), Fifth Coast Guard District, Federal Building, 1st Floor, 431 Crawford Street, Portsmouth, VA 23704-5004. The Fifth Coast Guard District maintains the public docket for this rulemaking. Comments and material received from the public, as well as documents indicated in this preamble as being available in the docket, will become part of this docket and will be available for inspection or copying at Commander (obr), Fifth Coast Guard District between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Gary Heyer, Bridge Management Specialist, Fifth Coast Guard District, at (757) 398-6629.

SUPPLEMENTARY INFORMATION:

Request for Comments

We encourage you to participate in this rulemaking by submitting comments and related material. If you do so, please include your name and address, identify the docket number for this rulemaking CGD05-04-215, indicate the specific section of this document to which each comment applies, and give the reason for each comment. Please submit all comments and related material in an unbound format, no larger than 8½ by 11 inches, suitable for copying. If you would like a return receipt, please enclose a stamped, self-addressed postcard or envelope. We will consider all submittals received during the comment period. We may change this proposed rule in view of them.

Public Meeting

We do not now plan to hold a public meeting. But you may submit a request for a meeting by writing to Commander (obr), Fifth Coast Guard District at the address under **ADDRESSES** explaining why one 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**.

Background and Purpose

The Virginia Department of Transportation (VDOT) owns and operates this swing-type bridge. The current regulation requires the SR 175 Bridge, mile 3.5, at Chincoteague to open on signal except the draw may remain in the closed position to vessels from 7 a.m. to 5 p.m. on the last consecutive Wednesday and Thursday in July of every year.

On behalf of the Chincoteague Town Council (the Council), residents and business owners in the area, VDOT has requested a change to the existing regulations for the SR 175 Bridge. This proposal is an effort to schedule the number of drawbridge openings thereby reducing traffic congestion for public safety. By scheduling the number of openings this proposal will also extend the structural and operational integrity of the movable span, while balancing the needs of mariners and vehicular traffic transiting in and around this seaside resort area. SR 175 highway is also the principal arterial route that serves as the major evacuation highway in the event of emergencies or tidal flooding.

On June 28, 2004, we published a notice of temporary deviation from the regulations and request for comments entitled "Drawbridge Operation Regulations; Chincoteague Channel,

VA" in the **Federal Register** (69 FR 36011). The temporary deviation was an operation to test an alternate drawbridge operation schedule for 90 days and to solicit comments from the public. In accordance with the temporary deviation, from July 2, 2004 through September 29, 2004, the draw of the bridge opened every two hours on the even hour from 6 a.m. to midnight; except from 7 a.m. to 5 p.m., on the last consecutive Wednesday and Thursday of July, the draw need not be opened. Finally, at all other times, the draw was not opened.

The Coast Guard received six letters and four petitions commenting on the provisions of the temporary deviation. Several comments from residents of the Town of Chincoteague favored the two-hour opening schedule. The commercial vessel owners favored a less restrictive hourly opening schedule. To ease vehicular traffic congestion, VDOT requested the movement of marine traffic be regulated. The Coast Guard reviewed the vehicle traffic information and bridge logs provided by VDOT. Bridge opening log data from 2001 to 2003 revealed that the highest concentration of vessel and vehicular traffic occurred during the peak tourist season from April to October. VDOT submitted a weekly vehicular traffic count for August 2004. The eastbound and westbound traffic counts revealed for August 19, 20, 21 and 22, that approximately 8150, 9729, 8365 and 7447 vehicles cross the SR 175 Bridge, respectively.

VDOT records reveal an increase in yearly bridge openings. For 2001 to 2003, the bridge opened for vessels 1789, 2063 and 2337 times during these years, respectively. During the peak tourist season for the same period, the bridge opened for vessels 1356, 1558 and 1761 times, respectively. With an average of only 12 openings per day (yearly) or approximately one opening per hour, restricting openings of the drawbridge hourly from 6 a.m. to midnight is not expected to seriously disrupt marine traffic, and is expected to substantially reduce vehicular traffic congestion.

This change is being requested to make the operation of the SR 175 Bridge more efficient. It will reduce vehicular traffic congestion to increase public safety and to extend the structural and operational integrity of the movable span while still balancing the needs of marine and vehicular traffic.

Discussion of Proposed Rule

The Coast Guard proposes to amend the regulations governing the SR 175 Bridge, mile 3.5, at Chincoteague, which

currently operates on signal, except the draw may remain in the closed position to vessels from 7 a.m. to 5 p.m. on the last consecutive Wednesday and Thursday in July of every year. At all other times, the draw need not open. The Coast Guard proposes to amend 33 CFR § 117.1005 by inserting a new provision, which would limit the required openings of the draw year-round from 6 a.m. to midnight to once an hour with closure periods from 7 a.m. to 5 p.m. on the last consecutive Wednesday and Thursday in July of every year; and at all other times, the draw need not open.

Regulatory Evaluation

This proposed rule is not a “significant regulatory action” under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not “significant” under the regulatory policies and procedures of the Department of Homeland Security (DHS).

We expect the economic impact of this proposed rule to be so minimal that a full Regulatory Evaluation under the regulatory policies and procedures of DHS is unnecessary. We reached this conclusion based on the fact that the proposed changes have only a minimal impact on maritime traffic transiting the bridge. Mariners can plan their trips in accordance with the scheduled bridge openings, to minimize delays.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this proposed rule would have a significant economic impact on a substantial number of small entities. 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 would not have a significant economic impact on a substantial number of small entities.

This proposed rule would not have a significant economic impact on a substantial number of small entities because the rule only adds minimal restrictions to the movement of navigation, and mariners who plan their transits in accordance with the

scheduled bridge openings can minimize delay.

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.

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 so that they can better evaluate its effects on them and participate in the rulemaking. 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 Waverly W. Gregory, Jr., Bridge Administrator, Fifth Coast Guard District, (757) 398–6222. 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.

Collection of Information

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

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

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

Taking of Private Property

This proposed rule would not affect a taking of private property or otherwise have taking implications under

Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

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.

Protection of Children

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.

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.

Energy Effects

We have analyzed this proposed 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.

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

Environment

We have analyzed this proposed rule under Commandant Instruction M16475.ID, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, this proposed rule is categorically excluded, under figure 2–1, paragraph (32)(e) of the Instruction, from further environmental documentation because it has been determined that the promulgation of operating regulations for drawbridges are categorically excluded.

List of Subjects in 33 CFR Part 117

Bridges.

Regulations

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

PART 117—DRAWBRIDGE OPERATION REGULATIONS

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

Authority: 33 U.S.C. 499; Department of Homeland Security Delegation No. 0170.1; 33 CFR 1.05–1(g); section 117.255 also issued under the authority of Pub. L. 102–587, 106 Stat. 5039.

2. Section 117.1005 is revised to read as follows:

§ 117.1005 Chincoteague Channel.

The draw of the SR 175 Bridge, mile 3.5, at Chincoteague shall open on the hour from 6 a.m. to Midnight; except that from 7 a.m. to 5 p.m. on the last consecutive Wednesday and Thursday in July of every year and from Midnight to 6 a.m. every day the draw need not be opened.

Dated: December 20, 2004.

Ben R. Thomason,

Captain, U. S. Coast Guard, Acting Commander, Fifth Coast Guard District.

[FR Doc. 04–28548 Filed 12–29–04; 8:45 am]

BILLING CODE 4910–15–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[NM–44–1–7603b; FRL–7856–4]

Approval and Promulgation of Air Quality Implementation Plans; New Mexico; Recodification and SIP Renumbering of the New Mexico Administrative Code for Albuquerque/Bernalillo County

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA is proposing to approve a State Implementation Plan (SIP) revision submitted by the Governor of New Mexico on May 2, 2003. The submittal revises the numbering and format of New Mexico's Albuquerque/Bernalillo County SIP and contains no substantive changes to the regulations. We are approving these revisions in accordance with the requirements of the Federal Clean Air Act (the Act).

DATES: Written comments must be received by January 31, 2005.

ADDRESSES: Comments may be mailed to Mr. Thomas Diggs, Chief, Air Planning Section (6PD–L), Environmental Protection Agency, 1445 Ross Avenue, Suite 1200, Dallas, Texas 75202–2733.

Comments may also be submitted electronically or through hand delivery/courier by following the detailed instructions in the **ADDRESSES** section of the direct final rule located in the rules section of this **Federal Register**.

FOR FURTHER INFORMATION CONTACT:

Carrie Paige, Air Planning Section (6PD–L), EPA Region 6, 1445 Ross Avenue, Dallas, Texas 75202–2733, telephone (214) 665–6521; fax number 214–665–7263; email address paige.carrie@epa.gov.

SUPPLEMENTARY INFORMATION: In the final rules section of this **Federal Register**, EPA is approving the State's SIP submittal as a direct final rule without prior proposal because the EPA views this as a noncontroversial submittal and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If EPA receives no relevant adverse comments, the EPA will not take further action on this proposed rule. If EPA receives relevant adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. EPA will not institute a second comment period on this action. Any parties interested in

commenting on this action must do so at this time.

For additional information, see the direct final rule which is located in the "Rules and Regulations" section of this **Federal Register**.

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

Dated: December 16, 2004.

Richard E. Greene,

Regional Administrator, Region 6.

[FR Doc. 04–28502 Filed 12–29–04; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF TRANSPORTATION

Research and Special Programs Administration

49 CFR Part 173

[Docket No. RSPA–99–6223 (HM–213B)]

RIN 2137–AD36

Hazardous Materials: Safety Requirements for External Product Piping on Cargo Tanks Transporting Flammable Liquids

AGENCY: Research and Special Programs Administration (RSPA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: RSPA is proposing to amend the Hazardous Materials Regulations to prohibit flammable liquids from being transported in unprotected product piping on existing and newly manufactured DOT specification cargo tank motor vehicles. If adopted as proposed, this action will reduce fatalities and injuries that result from accidents involving unprotected product piping. This proposal was developed jointly with the Federal Motor Carrier Safety Administration.

DATES: Comments must be received by February 28, 2005.

ADDRESSES: You may submit comments identified by the docket number RSPA–99–6223 (HM–213B) by any of the following methods:

- Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.
- Web Site: <http://dms.dot.gov>. Follow the instructions for submitting comments on the DOT electronic docket site.

- Fax: 1–202–493–2251.
- Mail: Docket Management System; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–001.

- Hand Delivery: To the Docket Management System; Room PL–401 on

the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC between 9 am and 5 pm, Monday through Friday, except Federal Holidays.

Instructions: You must include the agency name and docket number RSPA-99-6223 (HM-213B) or the Regulatory Identification Number (RIN) for this notice at the beginning of your comment. For detailed instructions on submitting comments and additional information on the rulemaking process, see the Public Participation section of this document. Note that all comments received will be posted without change to <http://dms.dot.gov> including any personal information provided. Please see the Privacy Act section of this document.

Docket: You may view the public docket through the Internet at <http://dms.dot.gov> or in person at the Docket Management System office at the above address.

FOR FURTHER INFORMATION CONTACT: Mr. Michael Stevens, Office of Hazardous Materials Standards, Research and Special Programs Administration, telephone (202) 366-8553; Mr. Philip Olson, Office of Hazardous Materials Technology, Research and Special Programs Administration, telephone (202) 366-4545; or Mr. Danny Shelton, Hazardous Materials Division, Federal Motor Carrier Safety Administration, telephone (202) 366-6121, U.S. Department of Transportation, 400 Seventh Street SW., Washington, DC 20590-0001.

SUPPLEMENTARY INFORMATION:

I. Background

The Hazardous Materials Regulations (HMR; 49 CFR Parts 171-180), at § 173.33(e), prohibit the retention of certain liquid hazardous materials in the external product piping (wetlines) of a DOT specification cargo tank, unless the cargo tank motor vehicle (CTMV) is equipped with bottom damage protection devices. The current prohibition applies to liquid hazardous materials in Divisions 5.1 (oxidizer), 5.2 (organic peroxide), 6.1 (toxic), and Class 8 (corrosive to skin only), but does not apply to flammable liquids.

Wetlines are product piping located beneath the cargo tank on MC 306, MC 307, DOT 406, and DOT 407 CTMVs that remain filled with product after loading or unloading. Wetlines on a five-compartment CTMV carrying gasoline typically contain 30-50 gallons of gasoline. If a passenger vehicle strikes the side of a CTMV, the impact likely will fracture unprotected wetlines. In such collisions, the passenger vehicle is

often wedged under the CTMV. With the automobile driver and passenger(s) trapped in the vehicle under the CTMV, the fractured wetlines may release their entire contents onto the passenger vehicle. If ignited, fire will rapidly engulf the vehicle. When ignited, a gasoline spill of 50 gallons will create a fire over an area of up to 5000 square feet, dooming those trapped in a vehicle at the site of the release and fire. If it is not extinguished immediately, the fire could result in significant loss of life or damage to property or the environment.

On February 10, 2003, the Research and Special Programs Administration (RSPA, we) published an advance notice of proposed rulemaking (ANPRM; 68 FR 6689) to solicit comments and information regarding methods to reduce the safety risks associated with the retention of lading in unprotected wetlines. The ANPRM described the regulatory history for the current requirements in § 173.33 and detailed our long-standing concern for the inherent safety risk presented by the carriage of flammable liquids in unprotected wetlines. In addition, the ANPRM asked commenters to address a number of issues to assist us in making a determination as to whether regulatory changes are needed, including the current state of technological development, practical alternatives that will protect the wetlines or eliminate the problem, the effectiveness of measures such as increased conspicuity or side guards, and current industry practices to minimize the potential safety problem posed by wetlines.

II. Proposal in This NPRM

Based on comments and information received in response to the ANPRM (see discussion below), in this NPRM we propose to prohibit the carriage of flammable liquids in wetlines, unless the cargo tank motor vehicle conforms to the accident damage protection requirements of § 178.337-10 or the bottom damage protection requirements of § 178.345-8(b)(1), as appropriate.

Since product piping configurations on cargo tank motor vehicles transporting gasoline may contain unsafe amounts even when drained, we are proposing a quantity limit of one liter or less in each pipe after it is drained. This is a performance standard. We are not proposing a specific method for achieving this standard. A performance standard permits the industry wide latitude to develop measures to meet the requirement. For example, an operator may elect to install accident damage protection devices or it may decide to equip each CTMV with a system that will remove any lading remaining in

unprotected wetlines after loading. This wetline prohibition would not apply to a material classed as a combustible liquid or to a flammable liquid reclassified as a combustible liquid. For hazardous materials other than flammable liquids, the existing unprotected wetline prohibition would remain in effect.

Exception for Truck-Mounted DOT Specification Cargo Tank Motor Vehicles. In this NPRM, we propose to grant an exception from the piping damage protection requirements of §§ 178.337-10 and 178.345-8(b)(1) for truck-mounted (e.g., straight truck) DOT specification CTMVs. Truck-mounted CTMVs are designed and constructed with engine, body, and cargo tank permanently mounted to the same chassis. Based on the protective features afforded by their chassis and running gear, we believe that these cargo tank motor vehicles pose a significantly lower risk than most trailer and semi-trailer cargo tank motor vehicles. Under this proposal, components of the CTMV framework such as chassis rails and cross-members, suspension components, structural mounting members, or any other device that substantially protects product piping from the impact forces of another motor vehicle are expected to provide adequate accident damage protection. We are soliciting comments on whether this exception for truck-mounted cargo tank motor vehicles provides an acceptable level of safety, whether prohibiting flammable liquids in external product piping on truck-mounted DOT specification cargo tank motor vehicles should be considered, or if a quantifiable design or performance standard should be developed for these cargo tank motor vehicles. In addition, we invite comments on whether a Design Certifying Engineer should be required to determine if the product piping on a truck-mounted CTMV is adequately protected as part of the design certification process that is required for all DOT specification CTMVs.

Transitional period. We propose to make the changes in this NPRM effective two years after the effective date of a final rule and to permit CTMV operators five years to phase in requirements applicable to existing CTMVs. The two-year period provides time for planning, developing, and testing damage protection systems or systems designed to remove hazardous materials from product piping, or for redesigning cargo tank motor vehicles to eliminate external product piping altogether. Following this two-year deferral period, each newly manufactured cargo tank motor vehicle,

other than excepted truck-mounted tanks, would be subject to the new requirements. Existing cargo tank motor vehicles, other than excepted truck-mounted cargo tank motor vehicles, would have to be brought into conformance on or before the date of each cargo tank motor vehicle's first scheduled pressure retest after the two-year deferral period. Retrofits for existing CTMVs would be required to be completed no later than five years after the effective date of a final rule. The proposed seven-year transition period is needed to minimize the economic and operational impacts on CTMV operators and ensure realistic progress in implementing these safety enhancements.

Comment Summary

We received fifteen comments in response to the ANPRM. They were submitted by petroleum industry representatives, carriers, cargo tank manufacturers, and companies that manufacture cargo tank accessories. A detailed discussion of the comments follows. Note that, as appropriate, we used specific data and information provided in the comments to develop the regulatory evaluation that supports this NPRM.

A. Wetlines Accidents

The ANPRM stated that, since 1992, there have been seven fatal accidents, resulting in eight fatalities, where unprotected wetlines were damaged and gasoline released. These fatal accidents primarily involved collisions with passenger vehicles. Our experience indicates that there is a degree of under-reporting of hazardous materials transportation accidents of all types. In addition, prior to October 1, 1998, certain intrastate highway carriers were not required to report hazardous materials releases to RSPA. Therefore, our accident database probably does not include all accidents involving damage to wetlines on cargo tank motor vehicles. The ANPRM asked commenters whether our accident statistics are accurate.

One commenter, Cargo Tank Concepts (CTC), suggests that there are at least 21 accidents involving flammable liquids in unprotected wetlines that we did not include in our discussion in the ANPRM. CTC also provided a detailed analysis of the accidents it identified. This comment indicates that, as we noted in the ANPRM, our accident database is not inclusive of all wetlines incidents. We agree with CTC that in estimating the potential benefits of any proposed regulatory changes we should make an effort to account for all relevant

accidents in order to accurately quantify the benefits of the proposed change. The regulatory evaluation developed in support of this ANPRM includes a detailed accident analysis.

B. Alternatives for Addressing the Safety Problem

For purposes of assessing the costs that industry might incur to comply with a performance standard, such as is proposed in this NPRM, the ANPRM identified two systems that could be used to meet the performance standard: (1) A purging system; and (2) short loading lines. In addition, the ANPRM asked commenters to address alternative strategies for reducing the risks associated with carriage of flammable liquids in unprotected wetlines, including improved vehicle conspicuity, modified accident damage protection systems, and non-regulatory alternatives.

1. Purging System

The purging system is an onboard system that evacuates the wetlines by forcing the lading out of the product piping and into the cargo tank body. After loading is complete and the main cargo compartment valves are closed, the system introduces compressed air from an auxiliary tank into the product piping under low pressure and at a low flow rate. Lading in the product piping is displaced by air and flows through separate purging lines into the cargo tank body. This purging process is controlled automatically and lasts approximately six minutes. The system is also capable of detecting and automatically purging any leakage of product through the cargo tank's internal shutoff valve into the product piping, thereby eliminating a potential wetline condition during transportation. In the ANPRM we asked if such a system would effectively reduce the risks posed by unprotected wetlines.

In response to our question, the American Petroleum Institute (API) said, "In theory, a properly operating purging system should be very effective because the lines and equipment would be dry." Other commenters, however, state that such a safety system would generate more concerns than it averts. The Petroleum Transportation and Storage Association (PTSA) notes that anywhere from one half to a full gallon of gasoline would be left in the hoses after purging. PTSA states that the trapped gasoline, while reducing the risk of ignition due to accidental impact, could send vapors back to an otherwise empty and purged compartment, creating a significant risk of explosion.

CTC suggests that the purging system has already been proven to be very effective. In one instance a tanker equipped with a purging system ran over a discarded drive shaft that was then propelled into the outlet piping and tore a hole in the thin schedule 10 aluminum. No product spilled from the piping because it had been purged. CTC reports another incident that occurred when a woman driving a passenger vehicle hit and damaged the outlet piping, trapping her vehicle beneath the cargo tank. Although the tanker was empty, the owner of the tanker stated that several gallons of gasoline would have poured onto the hood of her car if the lines had not been purged.

We agree with API and CTC that a properly operating purging system will be effective in reducing the risks associated with unprotected wetlines. We disagree with PTSA. A purged wetline will not send a larger quantity of vapors back to an otherwise empty and purged compartment than would be sent by a saturated wetline. The residue remaining in the wetline after it has been purged will not pose a significant risk of explosion.

In the ANPRM we asked if a purging system would be practicable for installation on new and/or existing CTMVs. Nearly all the commenters believe that any future wetlines requirement should apply to newly manufactured equipment and that it should be phased in over a period of years as existing equipment is taken out of service. Most commenters believe that retrofit is not practicable; however, NTTC indicates that retrofit would be practicable so long as the purging equipment can be installed without welding. CTC suggests that "it is more than obvious that our system is practicable for installation on both new and existing equipment. Over the last five years more than 130 fully automated systems have been installed nationwide and have been on the road for an average of three years. More than half of these systems were installed as retrofits."

The ANPRM noted our understanding that one major oil company, representing less than one percent of the potentially affected cargo tank population, has chosen to outfit its entire fleet with a system that purges product from unprotected external piping. Two additional carriers installed the same purging system on a small portion of their fleets as part of a successful field evaluation and expressed interest in equipping their entire fleets. To verify our understanding we asked if any carriers were installing the systems on their

tanks and, if so, we asked for the costs associated with installation and maintenance.

Most commenters know of only one carrier, Sun Oil Co. (Sunoco), currently operating a purging system on its cargo tanks. Sunoco worked with CTC to develop a purging system that is reliable and easy to understand and operate. According to CTC, Sunoco's experience demonstrates that vapor does not escape from a purged wetline, enter an empty compartment, and create a more volatile atmosphere than if the wetline contained a greater quantity of the flammable liquid. Further, Sunoco has indicated to CTC that it is confident that the outcome of an accident will be less serious because gasoline will have been purged from the product piping. According to CTC, British Petroleum (BP)/AMOCO/ARCO, Getty, and Motiva/Shell have each installed a CTC purging system on one of its units. Carriers that have installed the CTC purging system indicate that they are satisfied with the purging system, but they are postponing further purchases pending the issuance of a RSPA regulation. The regulatory evaluation includes a more complete discussion of the costs involved with installation of a purging system on both new and existing CTMVs.

2. Short Loading Lines

The installation of short, or independent, loading lines involves adding a set of short lines for loading that are independent of the unloading lines. These short-loading lines, placed on the lower part of the cargo tank, are accessible and are not exposed to damage in case of rollover. Each short four-inch inside diameter pipe extends from the cargo tank wall and contains approximately one gallon of hazardous material rather than the 30 to 50 gallons contained in a typical product piping system. In the ANPRM we voiced our concern regarding the effectiveness of such a design and whether it might adversely impact the structural integrity of the cargo tank. We were interested in obtaining the industry's thoughts on the practicality of installing independent loading lines on new and/or existing tanks. We also asked if any carriers are currently installing the systems on their tanks and, if so, we asked for the costs associated with installation and maintenance.

The commenters state that short and recessed loading lines are not practicable options for installation on new or existing cargo tanks. They state that recessed loading lines will be more difficult for drivers and terminal workers to access, increasing accidents

and OSHA claims. Also, commenters suggest that such a requirement would require loading rack modifications, cause increased splashing and concern for static ignition, and require a longer flow period. Commenters agree that the installation of short or recessed loading lines may be unrealistic because substantial modifications to existing loading racks may be necessary or loading times may increase. API suggests that such a substantial change to the loading rack would cost \$1 million per loading lane. Commenters also assert that if the product flow were reversed at the rack and the lines were purged, there would be problems with the fuel tax accounting system, fuel blends due to mixing at the rack, and the mixing of flammable liquids in slop tanks. All of the commenters agree that draining the product at the rack is neither a feasible nor cost-effective option.

We agree with the commenters. Our analysis of short or recessed loading lines indicates that the system would not be a cost-effective means of mitigating the risks associated with unprotected wetlines. Due to the high cost of facility modification and the potential for greater risks to workers, the public, and the environment, implementation of an independent loading line requirement is not feasible at this time.

3. Accident Damage Protection

In the ANPRM, we stated that we are aware of at least one cargo tank operator that has installed under-ride protection on its cargo tank motor vehicles. Although this protection may not meet the bottom damage protection requirements in § 178.345–8(b), we invited comments on whether this may or may not substantially reduce the risks posed by unprotected product piping. We also asked if there were cost-effective designs that would provide a level of protection that would sufficiently reduce the risks associated with unprotected wetlines.

Commenters agree that there are designs for accident damage protection that would protect the wetlines from rupture during a collision, but both API and the Society of Independent Gasoline Marketers of America (SIGMA) suggest that the same structure could puncture the shell of the tank due to the impact of a collision. Also, the weight of accident damage protection rigid enough to protect the wetlines in a side impact situation would be approximately 1,100 to 1,200 pounds, which would significantly reduce the amount of product hauled per trip. API states that accident damage protection

would cost between \$3,000 and \$5,000 for "light duty," which would most likely be insufficient in a side impact, or \$11,000 and \$12,000 for "heavy duty," which would be adequate protection. Commenters suggest that accident damage protection capable of protecting the wetlines in a side impact situation is not cost-effective at this time.

We agree with the commenters. Adequate accident damage protection is available, but we realize that there are some valid concerns regarding rigid tubing puncturing the tank shell during an accident situation and the costs involved with installation of systems that would be effective in reducing accidents involving unprotected wetlines.

4. Conspicuity

In the ANPRM, we suggested that perhaps marking or other systems that increase vehicle conspicuity could be effective in reducing collisions between cargo tank motor vehicles and automobiles. All commenters agree that improved conspicuity or lighting requirements would not reduce the risk of wetlines incidents. The current conspicuity requirements make cargo tanks highly visible. Commenters further suggest that the accidents that resulted in wetlines incidents were not a result of impaired visibility.

We agree with the commenters that the conspicuity requirements currently in place are sufficient and we have decided not to propose any changes to the conspicuity features already required on cargo tank motor vehicles.

5. Non-Regulatory Alternatives

In the ANPRM, we asked if an awareness campaign might be a successful means of reducing the risk associated with unprotected wetlines. Most commenters do not see this as a reasonable approach for reducing the number of wetlines accidents. Indeed, the Petroleum Marketers Association of America (PMAA) suggests that a public awareness campaign "might cause unnecessary alarm among the public over a risk that we see as so minimal." On the other hand CTC states that "the public has every right to be alerted to the fact that cargo tank outlet piping, designed to fail if impacted in an accident, is being used to transport up to 50 gallons of gasoline located underneath a cargo tank that carries thousands of gallons of flammable liquids." Further, CTC indicated that the frequency and accuracy of wetlines incidents being reported would increase as the public becomes more aware of the situation.

We agree that the public should understand the risks involved with the transportation of flammable liquids and be sure to utilize safe driving techniques, but an awareness campaign would not solve the safety problem associated with the retention of flammable liquids in unprotected wetlines. We agree with CTC that an awareness campaign could help to expand data collected on wetlines incidents, but making the public aware of this situation does not eliminate the inherent safety problem.

In the ANPRM, we asked for comments on additional safety practices that the industry is currently utilizing to minimize the safety risk associated with the retention of flammable liquids in unprotected wetlines. Commenters suggest that the driver training they provide constitutes an adequate safety practice and sufficiently mitigates the risks associated with unprotected wetlines. They state that motor carriers train cargo tank motor vehicle drivers on the dangers associated with flammable liquids in wetlines and some even provide defensive driver training. Commenters did not provide any definitive costs associated with the wetlines training the industry provides. The Society of Independent Gasoline Marketers of America (SIGMA), states that "in the past, SIGMA members have estimated their per-employee hazmat training costs at approximately \$4,000 per employee." Other commenters indicate that significant resources were dedicated to safety training.

We agree that providing drivers with defensive driver training is beneficial to both the driver and the public, but the wetlines accidents that have occurred indicate that this type of training does not adequately alleviate the safety risk associated with the retention of flammable liquids in unprotected wetlines. We are encouraged that carriers realize the dangers associated with unprotected wetlines and are searching for a safety solution. We do not agree that training alone is an adequate solution; we note, however, that training is essential to the success of any proposed safety practice.

In the ANPRM we asked if an industry or an industry/government research initiative to explore new methods to address the wetlines safety problem would be of value. Commenters disagree as to the value of such research. SIGMA states that "a research initiative would be valuable if potential methods of enhancing safety of wetlines were identified." On the other hand, PMAA's view is that "the risk is so low, we do not believe further research is warranted."

We continue to believe that the risks associated with unprotected wetlines are significant. At this time, we do not believe that an industry/government research initiative is necessary to identify potential solutions to the safety problem because, in our view, a purging system reduces the risks associated with unprotected wetlines in a cost-effective manner. We will keep abreast of technological advances that affect the safe transportation of hazardous materials and, as necessary, conduct or participate in research projects that might provide information about new technologies or innovative ideas that could increase hazmat safety.

6. Other

In the ANPRM, we suggested that there might be other cost-effective solutions that could significantly reduce or eliminate the current level of risk. We asked commenters to identify other possible approaches to reducing or eliminating the risks posed by the transportation of flammable liquids in unprotected wetlines. We asked them to provide information on the costs, effectiveness, phase of development, or any other concepts, either facility- or vehicle-related, that might reduce the risks posed by unprotected wetlines.

Two commenters indicated that there is a new technology that could reduce the safety risks associated with wetlines. These commenters are marketing two versions of a double-poppeted emergency valve that allows the external link to rotate if the valve is sheared during an accident situation, thereby closing the valve and trapping the product in the wetline. The commenters suggest that the installation of this valve requires no modification to the existing cargo tank, except for installation of the valve, and that it is easily retrofitted onto the cargo tank in place of the current emergency valve.

While we agree that a double-poppeted emergency valve could be of some value in reducing the potential consequences of an accident involving unprotected wetlines, we note that the valve's external link operates only in the event that the valve is sheared from the piping; this limitation means that for accidents that do not shear the valve from the piping, the valve's utility in mitigating the consequences of the accident is limited. In our view, a regulatory solution must comprehensively address the underlying safety risks associated with the retention of flammable liquids in unprotected wetlines.

C. Costs Associated With Regulations

In the ANPRM, we stated that we are aware of two systems that may be used to meet the performance standard proposed in this NPRM—a manual onboard purging system and short or recessed loading lines. We estimated that the manual onboard purging system could be installed on a newly constructed CTMV for around \$2,120 (welded) or \$2,256 (non-welded) (2002 dollars). A short loading line system can be installed for \$1,540 per cargo tank motor vehicle (2002 dollars). Equipment and installation costs are the same for the retrofit of existing CTMVs; however, additional costs in the form of lost profit or risks to technicians installing new equipment may be incurred when systems are installed on existing CTMVs. We invited comments on the accuracy of the data that we used in the ANPRM. Specifically, we asked for information on the costs for the purging system and short and recessed loading lines.

Several commenters provided figures for the costs associated with retrofitting tanks with purging systems and short loading lines. The American Petroleum Institute (API) and the Petroleum Transportation & Storage Association (PTSA) both indicate that the hardware and installation costs of retrofitting a cargo tank with a wetline purging system could total as much as \$5,000 per tank. These commenters suggest that adding in the costs associated with cleaning and purging the tank and the losses due to the time out of service for the retrofit suggests that the actual cost of the retrofit could be well over \$5,000 dollars per tank. PTSA estimates the cost for installing short loading lines on a CTMV to be approximately \$2,000 per tank.

Another commenter, CTC, states that it sells both automatic and manual purging systems. CTC indicates that a semi-manual system, a system that does not include optical sensors, solenoids and LEDs, would be consistent with the costs used in the ANPRM, that is \$2,100 to \$2,300. CTC further states that, depending on the options chosen, prices range from \$3,000 to \$4,000 for a fully automatic wetlines purging system; on average, according to CTC, the cost for a fully automated system, either new or retrofit, averages \$3,800.

We agree with PTSA that the cost of retrofitting a tank with short lines would be approximately \$2,000. However, in our view both PTSA and API are overestimating the cost of retrofitting a tank with a wetlines purging system. CTC has manufactured and installed over 130 wetline purging

systems. Given CTC's experience, we believe that its estimate of the costs of installing a purging system is more accurate than the estimates provided by PTSA and API. Therefore, in the regulatory evaluation, we use the CTC cost estimates in our analysis of the costs associated with the performance standard proposed in this NPRM.

In the ANPRM we asked commenters if reductions in the costs associated with purging systems would stem from economies of scale. Most commenters indicate that economies of scale would not be applicable because there are not a sufficient number of tanks affected to provide the benefits associated with economies of scale. CTC states that over the past five years it has sold 130 systems nationwide. This does not indicate a market that could benefit from economies of scale. However, CTC suggests that if demand for its purging system were to reach 1,000 units per year, then the cost of the system would be substantially reduced. Because of the conflicting information provided by commenters, we do not include potential economies of scale in the analysis of system costs in the regulatory evaluation. However, we invite commenters to provide data and information concerning cost reductions that would be achieved as a result of economies of scale.

D. Cargo Tank Population

Based on information in the U.S. Census Bureau's 1997 Vehicle Inventory and Use Survey, we estimated in the ANPRM that the population of vehicles that would be affected by any regulatory action to address the safety risks associated with the retention of flammable liquids in unprotected wetlines is approximately 63,000. Commenters to the ANPRM indicate that there are actually between 10,000 and 50,000 vehicles that will be affected. For example, PTSA states that there are "more than 50,000 cargo tank vehicles in flammable [liquid] service nationwide" that "deliver approximately 42,000 shipments per day." The National Tank Truck Carriers, Inc. (NTTC) states, "respondents to NTTC's membership survey reported a total fleet of 10,648 cargo tank motor vehicles designed, primarily, for the transportation of petroleum products (i.e., Specifications MC 306, DOT 406 and older equivalents)."

A May 2003 editorial entitled *Fuel haulers find the key*, published in *Modern Bulk Transporter*, reports an industry estimate of the number of petroleum trailers in service to be 15,000 units. The article states: "A surprising result of the research was the

finding that the number of petroleum trailers in service today may be less than half of what was estimated 10 years ago. The new estimate suggests a total petroleum fleet of around 15,000 units, down significantly from the 48,000-unit figure that has been quoted since the mid 1990s." The article indicates that this decline can be attributed in large part to 24-hour loading and delivery operations. Based on the information in this article, increases in productivity achieved by the industry over the past decade, and the inconclusive nature of the comments provided by the industry in response to the ANPRM, we believe that 15,000 vehicles is a reasonably accurate estimate for the population of CTMVs that would be affected by regulatory action to address the wetlines safety issue. A more detailed analysis of the population of vehicles that will be affected by this proposal can be found in the regulatory evaluation.

E. Cargo Tank Useful Life

The ANPRM stated our understanding that the useful life of a cargo tank is at least 20 years and may extend to 30 years. The American Petroleum Institute (API) suggests that the useful life of a cargo tank is between five and twelve years, after which time the tanks must be upgraded or replaced. Other commenters, notably NTTC and PMAA, agree that the average useful life for a cargo tank in flammable liquid service is about 20 years and that 25-year-old cargo tanks are not uncommon. For the regulatory evaluation, we used a 20-year useful life estimate to evaluate the costs to the industry of the performance standard proposed in this NPRM.

F. Maximum Weight Limits

The ANPRM asked commenters to estimate the percentage of CTMVs in flammable liquid service that are operated at maximum weight limits. Several commenters indicate that virtually all CTMVs are loaded to the maximum weight limit permitted by state or Federal regulations, whichever is greater. Commenters also suggest that for every six pounds added to the tare weight of a cargo tank, one gallon of gasoline is displaced from each load. We agree that the added weight of a system designed to reduce or eliminate lading from wetlines would have a negative impact on the amount of product that can be transported and that this cost must be addressed as part of any proposed regulatory changes. In addition, the additional risk to the general public that results from more frequent deliveries to compensate for any added weight must be addressed. The regulatory evaluation includes a

more complete analysis of this issue in the discussion of costs that may be incurred by the industry to comply with the proposals in this NPRM.

G. Average Distance Traveled

In the ANPRM, we asked for an estimate of the average distance traveled by a typical CTMV during a delivery route. Most commenters indicate that the average round trip falls somewhere between 40 and 60 miles. However, some commenters suggest that the average distance per trip varies greatly depending on the areas within which deliveries are made. For example, some commenters note that tankers operating in rural areas travel significantly higher round-trip distances than tankers operating in urban areas. These commenters estimate a range of from 25 miles for an urban round-trip to 100 miles for a round-trip completed in a rural area.

Based on comments received to the ANPRM, in the regulatory evaluation, we estimate that the average round trip should fall somewhere between 40 and 60 miles. While commenters are correct that an urban route is, on average, significantly shorter than a rural route, because the demand for flammable liquids, especially gasoline, is higher in urban areas, suppliers will make far more urban delivery trips than rural delivery trips. A weighted average takes account of the larger number of short round-trips and results in an average distance per trip of between 40 and 60 miles.

H. Additional Benefits

In the ANPRM we asked if additional benefits, either measurable or otherwise, would result from the implementation of requirements established to reduce the safety risks associated with unprotected wetlines. Only one commenter addressed this question. CTC suggests that one of the additional benefits of an automatic wetlines purging system is that the system provides a continual means to detect leaking or malfunctioning emergency valves. Under the bottom loading system the outlet piping is filled with the flammable liquid that is in the cargo tank. CTC states "[a] recent installation of a purging system for a major oil company revealed that all five emergency valves were stuck open, despite their procedures for periodic inspections. A wetlines incident in this case would have caused the loss of the entire contents of the affected compartments."

As we noted in the ANPRM, we are aware that the automatic purging system is also capable of detecting and purging

any leakage of product through the cargo tank's internal shutoff valve into the product piping, thereby eliminating a potentially serious safety condition during transportation. We agree with CTC that this should be included as an additional benefit of the automatic purging system.

I. Low-Frequency/High-Consequence Events

In the ANPRM, we asked if a cost-benefit analysis developed to support a regulatory change should include a reduction in risks associated with low-frequency, high-consequence events. Commenters suggest that any cost-benefit analysis should include all relevant events, regardless of their frequency or magnitude. CTC gives the following example: "Much attention has been given lately to regulations that might reduce the risk of gasoline cargo tanks being hijacked by terrorists, but a cargo tank does not need to be hijacked, nor does it need to be rigged with explosives to create a catastrophe." CTC suggests that if terrorists decide to cause intentional accidents involving wetlines, then low-frequency, high-consequence events could rapidly become common and more than a threat to public safety. CTC argues that the benefits for addressing this vulnerability would be substantial.

We agree with the commenters that all relevant events should be included in a cost-benefit analysis. We also agree with CTC's comments regarding security concerns associated with the transportation of hazardous materials, specifically a cargo tank filled with gasoline. However, the intention of this rulemaking is to identify a cost-effective solution to the safety risks associated with the transportation of flammable liquids in unprotected product piping. We are addressing the security risks associated with hazardous materials transportation in several other rulemaking projects. Although CTC's points are valid, we do not agree that attaching security concerns to our search for a cost-effective solution to the wetlines issue would be appropriate.

III. Regulatory Analyses and Notices

A. Executive Order 12866 and DOT Regulatory Policies and Procedures

This proposed rule is a significant regulatory action under section 3(f) of Executive Order 12866 and, therefore, was reviewed by the Office of Management and Budget. The proposed rule is also a significant rule under the Regulatory Policies and Procedures of the Department of Transportation (44 FR 11034). A regulatory evaluation is

available for review in the docket. This regulatory evaluation makes a number of key assumptions, as follows: (1) The estimated number of CTMVs affected by our proposal is 15,000 units; (2) the lowest-cost solution identified in our proposal is 100% effective in eliminating the risk posed by wetlines; (3) for retrofit of existing CTMVs, equipment downtime would be limited to time already accounted for during DOT-mandated qualification testing; (4) affected parties will select the lowest-cost alternative available (the non-welded purging system); and (5) the benefits identified in our regulatory evaluation are from actual wetlines-related incidents.

Number of CTMVs. In our regulatory evaluation we estimate the number of affected CTMVs to be 15,000. We arrived at this conclusion using several different methodologies. For example, the daily consumption of gasoline in the United States is 7,900,000 barrels or 332,000,000 gallons. Shipment of this amount, together with the subsequent daily reshipment of gasoline from bulk storage to intermediate or jobber storage, results in 43,824 (88%) bulk shipments in 8,000 gallon CTMVs and 23,904 (12%) bulk shipments in 2,000 gallon CTMVs. Based on an average of five trips per day per CTMV and 12% of CTMVs out of service at any time, the total number of CTMVs required to transport the gasoline is 9,817 8,000-gallon cargo tanks and 5,737 2,000-gallon cargo tanks, or, a total of 15,554 CTMVs. This figure is consistent with industry estimates on the number of CTMVs currently in petroleum service (15,000). This proposed rule would except truck-mounted cargo tanks, which are typically in the 2,000–3,500 gallon range, from the wetlines prohibition; this exception would apply to a total of 5,737 CTMVs. Our regulatory evaluation assumes that 15,000 CTMVs will be affected under this NPRM. This total includes about 5,183 CTMVs that transport flammable liquids other than petroleum products that may be subject to the requirements of this NPRM. We invite comments to provide us with additional data concerning the number of CTMVs that may be affected by the provisions of this NPRM.

Effectiveness of technology solutions. The intent of this proposed rule is to eliminate the risks posed by unprotected product piping containing flammable liquids during transportation. To evaluate the benefits and costs of the proposal to prohibit the carriage of flammable liquids in wetlines, we identified several technologies that would permit

operators of CTMVs to meet the proposed performance standard. The system used for our regulatory analysis is the lowest-cost system currently available—a purging system that can be installed on a CTMV without welding. A purging system evacuates the loading/unloading lines by forcing the flammable liquid out of the product lines and into the cargo tank body. After loading is complete and the main cargo compartment valves are closed, the system introduces compressed air from an auxiliary tank through an air filter and regulator into the lines. We agree with most commenters to the ANPRM that the purging-system technology that currently exists will eliminate the risks posed by wetlines and, therefore, would be 100% effective whether installed in newly manufactured CTMVs or retrofitted on existing CTMVs. We welcome additional comments on whether a purging system would be 100% effective in eliminating the risk posed by wetlines.

Costs associated with system installation. We believe that systems designed to purge loading lines on CTMVs will be installed at the point of manufacture on newly constructed CTMVs and, therefore, no additional costs would be incurred. For existing CTMVs, we propose to permit retrofits over a five-year period, thereby permitting systems designed to purge loading lines to be installed at the time of a CTMV's required 5-year pressure test. This policy would allow maximum flexibility to CTMV owners and operators when scheduling installation time and is consistent with previous rulemakings requiring the retrofit of existing CTMVs. In our regulatory evaluation we assume that labor man-hour costs are the only additional costs incurred when retrofitting existing CTMVs. Other down-time costs, such as loss of profit, are not taken into account based on our assumption that the CTMV will already be out of service at the time of installation. We welcome comments on whether the down-time costs we quote are either realistic or accurate and if there would be any extenuating circumstances of which we are not aware.

Selection of low-cost alternative. Both "welded" and "non-welded" systems are equally effective in meeting the performance standard proposed in the NPRM. An automated purging system must be installed by welding; a manual purging system may be installed with or without welding. For new construction, some companies may elect to install a "welded" purging system over a "non-welded" system, notwithstanding the lower per-unit cost of the "non-welded"

system, based on convenience (installation at the point of manufacture) and the opportunity to install an automated purging system rather than a manual purging system if they so choose. Although unlikely (costs and risk are higher), some companies may elect to retrofit a "welded" purging system over a "non-welded" purging system for the opportunity to install an automated rather than a manual purging system. In our regulatory analysis we assume that CTMV owners/operators will choose to install the lowest-cost alternative (the non-welded purging system) that satisfies the performance standard proposed in the NPRM for newly constructed and existing CTMVs due to its ease of installation, lower cost, and the elimination of risk posed to welders. We have included a sensitivity analysis in our regulatory evaluation that compares benefits and costs for different scenarios, including two tables highlighting a "welded" manual purging system installed on both newly constructed and existing CTMVs. We welcome comments on whether CTMV owners/operators would select the "welded" or "non-welded" option.

Benefits of proposed rule. We identified 190 reported incidents involving wetlines during the 12-year period from January 1, 1990, through December 31, 2001, which is a rate of about 16 incidents per year. Incidents reported by carriers to RSPA, under §§ 171.15 and 171.16 of the HMR, are a direct result of the hazardous material involved. Therefore, all quantified reported and non-reported costs to society to avoid a wetlines incident accrued in our regulatory evaluation are the direct result of the release of flammable liquids in unprotected product piping during an accident.

In our benefit-cost analysis we determined that achieving compliance with the proposed rule under the lowest cost system of which we are aware, the non-welded purging system, and within an acceptable time frame, would cost industry \$39.9 million in present value (discounted 7%) over a period of 20 years, the estimated maximum useful life of a CTMV. The corresponding present-value benefits are \$45.3 million, for a benefit-cost ratio of 1.14:1 when discounted by 7%. The benefits include lives saved, injuries prevented, and property damage avoided. In addition, the proposal to prohibit the transportation of flammable liquids in unprotected product lines reduces losses by the private sector (in terms of time and productivity), by government (in terms of allocation of scarce resources, including emergency

responders, their support vehicles, and equipment), and by the general public (in terms of time and inconvenience).

Associated Damages Caused by Wetlines That Are Not Reported to RSPA. The damages caused by wetlines incidents are greater than what is reported on Incident Reports submitted to RSPA. Associated damages caused by wetlines incidents include the costs of traffic delays, additional vehicle operating expenses, commercial losses beyond those that may be included in evacuation costs, environmental damage, and emergency services beyond those that may be included in decontamination/cleanup costs. These associated damages are not reported to RSPA; however, they are part of the true costs of the wetlines incidents that are reported. Associated damages are difficult to estimate; however, high profile incidents, such as the Yonkers, New York, incident, provide insight into some of these associated damages. At best, we can provide a range of values for these associated damages that are informed by empirical and other evidence.

Because of the difficulty in estimating associated benefits, some of the estimates for the benefits discussed in this section may be over- or understated. For example, the estimate derived for traffic delays is extrapolated from information about delays associated with several wetlines incidents, including the incident in Yonkers that destroyed an overpass section of the New York State Thruway and incidents in Huntsville, Alabama; Mesa, Arizona; and Chatham, Ohio, that resulted in lengthy highway closures. For purposes of this analysis, we assume that these delays are directly attributable to the release of the hazardous materials as a result of the accidents in question. However, it is also true that traffic delays result from accidents that are not related to hazardous materials or where a hazardous material is not released from its packaging during an accident. We did not try to identify the incremental costs of traffic delays resulting from the hazardous materials spill over and above the costs for delays that may have resulted had the hazardous material not been released. For this reason, these costs may be overstated. It is reasonable to assume that most, if not all, of the costs related to traffic delays resulting from wetlines accidents are directly attributable to the release of hazardous materials. Such delays would not have been as severe if a hazardous material were not involved or had not been released. In the Yonkers incident, for example, the overpass section would not have been destroyed

had the hazardous material not been released and ignited. In addition, for traffic delays, our extrapolation is based on information concerning 15 of the 190 wetlines-related incidents reported to RSPA. If the full cost of traffic delays were calculated for the remaining 175 wetlines-related incidents, the corresponding associated benefits would be much higher. However, even if only 61% of the cost to society to avoid traffic delays estimated here, when discounted by 7%, are directly attributable to wetlines incidents or, if only 40% of the costs to society to avoid traffic delays estimated here, when discounted by 3%, are directly attributable to wetlines incidents, the measures proposed in the NPRM will result in benefits exceeding costs. We invite comments on whether all associated benefits should be considered in a regulatory analysis or if a range of benefits is more appropriate.

When product piping is damaged, the potential for fire is great and the consequences of such accidents may be substantial. We believe, therefore, that transportation of flammable liquids in unprotected product piping poses an unacceptable risk and continuing to permit this practice is not in the public interest.

B. Executive Order 13132

This proposed rule has been analyzed in accordance with the principles and criteria contained in Executive Order 13132 ("Federalism"). This proposed rule would preempt State, local and Indian tribe requirements, but does not propose any regulation that has direct effects on the States, the relationship between the national government and the States, or the distribution of power and responsibilities among the various levels of government. Therefore, the consultation and funding requirements of Executive Order 13132 do not apply.

The Federal hazardous material transportation law, 49 U.S.C. 5101–5127, contains an express preemption provision (49 U.S.C. 5125(b)) that preempts State, local, and Indian tribe requirements on certain subjects. These subjects are:

- (1) The designation, description, and classification of hazardous material;
- (2) The packing, repacking, handling, labeling, marking, and placarding of hazardous material;
- (3) The preparation, execution, and use of shipping documents related to hazardous material and requirements related to the number, contents, and placement of those documents;
- (4) The written notification, recording, and reporting of the

unintentional release in transportation of hazardous material; or

(5) the design, manufacturing, fabricating, marking, maintenance, reconditioning, repairing, or testing of a packaging or container represented, marked, certified, or sold as qualified for use in transporting hazardous material.

This proposed rule covers item 5 and would preempt any State, local, or Indian tribe requirements not meeting the “substantively the same” standard.

Federal hazardous materials transportation law provides at 49 U.S.C. § 5125(b)(2) that, if the Secretary of Transportation issues a regulation concerning any of the covered subjects, the Secretary must determine and publish in the **Federal Register** the effective date of Federal preemption. The effective date may not be earlier than the 90th day following the date of issuance of the final rule and not later than two years after the date of issuance. We propose that the effective date of Federal preemption will be 90 days from publication of a final rule in the **Federal Register**.

C. Executive Order 13175

This proposed rule has been analyzed in accordance with the principles and criteria contained in Executive Order 13175 (“Consultation and Coordination with Indian Tribal Governments”). Because this proposed rule does not have tribal implications, does not impose substantial direct compliance costs, and is not required by statute, the funding and consultation requirements of Executive Order 13175 do not apply.

D. Regulatory Flexibility Act, Executive Order 13272, and DOT Procedures and Policies

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) requires an agency to review regulations to assess their impact on small entities unless the agency determines a rule is not expected to have a significant economic impact on a substantial number of small entities. Based on the assessment in the regulatory evaluation, we believe that this NPRM may have a significant impact on a substantial number of small entities. However, many small businesses will not be affected by the proposals in this NPRM because they tend to own single-unit (*i.e.* “straight”) trucks, which are excepted from the proposals.

The detailed small business analysis is available for review in the docket. We invite commenters to address the impact that the proposals in this NPRM may have on small entities.

This proposed rule has been developed in accordance with Executive Order 13272 (“Proper Consideration of Small Entities in Agency Rulemaking”) and DOT’s procedures and policies to promote compliance with the Regulatory Flexibility Act to ensure that potential impacts of draft rules on small entities are properly considered. DOT has notified the Small Business Administration’s Chief Counsel for Advocacy (SBA) of this draft proposed rule.

E. Paperwork Reduction Act

This proposed rule imposes no new information collection requirements.

F. Regulation Identifier Number (RIN)

A regulation identifier number (RIN) is assigned to each regulatory action listed in the Unified Agenda of Federal Regulations. The Regulatory Information Service Center publishes the Unified Agenda in April and October of each year. The RIN number contained in the heading of this document can be used to cross-reference this action with the Unified Agenda.

G. Unfunded Mandates Reform Act

This proposed rule does not impose unfunded mandates under the Unfunded Mandates Reform Act of 1995. It does not result in costs of \$100 million or more to either State, local, or tribal governments, in the aggregate, or to the private sector, and is the least burdensome alternative that achieves the objectives of the rule.

H. Environmental Assessment

The National Environmental Policy Act of 1969 (NEPA), as amended (42 U.S.C. 4321–4347), requires Federal agencies to consider the consequences of major federal actions and prepare a detailed statement on actions significantly affecting the quality of the human environment. There are no significant environmental impacts associated with this proposed rule. An initial environmental assessment is available in the docket.

I. 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) or you may visit <http://dms.dot.gov>.

List of Subjects in 49 CFR Part 173

Hazardous materials transportation, packaging and containers, Radioactive materials, Uranium.

In consideration of the foregoing, we propose to amend 49 CFR Part 173 as follows:

PART 173—SHIPPERS—GENERAL REQUIREMENTS FOR SHIPMENTS AND PACKAGINGS

1. The authority citation for part 173 continues to read as follows:

Authority: 49 U.S.C. 5101–5127, 44701; 49 CFR 1.45, 1.53.

2. In § 173.33, paragraph (e) is revised to read as follows:

§ 173.33 Hazardous materials in cargo tank motor vehicles.

* * * * *

(e) *Retention of hazardous materials in external product piping during transportation.*

(1) No person may offer or transport a liquid hazardous material in Division 5.1 (oxidizer), Division 5.2 (organic peroxide), Division 6.1 (toxic), or Class 8 (corrosive which is corrosive to skin only) in the external product piping of a DOT specification cargo tank motor vehicle unless the vehicle is equipped with bottom damage protection devices conforming to the appropriate requirements of § 178.337–10 or § 178.345–8(b)(1) of this subchapter, or the accident damage protection requirements of the specification under which the cargo tank motor vehicle was manufactured. This requirement does not apply to a residue that remains after the external product piping is drained to the maximum extent practicable.

(2) No person may offer or transport a Class 3 (flammable liquid) material in the external product piping of a DOT specification cargo tank motor vehicle on or after [date two years after the effective date of the final rule], unless the cargo tank motor vehicle is protected with bottom damage protection devices conforming to the requirements of § 178.337–10 or § 178.345–8(b)(1) of this subchapter, as appropriate. The requirements of this paragraph (e)(2) do not apply to—

(i) A cargo tank motor vehicle that is marked or certified to a DOT specification before [date two years after the effective date of the final rule], until the date of the first required periodic pressure test occurring after [date two years after the effective date of the final rule];

(ii) A cargo tank motor vehicle designed and constructed with engine, body, and cargo tank permanently mounted on the same chassis with

product piping protected from impact by another motor vehicle by the structural components of the cargo tank motor vehicle, such as damage protection guards, framing members, or wheel assemblies.

(iii) A combustible liquid.

(iv) Flammable liquid residue, not to exceed one liter (0.26 gallons) per line,

that may remain in piping after it is drained.

(3) A sacrificial device in accordance with § 178.345–8(b)(2) of this subchapter may not be used to satisfy the bottom damage protection requirements of this paragraph (e) if hazardous material is retained in product piping during transportation.

* * * * *

Issued in Washington, DC, on December 23, 2004 under authority delegated in 49 CFR Part 106.

Robert A. McGuire,

Associate Administrator for Hazardous Materials Safety.

[FR Doc. 04–28561 Filed 12–29–04; 8:45 am]

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Notices

Federal Register

Vol. 69, No. 250

Thursday, December 30, 2004

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.

AGENCY FOR INTERNATIONAL DEVELOPMENT

Renewal of the Advisory Committee on Voluntary Foreign Aid

AGENCY: United States Agency for International Development.

ACTION: Notice of renewal of advisory committee.

SUMMARY: Pursuant to the Federal Advisory Committee Act, the Administrator has determined that renewal of the Advisory Committee on Voluntary Foreign Aid for a two-year period beginning January 22, 2005, is necessary and in the public interest.

FOR FURTHER INFORMATION CONTACT: Jocelyn Rowe, 202-712-4002.

Dated: December 22, 2004.

Jocelyn M. Rowe,

Executive Director, Advisory Committee on Voluntary Foreign Aid (ACVFA), U.S. Agency for International Development.

[FR Doc. 04-28606 Filed 12-29-04; 8:45 am]

BILLING CODE 6116-01-P

DEPARTMENT OF AGRICULTURE

Animal And Plant Health Inspection Service

[Docket No. 04-131-1]

Notice of Request for Extension of Approval of an Information Collection

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Extension of approval of an information collection; comment request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Animal and Plant Health Inspection Service's intention to request an extension of approval of an information collection associated with the gypsy moth program.

DATES: We will consider all comments that we receive on or before February 28, 2005.

ADDRESSES: You may submit comments by any of the following methods:

EDOCKET: Go to <http://www.epa.gov/feddoctet> to submit or view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Once you have entered EDOCKET, click on the "View Open APHIS Dockets" link to locate this document. Postal Mail/Commercial Delivery: Please send four copies of your comment (an original and three copies) to Docket No. 04-131-1, Regulatory Analysis and Development, PPD, APHIS, Station 3C71, 4700 River Road Unit 118, Riverdale, MD 20737-1238. Please state that your comment refers to Docket No. 04-131-1.

E-mail: Address your comment to regulations@aphis.usda.gov. Your comment must be contained in the body of your message; do not send attached files. Please include your name and address in your message and "Docket No. 04-131-1" on the subject line.

Reading Room: You may read any comments that we receive on this docket in our reading room. The reading room is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue SW., Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 690-2817 before coming.

Other Information: You may view APHIS documents published in the **Federal Register** and related information, including the names of groups and individuals who have commented on APHIS dockets, on the Internet at <http://www.aphis.usda.gov/ppd/rad/webrepor.html>.

FOR FURTHER INFORMATION CONTACT: For information on the gypsy moth program, contact Dr. Weyman Fussell, Program Manager, Invasive Species and Pest Management, PPQ, APHIS, 4700 River Road Unit 134, Riverdale, MD 20737-1231; (301) 734-5705. For copies of more detailed information on the information collection, contact Mrs. Celeste Sickles, APHIS' Information Collection Coordinator, at (301) 734-7477.

SUPPLEMENTARY INFORMATION:

Title: Gypsy Moth Identification Worksheet.

OMB Number: 0579-0104.

Type of Request: Extension of approval of an information collection.

Abstract: The United States Department of Agriculture (USDA) is responsible for, among other things, the control and eradication of plant pests. The Plant Protection Act (7 U.S.C. 7701-7772) authorizes the Department to carry out this mission.

As part of this mission, Plant Protection and Quarantine (PPQ) of the Animal and Plant Health Inspection Service (APHIS), USDA, engages in detection surveys to monitor for the presence of, among other things, the European gypsy moth and the Asian gypsy moth. The European gypsy moth was introduced into the United States in the 1860's and has been damaging woodland areas in the Northeast for more than the last 100 years. The Asian gypsy moth, which is not established in this country, is considered to pose an even greater threat to trees and forested areas.

Unlike the flightless European gypsy moth female adult, the Asian gypsy moth female adult is capable of strong directed flight between mating and egg deposition, significantly increasing its ability to spread over a much greater area and become widely established within a short time.

To determine the presence and extent of a European gypsy moth or an Asian gypsy moth infestation, we set traps in high-risk areas to collect specimens. Once an infestation is identified, control and eradication work (usually involving State cooperation) is initiated to eliminate the moths.

APHIS personnel, with assistance from State agriculture personnel, check traps for the presence of gypsy moths. If a suspicious moth is found in the trap, it is sent to APHIS laboratories at the Otis Methods Development Center in Massachusetts so that it can be correctly identified through DNA analysis. (Since the European gypsy moth and the Asian gypsy moth are strains of the same species, they cannot be visually distinguished from each other. DNA analysis is the only way to accurately identify these insects.)

The PPQ or State employee submitting the moth for analysis completes a gypsy moth identification

worksheet (PPQ Form 305), which accompanies the insect to the laboratory. The worksheet enables both Federal and State regulatory officials to identify and track specific specimens through the DNA identification tests that we conduct.

The information provided by the gypsy moth identification worksheets is vital to our ability to monitor, detect, and eradicate gypsy moth infestations.

We are asking the Office of Management and Budget (OMB) to approve our use of this information collection activity for an additional 3 years.

The purpose of this notice is to solicit comments from the public (as well as affected agencies) concerning our information collection. These comments will help us:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of our estimate of the burden of the information collection, 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 information collection on those who are to respond, through use, as appropriate, of automated, electronic, mechanical, and other collection technologies, *e.g.*, permitting electronic submission of responses.

Estimate of burden: The public reporting burden for this collection of information is estimated to average 0.1708 hours per response.

Respondents: State cooperators.

Estimated annual number of respondents: 120.

Estimated annual number of responses per respondent: 2.

Estimated annual number of responses: 240.

Estimated total annual burden on respondents: 41 hours. (Due to averaging, the total annual burden hours may not equal the product of the annual number of responses multiplied by the reporting burden per response.)

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Done in Washington, DC, this 27th day of December 2004.

Kevin Shea,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. E4-3898 Filed 12-29-04; 8:45 am]

BILLING CODE 3410-34-P

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

Summer Food Service Program for Children; Program Reimbursement for 2005

AGENCY: Food and Nutrition Service, USDA.

ACTION: Notice.

SUMMARY: This notice informs the public of the annual adjustments to the reimbursement rates for meals served in the Summer Food Service Program for Children (SFSP). These adjustments reflect changes in the Consumer Price Index and are required by the statute governing the Program. In addition, further adjustments are made to these rates to reflect the higher costs of providing meals in the States of Alaska and Hawaii, as authorized by the William F. Goodling Child Nutrition Reauthorization Act of 1998.

EFFECTIVE DATE: January 1, 2005.

FOR FURTHER INFORMATION CONTACT:

Robert M. Eadie, Branch Chief, Policy and Program Development Branch, Child Nutrition Division, Food and Nutrition Service, U.S. Department of Agriculture, 3101 Park Center Drive, Room 640, Alexandria, Virginia 22302, (703) 305-2590.

SUPPLEMENTARY INFORMATION: This program is listed in the Catalog of Federal Domestic Assistance under No. 10.559 and is subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials (7 CFR part 3015, subpart V, and final rule related

notice published at 48 FR 29114, June 24, 1983).

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3518), no new recordkeeping or reporting requirements have been included that are subject to approval from the Office of Management and Budget.

This notice is not a rule as defined by the Regulatory Flexibility Act (5 U.S.C. 601-612) and thus is exempt from the provisions of that Act. Additionally, this notice has been determined to be exempt from review by the Office of Management and Budget under Executive Order 12866.

Definitions

The terms used in this Notice shall have the meaning ascribed to them in the regulations governing the Summer Food Service Program for Children (7 CFR part 225).

Background

In accordance with Section 13 of the National School Lunch Act (NSLA)(42 U.S.C. 1761) and the regulations governing the SFSP (7 CFR part 225), notice is hereby given of adjustments in Program payments for meals served to children participating in the SFSP in 2005. Adjustments are based on changes in the food away from home series of the Consumer Price Index (CPI) for All Urban Consumers for the period November 2003 through November 2004.

Section 104(a) of the William F. Goodling Child Nutrition Reauthorization Act of 1998 (Public Law 105-336) amended Section 12(f) of the NSLA (42 U.S.C. 1760(f)) to allow adjustments to SFSP reimbursement rates to reflect the higher cost of providing meals in the SFSP in Alaska and Hawaii. Therefore, this notice contains adjusted rates for Alaska and Hawaii. This change was made in an effort to be consistent with other Child Nutrition Programs, such as the National School Lunch Program and the School Breakfast Program, which already had the authority to provide higher reimbursement rates for programs in Alaska and Hawaii:

MAXIMUM PER MEAL REIMBURSEMENT RATES FOR ALL STATES (NOT AK OR HI)

	Operating costs (dollars)	Administrative costs (dollars)	
		Rural or Self- Preparation Sites	Other Types of Sites
Breakfast	1.42	.1400	.1125
Lunch or Supper	2.48	.2600	.2150
Supplement	.58	.0700	.0550

The 2005 reimbursement rates, in dollars, for Alaska:

MAXIMUM PER MEAL REIMBURSEMENT RATES FOR ALASKA ONLY

	Operating costs (dollars)	Administrative costs (dollars)	
		Rural or Self-preparation sites	Other types of sites
Breakfast	2.31	.2300	.1800
Lunch or Supper	4.02	.4200	.3500
Supplement	.94	.1150	.0900

The 2005 reimbursement rates, in dollars, for Hawaii:

MAXIMUM PER MEAL REIMBURSEMENT RATES FOR HAWAII ONLY

	Operating costs (dollars)	Administrative costs (dollars)	
		Rural or self preparation sites	Other types of sites
Breakfast	1.66	.1650	.1300
Lunch or Supper	2.90	.3050	.2525
Supplement	.67	.0825	.0650

The total amount of payments to State agencies for disbursement to Program sponsors will be based upon these Program reimbursement rates and the number of meals of each type served. The above reimbursement rates, for both operating and administrative reimbursement rates, represent a 3.2 percent increase during 2004 (from 183.8 in November 2003 to 189.6 in November 2004) in the food away from home series of the Consumer Price Index for All Urban Consumers, published by the Bureau of Labor Statistics of the Department of Labor. The Department would like to point out that the SFSP administrative reimbursement rates continue to be adjusted up or down to the nearest quarter-cent, as has previously been the case. Additionally, operating reimbursement rates have been rounded down to the nearest whole cent, as required by Section 11(a)(3)(B) of the NSLA (42 U.S.C. 1759 (a)(3)(B)).

Authority: Secs. 9, 13 and 14, National School Lunch Act, as amended (42 U.S.C. 1758, 1761, and 1762a).

Dated: December 23, 2004.

Roberto Salazar,
Administrator.

[FR Doc. 04-28587 Filed 12-29-04; 8:45 am]

BILLING CODE 3410-30-P

DEPARTMENT OF AGRICULTURE

Forest Service

Revised Notice of Intent, Land Management Planning

AGENCY: Forest Service, USDA.

ACTION: Notice.

SUMMARY: This notice revises the previous notice of intent to prepare an environmental impact statement for the Southern Rockies Lynx Amendment published on June 30, 2000 (Volume 65 number 127, pages 40601 through 40606) to add the White River National Forest to the Southern Rockies Canada Lynx Amendment effort. USDA Deputy Under Secretary for Natural Resources and Environment, David Tenny, instructed the Forest Service to include the White River National Forest in the Southern Rockies Lynx Amendment process in his December 2, 2004 Discretionary Review Decision regarding the White River National Forest Revised Land and Resource Management Plan. This notice pertains only to the addition of the White River National Forest with the ongoing amendment effort.

DATES: Comments concerning the addition of the White River National Forest to the Southern Rockies Lynx Amendment effort should be postmarked by February 14, 2005.

ADDRESSES: Sylvia Arbelbide, Deputy Director of Strategic Planning, USDA

Forest Service, 740 Simms Street, Golden, CO 80401.

FOR FURTHER INFORMATION CONTACT: Lois Pfeffer, Interdisciplinary Team Leader, 559-359-7023.

SUPPLEMENTARY INFORMATION: The White River National Forest completed its final revised forest plan April 2, 2002. USDA Deputy Under Secretary for Natural Resources and Environment, David Tenny, instructed the Forest Service to include the White River in the Southern Rockies Lynx Amendment process in his December 2, 2004 Discretionary Review Decision regarding the White River National Forest Revised Land and Resource Management Plan. This notice pertains only to the addition of the White River National Forest with the ongoing amendment effort. Comments specific to the addition of the White River National Forest are requested.

Comments previously submitted for the Southern Rockies Canada Lynx Amendment draft environmental impact statement will be addressed in the final environmental impact statement and do not need to be resubmitted. The agency expects to file a supplemental draft environmental impact statement with the Environmental Protection Agency (EPA) and make it available for public, agency, and tribal government comment in April 2005. A final environmental impact statement is expected to be filed in late 2005.

Responsible Official: Rick Cables,
Rocky Mountain Regional Forester, P.O.
Box 25127, Lakewood, CO 80225-0127.

Dated: December 22, 2004.

James M. Moe,

*Deputy Director, Engineering, Rocky
Mountain Region.*

[FR Doc. 04-28659 Filed 12-29-04; 8:45 am]

BILLING CODE 3410-ED-P

DEPARTMENT OF AGRICULTURE

Forest Service

Meeting Notice

AGENCY: Notice of Resource Advisory Committee, Sundance, Wyoming, USDA Forest Service.

ACTION: Notice of meeting.

SUMMARY: Pursuant to the authorities in the Federal Advisory Committee Act (Public Law 92-463) and under the Secure Rural Schools and Community Self-Determination Act of 2000 (Public Law 106-393) the Black Hills National Forests' Crook County Resource Advisory Committee will meet Monday, January 17, 2005 in Sundance, Wyoming for a business meeting. The meeting is open to the public.

FOR FURTHER INFORMATION CONTACT: Steve Kozel, Bearlodge District Ranger and Designated Federal Officer at (307) 283-1361.

SUPPLEMENTARY INFORMATION: The business meeting on January 17 will begin at 6:30 p.m., at the USFS Bearlodge Ranger District office, 121 South 21st Street, Sundance, Wyoming. Agenda topics will include an announcement of recently received Regional Forester's Award, a review of previously presented project proposals, and a presentation of any new project proposals. A public forum will begin at 8:30 p.m. (MT).

Dated: December 14, 2004.

Steve Kozel,

District Ranger, Bearlodge Ranger District.

[FR Doc. 04-27951 Filed 12-29-04; 8:45 am]

BILLING CODE 3410-11-M

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Proposed Additions and Deletions

AGENCY: Committee for Purchase from People Who Are Blind or Severely Disabled.

ACTION: Proposed additions to and deletions from Procurement List.

SUMMARY: The Committee is proposing to add to the Procurement List a product and services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and to delete products previously furnished by such agencies.

Comments Must Be Received On or Before: January 30, 2005.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia, 22202-3259.

FOR FURTHER INFORMATION CONTACT: Sheryl D. Kennerly, Telephone: (703) 603-7740, Fax: (703) 603-0655, or e-mail SKennerly@jwod.gov.

SUPPLEMENTARY INFORMATION: This notice is published pursuant to 41 U.S.C. 47(a)(2) and 41 CFR 51-2.3. Its purpose is to provide interested persons an opportunity to submit comments on the proposed actions.

Additions: If the Committee approves the proposed additions, the entities of the Federal Government identified in this notice for each product or service will be required to procure the product and services listed below from nonprofit agencies employing persons who are blind or have other severe disabilities.

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. If approved, the action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the product and services to the Government.

2. If approved, the action will result in authorizing small entities to furnish the product and services to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46-48c) in connection with the product and services proposed for addition to the Procurement List. Comments on this certification are invited. Commenters should identify the statement(s) underlying the certification on which they are providing additional information.

End of Certification

The following product and services are proposed for addition to Procurement List for production by the nonprofit agencies listed:

Product:

Product/NSN: Personal Hygiene Kit, 8970-00-NIB-0034.

NPA: Blind Industries & Services of Maryland, Baltimore, Maryland.

Contracting Activity: Federal Emergency Management Agency, Fort Worth, Texas.

Contracting Activity: UNICOR, Washington, DC.

Services

Service Type/Location: Base Operating Services, Defense Supply Center Richmond, 800 Jefferson Davis Highway, Richmond, Virginia.

NPA: Goodwill Services, Inc., Richmond, Virginia.

Contracting Activity: Defense Supply Center Richmond, Richmond, Virginia.

Service Type/Location: Base Supply Center, Building T39, Fort Knox, Kentucky.

NPA: Blind Industries & Services of Maryland, Baltimore, Maryland.

Contracting Activity: Directorate of Contracting, Fort Knox, Kentucky.

Deletions

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. If approved, the action may result in additional reporting, recordkeeping or other compliance requirements for small entities.

2. If approved, the action may result in authorizing small entities to furnish the products to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46-48c) in connection with the products proposed for deletion from the Procurement List.

End of Certification

The following products are proposed for deletion from the Procurement List:

Products

Product/NSN: Staff Section, 1025-01-044-2587.

NPA: Montgomery County Chapter, NYSARC, Inc., Amsterdam, New York.

Contracting Activity: U.S. Armament & Chemical Acquisition, Rock Island, Illinois.

Product/NSN: Table, Office, Steel, 7110-00-113-0448, 7110-00-113-0454, 7110-00-149-2044, 7110-00-149-2045, 7110-00-149-2046.

NPA: Yuma WORC Center, Inc., Yuma, Arizona.

Contracting Activity: GSA, National Furniture Center, Washington, DC.

Patrick Rowe,

Deputy Executive Director.

[FR Doc. 04-28621 Filed 12-29-04; 8:45 am]

BILLING CODE 6353-01-P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Additions and Deletions

AGENCY: Committee for Purchase from People Who Are Blind or Severely Disabled.

ACTION: Additions to and deletions from Procurement List.

SUMMARY: This action adds to the Procurement List services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and deletes from the Procurement List products and a service previously furnished by such agencies.

EFFECTIVE DATE: January 30, 2005.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia, 22202-3259.

FOR FURTHER INFORMATION CONTACT: Sheryl D. Kennerly, Telephone: (703) 603-7740, Fax: (703) 603-0655, or e-mail SKennerly@jwod.gov.

SUPPLEMENTARY INFORMATION:

Additions

On October 15, and October 29, 2004, the Committee for Purchase From People Who Are Blind or Severely Disabled published notice (69 FR 61202 and 63139) of proposed additions to the Procurement List.

After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the services and impact of the additions on the current or most recent contractors, the Committee has determined that the services listed below are suitable for procurement by the Federal Government under 41 U.S.C. 46-48c and 41 CFR 51-2.4.

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the services to the Government.
2. The action will result in authorizing small entities to furnish the services to the Government.
3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-

O'Day Act (41 U.S.C. 46-48c) in connection with the services proposed for addition to the Procurement List.

End of Certification

Accordingly, the following services are added to the Procurement List:

Services

Service Type/Location: Base Supply Center, Building 1304 and 1305, Fort Rucker, Alabama.

NPA: Alabama Industries for the Blind, Talladega, Alabama.

Contracting Activity: Department of the Army, Directorate of Contracting, Fort Rucker, Alabama.

Service Type/Location: Custodial Services, E. Ross Adair Federal Building and U.S. Courthouse, 1300 S. Harrison Street, Fort Wayne, Indiana.

NPA: The Arc of Northeast Indiana, Inc., Fort Wayne, Indiana.

Contracting Activity: GSA, PBS-5P, Chicago, Illinois.

Deletions

On October 29, and November 5, 2004, the Committee for Purchase From People Who Are Blind or Severely Disabled published notice (69 FR 63139 and 64562) of proposed deletions to the Procurement List.

After consideration of the relevant matter presented, the Committee has determined that the products and service listed below are no longer suitable for procurement by the Federal Government under 41 U.S.C. 46-48c and 41 CFR 51-2.4.

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities.

The major factors considered for this certification were:

1. The action may result in additional reporting, recordkeeping or other compliance requirements for small entities.
2. The action may result in authorizing small entities to furnish the products and service to the Government.
3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46-48c) in connection with the products and service deleted from the Procurement List.

End of Certification

Accordingly, the following products and service are deleted from the Procurement List:

Products

Product/NSN: Cloth, Abrasive, 5350-00-187-6286, 5350-00-187-7986, 5350-00-192-9325.

NPA: Louisiana Association for the Blind, Shreveport, Louisiana.

Contracting Activity: GSA, Southwest Supply Center, Fort Worth, Texas.

Product/NSN: Cover Assembly, Pitot, 1560-01-208-7831.

NPA: Huntsville Rehabilitation Foundation,

Huntsville, Alabama.

Contracting Activity: U.S. Army Missile Command, Redstone Arsenal, Alabama.

Product/NSN: Cutlery, Plastic, Medium Weight,

7340-00-NIB-0009,

7340-00-NIB-0010,

7340-00-NIB-0011,

7340-00-NIB-0012,

7340-00-NIB-0015,

7340-00-NIB-0016,

7340-00-NIB-0017.

NPA: L.C. Industries For The Blind, Inc., Durham, North Carolina.

Contracting Activity: Navy Exchange Service Command (NEXCOM), Virginia Beach, Virginia.

Product/NSN: Refill, Ballpoint Pen, 7510-00-754-2691 (Red Fine Point).

NPA: Industries for the Blind, Inc., Milwaukee, Wisconsin.

Contracting Activity: Office Supplies & Paper Products Acquisition Center, New York, New York.

Service

Service Type/Location: Janitorial/Custodial, DLA Gadsden Depot, Gadsden, Alabama.

NPA: None currently authorized.

Contracting Activity: Department of Defense.

Patrick Rowe,

Deputy Executive Director.

[FR Doc. 04-28622 Filed 12-29-04; 8:45 am]

BILLING CODE 6353-01-P

DEPARTMENT OF COMMERCE

[Docket No. 010925233-4337-03]

Department of Commerce Pre-Award Notification Requirements for Grants and Cooperative Agreements

AGENCY: Department of Commerce (DOC).

ACTION: Notice.

SUMMARY: This notice revises and updates the Department of Commerce (DOC) Pre-Award Notification Requirements for Grants and Cooperative Agreements published in the **Federal Register** (66 FR 49917) on October 1, 2001, as amended on October 30, 2002 (67 FR 66109), which pertain to information provided to applicants for funding under grants and cooperative agreements awarded by the DOC. This announcement constitutes a recompilation of the notice with all amendments and revisions to date.

DATES: These provisions are effective December 30, 2004.

FOR FURTHER INFORMATION CONTACT: Gary Johnson, Office of Acquisition Management, Telephone Number—202-482-1679.

SUPPLEMENTARY INFORMATION: The DOC is authorized to award grants and cooperative agreements under a wide

range of programs that support economic development; international trade; minority businesses; standards and technology; oceanic/atmospheric services; and telecommunications and information.

It is the policy of DOC to seek full and open competition for award of discretionary financial assistance funds. Moreover, DOC financial assistance must be awarded through a merit-based review and selection process whenever possible. Notices announcing the availability of Federal funds for each DOC competitive financial assistance program with funds available for new awards will be published by the sponsoring operating unit in the **Federal Register** and posted on the Grant.gov Web site in the uniform format for announcements of funding opportunities mandated by the Office of Management and Budget (OMB). These announcements will reference or include the DOC Pre-Award Notification Requirements identified in Sections A and B of this notice, and will include program-specific information as identified in Section C of this notice and will follow the uniform format for announcements of funding opportunities as identified in Section D.

This announcement provides notice of the DOC Pre-Award Notification Requirements that apply to all DOC sponsored grant and cooperative agreement programs and may supplement those program announcements which make reference to this notice. Some of the DOC general provisions published herein contain, by reference or substance, a summary of the pertinent statutes or regulations published in the U.S. Code (U.S.C.), **Federal Register**, Code of Federal Regulations (CFR), Executive Orders (EOs), OMB Circulars (circulars), or Assurances (Forms SF-424B, 424D). To the extent that it is a summary, such provision is not in derogation of, or an amendment to, any such statute, regulation, EO, circulars, or Forms SF-424B and SF-424D.

Each individual award notice will complete and include an analysis of the requirements in Executive Order 12866, Executive Order 13132, the Administrative Procedure Act, the Regulatory Flexibility Act, and the Paperwork Reduction Act, as applicable.

A. The following pre-award notice provisions will apply to all applicants for and recipients of DOC grants and cooperative agreements:

1. **Federal Policies and Procedures.** Applicants, recipients and subrecipients are subject to all Federal laws and Federal and DOC policies, regulations,

and procedures applicable to Federal financial assistance.

2. **Debarment, Suspension, Drug-Free Workplace, and Lobbying Provisions.** All applicants must comply with the requirements of Subpart C of 15 CFR Part 26, "Governmentwide Debarment and Suspension (Nonprocurement)," 15 CFR Part 29, "Governmentwide Requirements for Drug-Free Workplace (Financial Assistance)" (published in the **Federal Register** on November 26, 2003, 68 FR 66534), and 15 CFR Part 28, "New Restrictions on Lobbying," including the submission of required forms and obtaining certification from lower tier applicants/bidders.

3. **Pre-Award Screening of Applicant's and Recipient's Management Capabilities, Financial Condition, and Present Responsibility.** It is the policy of DOC to make awards to applicants and recipients who are competently managed, responsible, financially capable and committed to achieving the objectives of the award(s) they receive. Therefore, pre-award screening may include, but is not limited to, the following reviews:

(a) **Past Performance.** Unsatisfactory performance under prior Federal awards may result in an application not being considered for funding.

(b) **Credit Checks.** A credit check will be performed on individuals, for-profit, and non-profit organizations.

(c) **Delinquent Federal Debts.** No award of Federal funds shall be made to an applicant who has an outstanding delinquent Federal debt until:

(1) The delinquent account is paid in full,

(2) A negotiated repayment schedule is established and at least one payment is received, or

(3) Other arrangements satisfactory to DOC are made.

(4) Pursuant to 31 U.S.C. 3720B, unless waived, the DOC is not permitted to extend financial assistance in the form of a loan, loan guarantee, or loan insurance to any person delinquent on a nontax debt owed to a Federal agency. This prohibition does not apply to disaster loans.

(5) Pursuant to 28 U.S.C. 3201(e), unless waived by the DOC, a debtor who has a judgment lien against the debtor's property for a debt to the United States shall not be eligible to receive any grant or loan which is made, insured, guaranteed, or financed directly or indirectly by the United States or to receive funds directly from the Federal Government in any program, except funds to which the debtor is entitled as beneficiary, until the judgment is paid in full or otherwise satisfied.

(d) **Name Check Review.** A name check review will be performed by the OIG on key individuals associated with non-profit and for-profit organizations, unless (1) proposed award amounts are \$100,000 or less; (2) applicants have been recipients of financial assistance from the Department of Commerce for three or more consecutive years without any adverse programmatic or audit finding; or (3) applicants are units of a state or local government. Name checks are intended to reveal if any key individuals associated with the applicant have been convicted of or are presently facing criminal charges (e.g., fraud, theft, perjury), or other matters which significantly reflect on the applicant's management honesty or financial integrity. If any of the conditions listed below in paragraphs (1), (2), or (3) occur, DOC reserves the right to take one or more of the following actions: Consider suspension/termination of an award immediately for cause; require the removal of any key individual from association with management of and/or implementation of the award; and make appropriate provisions or revisions with respect to the method of payment and/or financial reporting requirements:

(1) A key individual fails to submit the required Form CD-346, Applicant for Funding Assistance;

(2) A key individual makes an incorrect statement or omits a material fact on the Form CD-346; or

(3) The name check reveals significant adverse findings that reflect on the business integrity or responsibility of the recipient and/or key individual.

(e) **List of Parties Excluded from Procurement and Nonprocurement Programs.** The Excluded Parties Listing System (EPLS) maintained by the General Services Administration (GSA) {Found at <http://epls.arnet.gov>} that lists parties excluded from Federal procurement and nonprocurement programs will be checked to assure that an applicant is not debarred or suspended on a government-wide basis from receiving financial assistance.

(f) **Pre-Award Accounting System Surveys.** The Grants Office, in cooperation with the OIG when appropriate, may require a pre-award survey of the applicant's financial management system in cases where the recommended applicant has had no prior Federal support, the operating unit has reason to question whether the financial management system meets Federal financial management standards, or the applicant is being considered for a high-risk designation.

4. **No Obligation for Future Funding.** If an application is selected for funding,

DOC has no obligation to provide any additional future funding in connection with that award. Amendment of an award to increase funding or to extend the period of performance is at the total discretion of DOC.

5. Pre-Award Activities. If applicants incur any costs prior to an award being made, they do so solely at their own risk of not being reimbursed by the Government. Notwithstanding any verbal or written assurance that may have been received, there is no obligation on the part of DOC to cover preaward costs unless approved by the Grants Officer as part of the terms when the award is made, or as authorized for awards that support research by 15 CFR 14.25(e)(4).

6. Freedom of Information Act (FOIA) Disclosure. The FOIA, 5 U.S.C. 552 and implementing DOC regulations at 15 CFR Part 4, set forth DOC's rules to make requested material, information, and records publicly available. Unless prohibited by law and to the extent required under the FOIA, contents of applications and proposals submitted by applicants may be released in response to FOIA requests.

7. False Statements. A false statement on an application is grounds for denial or termination of an award and grounds for possible punishment by a fine or imprisonment as provided in 18 U.S.C. 1001.

8. Application Forms. Unless the individual programs specify differently in their annual notice of availability of funding or in other appropriate publications, the following forms and certifications will be used in applying for DOC grants and cooperative agreements: OMB Standard Forms 424, Application for Federal Assistance; SF-424A, Budget Information—Non-Construction Programs; SF-424B, Assurances—Non-Construction Programs; SF-424C, Budget Information—Construction Programs; SF-424D, Assurances—Construction Programs; as well as the Commerce Department (CD) form CD-346, Applicant for Funding Assistance, as appropriate, shall be used in applying for financial assistance. In addition, Forms CD-511, Certification Regarding Lobbying; CD-512, Certification Regarding Lobbying—Lower-Tier Covered Transactions; and SF-LLL, Disclosure of Lobbying Activities, will be used as appropriate.

9. Environmental Requirements. Environmental impacts must be considered by Federal decision makers in their decisions whether or not to (1) approve a proposal for Federal assistance; (2) approve the proposal with mitigation; or (3) approve a

different proposal/grant having less adverse environmental impacts. Federal environmental laws require that the funding agency initiate a planning process with an early consideration of potential environmental impacts that projects funded with Federal assistance may have on the environment. The recipient and subrecipients must comply with all environmental standards, to include those prescribed under the following statutes and Executive Orders, and shall identify to the awarding agency any impact the award may have on the environment. In some cases, award funds can be withheld by the Grants Officer under a special award condition requiring the recipient to submit additional environmental compliance information sufficient to enable the DOC to make an assessment on any impacts that a project may have on the environment.

(a) The National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*). Recipients of Federal assistance are required to identify to the awarding agency any impact an award will have on the quality of the human environment, and assist the agency to comply with the National Environmental Policy Act. Applicants for assistance may be required to prepare environmental impact information as part of a proposal.

(b) Floodplain Management, EO 11988 and, Protection of Wetlands, EO 11990, May 24, 1977. Recipients must identify proposed actions in Federally defined floodplains and wetlands to enable the agency to make a determination whether there is an alternative to minimize any potential harm.

(c) Clean Air Act, Clean Water Act, and EO 11738. Recipients must comply with the provisions of the Clean Air Act (42 U.S.C. 7401 *et seq.*), Clean Water Act (33 U.S.C. 1251 *et seq.*), and EO 11738, and shall not use a facility on EPA's List of Violating Facilities in performing any award that is nonexempt under 40 CFR 15.5, and shall notify the Program Officer in writing if it intends to use a facility that is on the EPA List of Violating Facilities or knows that the facility has been recommended to be placed on the List.

(d) The Flood Disaster Protection Act of 1973 (42 U.S.C. 4002 *et seq.*). Flood insurance, when available, is required for Federally assisted construction or acquisition in flood-prone areas.

(e) The Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*). Recipients must identify any impact or activities which may involve a threatened or endangered species. Federal agencies have the responsibility

to ensure that no adverse effects to a protected species or habitat occur from actions under Federal assistance awards and conduct the required reviews under the Endangered Species Act, as applicable.

(f) The Coastal Zone Management Act, as amended (16 U.S.C. 1451 *et seq.*). Funded projects must be consistent with a coastal state's approved management program for the coastal zone.

(g) The Coastal Barriers Resources Act (16 U.S.C. 3501 *et seq.*). Restrictions are placed on Federal funding for actions within a Coastal Barrier System.

(h) The Wild and Scenic Rivers Act, as amended (16 U.S.C. 1271 *et seq.*). This Act applies to awards that may affect existing or proposed components of the National Wild and Scenic Rivers system.

(i) The Safe Drinking Water Act of 1974, as amended (42 U.S.C. 300f–j). This Act precludes Federal assistance for any project that the EPA determines may contaminate a sole-source aquifer so as to threaten public health.

(j) The Resource Conservation and Recovery Act of 1976, as amended (42 U.S.C. 6901 *et seq.*). This act regulates the generation, transportation, treatment, and disposal of hazardous wastes, and also provides that recipients of Federal funds give preference in their procurement programs to the purchase of recycled products pursuant to EPA guidelines.

(k) The Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended, and the Superfund Amendments and Reauthorization Act of 1986, and the Community Environmental Response Facilitation Act of 1992, as amended, (42 U.S.C. 9601 *et seq.*). These requirements address responsibilities of hazardous substance releases, threatened releases and environmental cleanup. There is also a requirement to impose reporting and community involvement requirements to ensure disclosure of the release or disposal of regulated substances and cleanup of hazards.

(l) Environmental Justice in Minority Populations and Low Income Populations, EO 12898, February 11, 1994. This order identifies and addresses adverse human health or environmental effects of programs, policies and activities on low income and minority populations.

10. Limitation of Liability. In no event will the Department of Commerce be responsible for proposal preparation costs if programs announced under notices of funding availability fail to receive funding or are cancelled because of other agency priorities. Publication of

announcements of funding availability do not oblige the agency to award any specific project or to obligate any available funds.

B. The following general provisions will apply to all DOC grant and cooperative agreement awards:

1. Administrative Requirements and Cost Principles. The uniform administrative requirements for all DOC grants and cooperative agreements are codified at 15 CFR Part 14, "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, Other Non-Profit, and Commercial Organizations;" and 15 CFR Part 24, "Uniform Administrative Requirements for Grants and Agreements to State and Local Governments." The following list of cost principles incorporated by reference in 15 CFR Parts 14 and 24 are included in DOC's grants and cooperative agreements: OMB Circular A-21, "Cost Principles for Educational Institutions;" OMB Circular A-87, "Cost Principles for State, Local and Indian Tribal Governments;" OMB Circular A-122, "Cost Principles for Nonprofit Organizations;" and Federal Acquisition Regulation Subpart 31.2, "Contracts with Commercial Organizations," codified at 48 CFR 31.2. Applicable administrative requirements and cost principles are identified in each award and are incorporated into the award by reference.

2. Award Payments. When advanced payment is authorized, advances will be limited to the minimum amounts necessary to meet *immediate* disbursement needs, but in no case should advances exceed the amount of cash required for a 30-day period. Advanced funds not disbursed in a timely manner must be promptly returned to DOC. Certain bureaus within the DOC use the Department of Treasury's Automated Standard Application for Payment (ASAP) system. In order to receive payments under ASAP, recipients will be required to enroll with the Department of Treasury, Financial Service, Regional Financial Centers, which allows them to use the on-line and Voice Response System (VRS) method of withdrawing funds from their ASAP established accounts.

3. Federal and Non-Federal Sharing.

(a) Awards that include Federal and non-Federal sharing will incorporate a budget consisting of shared allowable costs. If actual allowable costs are less than the total approved budget, the Federal and non-Federal cost shares shall be calculated by applying the approved Federal and non-Federal cost share ratios to actual allowable costs. If

actual allowable costs are greater than the total approved budget, the Federal share will not exceed the total Federal dollar amount authorized by the award.

(b) The non-Federal share, whether in cash or in-kind, will be expected to be paid out at the same general rate as the Federal share. Exceptions to this requirement may be granted by the Grants Officer based on sufficient documentation demonstrating previously determined plans for or later commitment of cash or in-kind contributions. In any case, recipients must meet the cost share commitment over the life of the award.

4. Budget Changes. When the terms of an award allow the recipient to transfer funds among approved direct cost categories, the transfer authority does not authorize the recipient to create new budget categories within an approved budget unless the Grants Officer has provided prior approval. In addition, the recipient will not be authorized at any time to transfer amounts budgeted for direct costs to the indirect costs line item or vice versa, without written prior approval of the Grants Officer.

5. Indirect Costs.

(a) Indirect costs will not be allowable charges against an award unless specifically included as a line item in the approved budget incorporated into the award. (The term "indirect cost" has been replaced with the term "facilities and administrative costs" under OMB Circular A-21, "Cost Principles for Educational Institutions.")

(b) Excess indirect costs may not be used to offset unallowable direct costs.

(c) If the recipient has not previously established an indirect cost rate with a Federal agency, the negotiation and approval of a rate will be subject to the procedures in the applicable cost principles and the following subparagraphs:

(1) a. State, local, and Indian Tribal Governments; Educational Institutions; and Non-Profit Organizations (Non-Commercial Organizations)

For those organizations for which DOC is cognizant or has oversight, DOC or its designee *will either* negotiate a fixed rate with carryforward provisions or, in some instances, limit its review to evaluating the procedures described in the recipient's cost allocation methodology plan. Indirect cost rates and cost allocation methodology reviews are subject to future audits to determine actual indirect costs.

b. Commercial Organizations

For commercial organizations, cognizant federal agency is defined as the agency that provides the largest dollar amount of negotiated contracts, including options. If the only federal

funds received by a commercial organization are DOC award funds, then DOC becomes the cognizant federal agency for the purpose of indirect cost negotiations. For those organizations for which DOC is cognizant, DOC or its designee will negotiate a fixed rate with carryforward provisions for the recipient. Fixed rate means an indirect cost rate which has the same characteristics as a pre-determined rate, except that the difference between the estimated costs and the actual costs of the period covered by the rate is carried forward as an adjustment to the rate computation of the subsequent period. DOC or its designee will negotiate indirect cost rates using the cost principles found in 48 CFR Part 31, "Contract Cost Principles and Procedures." For guidance on how to put an indirect cost plan together go to: <http://www2.dol.gov/oasam/programs/guide.htm>.

(2) Within 90 days of the award start date, the recipient shall submit to the address listed below documentation (indirect cost proposal, cost allocation plan, etc.) necessary to perform the review. The recipient shall provide the Grants Officer with a copy of the transmittal letter. Office of Acquisition Management, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Room-6054, Washington, DC 20230.

(3) The recipient can use the fixed rate proposed in the indirect cost plan until such time as the DOC provides a response to the submitted plan. Actual indirect costs must be calculated annually and adjustments made through the carryforward provision used in calculating next year's rate. This calculation of actual indirect costs and the carryforward provision is subject to audit. Indirect cost rate proposals must be submitted annually. Organizations that have previously established indirect cost rates must submit a new indirect cost proposal to the cognizant agency within six months after the close of each recipient's fiscal year.

(4) When DOC is not the oversight or cognizant Federal agency, the recipient shall provide the Grants Officer with a copy of a negotiated rate agreement or a copy of the transmittal letter submitted to the cognizant or oversight Federal agency requesting a negotiated rate agreement.

(5) If the recipient fails to submit the required documentation to the DOC within 90 days of the award start date, the recipient may be precluded from recovering any indirect costs under the award. If the DOC, oversight, or cognizant Federal agency determines there is a finding of good and sufficient

cause to excuse the recipient's delay in submitting the documentation, an extension of the 90-day due date may be approved by the Grants Officer.

(6) Regardless of any approved indirect cost rate applicable to the award, the maximum dollar amount of allocable indirect costs for which DOC will reimburse the recipient shall be the lesser of the line item amount for the Federal share of indirect costs contained in the approved budget of the award, or the Federal share of the total allocable indirect costs of the award based on the indirect cost rate approved by an oversight or cognizant Federal agency and current at the time the cost was incurred, provided the rate is approved on or before the award end date.

6. Tax Refunds. Refunds of FICA/FUTA taxes received by a recipient during or after an award period must be refunded or credited to DOC where the benefits were financed with Federal funds under the award. Recipients must agree to contact the Grants Officer immediately upon receipt of these refunds. Recipients must further agree to refund portions of FICA/FUTA taxes determined to belong to the Federal Government, including refunds received after the award end date.

7. Other Federal Awards with Similar Programmatic Activities. Recipients will be required to provide written notification to the Federal Program Officer and the Grants Officer in the event that, subsequent to receipt of the DOC award, other financial assistance is received to support or fund any portion of the scope of work incorporated into the DOC award. DOC will not pay for costs that are funded by other sources.

8. Non-Compliance With Award Provisions. Failure to comply with any or all of the provisions of an award may have a negative impact on future funding by DOC and may be considered grounds for any or all of the following actions: establishment of an account receivable, withholding payments under any DOC awards to the recipient, changing the method of payment from advance to *reimbursement only*, or the imposition of other special award conditions, suspension of any DOC active awards, and termination of any DOC active awards.

9. Prohibition Against Assignment by the Recipient. Notwithstanding any other provision of an award, recipients may not transfer, pledge, mortgage, or otherwise assign an award, or any interest therein, or any claim arising thereunder, to any party or parties, banks, trust companies, or other financing or financial institutions without the express written approval of the Grants Officer.

10. Non-Discrimination Requirements. There are several Federal statutes, regulations, Executive Orders, and policies relating to nondiscrimination. No person in the United States shall, on the ground of race, color, national origin, handicap, religion, age, or sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance. These requirements include but are not limited to:

(a) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*) and DOC implementing regulations published at 15 CFR Part 8 prohibiting discrimination on the grounds of race, color, or national origin under programs or activities receiving Federal financial assistance;

(b) Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq.*) and implementing regulations at 15 CFR Part 8a prohibiting discrimination on the basis of sex under Federally assisted education programs or activities;

(c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794) and DOC implementing regulations published at 15 CFR Part 8b prohibiting discrimination on the basis of handicap under any program or activity receiving or benefiting from Federal assistance;

(d) The Age Discrimination Act of 1975, as amended (42 U.S.C. 6101 *et seq.*) and DOC implementing regulations published at 15 CFR Part 20 prohibiting discrimination on the basis of age in programs or activities receiving Federal financial assistance;

(e) The Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.*) prohibiting discrimination on the basis of disability under programs, activities, and services provided or made available by state and local governments or instrumentalities or agencies thereto, as well as public or private entities that provide public transportation;

(f) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. 3601 *et seq.*), as amended, relating to nondiscrimination in the sale, rental or financing of housing;

(g) Parts II and III of Executive Order 11246, as amended by Executive Orders 11375 and 12086 requiring Federally assisted construction contracts to include the nondiscrimination provisions of § 202 and 203 of that Executive Order and Department of Labor regulations implementing Executive Order 11246, 41 CFR 60–1.4(b).

(h) EO 13166 (August 11, 2000), "Improving Access to Services for

Persons With Limited English Proficiency," and DOC policy guidance issued on March 24, 2003 (68 FR 14180) to Federal financial assistance recipients on the Title VI prohibition against national origin discrimination affecting Limited English Proficient (LEP) persons.

(i) In recognition of the constitutionally-protected interest of religious organizations in making religiously-motivated employment decisions, Title VII of the Civil Rights Act of 1964, 42 U.S.C. 2000e *et seq.*, expressly exempts religious organizations from the prohibition against discrimination on the basis of religion. 42 U.S.C. 2000e–1(a).

11. Audits of Organizations Not Covered By OMB Circular A–133. In accordance with 15 CFR 14.26(c) and (d), for-profit hospitals, commercial, and other organizations not covered by the audit provisions of OMB Circular A–133 that expend \$500,000 or more in a year in Federal funding, are required to have a program-specific audit performed at the conclusion of the project, but no less than once every five years. The DOC award may include a line item in the budget for the cost of the audit. Some DOC programs have specific audit guidelines that will be incorporated into the award. If DOC does not have a program-specific audit guide available for the program, the auditor should follow Generally Accepted Government Auditing Standards and the requirements for a program-specific audit as described in OMB Circular A–133 § 235.

12. Policies and Procedures for Resolution of Audit-Related Debts. DOC has established policies and procedures for handling the resolution and reconsideration of financial assistance audits which have resulted in, or may result in, the establishment of a debt (account receivable) for financial assistance awards. These policies and procedures are contained in the **Federal Register** notice dated January 27, 1989. See 54 FR 4053. The policies and procedures are also provided in more detail in the Department of Commerce Financial Assistance Standard Terms and Conditions.

13. Debts. Any debts determined to be owed the Federal Government shall be paid promptly by the recipient. In accordance with 15 CFR 21.4, a debt will be considered delinquent if it is not paid within 15 days of the due date, or if there is no due date, within 30 days of the billing date. Failure to pay a debt by the due date, or if there is no due date, within 30 days of the billing date, shall result in the imposition of late payment charges. In addition, failure to

pay the debt or establish a repayment agreement by the due date, or if there is no due date, within 30 days of the billing date, will also result in the referral of the debt for collection action and may result in DOC taking further action as specified in the terms of the award. Funds for payment of a debt must not come from other Federally sponsored programs. Verification that other Federal funds have not been used will be made, *e.g.*, during on-site visits and audits.

14. Post-Award Discovery of Adverse Information. After an award is made, if adverse information on a recipient or any key individual associated with a recipient is discovered which reflects significantly and adversely on the recipient's responsibility, the Grants Officer may take the following actions:

(a) Require the recipient to correct the conditions.

(b) Consider the recipient to be "high risk" and unilaterally impose special award conditions to protect the Federal Government's interest.

(c) Suspend or terminate an active award. The recipient will be afforded adequate due process while effecting such actions.

(d) Require the removal of personnel from association with the management of and/or implementation of the project and require Grants Officer approval of personnel replacements.

15. Competition and Codes of Conduct.

(a) Pursuant to the certification in SF-424B, Paragraph 3, recipients must maintain written standards of conduct to establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of a personal or organizational conflict of interest, or personal gain in the administration of this award and any subawards.

(b) Recipients must maintain written standards of conduct governing the performance of their employees engaged in the award and administration of subawards. No employee, officer, or agent shall participate in the selection, award, or administration of a subaward supported by Federal funds if a real or apparent conflict of interest is or would be involved. Such a conflict would arise when the employee, officer, or agent, any member of his or her immediate family, his or her partner, or an organization in which he/she serves as an officer or which employs or is about to employ any of the parties mentioned in this section, has a financial or other interest in the organization selected or to be selected for a subaward. The officers, employees, and agents of the recipient may not solicit or accept

anything of monetary value from subrecipients. However, recipients may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value. The standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of a recipient.

(c) All subawards will be made in a manner to provide, to the maximum extent practicable, open and free competition. Recipients must be alert to organizational conflicts of interest as well as other practices among subrecipients that may restrict or eliminate competition. In order to ensure objective subrecipient performance and eliminate unfair competitive advantage, subrecipients that develop or draft work requirements, statements of work, or requests for proposals will be excluded from competing for such subawards.

(d) For purposes of the award, a financial interest may include employment, stock ownership, a creditor or debtor relationship, or prospective employment with an applicant. An appearance of impairment of objectivity could result from an organizational conflict where, because of other activities or relationships with other persons or entities, a person is unable or potentially unable to act in an impartial manner. It could also result from non-financial gain to the individual, such as benefit to reputation or prestige in a professional field.

16. Minority Owned Business Enterprise. DOC encourages recipients to utilize minority and women-owned firms and enterprises in contracts under financial assistance awards. The Minority Business Development Agency can assist recipients in matching qualified minority owned enterprises with contract opportunities.

17. Subaward and/or Contract to a Federal Agency. Recipients, subrecipients, contractors, and/or subcontractors may not sub-grant or sub-contract any part of an approved project to any Federal department, agency, instrumentality, or employee thereof, without the prior written approval of the Grants Officer.

18. Foreign Travel. Recipients must comply with the provisions of the Fly America Act, 49 U.S.C. 40118. The Fly America Act requires that Federal travelers and others performing U.S. Government-financed foreign air travel must use U.S. flag carriers, to the extent that service by such carriers is available. Foreign air carriers may be used only in specific instances, such as when a U.S. flag air carrier is unavailable, or use of

U.S. flag carrier service will not accomplish the agency's mission. The implementing Federal Travel Regulations are found at 41 CFR 301-10.131 through 301-10.143.

19. Purchase of American-Made Equipment and Products. Recipients are hereby notified that they are encouraged, to the greatest extent practicable, to purchase American-made equipment and products with funding provided under DOC financial assistance awards.

20. Intellectual Property Rights.

(a) Inventions. The rights to any invention made by a recipient under a DOC financial assistance award are determined by the Bayh-Dole Act, Pub. L. 96-517, as amended, and codified in 35 U.S.C. 200 *et seq.*, except as otherwise required by law. The specific rights and responsibilities are described in more detail in 37 CFR Part 401 and in particular, in the standard patent rights clause in 37 CFR 401.14, which is incorporated by reference into awards.

(b) Patent Notification Procedures. Pursuant to EO 12889, the Department of Commerce (DOC) is required to notify the owner of any valid patent covering technology whenever the DOC or its financial assistance recipients, without making a patent search, knows (or has demonstrable reasonable grounds to know) that technology covered by a valid United States patent has been or will be used without a license from the owner. To ensure proper notification, if the recipient uses or has used patented technology under this award without a license or permission from the owner, the recipient will be required to notify the DOC Patent Counsel and the Grants Officer. This notice does not necessarily mean that the government authorizes and consents to any copyright or patent infringement occurring under the financial assistance.

(c) Data, Databases, and Software. The rights to any work produced or purchased under a DOC Federal financial assistance award are determined by 15 CFR 24.34 and 15 CFR 14.36. Such works may include data, databases or software. The recipient owns any work produced or purchased under a DOC Federal financial assistance award subject to DOC's right to obtain, reproduce, publish or otherwise use the work or authorize others to receive, reproduce, publish or otherwise use the data for Government purposes.

(d) Copyright. The recipient may copyright any work produced under a DOC Federal financial assistance award subject to DOC's royalty-free nonexclusive and irrevocable right to

reproduce, publish or otherwise use the work or authorize others to do so for Government purposes. Works jointly authored by DOC and recipient employees may be copyrighted but only the part authored by the recipient is protected because, under 17 U.S.C. 105, works produced by Government employees are not copyrightable in the United States. On occasion, DOC may ask the recipient to transfer to DOC its copyright in a particular work when DOC is undertaking the primary dissemination of the work. Ownership of copyright by the Government through assignment is permitted by 17 U.S.C. 105.

21. Seat Belt Use. Pursuant to EO 13043, recipients should encourage employees and contractors to enforce on-the-job seat belt policies and programs when operating recipient/company-owned, rented or personally owned vehicles.

22. Research Involving Human Subjects. All proposed research involving human subjects must be conducted in accordance with 15 CFR Part 27, "Protection of Human Subject." No research involving human subjects is permitted under any DOC financial assistance award unless expressly authorized by the Grants Officer.

23. Federal Employee Expenses. Federal agencies are generally barred from accepting funds from a recipient to pay transportation, travel, or other expenses for any Federal employee unless specifically approved in the terms of the award. Use of award funds (Federal or non-Federal) or the recipient's provision of in-kind goods or services for the purposes of transportation, travel, or any other expenses for any Federal employee, may raise appropriation augmentation issues. In addition, DOC policy prohibits the acceptance of gifts, including travel payments for Federal employees, from recipients or applicants regardless of the source.

24. Preservation of Open Competition and Government Neutrality Towards Government Contractors' Labor Relations on Federal and Federally Funded Construction Projects. Pursuant to EO 13202, "Preservation of Open Competition and Government Neutrality Towards Government Contractors' Labor Relations on Federal and Federally Funded Construction Projects," unless the project is exempted under section 5(c) of the order, bid specifications, project agreements, or other controlling DOCuments for construction contracts awarded by recipients of grants or cooperative agreements, or those of any construction manager acting on their behalf, shall not: (1) Include any

requirement or prohibition on bidders, offerors, contractors, or subcontractors about entering into or adhering to agreements with one or more labor organizations on the same or related construction project(s); or (2) otherwise discriminate against bidders, offerors, contractors, or subcontractors for becoming or refusing to become or remain signatories or otherwise to adhere to agreements with one or more labor organizations, on the same or other related construction project(s).

25. Minority Serving Institutions (MSIs) Initiative. Pursuant to EOs 12876, 12900, and 13021, DOC is strongly committed to broadening the participation of MSIs in its financial assistance programs. DOC goals include achieving full participation of MSIs in order to advance the development of human potential, strengthen the Nation's capacity to provide high-quality education, and increase opportunities for MSIs to participate in and benefit from Federal financial assistance programs. DOC encourages all applicants and recipients to include meaningful participation of MSIs. Institutions eligible to be considered MSIs are listed on the Department of Education Web site at <http://www.ed.gov/offices/OCR/minorityinst.html>.

26. Access to Records. The Inspector General of the DOC, or any of his or her duly authorized representatives, the Comptroller of the United States and, if appropriate, the State, shall have access to any pertinent books, documents, papers and records of the parties to a grant or cooperative agreement, whether written, printed, recorded, produced, or reproduced by any electronic, mechanical, magnetic or other process or medium, in order to make audits, inspections, excerpts, transcripts, or other examinations as authorized by law. An audit of an award may be conducted at any time. Recipients that are subject to OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations," and that expend \$500,000 or more annually in Federal awards shall have an organization-wide audit performed, unless a program-specific audit is determined by DOC to be more appropriate. Other recipients will be subject to the audit requirements as stipulated in the award or subaward document.

27. Scientific or Research Misconduct. Scientific or research misconduct refers to the fabrication, falsification, or plagiarism in proposing, performing, or reviewing research, or in reporting research results. It does not include honest errors or differences of opinion.

The recipient organization has the primary responsibility to investigate allegations and provide reports to the Federal Government. Funds expended on an activity that is determined to be invalid or unreliable because of scientific misconduct may result in a disallowance of costs for which the institution may be liable for repayment to the awarding agency. The Office of Science and Technology Policy at the White House published in the **Federal Register** on December 6, 2000, a final policy that addressed research misconduct. The policy was developed by the National Science and Technology Council (65 FR 76260). The DOC requires that any allegation be submitted to the Grants Officer, who will also notify the OIG of such allegation. Generally, the recipient organization shall investigate the allegation and submit its findings to the Grants Officer. The DOC may accept the recipient's findings or proceed with its own investigation. The Grants Officer shall inform the recipient of the DOC's final determination.

28. Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728-4763). Recipients must comply with this act relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of the Office of Personnel Management Standards for a Merit System of Personnel Administration (5 CFR Part 900, Subpart F).

29. Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended, (42 U.S.C. 4601 *et seq.*); and implementing regulations issued at 15 CFR Part 11. These provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or Federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

30. Historic Preservation. Recipients must assist the DOC in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended and the Advisory Council on Historic Preservation Guidelines, (16 U.S.C. 470 *et seq.*); the Archaeological and Historic Preservation Act of 1974, (16 U.S.C. 469a-1 *et seq.*); Protection and Enhancement of the Cultural Environment, EO 11593; Locating Federal Facilities on Historic Properties in our Nation's Central Cities, EO 13006; and Indian Sacred Sites, EO 13007 (ensures protection and accommodation of access).

31. Lead-Based Paint Poisoning Prevention Act (42 U.S.C. 4801 *et seq.*). This act prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

32. Hatch Act (5 U.S.C. 1501–1508 and 7324–7328). This act limits the political activities of employees or officers of state or local governments whose principal employment activities are funded in whole or in part with Federal funds.

33. Labor standards for Federally-assisted construction subagreements (wage guarantees). Recipients must comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. 276a to 276a–7); the Copeland Act (40 U.S.C. 276c and 18 U.S.C. 874); and the Contract Work Hours and Safety Standards Act (40 U.S.C. 327–333).

34. Care and Use of Live Vertebrate Animals. Recipients must comply with the Laboratory Animal Welfare Act of 1966 (Pub. L. 89–544), as amended, (7 U.S.C. 2131 *et seq.*) (animal acquisition, transport, care, handling, and use in projects), and implementing regulations, 9 CFR Parts 1, 2, and 3; the Endangered Species Act (16 U.S.C. 1531 *et seq.*); Marine Mammal Protection Act (16 U.S.C. 1361 *et seq.*) (taking possession, transport, purchase, sale, export or import of wildlife and plants); The Nonindigenous Aquatic Nuisance Prevention and Control Act (16 U.S.C. 4701 *et seq.*) (ensure preventive measures are taken or that probable harm of using species is minimal if there is an escape or release); and all other applicable statutes pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by Federal financial assistance. No research involving vertebrate animals is permitted under any DOC financial assistance award unless authorized by the Grants Officer.

35. Publications and Acknowledgment of Sponsorship. Publication of the results of a research project in appropriate professional journals is encouraged as an important method of recording and reporting scientific information. The recipient is required to submit a copy to the funding agency and when releasing information related to a funded project include a statement that the project or effort undertaken was or is sponsored by DOC. The recipient is also responsible for assuring that every publication of material (including Internet sites) based on or developed under an award, except scientific articles or papers appearing in scientific, technical or professional journals, contains the following disclaimer: “This [report/video] was

prepared by [recipient name] under award [number] from [name of operating unit], U.S. Department of Commerce. The statements, findings, conclusions, and recommendations are those of the author(s) and do not necessarily reflect the views of the [name of operating unit] or the U.S. Department of Commerce.” This also applies to videos produced under DOC financial assistance awards.

36. Videos Produced under DOC Financial Assistance Awards. Before production of a video for public viewing is begun, the Grants Officer must review and approve the production plans and the final video to ensure that it will be of an acceptable quality and appropriately represents the DOC.

C. The **Federal Register** notices announcing the availability of Federal funds for each DOC competitive financial assistance program will contain only the following program-specific information: Summary description of program; deadline dates; addresses for submission of applications; information contacts (including electronic access); amount of funding available; statutory authority; Catalog of Federal Domestic Assistance (CFDA) number; eligibility requirements; cost sharing or matching requirements; Intergovernmental Review requirements; evaluation criteria used by the merit reviewers; selection procedures, including funding priorities/selection factors/policy factors to be applied by the selecting official; and Administrative and National Policy Requirements.

D. The DOC follows the uniform format for announcements of funding opportunities for discretionary grants and cooperative agreements established by the Office of Management and Budget in a policy letter published in the **Federal Register**. See 68 FR 37370 (June 23, 2003). These funding opportunity announcements are available on grants.gov or from the information contact listed in the **Federal Register**.

Executive Order 12866

This notice has been determined to be “not significant” for purposes of EO 12866, “Regulatory Planning and Review.”

Administrative Procedure Act and Regulatory Flexibility Act

Because notice and comment are not required under 5 U.S.C. 553, or any other law, for this notice relating to public property, loans, grants benefits or contracts (5 U.S.C. 553(a)), a Regulatory Flexibility Analysis is not required and has not been prepared for this notice.

Executive Order 12132 (Federalism)

It has been determined that this notice does not contain policies with Federalism implications as that term is defined in EO 13132.

Paperwork Reduction Act

These regulatory actions do not impose any new reporting or recordkeeping requirements under the Paperwork Reduction Act. Notwithstanding any other provisions of the law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with a collection-of-information, subject to the requirements of the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*, unless that collection of information displays a currently valid Office of Management and Budget (OMB) control number. Forms SF–424, SF–424A, SF–424B, SF–424C, SF–424D, SF–LLL, and CD–346, have been approved under control numbers 0348–0043, 0348–0044, 0348–0040, 0348–0041, 0348–0042, 0348–0046, and 0605–0001, respectively.

Catalog of Federal Domestic Assistance

This notice affects all of the grant and cooperative agreement programs funded by DOC. The Catalog of Federal Domestic Assistance can be accessed on the Internet under the DOC Grants Management Web site at <http://www.cfda.gov>.

List of Subjects

Accounting, Administrative practice and procedures, Grants administration, Grant programs-economic development, Grant programs-oceans, atmosphere and fisheries management, Grant programs-minority businesses, Grant programs-technology, Grant programs-telecommunications, Grant programs-international, Reporting and recordkeeping requirements.

Issued this 22nd day of December, 2004, at Washington, DC.

Michael S. Sade,

Director for Acquisition Management and Procurement Executive.

[FR Doc. 04–28635 Filed 12–29–04; 8:45 am]

BILLING CODE 3510-FA-P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 121704A]

Fisheries Off West Coast States and in the Western Pacific; Western Pacific Pelagic Fisheries; Highly Migratory Species Fisheries; Overfishing Determination for Bigeye Tuna

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

ACTION: Notice of overfishing determination.

SUMMARY: This action serves as notice that NMFS, on behalf of the Secretary of Commerce (Secretary), has determined that overfishing is occurring Pacific-wide on bigeye tuna (*Thunnus obesus*), and requests the Western Pacific Fishery Management Council and the Pacific Fishery Management Council (Councils) to take appropriate action by June 14, 2005, to end overfishing. The intent of this action is to notify interested persons that bigeye tuna is undergoing overfishing in the Pacific Ocean.

SUPPLEMENTARY INFORMATION: The following reprint of a December 15, 2004, letter from NMFS to the Councils notifies the Councils of a determination that overfishing is occurring Pacific-wide on bigeye tuna, provides the background on how NMFS made the determination, provides the legal basis for the Councils to act in response to a determination that overfishing is occurring, and requests the Councils to take appropriate action to end overfishing on bigeye tuna.

Dear Chairmen Morioka and Hansen,

This letter is to advise the Western Pacific Fishery Management Council and the Pacific Fishery Management Council (Councils) that the National Marine Fisheries Service (NMFS), on behalf of the Secretary of Commerce (Secretary), has determined that overfishing is occurring Pacific-wide on bigeye tuna (*Thunnus obesus*), and to request the Councils to take appropriate action to end overfishing.

Determination

The Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) requires that the Secretary report annually on the status of fisheries within each regional fishery management council's geographical area of authority and identify those fisheries that are overfished or approaching a condition of being overfished (16 U.S.C. 1854(e)(1)). According to the guidelines for National Standard 1 of the Magnuson-Stevens Act (50 CFR 600.310), fishery stock status is assessed with respect to two status determination

criteria, one of which is used to determine whether a stock is "overfished" and the second of which is used to determine whether the stock is subject to "overfishing." A stock is considered to be overfished if its biomass falls below the minimum stock size threshold (MSST). A stock is subject to overfishing if the fishing mortality rate exceeds the maximum fishing mortality threshold (MFMT) for one year. The MSST and MFMT for particular stocks are specified in fishery management plans.

Based on the MFMT specifications for bigeye tuna in the Fishery Management Plan for the Pelagic Fisheries of the Western Pacific Region, effective July 3, 2003 (68 FR 46112, August 5, 2003), and in the Fishery Management Plan for U.S. West Coast Fisheries for Highly Migratory Species, approved February 4, 2004, the MFMT would be exceeded if the fishing mortality rate exceeded the rate associated with maximum sustainable yield (MSY). Recent assessments of the status of bigeye tuna in the Pacific, described below, indicate that the fishing mortality rate has, for at least one year, been greater than the rate associated with MSY. According to these assessments and the MFMT specifications in the two fishery management plans, therefore, overfishing is occurring.

The stock structure of bigeye tuna in the Pacific Ocean is unresolved. Bigeye tuna in the Pacific has been assessed using two different approaches, one that treats it as a single Pacific-wide stock and the other that treats it as two stocks, one in the western and central Pacific, corresponding to the area of interest of the Secretariat of the Pacific Community (SPC), and the other in the eastern Pacific, corresponding to the area of authority of the Inter-American Tropical Tuna Commission (IATTC). This overfishing determination relies on assessment results from both these approaches but it does not rely on any assumptions or conclusions about stock structure.

The most recent stock assessments continued the separate stock approach used by IATTC and SPC. An assessment for the western and central Pacific was completed in July 2004¹ and an assessment for the eastern Pacific was completed in May 2004.² A Pacific-wide stock assessment, including comparisons with results from separate stock assessments, was completed in July 2003.³

The July 2004 assessment for the western and central Pacific indicates that there is a

probability of at least 67 percent that the recent fishing mortality rate exceeded the fishing mortality rate associated with MSY.

The May 2004 assessment results for the eastern Pacific indicate that in all scenarios considered, the recent fishing mortality rate exceeded the rate associated with average MSY.

The results of the collaborative July 2003 assessment for the western and central Pacific and for the Pacific Ocean as a whole were similar in that the recent fishing mortality rate in both cases exceeded the fishing mortality rate associated with MSY. While the results with respect to fishing mortality were uncertain for both stock assumptions, there was a high degree of correspondence between the estimates of stock trends for the western and central Pacific and those for the Pacific as a whole.

Based on these assessment results for bigeye tuna in the Pacific Ocean, NMFS, relying on the expertise and advice of its regional Fisheries Science Centers, has determined that overfishing is occurring Pacific-wide on bigeye tuna.

Notification

As required by the Magnuson-Stevens Act (16 U.S.C. 1854(e)(2)) and the implementing regulations at 50 CFR 600.310(e)(2), the Councils are notified by way of this letter that the Secretary has determined that overfishing is occurring Pacific-wide on bigeye tuna. The Councils must take appropriate action to address this overfishing. As required by the Magnuson-Stevens Act (16 U.S.C. 1854(e)(3)) and the implementing regulations at 50 CFR 600.310(e)(3), the Councils must take remedial action to end overfishing within one year of an identification by the Secretary that overfishing is occurring. In the case of Pacific bigeye tuna, such an identification was made in the annual report to the Congress and the Council on the status of fisheries in 2003. This report was transmitted to the Congress on June 15, 2004, so the one-year period for Councils to take remedial action ends June 14, 2005.

Pacific bigeye tuna occurs in the waters of multiple nations and the high seas and is fished by the fleets of other nations in addition to those of the U.S. The capacity for unilateral action by the U.S. to prevent overfishing, as required under National Standard 1 of the Magnuson-Stevens Act (16 U.S.C. 1851(a)(1)), is limited, as is the capacity for action taken by the Councils to end overfishing, as required under 50 CFR 600.310(e)(4)(i). Multilateral management action is essential to ensure that overfishing on bigeye tuna in the Pacific Ocean ends. NMFS will work with the Department of State, the regional fishery management councils, industry, and other interests to promote conservation and management measures in international and regional fishery management organizations to prevent further overfishing and ensure that bigeye tuna in the Pacific Ocean does not become overfished.

Sincerely,

William L. Robinson,
Regional Administrator, Pacific Islands
Region

¹ Hampton, J., P. Kleiber, A. Langley, and K. Hiramatsu. 2004. Stock assessment of bigeye tuna in the western and central Pacific Ocean. SCTB17 Working Paper SA-2. 17th Meeting of the Standing Committee on Tuna and Billfish, Majuro, Marshall Islands, 9-18 August 2004. July 2004.

² Harley, S.J. and M.N. Maunder. 2004. Status of Bigeye Tuna in the Eastern Pacific Ocean in 2003 and Outlook for 2004. Working Group on Stock Assessments, 5th Meeting, La Jolla, California (USA), 11-13 May 2004, Document SAR-5-05 BET. Inter-American Tropical Tuna Commission.

³ Hampton, J., P. Kleiber, Y. Takeuchi, H. Kurota, and M. Maunder. 2003. Stock assessment of bigeye tuna in the western and central Pacific Ocean, with comparisons to the entire Pacific Ocean. SCTB16 Working Paper BET-1. Sixteenth Meeting of the Standing Committee on Tuna and Billfish, Mooloolaba, Queensland, Australia, 9-16 July 2003.

Rodney McInnis,
Regional Administrator, Southwest Region

Dated: December 23, 2004.

Alan D. Risenhoover,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.
[FR Doc. 04-28632 Filed 12-29-04; 8:45 am]

BILLING CODE 3510-22-P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

I.D. 122704A

Mid-Atlantic Fishery Management Council (MAFMC); Meetings

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

ACTION: Notice of public meeting.

SUMMARY: The Mid-Atlantic Fishery Management Council (Council) and its Protected Resources Committee; its Squid, Mackerel, Butterfish Committee; its Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) Reauthorization Committee; its Executive Committee; and, Ecosystems Committee will hold public meetings.

DATES: Tuesday, January 18, 2005 through Thursday, January 20, 2005. On Tuesday, January 18 the Protected Resources Committee will meet from 9–11 a.m. The Squid, Mackerel, Butterfish Committee will meet from 11 a.m. through 1 p.m., and the MSA Reauthorization Committee will meet from 2–5 p.m. On Wednesday, January 19 from 8:30–9:30 a.m., the Executive Committee will meet and the Council will convene at 9:30 a.m. From 9:30 a.m. through 12:00 noon, Council will approve the October and December Council meeting minutes, hear organizational and liaison reports. At 1 p.m., Council will present its 2004 Fisheries Achievement Award; from 1:15–2 p.m., Council will hear a National Marine Fisheries Service (NMFS) presentation regarding “Front Loading” requirements of regulatory actions; and, from 2–4 p.m., Council will meet as a Committee of the Whole for the Demersal Committee. On Thursday, January 20 the Ecosystem Committee will meet from 8–10 a.m. Council will convene at 10 a.m., and from 10–11 a.m. will receive a NMFS presentation regarding its Northeast Regional Office’s (NERO) updated Draft Regional Bycatch Plan. At 11 a.m. Council will receive status of the Council’s Fishery Management Plans,

hear the Executive Director’s Report, and address any new and/or continuing business.

ADDRESSES: This meeting will be at the Radisson Hotel Hampton, 700 Settler’s Landing Road, Hampton, VA, telephone 757-727-9700.

Council address: Mid-Atlantic Fishery Management Council, 300 S. New Street, Dover, DE 19904, telephone 302-674-2331.

FOR FURTHER INFORMATION CONTACT:

Daniel T. Furlong, Executive Director, Mid-Atlantic Fishery Management Council; telephone: 302-674-2331, ext. 19.

SUPPLEMENTARY INFORMATION: Agenda items for the Council’s committees and the Council itself are: on January 18 the Protected Resources Committee will review and comment on a November 10, 2004 proposed rule regarding NMFS’ Bottlenose Dolphin Take-Reduction Plan. The Squid, Mackerel, Butterfish Committee will review the Public Hearing Document (PHD) and Draft Supplemental Environmental Impact Study (SEIS) for Amendment 9 to the Squid, Mackerel, Butterfish Fishery Management Plan. The Magnuson-Stevens Act Reauthorization Committee will review and discuss proposed changes to the Magnuson-Stevens Act and develop a Council position for suggested changes to the Act. On January 19 the Executive Committee will review changes in the Council’s Statement of Organization Practices and Procedures regarding pay administration for staff. Following the Executive Committee, the Council will convene and approve the October and December Council meeting minutes and hear organizational and liaison reports. Beginning its afternoon session, the Council will present its 2004 Fisheries Achievement Award to the Virginia Marine Resources Commission’s Law Enforcement Unit, and receive a presentation by the National Marine Fisheries Service (NMFS) regarding “Front Loading” requirements for regulatory actions. The Council will then meet as a Committee of the Whole for the Demersal Committee to review and comment on the status of action for Amendment 14 to the Summer Flounder, Scup, and Black Sea Bass Fishery Management Plan (Pre-Scoping). On Thursday, January 20 the Ecosystem Committee will review the NMFS Northeast Science Center’s ecosystem efforts regarding development of science-based approaches to fishery management. The Council will convene at 10 a.m. to receive a presentation from NMFS/NERO regarding its updated Draft

Regional Bycatch Plan; hear staff and committee reports; and, act on any new and/or continuing business.

Although non-emergency issues not contained in this agenda may come before the Council for discussion, these issues may not be the subject of formal Council action during this meeting. Council action will be restricted to those issues specifically listed in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the Council’s intent to take final actions to address such emergencies.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Debbie Donnangelo (302-674-2331) at least 5 days prior to the meeting date.

Dated: December 27, 2004.

Alan D. Risenhoover,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.
[FR Doc. E4-3897 Filed 12-29-04; 8:45 am]

BILLING CODE 3510-22-S

DEPARTMENT OF COMMERCE

Technology Administration

The United States-Russia Innovation Council on High Technologies (ICHT)

AGENCY: Technology Administration, U.S. Department of Commerce.

ACTION: Notice.

SUMMARY: The Technology Administration invites nominations of individuals representing high technology business in the United States for appointment to five vacancies on the U.S.-Russia Innovation Council on High Technologies. The U.S. Department of Commerce (D.O.C.) and the Ministry of Education and Science (M.E.S.) of the Russian Federation (hereinafter referred to as “the Participants”), formed the Innovation Council on High Technologies (hereinafter referred to as “the Council”) in accordance with Article 3 of the Memorandum of Understanding between the D.O.C. and the M.E.S. on Cooperation in Technology and Innovation, signed at Washington, DC on April 19, 2004. The Technology Administration will consider all nominations received in response to this notice.

DATES: Nominations must be received at the address below by no later than January 31, 2005.

ADDRESSES: Please submit nominations to Ken Ferguson, Chief, International Technology Programs, Office of Technology Policy, Technology Administration, U.S. Department of Commerce, Room 4817, 14th and Constitution Avenues, NW., Washington, DC 20230. Nominations may also be submitted by fax or e-mail to Ken Ferguson, Chief, International Technology Programs at 202-501-6849 or *Ken.Ferguson@Technology.Gov* if followed up with a hard copy sent by mail or courier.

FOR FURTHER INFORMATION CONTACT: Ken Ferguson, Chief, International Technology Programs, telephone: 202-482-0150; fax: 202-501-6849, e-mail: *Ken.Ferguson@Technology.Gov*.

General Principles of the Council

Innovation activities, commercialization of the results of scientific and technical activities, entrepreneurship, and a pro-competitive legal and policy environment are important stimulators of economic growth and job creation. The U.S. and Russia have a mutual interest in strengthening and expanding cooperation through the establishment of an ongoing dialogue and the creation of cooperative programs in order to develop sustained commercial partnerships between U.S. and Russian developers of high technologies and entrepreneurs.

The Council is a forum for the free exchange of information, ideas, and problems in the interests of:

- Studying existing problems and making recommendations on developing joint entrepreneurship in the field of innovation activities and commercialization of the results of scientific and technical activities;
- Preparing analytical reviews and developing recommendations on creating favorable conditions for cooperation in the field of innovation and high technologies, which promote the economic development of the U.S. and Russia;
- Providing guidance to private sector representatives in taking advantage of opportunities for cooperation in the field of innovation activities and commercialization of the results of scientific and technical activities;
- Establishing a dialogue on creating pro-competitive technology policies that stimulate scientific research and development based on sustainable U.S. and Russian private sector partnerships;
- Enabling U.S. and Russian technology joint ventures, in order to afford greater access to, and a greater ability to serve, global markets.

Aim of Council Activities

The aim of the Council is to promote development of cooperation between the U.S. and Russia in the field of innovation, commercialization, and high technologies, and to promote interaction and cooperation between representatives of government agencies and the business and scientific communities of the United States and of Russia for the purpose of commercializing the results of scientific and technical activities, including those developed through government funding or sponsorship.

Objectives of the Council

- The objectives of the Council are to:
- Identify promising areas of innovation cooperation for commercialization of the results of scientific and technical activities,
 - Stimulate joint research and development that has significant commercial potential, and support joint innovation projects to bring the results of such research and development to the market for science-intensive products and services,
 - Create and maintain a pro-competitive environment that allows business and partnerships in innovation to develop successfully,
 - Facilitate the establishment of U.S.-Russian business partnerships to produce new jointly developed science-intensive goods and services and to promote them on world markets through market-based commercialization programs,
 - Develop recommendations for harmonizing legislation in the field of innovation activities and technology standards of the U.S. and Russia, and
 - Promote in the global marketplace the commercial technology partnerships that have been established.

Council Structure and Work

The Council will be headed by two Co-Chairs, one from each Participant. The U.S. Co-Chair will be appointed by the Department of Commerce. The Russian Co-Chair will be appointed by the Ministry of Education and Science. The Council will be composed of not more than twenty representatives. The Participants will each select ten representatives from government agencies, and business and scientific communities of the U.S. and Russia, respectively.

The Council will establish working groups on the main areas of its activities. These working groups will be responsible for:

- Reviewing possibilities for harmonizing legislation in the area of

- innovation activities and studying the results of intellectual activities;
- Providing guidance on the management, funding, and effectiveness of innovation programs and projects, including joint programs for market-based commercialization of technologies;
- Promoting the formation of U.S. and Russian innovation and technology business partnerships; and
- Stimulating technology incubation by identifying scientific innovations with commercial applications.

Meetings of the Council

Council meetings are to be held at least once a year, alternately in the U.S. and Russia, on issues proposed for consideration and coordinated between the Council Co-Chairs. The first meeting of the Council will be on or before May 16, 2005, in Russia at a location to be determined. Travel and living expenses associated with attending these meetings are the responsibility of the Council members.

Length of Service

A U.S. member's length of service on the Council is discretionary with the U.S. Department of Commerce. Individuals chosen for membership will serve a term that is consistent with the needs and objectives of the Council although the term's average duration is expected to last around two years. Upon the completion of a U.S. member's term, the U.S. Department of Commerce may either repeat this recruitment and selection process or extend the member's term, based on the member's expertise and participation on the Council.

Membership Criteria and Requirements

The U.S. business members of the Council are expected to be eminent leaders in the private sector, representative of industry, who have experience in science and technology development, technology diffusion, and technology collaboration in the Russian Federation. They shall be U.S. citizens. They should be familiar with the business climate and the status of technology and economic development in the Russian Federation and with Russian industry. Members of the Council will serve without compensation.

Conflict of Interest

Nominees will be evaluated for their ability to contribute to the goals and objectives of the Council. Nominees will be vetted in accordance with processes established by the U.S. Department of Commerce in February 1997, as soon as

possible following tentative selection. The vetting system has three components: (1) An internal review for possible appearance of conflict problems; (2) an external review for possible appearance of problems; and (3) a recusal/ethics agreement review.

Dated: December 21, 2004.

Phillip J. Bond,

Under Secretary of Commerce for Technology.
[FR Doc. 04-28395 Filed 12-29-04; 8:45 am]

BILLING CODE 3510-GN-P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.
SUMMARY: The Director, Regulatory Information Management Services, Office of the Chief Information Officer invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before January 31, 2005.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Carolyn Lovett, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10235, New Executive Office Building, Washington, DC 20503 or faxed to (202) 395-6974.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Director, Regulatory Information Management Services, Office of the Chief Information Officer, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, *e.g.* new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of

collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: December 23, 2004.

Jeanne Van Vlandren,

Director, Regulatory Information Management Services, Office of the Chief Information Officer.

Institute of Education Sciences

Type of Review: New.

Title: 2005 High School Transcript Study (KA).

Frequency: One time.

Affected Public: State, Local, or Tribal Gov't, SEAs or LEAs; Not-for-profit institutions.

Reporting and Recordkeeping Hour Burden: Responses, 768, Burden Hours, 2304.

Abstract: This clearance package contains descriptions, supporting statements, and burden information for the 2005 High School Transcript Study. The study collects transcripts for graduating high school students from schools participating in the 2005 NAEP 12th grade assessment. To interpret the transcript information school catalogs are collected and school administrative personnel are interviewed.

Requests for copies of the submission for OMB review; comment request may be accessed from <http://edicsweb.ed.gov>, by selecting the "Browse Pending Collections" link and by clicking on link number 2627. When you access the information collection, click on "Download Attachments" to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue, SW., Potomac Center, 9th Floor, Washington, DC 20202-4700. Requests may also be electronically mailed to the Internet address OCIO_RIMS@ed.gov or faxed to 202-245-6621. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be directed to Kathy Axt at 540-776-7742. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1-800-877-8339.

[FR Doc. 04-28563 Filed 12-29-04; 8:45 am]

BILLING CODE 4000-01-P

DEPARTMENT OF EDUCATION

Meeting of the National Advisory Council on Indian Education

AGENCY: National Advisory Council on Indian Education (NACIE), U.S. Department of Education.

ACTION: Notice of teleconference meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of an upcoming teleconference meeting of the National Advisory Council on Indian Education (the Council) and is intended to notify the general public of their opportunity to listen as the council conducts their meeting by teleconference. This notice also describes the functions of the Council. Notice of the Council's meetings is required under Section 10(a)(2) of the Federal Advisory Committee Act and by the Council's charter.

Agenda: The purpose of the meeting will be a discussion of the NACIE activity work plan, development of the annual report to Congress, and preparations for making recommendations for reauthorization of the Elementary and Secondary Education Act (ESEA) legislation.

Date and Time: January 18, 2005; 2 p.m. to 4 p.m.

Location: The Department of Education, Room 1W103, 400 Maryland Avenue, SW., Washington, DC 20202.

Note: Attendees will be required to show picture identification to enter the building.

FOR FURTHER INFORMATION CONTACT:

Bernard Garcia, Group Leader, Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, SW., Washington, DC 20202. Telephone: 202-260-1454. Fax: 202-260-7770. For security clearance to the building, please submit your name to Bernard Garcia by January 6, 2005.

SUPPLEMENTARY INFORMATION: The Council advises the Secretary of Education on the funding and administration (including the development of regulations, and administrative policies and practices) of any program over which the Secretary has jurisdiction and includes Indian children or adults as participants or programs that may benefit Indian children or adults, including any program established under Title VII, Part A of the ESEA. The Council submits to the Congress, not later than June 30 of each year, a report on the activities of the Council that includes recommendations the Council considers appropriate for the improvement of Federal education programs that include Indian children or adults as participants or that may benefit Indian children or adults, and recommendations concerning the funding of any such program.

The general public is welcome to listen to the January 18, 2005 meeting to be held from 2 p.m. to 4 p.m. at the U.S.

Department of Education, Room 1W103, 400 Maryland Avenue, SW., Washington, DC. Individuals who need accommodations for a disability in order to participate (i.e., interpreting services, assistive listening devices, materials in alternative format) should notify Bernard Garcia at 202-260-1454 by January 6, 2005. We will attempt to meet requests after this date, but cannot guarantee availability of the requested accommodation. This meeting site is accessible to individuals with disabilities.

A summary of the activities of the meeting and other related materials that are informative to the public and will be available to the public within 14 days after the meeting. Records are kept of all Council proceedings and are available for public inspection at the Office of Indian Education, United States Department of Education, Room 5C141, 400 Maryland Avenue, SW., Washington, DC 20202.

Dated: December 22, 2004.

Rod Paige,

Secretary, U.S. Department of Education.

[FR Doc. 04-28616 Filed 12-29-04; 8:45 am]

BILLING CODE 4000-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP05-129-000]

CenterPoint Energy-Mississippi River Transmission Corporation; Notice of Tariff Filing

December 22, 2004.

Take notice that on December 20, 2004, CenterPoint Energy-Mississippi River Transmission Corporation (MRT) tendered for filing as part of its FERC Gas Tariff, Third Revised Volume No. 1, the tariff sheets listed in Appendix A to the filing, to be effective January 19, 2005.

MRT states that the purpose of this filing is to update Forms of Service Agreement and to make certain clarifications and "housekeeping" changes.

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 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as

appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

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 14 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 e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3894 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP05-128-000]

Columbia Gas Transmission Corporation; Notice of Tariff Filing

December 22, 2004.

Take notice that on December 17, 2004, Columbia Gas Transmission Corporation (Columbia) tendered for filing as part of its FERC Gas Tariff, Second Revised Volume No. 1, the following revised tariff sheets with a proposed date of January 16, 2005:

Seventh Revised Sheet No. 108,
Fourth Revised Sheet No. 196,
Third Revised Sheet No. 229,
Third Revised Sheet No. 322.

Columbia hereby proposes to modify Rate Schedules NTS, SIT and PAL, and Section 9.7 of the General Terms and Conditions of its Tariff to reflect name changes to certain price index locations,

along with changes reflecting the substitution of published price indices. These modifications are necessary to reflect changes to the names of certain price index locations and to reflect the fact that Columbia no longer subscribes to one currently referenced publication.

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 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

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 14 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 e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3893 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY**Federal Energy Regulatory Commission****[Docket No. RP05-125-000]****Columbia Gulf Transmission Company; Notice of Tariff Filing**

December 22, 2004.

Take notice that on December 17, 2004, Columbia Gulf Transmission Company (Columbia Gulf) tendered for filing as part of its FERC Gas Tariff, Second Revised Volume No. 1, the following revised tariff sheets with a proposed date of January 1, 2005:

Thirty-sixth Revised Sheet No. 18,
Thirty-seventh Revised Sheet No. 19.

Columbia Gulf states it is submitting a periodic filing (Periodic TRA Filing) to reduce its retainage factor for the mainline zone. Columbia Gulf submits the Periodic TRA Filing pursuant to the provisions of Section 33, "Transportation Retainage Adjustment (TRA)," of the General Terms and Conditions (GTC) of its FERC Gas Tariff, Second Revised Volume No. 1.

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 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

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 14 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 e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Linda Mitry,*Deputy Secretary.*

[FR Doc. E4-3890 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P**DEPARTMENT OF ENERGY****Federal Energy Regulatory Commission****[Docket No. RP05-126-000]****Columbia Gulf Transmission Company; Notice of Tariff Filing**

December 22, 2004.

Take notice that on December 17, 2004, Columbia Gulf Transmission Company (Columbia Gulf) tendered for filing as part of its FERC Gas Tariff, Second Revised Volume No. 1, the following revised tariff sheets with a proposed date of January 16, 2005:

Second Revised Sheet No. 87,
Third Revised Sheet No. 94.

Columbia Gulf hereby proposes to modify rate schedules PAL and IMS, and section 9.7 of the General Terms and Conditions of its Tariff to reflect name changes to certain price index locations, along with changes reflecting the substitution of published price indices. Columbia Gulf further states that these modifications are necessary to reflect changes to the names of certain price index locations and to reflect the fact that Columbia Gulf no longer subscribes to one currently referenced publication.

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 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or

before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

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 14 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 e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Linda Mitry,*Deputy Secretary.*

[FR Doc. E4-3891 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P**DEPARTMENT OF ENERGY****Federal Energy Regulatory Commission****[Docket No. RP05-127-000]****Columbia Gulf Transmission Company; Notice of Tariff Filing**

December 22, 2004.

Take notice that on December 17, 2004, Columbia Gulf Transmission Company (Columbia Gulf) pursuant to Section 19.6 of the General Terms and Conditions (GTC) of its FERC Gas Tariff, Second Revised Volume No. 1, filed a Penalty Revenue Crediting Report for the 2003-2004 contract year.

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 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR

154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

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 14 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 e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3892 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. PR04-6-001]

Cranberry Pipeline Corporation; Notice of Offer of Settlement

December 22, 2004.

Take notice that on December 17, 2004, Cranberry Pipeline Corporation (Cranberry) tendered for filing an Offer of Settlement (settlement) in the above-referenced proceeding. The proposed settlement establishes a system-wide transportation rate of 68.17 cents/Dth pursuant to NGPA section 311(a)(2). The proposed settlement also makes certain revisions to Cranberry's Statement of Operating Conditions.

Initial comments on Cranberry's filing are due on or before January 6, 2005, and reply comments are due on or before January 17, 2005.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3889 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP02-361-044]

Gulfstream Natural Gas System, L.L.C.; Notice of Negotiated Rate

December 22, 2004.

Take notice that on December 20, 2004, Gulfstream Natural Gas System, L.L.C. (Gulfstream) tendered for filing as part of its FERC Gas Tariff, Original Volume No. 1, Original Sheet No. 8.011, reflecting an effective date of January 1, 2004.

Gulfstream states that this filing is being made in connection with a negotiated rate transaction pursuant to section 31 of the General Terms and Conditions of Gulfstream's FERC Gas Tariff. Gulfstream states that Original Sheet No. 8.011 identifies and describes the negotiated rate transaction, including the exact legal name of the relevant shipper, the negotiated rate, the rate schedule, the contract terms, and the contract quantity. Gulfstream also states that Original Sheet No. 8.011 includes footnotes where necessary to provide further details on the transaction listed thereon.

Gulfstream states that copies of its filing have been mailed to all affected customers and interested state commissions.

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 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

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 14 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 e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3888 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP05-75-001]

Iroquois Gas Transmission System, L.P.; Notice of Compliance Filing

December 22, 2004.

Take notice that on December 16, 2004, Iroquois Gas Transmission System, L.P. (Iroquois) tendered for filing as part of its FERC Gas Tariff, First Revised Volume No. 1, Substitute Third Revised Sheet No. 88, to be effective on December 17, 2004.

Iroquois states that copies of its filing were served on all jurisdictional customers and interested state regulatory agencies and all parties to the proceeding.

Any person desiring to protest this filing must file in accordance with Rule 211 of the Commission's Rules of Practice and Procedure (18 CFR 385.211). Protests to this filing 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. Such protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing a protest must serve a copy of that document on all the parties to the proceeding.

The Commission encourages electronic submission of protests in lieu of paper using the "eFiling" link at <http://www.ferc.gov>. Persons unable to file electronically should submit an original and 14 copies of the protest 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 e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3895 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 477]

Portland General Electric Company; Notice of Authorization for Continued Project Operation

December 22, 2004.

The license for Portland General Electric Company's Bull Run Project No. 477, located on the Sandy, Little Sandy, and Bull Run Rivers in Clackamas County, Oregon, was issued for a period ending November 16, 2004. Section 15(a)(1) of the Federal Power Act (FPA), 16 U.S.C. 808(a)(1), requires the Commission, at the expiration of a license term, to issue from year to year an annual license to the then licensee under the terms and conditions of the prior license until a new license is issued, or the project is otherwise disposed of as provided in section 15 or any other applicable section of the FPA.

On November 12, 2002, pursuant to the FPA and the Commission's regulations thereunder, Portland General Electric Company filed an application to surrender the license for Project No. 477. On May 12, 2004, the Commission issued an order that granted the application to surrender, but provided that the licensee is to commence project removal after May 27, 2007, complete project removal by September 7, 2009, and that the surrender will not become effective until fulfillment of all surrender conditions as determined by the Commission and issuance by the Commission of a letter indicating that the surrender is effective. See 107 FERC ¶ 61,158.

Pursuant to section 15 of the FPA, notice is hereby given that an annual license for Project No. 477 is issued to Portland General Electric Company for a period effective November 17, 2004, through November 16, 2005, or until the Commission issues a letter indicating that the surrender granted by the order issued May 12, 2004, is effective, or other disposition under the FPA, whichever comes first. If effectiveness of the surrender (or other disposition) does not take place on or before November 17, 2005, notice is hereby given that, pursuant to 18 CFR 16.18(c), an annual license under section 15(a)(1) of the FPA is renewed automatically without further order or notice by the Commission, unless the Commission orders otherwise.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3887 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP05-37-000]

Transcontinental Gas Pipe Line Corporation; Notice of Application

December 22, 2004.

Take notice that on December 14, 2004, Transcontinental Gas Pipe Line Corporation (Transco), P.O. Box 1396, Houston, Texas 77251, filed an application in Docket No. CP05-37-000 pursuant to section 7(c) of the Natural Gas Act (NGA) and part 157(A) of the Commission's Regulations, for a certificate of public convenience and necessity authorizing Transco's construction and operation of certain facilities at Compressor Station No. 170 (Station 170) in Appomattox County, Virginia to comply with the Clean Air Act Amendments of 1990, all as more fully set forth in the application which is on file with the Commission and open to public inspection. This filing may be also viewed on the Web 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 FERCOnline Support at FERCOnlineSupport@ferc.gov or toll free at (866) 208-3676, or TTY, contact (202) 502-8659.

Any questions regarding this application should be directed to Scott Turkington, Director, Rates & Regulatory, at (713) 215-3391 or Alfred

E. White, Jr., Senior Attorney, at (713) 215-2323, Transcontinental Gas Pipe Line Corporation, P.O. Box 1396, Houston, Texas 77251-1396.

There are two ways to become involved in the Commission's review of this project. First, any person wishing to obtain legal status by becoming a party to the proceedings for this project should, on or before the comment date stated below, file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, a motion to intervene in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the NGA (18 CFR 157.10). A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies of all documents filed by the applicant and by all other parties. A party must submit 14 copies of filings made with the Commission and must mail a copy to the applicant and to every other party in the proceeding. Only parties to the proceeding can ask for court review of Commission orders in the proceeding.

However, a person does not have to intervene in order to have comments considered. The second way to participate is by filing with the Secretary of the Commission, as soon as possible, an original and two copies of comments in support of or in opposition to this project. The Commission will consider these comments in determining the appropriate action to be taken, but the filing of a comment alone will not serve to make the filer a party to the proceeding. The Commission's rules require that persons filing comments in opposition to the project provide copies of their protests only to the party or parties directly involved in the protest.

Persons who wish to comment only on the environmental review of this project should submit an original and two copies of their comments to the Secretary of the Commission. Environmental commenters will be placed on the Commission's environmental mailing list, will receive copies of the environmental documents, and will be notified of meetings associated with the Commission's environmental review process. Environmental commenters will not be required to serve copies of filed documents on all other parties. However, the non-party commenters will not receive copies of all documents filed by other parties or issued by the Commission (except for the mailing of environmental documents issued by the Commission) and will not have the right

to seek court review of the Commission's final order.

The Commission strongly encourages electronic filings of comments, protests and interventions via the Internet in lieu of paper. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site (<http://www.ferc.gov>) under the "e-Filing" link.

Comment Date: January 12, 2005.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3896 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. OR05-4-000]

BP West Coast Products LLC and ExxonMobile Oil Corporation, Complainants v. SFPP, LP, Respondents; Notice of Complaint

December 23, 2004.

Take notice that on December 22, 2004, BP West Coast Products LLC (BP) and ExxonMobil Oil Corporation (ExxonMobil) (collective, Complainants) tendered for filing their Fourth Original Complaint against SFPP, L.P. Complainants allege that SFPP's West Line Watson Vapaor Recovery Charge, Sepulveda Line, North Line, Oregon Line and East Line rates are unjust and unreasonable. Complainants request that the Commission review and investigate SFPP's rates; set the proceeding for an evidentiary hearing to determine just and reasonable rates for SFPP; require SFPP to pay reparations starting two years before the date of complaint for all rates; consolidate this proceeding with the complaint proceeding in Docket No. OR4-3; and award such other relief as is necessary and appropriate under the Interstate Commerce Act.

Complainants state that copies of the complaint were served on SFPP, L.P.

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 and 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 14 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 e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Comment Date: January 11, 2005.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3885 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EG05-25-000, et al.]

Elk River Windfarm, Inc., et al.; Electric Rate and Corporate Filings

December 23, 2004.

The following filings have been made with the Commission. The filings are listed in ascending order within each docket classification.

1. Elk River Windfarm LLC

[Docket No. EG05-25-000]

On December 21, 2004, Elk River Windfarm LLC (Elk River), filed an application for determination of exempt wholesale generator status pursuant to part 365 of the Commission's regulations. Elk River, a Kansas limited liability company, states that it will be engaged directly and exclusively in the business of owning all or part of one or more eligible facilities, and selling electric energy at wholesale.

Elk River states that it has served a copy of the filing on the Securities and Exchange Commission and the Oregon Public Utility Commission.

Comment Date: 5 p.m. Eastern Time on January 10, 2005.

2. New York Independent System Operator, Inc.

[Docket No. EL03-26-004]

Take notice that on December 17, 2004, the New York Independent System Operator, Inc. (NYISO) filed modifications to its services tariff to incorporate a formula for compensating electricity suppliers in certain instances of erroneous bid mitigation in compliance with the Commission's Order issued November 17, 2004, 109 FERC ¶ 61,163. The NYISO has requested that the modifications become effective on February 15, 2005.

The NYISO states that it has served a copy of the filing on all parties that have executed Service Agreements under the NYISO's OATT or services tariff, the New York State Public Service Commission, and upon the electric utility regulatory agencies in New Jersey and Pennsylvania.

Comment Date: 5 p.m. Eastern Time on January 7, 2005.

3. Consolidated Edison Company of New York, Inc.

[Docket No. EL04-126-001]

Take notice that on December 16, 2004, Consolidated Edison Company of New York, Inc. (Con Edison) tendered for filing a revised unexecuted Interconnection Agreement (Agreement) between Con Edison and PSEG Power In-City I, LLC in compliance with the Commission's order issued on November 22, 2004 in Docket No. EL04-126-000, 109 FERC ¶ 61,189.

Con Edison states that copies of this filing was served upon all parties to this proceeding.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

4. City of Banning, California

[Docket No. EL05-44-000]

Take notice that on December 17, 2004, the City of Banning, California (Banning) submitted for filing changes to its Transmission Revenue Balancing Account Adjustment (TRBAA) and to Appendix I of its Transmission Owner (TO) Tariff. Banning requests a January 1, 2005 effective date. Banning further requests that the Commission waive any fees for the filing of its revised TRBAA.

Comment Date: 5 p.m. Eastern Time on January 7, 2005.

5. City of Riverside, California

[Docket No. EL05-45-000]

Take notice that on December 16, 2004, the City of Riverside, California (Riverside) submitted for filing changes to its Transmission Revenue Balancing Account Adjustment (TRBAA) and to Appendix I of its Transmission Owner

(TO) Tariff. Riverside requests a January 1, 2005 effective date. Riverside further requests that the Commission waive any fees for the filing of its revised TRBAA.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

6. New York Independent System Operator, Inc.

[Docket No. EL05-47-000]

Take notice that on December 17, 2004, the New York Independent System Operator, Inc. (NYISO) submitted a request for waiver of tariff provisions and expedited Commission action in the above-captioned proceeding. NYISO states that the requested waivers would permit the NYISO to issue close-out of settlements for prior service months beginning on February 8, 2005.

The NYISO states it has electronically served a copy of this filing on the official representative of each of its customers, on each participant in its stakeholder committees, and on the New York Public Service Commission. NYISO further states that it has served a copy of this filing on the electric utility regulatory agencies of New Jersey and Pennsylvania.

Comment Date: January 7, 2005.

7. Great Lakes Hydro America, LLC

[Docket No. ER02-2397-002]

Take notice that, on December 17, 2004, Great Lakes Hydro America, LLC (GLHA) submitted for filing its triennial updated market analysis.

GLHA states that copies of the filing were served on parties on the official service list in the above-captioned proceeding.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

8. Mirant Delta, LLC, Mirant Potrero, LLC

[Docket No. ER04-343-000]

Take notice that on December 16, 2004, Mirant Delta, LLC (Mirant Delta) and Mirant Potrero, LLC (Mirant Potrero) (collectively, Mirant) tendered for filing revised tariff sheets to the Must-Run Service Agreements between Mirant Delta, Mirant Potrero, and the California Independent System Operator Corporation. Mirant requests an effective date of January 1, 2005.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

9. Midwest Independent Transmission System Operator, Inc.

[Docket No. ER05-344-000]

Take notice that on December 16, 2004, the Midwest Independent Transmission System Operator, Inc.

(Midwest ISO) filed a Large Generator Interconnection Agreement among Mankato Energy Center, LLC, Northern States Power Company d/b/a Xcel Energy and the Midwest ISO.

Midwest ISO states that copies of this filing was served on Mankato Energy Center, LLC and Northern States Power Company d/b/a Xcel Energy.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

10. Illinois Power Company

[Docket No. ER05-345-000]

Take notice that on December 16, 2004, Illinois Power Company tendered for filing a Tariff for Limited Sales of Capacity and Energy to Retail Electricity Suppliers' (Tariff). Illinois Power Company states that if accepted, the Tariff would permit AmerenIP to sell up to 200 MW of electric capacity and energy to Retail Electric Suppliers and Alternative Retail Electric Suppliers in the State of Illinois at cost-based rates. Illinois Power Company requests a January 1, 2005 effective date.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

11. New England Power Company

[Docket No. ER05-347-000]

Take notice that on December 16, 2004, New England Power Company (NEP) and USGen New England, Inc. (USGenNE) submitted for filing an amendment to the Amended and Restated Continuing Site/Interconnection Agreement (CSIA) between NEP and USGenNE. NEP requests an effective date of December 15, 2004.

NEP states that copies of this filing have been served on ISO-New England, Inc. and regulators in the States of Rhode Island, Vermont, New Hampshire and the Commonwealth of Massachusetts.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

12. MidAmerican Energy Company

[Docket No. ER05-348-000]

Take notice that on December 16, 2004, MidAmerican Energy Company (MidAmerican) filed a Firm Transmission Service Agreement between MidAmerican Energy Company and Corn Belt Power Cooperative (Corn Belt). MidAmerican requests an effective date of January 1, 2005.

MidAmerican states it has served a copy of the filing on Corn Belt, the Iowa Utilities Board, the Illinois Commerce Commission and the South Dakota Public Utilities Commission.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

13. Georgia Energy Corporation (An Electric Membership Corporation)

[Docket No. ER05-349-000]

Take notice that on December 16, 2004, Georgia Energy Cooperative (An Electric Membership Corporation) (GEC) filed an application for Market-Based Rate Authority and petitioned the Commission for acceptance of GEC Rate Schedule FERC No.1; the granting of certain blanket approvals; and the waiver of certain Commission regulations. CEG requests an effective date of February 15, 2005.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

14. Mitchell Electric Membership Corporation

[Docket No. ER05-350-000]

Take notice that on December 16, 2004, Mitchell Electric Membership Corporation (Mitchell) filed an application for Market-Based Rate Authority and petitioned the Commission for acceptance of Mitchell Rate Schedule FERC No.1; the granting of certain blanket approvals; and the waiver of certain Commission regulations. Mitchell requests an effective date of February 15, 2005.

Comment Date: 5 p.m. Eastern Time on January 6, 2005.

Standard Paragraph

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 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant and all parties to this proceeding.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at <http://www.ferc.gov>. Persons unable to file electronically should submit an original and 14 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 e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail FERCOnlineSupport@ferc.gov, or call (866) 208-3676 (toll free). For TTY, call (202) 502-8659.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3902 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 12462-000]

Indian River Power Supply, LLC; Notice of Competing Application Accepted for Filing With the Commission

December 22, 2004.

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection.

- a. *Type of Application:* 5-MW Exemption.
- b. *Project No.:* 12462-000.
- c. *Date Filed:* July 28, 2003.
- d. *Applicant:* Indian River Power Supply, LLC.
- e. *Name of Project:* Indian River.
- f. *Location:* On the Westfield River, in the Town of Russell, Hampden County, Massachusetts.
- g. *Filed Pursuant to:* Public Utility Regulatory Policies Act of 1978, 16 U.S.C. 2705, 2708.
- h. *Applicant Contact:* Peter B. Clark, P.O. Box 149, Hamilton, Massachusetts 01936.
- i. *FERC Contact:* Michael Spencer, (202) 502-6093, michael.spencer@ferc.fed.
- j. *Deadline for Filing Comments, Recommendations, Motions to Intervene and Protests:* 60 days from the issuance date of this notice.

All documents (original and eight copies) should be filed with: Magalie R. Salas, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

The Commission's Rules of Practice require all intervenors filing documents with the Commission to serve a copy of that document on each person on the official service list for the project. Further, if an intervenor files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a

particular resource agency, they must also serve a copy of the document on that resource agency.

Comments, recommendations, motions to intervene and protests may be filed electronically via the Internet in lieu of paper. The Commission strongly encourages electronic filings. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site (<http://www.ferc.gov>) under the "e-Filing" link.

k. *Competing Application:* 12430-000.

Date Filed: December 27, 2002.

Due Date: March 31, 2003.

l. This application has been accepted, but is not ready for environmental analysis at this time.

m. The Indian River Project would consist of: (1) The existing 30-foot-high, 425-foot-long Russell dam with flashboards; (2) a 14.11 acre reservoir; (3) a rackhouse for intake of the reservoir flow; (4) two 7-foot-diameter, 60-foot-long penstocks; (5) a powerhouse containing two generating units with a combined capacity of 700 kW and an estimated average annual generation of 3.2 GWh; (6) a 60-foot-long tailrace; (7) a 400-foot-long transmission line; and (8) appurtenant facilities.

n. A copy of the application is 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, contact FERC Online Support at FERCOnlineSupport@ferc.gov or toll-free at 1-866-208-3676, or for TTY, (202) 502-8659. A copy is also available for inspection and reproduction at the address in item h above.

You may also register online at <http://www.ferc.gov/docs-filing/esubscription.asp> to be notified via email of new filings and issuances related to this or other pending projects. For assistance, contact FERC Online Support.

o. Public notice of the filing of the preliminary permit application, which has already been given, established the due date for filing competing applications or notices of intent. Under the Commission's regulations, any competing development application must be filed in response to and in compliance with public notice of the preliminary permit application. No competing applications or notices of intent may be filed in response to this notice.

Anyone may submit a protest or a motion to intervene in accordance with

the requirements of Rules of Practice and Procedure, 18 CFR 385.210, 385.211, and 385.214. In determining the appropriate action to take, the Commission will consider all protests filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any protests or motions to intervene must be received on or before the specified deadline date for the particular application.

All filings must (1) bear in all capital letters the title "PROTEST" or "MOTION TO INTERVENE;" (2) set forth in the heading the name of the applicant and the project number of the application to which the filing responds; (3) furnish the name, address, and telephone number of the person protesting or intervening; and (4) otherwise comply with the requirements of 18 CFR 385.2001 through 385.2005. Agencies may obtain copies of the application directly from the applicant. A copy of any protest or motion to intervene must be served upon each representative of the applicant specified in the particular application.

Linda Mitry,

Deputy Secretary.

[FR Doc. E4-3886 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP04-411-000]

Crown Landing, LLC; Notice of Technical Conference

December 22, 2004.

On Wednesday, January 12, 2005, at 8:30 a.m. (EDT), staff from the Commission's Office of Energy Projects will convene a cryogenic design and technical conference regarding the proposed Crown Landing LNG import terminal. The cryogenic conference will be held at the Holiday Inn Hotel located at One Pureland Drive, Swedesboro, New Jersey (I-295 exit 10). For hotel details call 856-467-3322.

In view of the critical energy infrastructure information and security issues to be explored, the cryogenic conference will not be open to the public. Attendance at this conference will be limited to existing parties to the proceeding (anyone who has specifically requested to intervene as a party) and to representatives of interested federal, state, and local agencies. Any person planning to attend this January 12th cryogenic conference

must register by close of business on Monday, January 10, 2005. Registrations may be submitted either online at <http://www.ferc.gov/whats-new/registration/cryo-conf-form.asp> or by faxing a copy of the form (found at the referenced online link) to 202-208-0353. All attendees must sign a non-disclosure statement prior to entering the conference. Upon arrival at the hotel, check the reader board in the hotel lobby for venue. For additional information regarding the cryogenic conference, please contact Phil Suter at phillip.suter@ferc.gov or 202-502-6368.

Magalie R. Salas,

Secretary.

[FR Doc. E4-3905 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. PR00-9-004]

Gulfterra Texas Pipeline, LP; Notice Of Technical Conference

December 22, 2004.

Take notice that a technical conference will be held on Thursday, January 6, 2005, at 1:30 p.m. (EST), in a room to be designated at the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

The conference will address questions related to the July 12, 2004, filing by Gulfterra Texas Pipeline, LP, to comply with the June 11, 2002, Order on Staff Panel and the February 25, 2004, Order on Rehearing and Denying Late Intervention.

FERC conferences are accessible under section 508 of the Rehabilitation Act of 1973. For accessibility accommodations please send an e-mail to accessibility@ferc.gov or call toll free (866) 208-3372 (voice) or 202-208-1659 (TTY), or send a FAX to 202-208-2106 with the required accommodations.

All interested parties and staff are permitted to attend.

Magalie R. Salas,

Secretary.

[FR Doc. E4-3903 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RM04-7-000]

Market Based Rates for Public Utilities; Notice of Technical Conference

December 22, 2004.

Take notice that a technical conference will be held concerning issues associated with the above-captioned rulemaking proceeding on market based rates. The technical conference will take place on January 27 and 28, 2005, from 9 a.m. to 4:30 p.m. (EST), in the Commission Meeting Room at the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC. Members of the Commission will attend the conference. An agenda will be issued at a later time.

The topic of the conference will be issues associated with generation market power and affiliate abuse, two of the four prongs the Commission uses to determine market power in electric markets. The first day of the conference will consider whether, and if so to what extent, the Commission should modify the interim generation market power screens adopted by the Commission and the appropriate mitigation for those found to have generation market power.¹ The second day of the technical conference will address issues of affiliate abuse and reciprocal dealing, including any mitigation measures the Commission should consider.

The Commission is now soliciting nominations for speakers at the technical conference. Those persons wishing to nominate speakers should do so using the electronic link: <http://www.ferc.gov/whats-new/registration/mbr-01-27-speaker-form.asp> Such nominations must be made before the close of business, Friday, January 7, 2005. The Commission may not be able to accommodate all nominated speakers.

Transcripts of the conference will be immediately available from Ace Reporting Company (202-347-3700 or 1-800-336-6646) for a fee. They will be available for the public on the Commission's eLibrary system seven calendar days after FERC receives the transcripts. Additionally, Capitol Connection offers the opportunity for remote listening of the conference via the Internet or a Phone Bridge Connection for a fee. Interested persons should make arrangements as soon as possible by visiting the Capitol

Connection Web site at <http://www.capitolconnection.gmu.edu> and clicking on "FERC." If you have any questions contact David Reininger or Julia Morelli at the Capitol Connection (703-993-3100).

FERC conferences are accessible under section 508 of the Rehabilitation Act of 1973. For accessibility accommodations please send an email to accessibility@ferc.gov or call toll free (866) 208-3372 (voice) or 202-208-1659 (TTY), or send a FAX to 202-208-2106 with the required accommodations.

For more information about the conference, please contact Kelly Perl at 202-502-6421 or kelly.perl@ferc.gov.

Additional details and the panelists for this conference will be included in a supplemental notice to be issued later.

Magalie R. Salas,

Secretary.

[FR Doc. E4-3904 Filed 12-29-04; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Western Area Power Administration

Parker-Davis Project—Post-2008 Resource Pool

AGENCY: Western Area Power Administration, DOE.

ACTION: Notice of extension of comment and application period.

SUMMARY: The Western Area Power Administration (Western), a Federal power marketing agency of the Department of Energy (DOE), published a notice of proposed procedures and call for applications, Parker-Davis Project—Post-2008 Resource Pool in the **Federal Register** on October 1, 2004. This notice extends the filing date for the submission of comments on the proposed procedures for allocating the Parker-Davis Project Post-2008 resource pool power, along with the date for filing applications for an allocation of power from the resource pool, for a period of 30 days.

DATES: Entities interested in commenting on proposed procedures must submit written comments to Western's Desert Southwest Regional Office at the address below. Entities applying for an allocation of Parker-Davis Project power must submit an application to the address below. Western will accept written comments and/or applications received on or before January 30, 2005. Western reserves the right to not consider any comments and/or applications received after this date.

¹ American Electric Power Marketing, Inc., 107 FERC ¶ 61,018 (2004), order on reh'g, 108 FERC ¶ 61,026 (2004).

ADDRESSES: Submit applications for an allocation of Parker-Davis Project power and written comments regarding the proposed procedures to Mr. J. Tyler Carlson, Regional Manager, Desert Southwest Region, Western Area Power Administration, P.O. Box 6457, Phoenix, AZ 85005-6457. You may also fax applications or comments to Western at (602) 352-2490 or e-mail them to post2008pdp@wapa.gov. Application forms are available upon request or may be accessed at <http://www.wapa.gov/dsw/pwrmkt/FRN>. Applicants are encouraged to use the application form provided at the above Web site.

FOR FURTHER INFORMATION CONTACT: Roy Tinsley, Project Manager, Desert Southwest Region, Western Area Power Administration, 615 South 43rd Ave, Phoenix, AZ 85005, telephone (602) 352-2788, e-mail post2008pdp@wapa.gov.

The current Parker-Davis Project (P-DP) marketing plan and related information are available online at <http://www.wapa.gov/dsw/pwrmkt>. Western will also post all public comments from this process on this Web site after the close of the comment period.

SUPPLEMENTARY INFORMATION: In the **Federal Register** notice published on October 1, 2004 (69 FR 58900), Western established a due date of 90 days after publication or December 30, 2004, for receipt of comments on proposed procedures and applications for allocations of Parker-Davis Project resource pool power. At the Public Comment Forum held on December 1, 2004, Western received a request to extend the time allowed for submission of applications. As a result of this request, Western has determined to extend the comment and application period for 30 days.

Dated: December 20, 2004.

Michael S. Hacksaylo,
Administrator.

[FR Doc. 04-28607 Filed 12-29-04; 8:45 am]
BILLING CODE 6450-01-P

ENVIRONMENTAL PROTECTION AGENCY

[ER-FRL-6659-2]

Environmental Impact Statements and Regulations; Availability of EPA Comments

Availability of EPA comments prepared pursuant to the Environmental Review Process (ERP), under section 309 of the Clean Air Act and section 102(2)(c) of the National Environmental

Policy Act, as amended. Requests for copies of EPA comments can be directed to the Office of Federal Activities at (202) 564-7167. An explanation of the ratings assigned to draft environmental impact statements (EISs) was published in the **Federal Register** dated April 2, 2004 (69 FR 17403).

Draft EISs

ERP No. D-DOD-A10076-00 Rating LO, Programmatic—Missile Defense Agency, To Incrementally Develop, Test, Deploy and Plan for Decommissioning of the Ballistic Missile Defense System (BMDS).

Summary: EPA has no objections to the proposed action, but did request clarification on the criteria that will be used in making future decisions for site-specific locations. EPA also recommended that the EIS discuss the existence of multiple species habitat conservation planning efforts that are proximate to DoD lands. Finally, EPA recommended that the EIS confirm the validity of information of material incorporated into the PEIS by reference.

ERP No. D-FAA-D51050-PA Rating EC1, Philadelphia International Airport Project, Proposed Runway 17-35 Extension Project, Funding, NPDES Permit and U.S. Army COE Section 404 Permit, Philadelphia, PA.

Summary: EPA expressed concern regarding impacts to wetlands, air quality, environmental justice, and sole source aquifer issues.

Final EISs

ERP No. F-COE-K39084-AZ, Va Shly'ay Akimel Salt River Ecosystem Restoration Feasibility Study, Increasing and Improving Native Vegetation, in Portions of the Salt River Pima-Maricopa Indian Community (SRPMIC) and the City of Mesa, Maricopa County, AZ.

Summary: EPA commended the Corps for this valuable aquatic resources restoration effort. EPA also expressed continued concerns regarding the lack of impact analysis of the proposed Cultural Center and suggested that the Record of Decision include a commitment for the development of a water quality program to address any elevated levels of pollutants identified during storm water monitoring, including an assessment of impacts related to treatment facilities or structures.

ERP No. F-FAA-D52002-WV, Adoption—Aircraft Conversion for the 167th Air Wing (167 AW) of the West Virginia Air National Guard, Converting C-130H Transport Aircraft to the Larges C-5 Transport Aircraft, Acquisition of Land via Lease, and Construction of

Facilities on existing and acquired Parcel, Berkeley County, WV.

Summary: While many of EPA's previous concerns were resolved, EPA continues to express concern due to noise and safety issues related to the closure of Runway 17/35.

ERP No. F-FAA-F51049-IN, Gary/Chicago International Airport Master Plan Development Including Runway Safety Area Enhancement/Extension of Runway 12-30, Funding, Lake County, IN.

Summary: While most of EPA's comments and concerns have been satisfactorily addressed in the FEIS, EPA continues to have concerns with the adequacy of the EIS documentation and proposed wetland mitigation. EPA recommends FAA provide additional information and commitments for wetland mitigation.

ERP No. FS-BLM-K36197-NV, Clark County Regional Flood Control Master Plan, Updated and Replaced the Original 1991 FEIS, Facilities Construction and Operation, Right-of-Way Approval and U.S. Army COE Section 404 Permit, Clark County, NV.

Summary: EPA urged BLM to consider opportunities to enhance, restore, and protect waters of the U.S. and wildlife habitat on site-specific projects over the life of the plan.

Dated: December 27, 2004.

Ken Mittelholtz,

Environmental Protection Specialist, Office of Federal Activities.

[FR Doc. 04-28603 Filed 12-29-04; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

[ER-FRL-6659-1]

Environmental Impact Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information (202) 564-7167 or <http://www.epa.gov/compliance/nepa/>.

Weekly receipt of Environmental Impact Statements filed December 20, 2004, through December 23, 2004, pursuant to 40 CFR 1506.9.

EIS No. 040595, Draft EIS, AFS, CA, Modoc National Forest Noxious Weed Treatment Project, Proposes to Implement a Control and Eradication Project, Lassen, Modoc and Siskiyou Counties, CA Comment Period Ends: February 14, 2005, Contact: Robert Haggard (530) 233-8840.

EIS No. 040596, Draft Supplement, IBW, CA, South Bay International Wastewater Treatment Plan

(SBIWTP), To Address Treatment Alternatives from Tijuana, Mexico that cross into United States/Mexico Border in San Diego County, CA, Comment Period Ends: February 28, 2005, Contact: Daniel Borunda (915) 832-4701.

EIS No. 040597, Draft EIS, AFS, WI, Lakewood/Laona Plantation Thinning Project, To Implement Vegetation Management Activities, Chequamegon-Nicolet National Forest, Lakewood Ranger District, Forest, Langlade and Oconto Counties, WI, Comment Period Ends: February 14, 2005, Contact: Annie F. Archie (715) 362-1300.

EIS No. 040598, Final EIS, AFS, ID, Caribou Sheep Allotment Management Plan Revision, Authorize Continue Livestock Grazing, Caribou-Targhee National Forest, Palisades Ranger District, Bonneville County, ID, Wait Period Ends: January 30, 2005, Contact: Greg Hanson (208) 523-1412.

EIS No. 040599, Final Supplement, FTA, NY, Erie Canal Harbor Project (formerly known as the Buffalo Inner Harbor Development Project) Updated Information on the Original Project, City of Buffalo, Erie County, NY, Wait Period Ends: January 30, 2005, Contact: Irwin Kessman (212) 668-2170.

EIS No. 040600, Draft EIS, FHW, PA, Southern Beltway Transportation Project, Improvement from US-22 in Robinson Township to Interstate 79 in South Fayette Township and Cecil Township, Funding and U.S. Army COE Section 404 Permit, Washington and Allegheny Counties, PA, Comment Period Ends: February 25, 2005, Contact: James A. Cheatham (717) 221-3461.

EIS No. 040601, Final EIS, NRS, Programmatic EIS -Emergency Watershed Protection Program, Improvements and Expansion, To Preserve Life and Property Threatened by Disaster-Caused Erosion and Flooding, U.S. 50 States and Territories except Coastal Area, Wait Period Ends: January 30, 2005, Contact: Victor Cole (202) 690-4575.

EIS No. 040602, Final EIS, NOAA, WA, OR, Puget Sound Chinook Harvest Resource Management Plan (RMP) 2004-2009, Implementation, Endangered Species Act, OR and WA, Wait Period Ends: January 31, 2005, Contact: Susan Bishop (206) 526-4587.

Amended Notices

EIS No. 040465, Draft EIS, NPS, AZ, Colorado River Management Plan, To Provide a Wilderness-Type River

Experience for Visitors, General Management Plan, Grand Canyon National Park, Colorado River, Coconino County, AZ, Comment Period Ends: February 01, 2005, Contact: Rick Ernenwein (928) 779-6279.

Revision of Federal Register Notice Published on 10/08/04: CEQ Comment Period Ending 01/06/2005 has been Extended to 02/01/2005.

Dated: December 27, 2004.

Ken Mittelholtz,

Environmental Protection Specialist, Office of Federal Activities.

[FR Doc. 04-28604 Filed 12-29-04; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

[OPP-426; FRL-7694-8]

Exposure Modeling Work Group; Notice of Public Meeting

AGENCY: Environment Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Exposure Modeling Work Group (EMWG) will hold a one-day meeting on January 11, 2005. This notice announces the location and time for the meeting and sets forth the tentative agenda topics.

DATES: The meeting will be held on January 11, 2005, from 9 a.m. to 3 p.m.

ADDRESSES: The meeting will be held at the Office of Pesticide Programs (OPP), Environmental Protection Agency, Crystal Mall #2, Room 1126 (Fishbowl), 1801 S. Bell Street, Arlington, VA 22202.

FOR FURTHER INFORMATION CONTACT: Ronald Parker, Environmental Fate and Effects Division (7507C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460-0001; telephone number: (703) 305-5505; fax number: (703) 305-6309; e-mail address: parker.ronald@epa.gov.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

This action is directed to the public in general, and may be of particular interest to those persons who are or may be required to conduct testing of chemical substances under the Toxic Substances Control Act (TSCA), the Federal Food, Drug, and Cosmetic Act (FFDCA), or the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA). Since other entities may also

be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Get Copies of this Document and Other Related Information?

1. *Docket.* EPA has established an official public docket for this action under docket identification (ID) number OPP-2004-0426. The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Although a part of the official docket, the public docket does not include Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the Public Information and Records Integrity Branch (PIRIB), Rm. 119, Crystal Mall #2, 1801 S. Bell Street, Arlington, VA. This docket facility is open from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The docket telephone number is (703) 305-5805.

2. *Electronic access.* You may access this **Federal Register** document electronically through the EPA Internet under the "Federal Register" listings at <http://www.epa.gov/fedrgstr/>.

An electronic version of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. You may use EPA Dockets at <http://www.epa.gov/edocket/> to view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Although not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in Unit I.B.1. Once in the system, select "search," then key in the appropriate docket ID number.

II. Background

On a quarterly interval, the Exposure Modeling Workgroup meets to discuss current issues in modeling pesticide fate, transport, and exposure to pesticides in support of risk assessment in a regulatory context.

III. How Can I Request to Participate in this Meeting?

You may submit a request to participate in this meeting to the person listed under **FOR FURTHER INFORMATION CONTACT**.

IV. Tentative Agenda

A. Welcome and Introductions

B. Old Action Items

C. Brief Updates

- PRZM3.12.2 Evaluation
- EXPRESS
- Review of Public Comments on EFED's Modeling Scenarios
- Spray Drift Update
- Release of PGW Guidance Document
- WARP daily values methodologies

D. Major Topics

1. Morning Session
 - PRZM Diary -- Silk purse or sow's ear? Comparing the predicted occurrence of atrazine in the vadose zone (PRZM3) with observed detections in shallow ground water across the United States (NAWQA)
 - Comparison of LEACHM and PRZM Modeling to Field Data: Effect of Evaporation Simulation on Water Balance and Pesticide Movement
2. Afternoon Session
 - Root Zone Water Quality Model (RZWQM): Brief Overview and Case Study
 - Groundwater Modeling for Carbamate Cumulative Assessment
 - User-friendly CXTFIT2 Model to Estimate Setback Distances

List of Subjects

Environmental protection, pesticides, pests, modeling.

Dated: December 22, 2004.

Ingrid Sunzenauer,

Acting Director, Environmental Fate and Effects Division.

[FR Doc. 04-28601 Filed 12-29-05; 8:45 am]

BILLING CODE: 6560-50-S

ENVIRONMENTAL PROTECTION AGENCY

[ORD-2004-0021; FRL-7856-5]

Board of Scientific Counselors, Mercury Subcommittee Meetings—Winter 2005

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of meetings.

SUMMARY: Pursuant to the Federal Advisory Committee Act, Public Law

92-463, the Environmental Protection Agency, Office of Research and Development (ORD), gives notice of three meetings of the Board of Scientific Counselors (BOSC) Mercury Subcommittee.

DATES: Two conference call meetings will be held on: (1) Wednesday, January 19, 2005, from 9 a.m. to 12 p.m., and (2) Tuesday, March 29, 2005, from 9 a.m. to 11 a.m. One face-to-face meeting will begin on Wednesday, February 23, 2005 (9 a.m. to 5 p.m.), and conclude on Thursday, February 24, 2005 (9 a.m. to 12 p.m.). All times noted are eastern standard time. The meetings may adjourn early if all business is finished. Public comment on the Subcommittee will be accepted until March 28, 2005.

ADDRESSES: Conference Calls:

Participation in the conference calls will be by teleconference only—meeting rooms will not be used. Members of the public who wish to obtain the call-in number and access code to participate in a teleconference meeting may contact Heather Drumm, Designated Federal Officer, via telephone/voice mail at (202) 564-8239, via e-mail at drumm.heather@epa.gov, or by mail at Environmental Protection Agency, Office of Research and Development, Mail Code 8104-R, 1200 Pennsylvania Avenue, NW., Washington, DC 20460, by four work days prior to each conference call. **Face-to-Face Meeting:** The Subcommittee will meet face-to-face in Arlington, VA at the Holiday Inn Rosslyn at Key Bridge on Wednesday, February 23 and Thursday, February 24. The Holiday Inn is located at 1900 N. Fort Myer Drive.

Document Availability

Any member of the public interested in receiving a draft agenda for, or making a presentation at, one of the conference calls or the face-to-face meeting, may contact Heather Drumm, Designated Federal Officer, via telephone/voice mail at (202) 564-8239, via e-mail at drumm.heather@epa.gov, or by mail at Environmental Protection Agency, Office of Research and Development, Mail Code 8104-R, 1200 Pennsylvania Avenue, NW., Washington, DC 20460.

In general, each individual making an oral presentation will be limited to a total of three minutes. Requests for the draft agendas or for making oral presentations at the conference calls or the face-to-face meeting will be accepted up to 1 business day before each conference call/meeting date. The draft agendas can also be viewed through EDOCKET, as provided in Unit I.A. of the **SUPPLEMENTARY INFORMATION** section.

Submitting Comments

Comments may be submitted electronically, by mail, or through hand delivery/courier. Follow the detailed instructions as provided in Unit I.B. of the **SUPPLEMENTARY INFORMATION** section. Written comments will be accepted up to 1 business day before the conference calls/meeting dates.

FOR FURTHER INFORMATION CONTACT:

Heather Drumm, Designated Federal Officer, via telephone/voice mail at (202) 564-8239, via e-mail at drumm.heather@epa.gov, or by mail at Environmental Protection Agency, Office of Research and Development, Mail Code 8104-R, 1200 Pennsylvania Avenue, NW., Washington, DC 20460.

SUPPLEMENTARY INFORMATION:

I. General Information

Proposed agenda items for the conference calls include, but are not limited to: Charge questions, objective of program reviews, background on the U.S. EPA's Mercury research program, writing assignments, and planning for the face-to-face meeting. Proposed agenda items for the face-to-face meeting include, but are not limited to: Presentations by key EPA staff in the Mercury research program, writing the draft report, and presentation of the subcommittee's draft responses to the charge questions. The conference calls and face-to-face meeting are open to the public.

Information on Services for the Handicapped: Individuals requiring special accommodations at this meeting should contact Heather Drumm, Designated Federal Officer, at (202) 564-8239 at least five business days prior to the meeting so that appropriate arrangements can be made to facilitate their participation.

A. How Can I Get Copies of Related Information?

1. **Docket.** EPA has established an official public docket for this action under Docket ID No. ORD-2004-0021. The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Documents in the official public docket are listed in the index in EPA's electronic public docket and comment system, EDOCKET. Documents may be available either electronically or in hard copy. Electronic documents may be viewed through EDOCKET. Hard copies of the draft agendas may be viewed at the Board of Scientific Counselors, Mercury Meetings Docket in the EPA Docket Center (EPA/DC), EPA West, Room

B102, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center 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 ORD Docket is (202) 566-1752.

2. *Electronic Access.* You may access this **Federal Register** document electronically through the EPA Internet under the “**Federal Register**” listings at <http://www.epa.gov/fedrgstr/>.

An electronic version of the public docket is available through EDOCKET. You may use EDOCKET at <http://www.epa.gov/edocket/> to submit or view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Once in the system, select “search,” then key in the appropriate docket identification number.

For public commenters, it is important to note that EPA’s policy is that public comments, whether submitted electronically or in paper, will be made available for public viewing in EPA’s electronic public docket as EPA receives them and without change, unless the comment contains copyrighted material, confidential business information (CBI), or other information whose disclosure is restricted by statute. When EPA identifies a comment containing copyrighted material, EPA will provide a reference to that material in the version of the comment that is placed in EPA’s electronic public docket. The entire printed comment, including the copyrighted material, will be available in the public docket.

Public comments submitted on computer disks that are mailed or delivered to the docket will be transferred to EPA’s electronic public docket. Public comments that are mailed or delivered to the Docket will be scanned and placed in EPA’s electronic public docket.

B. How and To Whom Do I Submit Comments?

You may submit comments electronically, by mail, or through hand delivery/courier. To ensure proper receipt by EPA, identify the appropriate docket identification number in the subject line on the first page of your comment. Please ensure that your comments are submitted within the specified comment period.

1. *Electronically.* If you submit an electronic comment as prescribed below, EPA recommends that you

include your name, mailing address, and an e-mail address or other contact information in the body of your comment. Also include this contact information on the outside of any disk or CD ROM you submit, and in any cover letter accompanying the disk or CD ROM. This ensures that you can be identified as the submitter of the comment and allows EPA to contact you in case EPA cannot read your comment due to technical difficulties or needs further information on the substance of your comment. EPA’s policy is that EPA will not edit your comment, and any identifying or contact information provided in the body of a comment will be included as part of the comment that is placed in the official public docket, and made available in EPA’s electronic public docket. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment.

i. *EDOCKET.* Your use of EPA’s electronic public docket to submit comments to EPA electronically is EPA’s preferred method for receiving comments. Go directly to EDOCKET at <http://www.epa.gov/edocket/>, and follow the online instructions for submitting comments. To access EPA’s electronic public docket from the EPA Internet home page, <http://www.epa.gov/>, select “Information Sources,” “Dockets,” and “EDOCKET.” Once in the system, select “search,” and then key in Docket ID No. ORD-2004-0021. The system is an anonymous access system, which means EPA will not know your identity, e-mail address, or other contact information unless you provide it in the body of your comment.

ii. *E-mail.* Comments may be sent by electronic mail (e-mail) to ORD.Docket@epa.gov, Attention Docket ID No. ORD-2004-0021. In contrast to EPA’s electronic public docket, EPA’s e-mail system is not an anonymous access system. If you send an e-mail comment directly to the docket without going through EPA’s electronic public docket, EPA’s e-mail system automatically captures your e-mail address. E-mail addresses that are automatically captured by EPA’s e-mail system are included as part of the comment that is placed in the official public docket, and made available in EPA’s electronic public docket.

iii. *Disk or CD ROM.* You may submit comments on a disk or CD ROM that you mail to the mailing address identified in Unit I.B.2. These electronic submissions will be accepted in WordPerfect or ASCII file format. Avoid the use of special characters and any form of encryption.

2. *By Mail.* Send your comments to: U.S. Environmental Protection Agency, ORD Docket, EPA Docket Center (EPA/DC), Mailcode: 28221T, 1200 Pennsylvania Ave., NW., Washington, DC 20460, Attention Docket ID No. ORD-2004-0021.

3. *By Hand Delivery or Courier.* Deliver your comments to: EPA Docket Center (EPA/DC), Room B102, EPA West Building, 1301 Constitution Avenue, NW., Washington, DC, Attention Docket ID No. ORD-2004-0021. (**Note:** This is not a mailing address). Such deliveries are only accepted during the docket’s normal hours of operation as identified in Unit I.A.1.

Dated: December 22, 2004.

Kevin Y. Teichman,

Director, Office of Science Policy.

[FR Doc. 04-28602 Filed 12-29-04; 8:45 am]

BILLING CODE 6560-50-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-05AT]

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 404-371-5973 or send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D74, Atlanta, GA 30333 or send an e-mail 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

Development of a Site Specific Evaluation Protocol for Outcome Measurement "New "Agency for Toxic Substances and Disease Registry (ATSDR).

ATSDR considers evaluation to be a critical component for enhancing program effectiveness and improving resource management. ATSDR's mandate under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), as amended, is to help prevent or reduce further exposures at hazardous waste sites and the illnesses that result from such exposures. A standardized methodology to monitor outcomes associated with agency intervention will provide the data needed for demonstrating effectiveness and efficiency as well as identifying areas for improvement.

ATSDR, in cooperation with our cooperative agreement partners, is developing a series of survey modules designed to measure individual attitudes, knowledge, behaviors, as well as mental and physical health self-assessments that may be influenced by health education and health promotion efforts conducted by the agency at hazardous waste sites. These modules will be used to determine knowledge improvements, attitude shifts, and behavior change following specific ATSDR program efforts and activities. The particular module used at a site will vary depending on the contaminant(s) of concern and education/health promotion actions undertaken. In addition, the timing of the data collection will vary depending on whether this is a new site or one that has been underway for some time. In general, for new sites or existing sites with new intervention efforts, we would aim for two data collections—baseline

and post-intervention. At existing sites where ATSDR interventions have been completed, we would collect data once—post-intervention.

Health education and promotion activities are conducted at approximately 250 sites annually. We estimate that 90% will have total exposed or potentially exposed populations of 10,000 or less, and we expect to survey up to 150 respondents at each site. At sites with exposed or potentially exposed populations of more than 10,000, we expect to survey up to 500 respondents at each site.

Using a standardized methodology and survey instrument to assess outcomes related to targeted intervention activities at hazardous waste sites will provide the agency with important feedback for program improvement. There will be no costs to respondents except for their time to participate in the survey.

ANNUALIZED BURDEN TABLE

Respondents	Number of sites annually	Number of respondents per site	Responses per respondent	Average burden per response (in hours)	Total annual burden hours
General Public at Existing Sites with Exposed Populations of 10,000 or Less	55	150	1	15/60	2,063
General Public at Existing Sites with New Interventions or New Sites with Exposed Populations of 10,000 or Less	170	150	2	15/60	12,750
General Public at Existing Sites with Exposed Populations of 10,000 or More	5	500	1	15/60	625
General Public at Existing Sites with New Interventions or New Sites with Exposed Populations of 10,000 or More	20	500	2	15/60	5,000
Total .....	.....	.....	.....	.....	20,438

Dated: December 23, 2004.

Joseph E. Salter,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28608 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-05AU]

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 404-371-5978 or send comments to Sandi Gambescia, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D74, Atlanta, GA 30333 or send an e-mail 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

Fire Fighter Fatality Investigation and Prevention Program (FFFIPP)—NEW—The National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

The Fire Fighter Fatality Investigation and Prevention Program (FFFIPP) addresses an important public health need to protect the lives of America's front line emergency responders, those whose job is to save lives and protect property. The FFFIPP was established in fiscal year 1998 in order to investigate the deaths and severe injuries that occur to fire fighters for the purpose of identifying high risk situations and to

develop recommendations for prevention.

The purpose of this project is to evaluate the impact of the Fire Fighter Fatality Investigation and Prevention Program (FFFIPP), and the effects of the FFFIPP recommendations and information products which are periodically distributed to the nation's 30,000 fire departments. This study will examine career and volunteer; large and small size; and urban and rural fire departments to determine the extent to which firefighter reports, recommendations and other information products are being implemented by fire departments. This evaluation will also measure the effects of the FFFIPP on the knowledge, behavior, attitudes and safety practices of fire department management.

This study will consist of a mail survey of 1,140 fire departments to obtain information from the officers (Captain, Safety Officer and Training Officer or Lieutenants) regarding use of the FFFIPP information products. There will also be a set of six focus groups for active, front-line firefighters; each focus group will have approximately 9 participants.

The FFFIPP investigated approximately 114 injury fatalities and 101 cardiovascular disease fatalities over the first 5 years of operations. Reports based on these investigations

are mailed to select fire departments on a regular basis. An evaluation of the program at this time is appropriate because the FFFIPP has acquired sufficient data on firefighter fatalities to permit substantial improvements in knowledge, awareness and the practice of fire fighting. The FFFIPP information products have been published and disseminated with sufficient time to allow positive changes. An evaluation at this time could ultimately reduce risk for firefighters through elimination of barriers to better knowledge, behavior, attitudes and safety practices for fire department leadership/management and for front-line firefighters. Evaluation provides a means to strengthen the impact of the program through modification or re-direction of the FFFIPP strategy.

CDC proposes to conduct an evaluation survey that will include 1,140 fire departments. A fire department survey (Tier 1) and focus groups (Tier 2) will be used to collect data for this evaluation. The fire department survey will use a cross-sectional design with restricted random sampling. The sample will include each of the 215 fire departments where an investigation has been done. For comparison, a random sample of 300 fire departments where there has not been any investigation will be selected and surveyed. The ten largest fire

departments will be deliberately included in the sample because of their unique status. The random selection of additional fire departments will be restricted to balance various factors such as the number of volunteer vs. career, rural vs. urban and other considerations. To supplement findings from the Tier 1 Fire Department Survey, the evaluation team will conduct a series of six focus groups with firefighters from across the country. These Tier 2 focus group discussions will serve as avenues for exploring how and why the FFFIPP may have had an impact. Information collected in the focus groups will thus complement the Tier 1 Fire Department Survey by providing rich descriptions of the ways in which FFFIPP may have affected firefighter knowledge, attitudes, behaviors, and safety practices. The focus groups (Tier 2) will take place either at a national conference of firefighters or at local venues convenient to the fire departments represented by the participants. Each focus group will take 1½ hours. Questions will address firefighter knowledge, attitudes, behavior, and safety practices. Data collection will take no more than 5 to 12 months to complete after OMB approval. There are no costs to respondents except their time to participate in the survey.

ANNUALIZED BURDEN TABLE

Data collection instruments	Number of respondents	Number of responses	Average burden per response	Total burden hours
Fire Dept. Survey	1,140	1	25/60	475
Focus Group Guide—Fire Fighters	54	1	1.5	81
Total	1,194	.....	.....	556

Dated: December 23, 2004.

Joseph E. Salter,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28609 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-05AV]

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 404-371-5973 or send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D74, Atlanta, GA 30333 or send an e-mail 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

Hemophilia Treatment Center Laboratory Survey—New—National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC).

Up to 2 million women in the United States may have an inherited bleeding disorder and not know it. Many women learn to live with the problems their bleeding causes, such as heavy periods, and not realize that they could have a bleeding disorder. Other women may have more serious bleeding problems such as hemorrhages after childbirth or surgery, and some have hysterectomies to end their heavy periods. With proper diagnosis, women with bleeding disorders could avoid these complications and surgeries. Management of bleeding in these women can decrease heavy periods and can improve quality of life.

The most common bleeding disorder is called Von Willebrand disease (VWD). VWD is caused by a deficiency or defect in the body's ability to make a protein, Von Willebrand factor, which helps blood clot. The symptoms of VWD can range in severity; however, 90 percent of people who have this disease have the mild form. VWD occurs in men and women equally, but women are more likely to notice the symptoms of VWD due to heavy or abnormal bleeding during their menstrual periods and after childbirth. There are many

gynecological and physical causes for heavy periods, such as endometriosis, thyroid problems and cancer; however, the cause is not identified in half the cases. A CDC–Emory University survey found that gynecologists rarely considered bleeding disorders as a cause of heavy menstrual bleeding. However, recent research from Europe and CDC has shown that 15–20% of women with heavy periods have inherited bleeding disorders. Women with VWD interviewed by CDC reported an average of 16 years between the onset of bleeding symptoms and diagnosis of a bleeding disorder. CDC and the National Hemophilia Foundation have been working to encourage gynecologists to consider bleeding disorders in women who have menorrhagia. As a result, the American College of Obstetricians and Gynecologists has recently recommended screening for VWD in these women.

An important part of increasing the awareness among physicians and their patients with heavy periods who may have an underlying bleeding disorder is referral for appropriate diagnosis. Federally funded Hemophilia Treatment Centers (HTCs) are thought to be the best source for appropriate laboratory diagnosis; however, the following concerns have been raised: (1) Anecdotal reports from HTC providers describe reduced capacity of in-house laboratory support and access to specialty coagulation laboratory tests that are essential for appropriate diagnosis of bleeding disorders; (2) A CDC study demonstrated reduced capacity to perform specific coagulation tests through their survey of hospital laboratories but it is impossible to know

if HTCs have higher capacity than the hospitals studied; and (3) HTCs report that changes in third party payer policies, especially health maintenance organizations, are dictating the source of laboratory testing requiring shipment of laboratory specimens to sites away from the hospital that reduce the quality of the sample and effect the reliability of the results. It is important to assess the HTCs and determine their capabilities and barriers to delivering comprehensive care to patients with bleeding disorders.

The setting for the proposed study are federally funded HTCs. The study participants are composed of medical directors, adult hematologists, pediatric hematologists, and coagulation laboratory technicians. A survey will be distributed to the above personnel to ascertain their perceptions of lab capabilities and procedures. Research questions of interest include the following:

- (1) What tests can be performed?
- (2) How timely can results be obtained?
- (3) Which HTCs have an in-house coagulation laboratory?
- (4) What percentage of tests must be sent to outside laboratories?
- (5) What is the perceived quality of results obtained from an outside laboratory?

A stamped, self-addressed envelope will be attached to each survey, along with a cover letter explaining the survey. After a specified period of time, non-responders will receive a phone call reminder and sent another copy of the survey if needed. There will be no cost to the respondents except their time to complete the survey.

ANNUALIZED BURDEN TABLE

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
HTC medical directors and coagulation technicians	325	1	20/60	108
Total .....	.....	.....	.....	108

Dated: December 23, 2004.

Joseph E. Salter,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28610 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-05AG]

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 404-498-1210 or send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-E11, 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

Process Evaluation of the Protocol for Assessing Community Excellence in Environmental Health—New—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

CDC, through a cooperative agreement with the National Association of City and County Health Organizations (NACCHO), developed and disseminated the Protocol for Assessing Community Excellence in Environmental Health (PACE EH). This document consists of 13 tasks to engage the community in environmental health planning and assessment activities. PACE EH seeks to strengthen public health leadership, promote community collaboration, and encourage environmental justice. In the long run, PACE EH seeks to establish a new leadership role for local public health agencies and build sustainable community processes for decision-making. More than 1,700 copies of a guidebook have been disseminated to the public and organizations that

requested one or more copies for review. Little is known about how each of the hundreds of potentially interested communities nationwide evaluates the suitability of the PACE EH methodology to its own situation; the relative advantages and disadvantages each perceives in this methodology compared to other tools; methods available for conducting environmental health assessments; and the range of challenges encountered in implementing the method.

The purpose of the proposed study is to obtain information from current and potential PACE EH users that will be used to guide resource decisions related to its continued support and development. Two data collection activities are proposed. The first is a Web survey of all state and local health agencies that requested a copy of the PACE EH Guidebook. The survey will ask questions about their decision whether to adopt the method; and if they did choose to adopt it, questions will be asked about their progress, challenges faced, and impact of the method on their agency, community, and environment. The second data collection activity is a one-day site visit to 24 of the communities that are actively engaged in implementation to conduct interviews with key staff and community members. These site visits will provide additional detail about implementation issues and challenges that are not readily obtained through survey methodology. There are no costs to respondents except for their time to participate.

ANNUALIZED BURDEN TABLE

Data collections	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
PACE EH Requestor Survey	700	1	45/60	525
PACE EH Participant Interview	192	1	1	192
Total .....	.....	.....	.....	717

Dated: December 21, 2004.

B. Kathy Skipper,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28611 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-05AS]

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) 371-5973 or send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 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

2005 Lead Disclosure Rule Public Awareness Survey—New—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

The proposed 2005 Lead Disclosure Rule Public Awareness Survey will assess small and medium-sized rental property owners' self-reported awareness of and compliance with the Lead Disclosure Rule. The Lead Disclosure Rule requires property owners to disclose to prospective tenants and buyers the presence of lead paint and lead-based paint hazards in

residential properties built before 1978, if known by the owners. The rule was published under the authority of Title X of the Housing and Community Development Act of 1992 by the Department of Housing and Urban Development (HUD) at 24 CFR 35, subpart A, and by the Environmental Protection Agency (EPA) at 40 CFR 745, subpart F.

Childhood lead poisoning, while on the decline, remains a threat to the health and well-being of young children across the United States. In accordance with the Healthy People 2010 goal to "eliminate elevated blood lead levels in children," there is a need for primary prevention of childhood lead poisoning. Primary prevention is the removal of lead hazards from a child's environment before the child is exposed. Ensuring compliance with the Lead Disclosure Rule is one component of a primary prevention strategy.

The U.S. Department of Justice, HUD, and EPA, in partnership with local health, housing, and law enforcement agencies have completed more than 34 enforcement settlements under the Lead Disclosure Rule. As a result, they have obtained commitments from property owners to test and abate lead-based paint hazards in their high-risk rental housing units. HUD has requested the

assistance of the Lead Poisoning Prevention Branch at CDC to design and implement an evaluation of their enforcement efforts.

As part of this evaluation effort, CDC is interested in the perception of the Lead Disclosure Rule by sectors of the property owner population that have been targeted less often for enforcement of the rule. This survey of small and medium-sized rental property owners (owning fewer than 50 rental units) will be the first effort of its kind to capture this particular population's self-reported awareness of and compliance with the Lead Disclosure Rule.

The survey will be administered in four U.S. cities during 2005 and 2006. Two of the cities will be involved in a compliance assistance and enforcement intervention by HUD. The other two cities will be control cities (without such an intervention). For all four cities, CDC will conduct a cross-sectional "before and after" study design, but utilizing different respondents. Therefore, each respondent will be surveyed only once. Participation is voluntary. Respondents will be asked to complete a brief written survey and return the survey anonymously via the addressed, stamped envelope CDC will provide. There is no cost to respondents except the time to complete the survey.

ANNUALIZED BURDEN TABLE

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours.)	Total burden (in hrs.)
Targeted Property Owners	1000	1	15/60	250
Total .....	.....	.....	.....	250

Dated: December 21, 2004.

B. Kathy Skipper,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28612 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-05-04JK]

Proposed Data Collections Submitted for Public Comment and Recommendations

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 the CDC Reports Clearance Officer at (404) 498-1210 or send an email to omb@cdc.gov. Send written comments to CDC Desk Officer, Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 or by fax to (202) 395-6974. Written comments should be received within 30 days of this notice.

Proposed Project

Cardiovascular Health Branch Management Information System—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

The Cardiovascular Health Branch Management Information System will collect the following in electronic format: (a) Data needed to measure progress by State Heart Disease and Stroke Prevention Programs toward, or achievement of, program performance measures, and (b) information on State Heart Disease and Stroke Prevention Programs currently being reported in hard copy.

In 1998, the U.S. Congress provided funding for the Centers for Disease Control and Prevention (CDC) to initiate a national, state-based heart disease and stroke prevention program. CDC's strategic plan is to implement a comprehensive national heart disease and stroke prevention program that supports state-based programs in all states and territories. In 2003 under Program Announcement 02045, CDC's

Cardiovascular Health Branch selected and funded 32 states and the District of Columbia to address heart disease and stroke. Awardees were selected through a competitive peer review process, and the awards are managed as CDC cooperative agreements. Awards are made for five years and may be renewed through a continuation application. This program is authorized under sections 301(a) and 317b(k)(2) of the Public Health Service (PHS) Act, [42 U.S.C. sections 241(a) and 247b(k)(2)], as amended.

All funded programs are required to submit continuation applications and semi-annual progress reports consistent with federal requirements that all agencies, in response to the Government Performance and Results Act of 1993, prepare performance plans and collect program-specific performance measures. There will be two respondents per site.

An internet-based management information system (MIS) will allow CDC to monitor, and report on state Heart Disease and Stroke Prevention Programs more efficiently. Data reported

to CDC through the MIS will be used by CDC to identify training and technical assistance needs, monitor compliance with cooperative agreement requirements, evaluate progress made in achieving program-specific goals, and obtain information needed to respond to Congressional and other inquiries regarding program activities and effectiveness. There are no costs to respondents except their time to respond. The total annual burden for this data collection is 396 hours.

ANNUALIZED BURDEN TABLE

Respondents	Number of respondents	Number of responses per respondent	Average burden per respondent (in hours)	Total burden hours
States and Washington, DC	66	2	3	396

Dated: December 21, 2004.

B. Kathy Skipper,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28613 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-050555]

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 404-371-5983 or send comments to Dale Verell, CDC Alternate OMB Clearance Officer, 1600 Clifton Road, MS-D74, Atlanta, GA 30333 or send an e-mail 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

National Public Health Performance Standards Program Local Public Health System Assessment (OMB 0920-0555)—Extension—Office of the Director, Centers for Disease Control and Prevention (CDC).

The Office of the Director, CDC is proposing to extend the currently approved National Public Health Performance Standards Program Local Public Health System Assessment. From 1998-2002, the CDC National Public Health Performance Standards Program convened workgroups with the National Association of County and City Health Officials (NACCHO), The Association of State and Territorial Health Officials

(ASTHO), the National Association of Local Boards of Health (NALBOH), the American Public Health Association (APHA), and the Public Health Foundation (PHF) to develop performance standards for public health systems based on the essential services of public health.

CDC is now proposing to extend the formal, voluntary data collection that assesses the capacity of local public health systems to deliver the essential services of public health. Local health departments will respond to the survey on behalf of the collective body of representatives from the local public health system. Electronic data submission will be used when local public health agencies complete the public health assessment.

The extension will provide additional time for local public health systems to undertake the assessment. Some states have sought to include mention of the assessment in legislation or regulations and are now encouraging their localities to respond to the assessment in the upcoming two years. The focus on bioterrorism and other emerging issues diverted resources and attention from immediate use of the assessment since its national release in 2002. A two-year extension will provide additional needed time.

The estimated annualized burden for each extension year is 4,200 hours.

Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
175	1	24	4200

Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Total			4200

Dated: December 22, 2004.

B. Kathy Skipper,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28617 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-050557]

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 404-371-5983 or send comments to Dale Verell, CDC Alternate OMB Clearance Officer, 1600 Clifton

Road, MS-D74, Atlanta, GA 30333 or send an e-mail 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

National Public Health Performance Standards Program State Public Health System Assessment (OMB 0920-0557)—Extension—Office of the Director, Centers for Disease Control and Prevention (CDC).

The Office of the Director, CDC is proposing to extend the currently approved National Public Health Performance Standards Program State Public Health System Assessment. From 1998 "2002, the CDC National Public Health Performance Standards Program

convened workgroups with the National Association of County and City Health Officials (NACCHO), The Association of State and Territorial Health Officials (ASTHO), the National Association of Local Boards of Health (NALBOH), the American Public Health Association (APHA), and the Public Health Foundation (PHF) to develop performance standards for public health systems based on the essential services of public health.

CDC is now proposing to extend the formal, voluntary data collection that assesses the capacity of state public health systems to deliver the essential services of public health. Electronic data submission will be used when state health departments complete the public health assessment.

The extension will provide additional time for state public health agencies to undertake the assessment. Some states have sought to include mention of the assessment in legislation or regulations and are planning to respond to the assessment in the upcoming year. The focus on bioterrorism and other emerging issues diverted resources and attention from immediate use of the assessment since its national release in 2002. A two-year extension will provide additional needed time.

The estimated annualized burden for each extension year is 105 hours.

No. of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
7	1	15	105
Total .....	.....	.....	105

Dated: December 22, 2004.

B. Kathy Skipper,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28618 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Youth Violence Prevention through Community-Level Change

Announcement Type: New.

Funding Opportunity Number: CE05-020.

Catalog of Federal Domestic Assistance Number: 93.136.

Key Dates:

Letter of Intent Deadline: January 31, 2005.

Application Deadline: March 30, 2005.

I. Funding Opportunity Description

Authority: This program is authorized under both section 391 (a) and 301 (a) of the Public Health Service Act, 42 U.S.C. section 280b (a).

Background: Youth violence has been linked to a variety of factors, including individual, family, community, and societal characteristics. While much research has been conducted on

interventions with individuals and families, fewer interventions have focused on variables at the broader community level.

Purpose: The purpose of the program is to announce the availability of fiscal year (FY) 2005 funds for a cooperative agreement to assess the efficacy or effectiveness of interventions designed to change community characteristics and social processes to reduce rates of youth violence perpetration and victimization. This program addresses the "Healthy People 2010" focus area(s) of Injury and Violence Prevention.

Measurable outcomes of the program will be in alignment with the following performance goal(s) for the National Center for Injury Prevention and Control (NCIPC): Conduct a targeted program of research to reduce injury-related death and disability.

Special Guidelines for Technical Assistance: Conference Call: Technical assistance will be available for potential applicants on one conference call. The call for eligible applicants will be held on (January 20, 2005) from 2:30 p.m. to 4 p.m. (Eastern Time). The conference can be accessed by calling 888-528-9061 and entering access code 21415.

The purpose of the conference call is to help potential applicants:

1. Understand the Request for Application Process for the RFA # CE05-020 Youth Violence through Community-Level Change.
2. Understand the scope and intent of the RFA # CE05-020 Youth Violence Prevention through Community-Level Change.
3. Become familiar with the Public Health Services funding policies and application and review procedures. Participation in this conference call is not mandatory. At the time of the call, if you have problems accessing the conference call, please call 404-639-7550 for assistance.

Research Objectives: There are a number of characteristics of communities that increase the probability of youth violence. Crime and violence tend to be high in areas in which at least 20 percent of the residents are poor (Lamison-White, 1996). These areas are often characterized by high concentrations of poverty and unemployment, high levels of residential instability, family disruption, crowded housing, drug-distribution networks, and low community participation (Sampson & Lauritsen, 1994). These areas also tend to have high rates of school dropouts, high rates of substance abuse and teenage pregnancy, and a disproportionate number of households

headed by women (Eller, 1996; Proctor & Dalaker, 2002; Reiss & Roth, 1993).

In addition to their demographic characteristics, economically poor neighborhoods differ from more affluent neighborhoods in a number of ways. Poor neighborhoods tend to be characterized by disorganization or a lack of neighborhood cohesion, and as a result, frequently lack effective social controls (Elliot *et al.*, 1996; Sampson, Raudenbush & Earls, 1997). Factors such as high levels of transiency make it difficult for individuals to establish common values and norms, and to develop informal support networks. As a result, people living in such neighborhoods often experience a sense of social isolation and exhibit lower levels of attachment to the community. High levels of social disorganization also limit the ability of community residents to supervise and control adolescent peer groups, especially gangs (Sampson & Lauritsen, 1994).

Research funded under this announcement is expected to further our understanding of how community-level interventions can reduce violence. A clear distinction is made here between community-based interventions, which are programs that are implemented in the community and/or by a community-based organization, from community-level interventions, which target community-level factors such as those described above (e.g., poverty, social cohesion, residential instability, neighborhood disorganization, etc.). Recipients are expected to implement and conduct an evaluation of an intervention that targets modifiable community-level variables that have been shown to increase the risk of youth violence and/or enhance the protective factors that decrease the risk of youth violence.

Priority will be given to the evaluation of primary prevention interventions and programs that focus on the social and economic environment (relationships among people and settings) and/or the physical environment, over those that focus on criminal justice responses (e.g., community policing, arrest strategies). These include:

- Strategies to increase social integration and cohesion by increasing community participation as well as formal and informal social support.
- Strategies to improve the physical and social characteristics of neighborhoods (e.g., through environmental design changes).
- Strategies to improve financial, housing, and/or employment issues in impoverished areas.

- Efforts to deconcentrate areas with high rates of poverty and violence.
- Strategies to increase formal and/or informal supervision of youth (e.g., access to after school programs).

- Strategies to reduce community density and availability of alcohol and drugs.

- Strategies to improve family stability by changing community characteristics (e.g., increasing the presence of or access to family support services; increasing neighborhood or civic support to facilitate family cohesion).
- Strategies focusing on increasing communities' investment in schools and commitment to education (e.g., school-community partnerships; policies or incentives to increase school attendance and graduation rates).

The proposed research is expected to detail one or more specific interventions for community-level variables, rather than propose a process for determining which interventions are appropriate for the chosen community. This program is intended to assess the effects of a community-level intervention alone, not as part of a larger multi-level intervention trial (a multi-level intervention trial is defined here as one that addresses the effects of community-level factors separately, and in combination with one or more components that address individual-level or family-level factors).

Research funded under this announcement is expected to adhere to high scientific standards, and to incorporate the following elements:

- Interventions and measures appropriate to the developmental level(s) and cultural/ethnic backgrounds of the population of interest.
- Interventions that are theoretically justified (*i.e.*, include a conceptual model or theory of change, with proposed mediators and moderators, for how the intervention will produce the intended reductions in youth violence), and supported with epidemiologic, methodologic, and behavioral research.
- Stringent and rigorous evaluation designs, namely experimental and quasi-experimental designs with appropriate baseline/pre-intervention data, post-intervention data, and at least one follow-up data collection point; data from at least one comparison or control community; and data collected from multiple sources.
- Robust evaluation designs that collect and analyze process data (e.g., intervention fidelity and program exposure) and outcome data associated with the intervention using measures with documented validity and/or reliability. Outcomes and impacts

appropriate for this program include those that are measured at the neighborhood or community level and that focus on risk and protective factors specific to that level of intervention. Examples include: police records of neighborhood or community arrests for violent crimes, violent school incidents (aggregated to the school or system level), violent injury-related hospital or emergency department data aggregated by neighborhood or community, or intake rates for juvenile detention facilities.

- Evaluation designs that make use of multiple sources of data (where possible) to improve validity and reliability on each outcome selected.

- Evaluation designs that collect information on intervention processes, outcomes, mediators that lead to change in those outcomes and data that document the economic costs of the intervention from the societal and programmatic perspectives (*e.g.*, cost to train implementers, implementation costs, and costs borne by participants). Measures are expected to have documented validity and reliability whenever possible. Outcomes are expected to be assessed at the appropriate level of intervention.

- Data analytic plans that are appropriate to the intervention, research design and hypotheses, data collection measures, and project period, and that anticipate and evaluate the effects of threats to the internal and external validity of the specified research design.

Rigorous evaluations are needed to determine the effectiveness of interventions, programs, and policies addressing the prevention of violence. Experimental designs are strongly encouraged. However, NCIPC will consider other evaluation designs, if justified, as required by the needs and constraints in a particular setting.

For effective interventions, it is possible to do cost-effectiveness studies. To be comparable to other cost effectiveness studies, they should follow the guidelines in the following references:

Gold MR, Siegel JE, Russell LB, Weinstein MC. Cost-effectiveness in Health and Medicine. New York: Oxford University Press, 1996.

Haddix AC, Teutsch SM, Corso PS. Prevention Effectiveness: A Guide to Decision Analysis and Economic Evaluation. Second Edition. New York: Oxford University Press, 2003.

Activities: Awardee activities for this program are as follows:

- Establish goals and objectives that are realistic, measurable, and time-oriented for all phases of the project.

- Develop a research protocol for Institutional Review Board (IRB) for review and approval by all cooperating institutions participating in the research project.

- Design and develop intervention components, data collection instruments, implementation and evaluation protocols, and data management procedures.

- Pilot test research instruments for data collection.

- Collect and compile process and outcome data. Develop a protocol/manual documenting the intervention and the manner in which it was implemented, including any information on activities occurring prior to the start of the intervention, such as stakeholder meetings, collaborative building, or focus groups.

- Collect data on the economic costs of program implementation for use in economic evaluations.

- Prepare data for analysis and publication.

- Analyze data and disseminate findings through peer-reviewed journals and presentations.

- Conduct one reverse site visit to meet with CDC staff in Atlanta on an annual basis.

- Complete all required reports as specified under Section VI.3 Reporting. In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC Activities for this program are as follows:

- Provide scientific and programmatic consultation. CDC will collaborate with project staff on decision-analyses, programmatic issues, and dissemination of the study results in publications and presentations.

- Assist in the development of a research protocol for IRB review by all cooperating institutions participating in the research project. The CDC IRB will review and approve the protocol initially and on at least an annual basis until the research project is finished.

- CDC staff will monitor and review scientific and operational accomplishments of the project through conference calls, site visits, and review of technical reports.

II. Award Information

Type of Award: Cooperative Agreement.

CDC involvement in this program is listed in the Activities Section above.

Mechanism of Support: U49.

Fiscal Year Funds: 2005.

Approximate Total Funding: \$1,200,000 (This amount is an estimate, and is subject to availability of funds.)

Approximate Number of Awards: Two.

Approximate Average Award: \$600,000 (This amount is for the first twelve month budget period and includes both direct and indirect costs. Approximately \$4,800,000 total is available over the entire four years of the project period.)

Floor of Award Range: None.

Ceiling of Award Range: \$600,000 (This ceiling is for the first twelve month budget period and includes both indirect and direct costs.)

Anticipated Award Date: September 1, 2005.

Budget Period Length: Twelve months.

Project Period Length: Four years.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

III.1. Eligible Applicants

Applications may be submitted by public and private nonprofit and for profit organizations and by governments and their agencies, such as:

- Public nonprofit organizations.
- Private nonprofit organizations.
- For profit organizations.
- Small, minority, women-owned businesses.
- Universities.
- Colleges.
- Research institutions.
- Hospitals.
- Community-based organizations.
- Faith-based organizations.
- Federally recognized Indian tribal governments.
- Indian tribes.
- Indian tribal organizations.
- State and local governments or their

Bona Fide Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau).

- Political subdivisions of States (in consultation with States).

A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If you are applying as a bona fide agent of a state or local

government, you must provide a letter from the state or local government as documentation of your status. Place this documentation behind the first page of your application form.

III.2. Cost Sharing or Matching

Matching funds are not required for this program.

III.3. Other

If you request a funding amount greater than the ceiling of the award range, which includes both direct and indirect costs, your application will be considered non-responsive, and will not be entered into the review process. You will be notified that your application did not meet the submission requirements.

Special Requirements: If your application is incomplete or non-responsive to the requirements listed in this section, it will not be entered into the review process. You will be notified that your application did not meet submission requirements.

- Demonstrated experience on the applicant's project team in conducting, evaluating, and publishing violence prevention research in peer-reviewed journals.

- Effective and well-defined working relationships within the performing organization and with outside entities expected to participate in the proposed research that will ensure implementation of the proposed activities, as evidenced by letters of support from the performing organization and outside entities.

- The overall match between the applicant's proposed research and the program priorities as described under the heading, "Research Objectives".

- Late applications will be considered non-responsive. See section "IV.3. Submission Dates and Times" for more information on deadlines.

- Principal Investigators (PIs) are encouraged to submit only one proposal in response to this program announcement. With few exceptions (e.g., research issues needing immediate public health attention) only one application per PI will be funded under this announcement.

- **Note:** Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant, or loan.

Individuals Eligible to Become Principal Investigators: Principal Investigator qualifications are as follows:

- A principal investigator who has documented prior training and experience in conducting efficacy and effectiveness trials as evidenced by peer-reviewed publications of such studies, or current or previous research grants for efficacy or effectiveness trials.

- A principal investigator who has conducted violence prevention research, published the findings in peer-review journals, and has the specific authority and responsibility to carry out the proposed research.

Any individual with the skills, knowledge, and resources necessary to carry out the proposed injury research is invited to work with their institution to develop an application for support. Individuals from underrepresented racial and ethnic groups as well as individuals with disabilities are always encouraged to apply for CDC programs.

IV. Application and Submission Information

IV.1. Address to Request Application Package

To apply for this funding opportunity, use application form PHS 398 (OMB number 0925-0001 rev. 5/2001). Forms and instructions are available in an interactive format on the CDC Web site, at the following Internet address: <http://www.cdc.gov/od/pgo/forninfo.htm>.

Forms and instructions are also available in an interactive format on the National Institutes of Health (NIH) Web site at the following Internet address: <http://grants.nih.gov/grants/funding/phs398/phs398.html>.

If you do not have access to the Internet, or if you have difficulty accessing the forms on-line, you may contact the CDC Procurement and Grants Office Technical Information Management Section (PGO-TIM) staff at: 770-488-2700. Application forms can be mailed to you.

IV.2. Content and Form of Application Submission

Letter of Intent (LOI): CDC requests that you send a LOI if you intend to apply for this program. Although the LOI is not required, not binding, and does not enter into the review of your subsequent application, your LOI will be used to gauge the level of interest in this program, and to allow CDC to plan the application review. Your LOI must be written in the following format:

- **Maximum number of pages:** Two.
- **Font size:** Twelve point unredacted.
- **Paper size:** Eight and a half by eleven inches.
- **Page margin size:** One inch.
- **Single-spaced.**

- Printed only on one side of page.
- Written in English, avoid jargon.

Your LOI must contain the following information:

- Descriptive title of the proposed research.
- Name, address, E-mail address, and telephone number of the Principal Investigator.
- Names of other key personnel.
- Participating institutions.
- Number and title of this Program Announcement (PA).
- A brief description of the proposed intervention and evaluation plan.

Application: Follow the PHS 398 application instructions for content and formatting of your application. If the instructions in this announcement differ in any way from the PHS 398 instructions, follow the instructions in this announcement. For further assistance with the PHS 398 application form, contact PGO-TIM staff at 770-488-2700, or contact GrantsInfo, Telephone (301) 435-0714, E-mail: GrantsInfo@nih.gov.

You are required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. Your DUNS number must be entered on line 11 of the facing page of the PHS 398 application form. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access <http://www.dunandbradstreet.com> or call 1-866-705-5711.

For more information, see the CDC Web site at: <http://www.cdc.gov/od/pgo/funding/pubcomm.htm>.

This announcement uses the non-modular budgeting format. Provide a detailed budget for each activity undertaken, with accompanying justification of all operating expenses that is consistent with the stated objectives and planned activities of the project.

In addition to the instructions provided in the PHS 398 for writing the Description on page 2 of the PHS 398 form, structure the Description using the following components: (1) Statement of the problem, (2) purpose of the proposed research, (3) methods, including study population, data sources and any statistical analyses to be performed, and (4) implications for prevention.

The Description (abstract) should answer the following questions:

- Does the Description state the hypothesis?
- Does the Description describe the objectives and specific aims?

- Does the Description state the importance of the research and how it is innovative?

- Does the Description outline the methods that will use to accomplish the goals?

Is the language of the Description simple and easy to understand for a broad audience?

You must include a research plan with your application. Your research plan should address activities to be conducted over the entire project period. Please follow the content requirements below in developing your research plan instead of those listed for the Research Plan in the PHS 398.

The research plan should consist of the following information:

1. *Purpose of the Proposed Research:* Describe the goals and objectives the proposal is designed to achieve in the short and long term. Specific research questions, hypotheses, and implications for prevention should also be included.

2. *Program Participants:* Describe the demographic and geographic characteristics of the community and/or neighborhood targeted by the intervention. This section should include incidence, prevalence, morbidity, and/or mortality rates associated with youth violence within that community. In addition, the proposal should provide evidence that the recipient (or collaborating partner) has access to the target community, and that the participation by the target community in the intervention will be adequate to produce the intended outcomes.

3. *Intervention:* Describe the proposed strategies or components of the intervention and the plan for implementing the intervention. Proposals should explicate the theoretical and empirical justification for the potential effectiveness of the intervention for reducing youth violence in the target community. This should include discussion of the modifiable risk and protective factors that will be influenced by the intervention of interest. The proposal should describe the location or setting in which the intervention component(s) will occur, and describe the relevance of this setting to the strategy and desired outcomes. The proposal should also describe how intervention fidelity will be monitored and measured.

4. *Methods:* Describe the proposed evaluation design, data sources, methods and analysis plan for assessing the efficacy or effectiveness and/or for conducting an economic evaluation. The specific type of evaluation method chosen should reflect the nature of the intervention, feasibility, and ethical

considerations. Potential threats to the validity of the study should be described along with how such threats will be recognized and addressed. The status of all necessary measurement instruments should be described. If any materials are not extant, the methods and time frame for measure development, pilot testing, and validation should be given. For data collected from archival records (e.g., hospital records, police records, etc.) the proposal should discuss issues of accessibility, reliability, and validity of those data.

5. *Project Management:* Provide evidence of the expertise, capacity, and community support necessary to successfully implement and evaluate the intervention to reduce community indicators of youth violence. Existing and proposed positions for the project should be described by job title, function, general duties, level of effort and allocation of time. Management operation principles, structure, and organization should also be noted.

6. *Collaborative Efforts:* List and describe any current or proposed collaboration with government, health, community-or faith-based organizations, minority organizations, and/or other researchers and academic institutions. Include letters of support and memoranda of understanding that specify the nature of past, present, and proposed collaborations, and the products/services/activities that will be provided by and to the applicant.

The research plan should be no more than 25 pages (eight and a half by eleven inches in size), single-spaced, printed on one side only, with one-inch margins on all sides, and unredacted 12-point font.

Additional requirements that may require you to submit additional documentation with your application are listed in section "VI.2. Administrative and National Policy Requirements." For additional help in preparing your application, please see the "frequently asked questions" section on the NCIPC Web page at: <http://www.cdc.gov/ncipc/res-ops/2004pas.htm>.

IV.3. Submission Dates and Times

LOI Deadline Date: January 31, 2005. CDC requests that you send a LOI if you intend to apply for this program. Although the LOI is not required, not binding, and does not enter into the review of your subsequent application, the LOI will be used to gauge the level of interest in this program, and to allow CDC to plan the application review.

Application Deadline Date: March 30, 2005.

Explanation of Deadlines:

Applications must be received in the CDC Procurement and Grants Office by 4 p.m. Eastern Time on the deadline date. If you submit your application by the United States Postal Service or commercial delivery service, you must ensure that the carrier will be able to guarantee delivery by the closing date and time. If CDC receives your submission after closing due to: (1) carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or (2) significant weather delays or natural disasters, you will be given the opportunity to submit documentation of the carrier's guarantee. If the documentation verifies a carrier problem, CDC will consider the submission as having been received by the deadline.

This announcement is the definitive guide on LOI and application content, submission address, and deadline. It supersedes information provided in the application instructions. If your application is not received in the CDC Procurement and Grants office by the deadline above, it will not be eligible for review, and will be discarded. You will be notified that you did not meet the submission requirements. CDC will not notify you upon receipt of your submission. If you have a question about the receipt of your LOI or application, first contact your courier. If you still have a question, contact the PGO-TIM staff at: 770-488-2700. Before calling, please wait two to three days after the submission deadline. This will allow time for submissions to be processed and logged.

IV.4. Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

IV.5. Funding Restrictions

Restrictions, which must be taken into account while writing your budget, are as follows:

- Funds relating to the conduct of research will not be released until the appropriate assurances and IRB approvals are in place.

If you are requesting indirect costs in your budget, you must include a copy of your indirect cost rate agreement. If your indirect cost rate is a provisional rate, the agreement should be less than 12 months of age.

IV.6. Other Submission Requirements

LOI Submission Address: Submit your LOI by express mail, delivery service, fax, or E-mail to:

Address for Express Mail or Delivery Service: NCIPC Extramural Resources Team, CDC, National Center for Injury Prevention and Control, 2945 Flowers Road, Yale Building, Room 2054, Atlanta, Georgia 30341.

Address for U.S. Postal Service Mail: NCIPC Extramural Resources Team, CDC, National Center for Injury Prevention and Control, 4770 Buford Hwy, NE., Mailstop K-62, Atlanta, GA 30341, Telephone: 770-488-4037, Fax: 770-488-1662, E-mail: cipert@cdc.gov.

Application Submission Address: Submit the original and one hard copy of your application by mail or express delivery service to: Technical Information Management—CE05-020, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341.

At the time of submission, four additional copies of the application, and four copies of all appendices must be sent to:

Address for Express Mail or Delivery Service: NCIPC Extramural Resources Team, CDC, National Center for Injury Prevention and Control, 2945 Flowers Road, Yale Building, Room 2054, Atlanta, Georgia 30341.

Address for U.S. Postal Service Mail: NCIPC Extramural Resources Team, CDC, National Center for Injury Prevention and Control, 4770 Buford Hwy, NE., Mailstop K-62, Atlanta, GA 30341.

Applications may not be submitted electronically at this time.

V. Application Review Information

V.1. Criteria

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. Measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures must be objective and quantitative, and must measure the intended outcome. These measures of effectiveness must be submitted with the application and will be an element of evaluation.

The goals of CDC-supported research are to advance the understanding of biological systems, improve the control and prevention of disease and injury, and enhance health. In the written comments, reviewers will be asked to evaluate the application in order to judge the likelihood that the proposed research will have a substantial impact on the pursuit of these goals.

The scientific review group will address and consider each of the

following criteria equally in assigning the application's overall score, weighting them as appropriate for each application. The application does not need to be strong in all categories to be judged likely to have major scientific impact and thus deserve a high priority score. For example, an investigator may propose to carry out important work that by its nature is not innovative, but is essential to move a field forward.

The review criteria are as follows:

Significance: Does this study address an important problem? If the aims of the application are achieved, how will scientific knowledge be advanced? What will be the effect of these studies on the concepts or methods that drive this field?

Approach: Are the conceptual framework, design, methods, and analyses adequately developed, well-integrated, and appropriate to the aims of the project? Does the applicant acknowledge potential problem areas and consider alternative tactics? Is the selection of a research design justified, and is the research design appropriate to answer the research question?

Innovation: Does the project employ novel concepts, approaches or methods? Are the aims original and innovative? Does the project challenge existing paradigms or develop new methodologies or technologies?

Investigator: Is the investigator appropriately trained and well suited to carry out this work? Is the work proposed appropriate to the experience level of the principal investigator and other researchers (if any)?

Environment: Does the scientific environment in which the work will be done contribute to the probability of success? Does the proposed research take advantage of unique features of the scientific environment or employ useful collaborative arrangements? Is there evidence of institutional support? If collaborations are being proposed, are the partners and their skills and expertise well described? Can proposed collaborations reasonably be expected to improve the quality of the implementation and evaluation of the intervention?

Additional Review Criteria: In addition to the above criteria, the following items will be considered in the determination of scientific merit and priority score:

Intervention: Is the potential effectiveness of the proposed intervention within the target community theoretically justified and supported with epidemiologic, methodological, and behavioral research? How feasible is the implementation of the intervention as

proposed? Can the intervention reasonably be predicted to produce the expected reductions in youth violence? Is the setting of implementation appropriate?

Protection of Human Subjects From Research Risks: Does the application adequately address the requirements of title 45 CFR part 46 for the protection of human subjects? This will not be scored; however, an application can be disapproved if the research risks are sufficiently serious and protection against risks is so inadequate as to make the entire application unacceptable.

Inclusion of Women and Minorities in Research: Does the application adequately address the CDC Policy requirements regarding the inclusion of women, ethnic, and racial groups in the proposed research? This includes: (1) The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation; (2) the proposed justification when representation is limited or absent; (3) a statement as to whether the design of the study is adequate to measure differences when warranted; and (4) a statement as to whether the plans for recruitment and outreach for study participants include the process of establishing partnerships with community(ies) and recognition of mutual benefits.

Inclusion of children as participants in research involving human subjects: The NIH maintains a policy that children (*i.e.*, individuals under the age of 21) must be included in all human subjects research, conducted or supported by the NIH, unless there are scientific and ethical reasons not to include them. This policy applies to all initial (Type 1) applications submitted for receipt dates after October 1, 1998. NCIPC has adopted this policy for this announcement.

All investigators proposing research involving human subjects should read the "NIH Policy and Guidelines" on the inclusion of children as participants in research involving human subjects that is available at: <http://grants.nih.gov/grants/funding/children/children.htm>.

Budget: The reasonableness of the proposed budget and the requested period of support in relation to the proposed research. The budget is not scored during the primary review.

V.2. Review and Selection Process

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO), and for responsiveness by the NCIPC. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance

through the review process. Applicants will be notified that their application did not meet submission requirements. Applicants will be notified 45 days prior to the award date regarding their application status.

Applications that are complete and responsive to the announcement will be evaluated for scientific and technical merit by an appropriate peer review group or charter study section convened by the NCIPC in accordance with the review criteria listed above. As part of the initial merit review, all applications may:

- Undergo a process in which only those applications deemed to have the highest scientific merit by the review group, generally the top half of the applications under review, will be discussed and assigned a priority score.

- Receive a written critique.
- Applications deemed to have the highest scientific merit will receive a second programmatic level review by the Science and Program Review Subcommittee (SPRS) of the Advisory Committee for Injury Prevention and Control (ACIPC).

Applications that are complete and responsive may be subjected to a preliminary evaluation (streamline review) by an external peer review committee, the NCIPC Initial Review Group (IRG), to determine if the application is of sufficient technical and scientific merit to warrant further review by the IRG. CDC will withdraw from further consideration applications judged to be noncompetitive and promptly notify the principal investigator/program director and the official signing for the applicant organization. Those applications judged to be competitive will be further evaluated by a dual review process.

All awards will be determined by the Director of the NCIPC based on priority scores assigned to applications by the primary review committee IRG, recommendations by the secondary review committee of the Science and Program Review Subcommittee of the Advisory Committee for Injury Prevention and Control (ACIPC), consultation with NCIPC senior staff, and the availability of funds.

The primary review will be an external peer review conducted by the IRG. All applications will be reviewed for scientific merit using current NIH criteria (a scoring system of 100–500 points) to evaluate the methods and scientific quality of the application.

The secondary review will be conducted by the Science and Program Review Subcommittee (SPRS) of the ACIPC. The external ACIPC Federal agency experts will be invited to attend

the secondary review and will receive modified briefing books (*i.e.*, abstracts, strengths and weaknesses from summary statements, and project officer's briefing materials). ACIPC Federal agency experts will be encouraged to participate in deliberations when applications address overlapping areas of research interest, so that unwarranted duplication in federally-funded research can be avoided and special subject area expertise can be shared. The NCIPC Division Associate Directors for Science (ADS) or their designees will attend the secondary review in a similar capacity as the ACIPC Federal agency experts to assure that research priorities of the announcement are understood and to provide background regarding current research activities. Only SPRS members will vote on funding recommendations, and their recommendations will be carried to the entire ACIPC for voting by the ACIPC members in closed session. If any further review is needed by the ACIPC, regarding the recommendations of the SPRS, the factors considered will be the same as those considered by the SPRS.

The secondary review committee's responsibility is to develop funding recommendations for the NCIPC Director based on the results of the primary review, the relevance and balance of proposed research relative to the NCIPC programs and priorities, and to assure that unwarranted duplication of federally-funded research does not occur. The secondary review committee has the latitude to recommend to the NCIPC Director, to reach over better ranked proposals in order to assure maximal impact and balance of proposed research. The factors to be considered will include:

- a. The results of the primary review including the application's priority score as the primary factor in the selection process.
- b. The relevance and balance of proposed research relative to the NCIPC programs and priorities.
- c. The significance of the proposed activities in relation to the priorities and objectives stated in "Healthy People 2010," the Institute of Medicine report, "Reducing the Burden of Injury," and the "CDC Injury Research Agenda."
- d. Budgetary considerations.

Award Criteria: Criteria that will be used to make award decisions during the programmatic review include:

- Scientific merit (as determined by peer review).
- Availability of funds.
- Programmatic priorities.
- Geographic diversity.
- Racial/ethnic diversity.

- Balance of intervention approaches and strategies.
- Consistency with research priorities in CDC's Injury Research Agenda.
- Availability of funds within categories of violence and injury funding streams.

V.3. Anticipated Announcement and Award Dates

September 1, 2005.

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Award (NOA) from the CDC Procurement and Grants Office. The NOA shall be the only binding, authorizing document between the recipient and CDC. The NOA will be signed by an authorized Grants Management Officer, and mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

VI.2. Administrative and National Policy Requirements

45 CFR part 74 and part 92

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>.

The following additional requirements apply to this project:

- AR-1 Human Subjects Requirements.
 - AR-2 Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research.
 - AR-8 Public Health System Reporting Requirements.
 - AR-9 Paperwork Reduction Act Requirements.
 - AR-10 Smoke-Free Workplace Requirements.
 - AR-11 Healthy People 2010.
 - AR-12 Lobbying Restrictions.
 - AR-13 Prohibition on Use of CDC Funds for Certain Gun Control Activities.
 - AR-14 Accounting System Requirements.
 - AR-15 Proof of Non-Profit Status.
 - AR-21 Small, Minority, and Women-Owned Business.
 - AR-22 Research Integrity.
 - AR-23 States and Faith-Based Organizations.
 - AR-24 Health Insurance Portability and Accountability Act Requirements.
 - AR-25 Release and Sharing of Data.
- Starting with the December 1, 2004 receipt date, all "Requests for

Applications (RFA)/Program Announcements (PA)" soliciting proposals for individual research projects of \$500,000 or more in total (direct and indirect) costs per year require the applicant to include a plan describing how the final research data will be shared/released or explain why data sharing is not possible. Details on data sharing and release, including information on the timeliness of the data and the name of the project data steward, should be included in a brief paragraph immediately following the Research Plan Section of the PHS 398 form. References to data sharing and release may also be appropriate in other sections of the application (*e.g.* background and significance, or human subjects requirements). The content of the data sharing and release plan will vary, depending on the data being collected and how the investigator is planning to share the data. The data sharing and release plan will not count towards the application page limit and will not factor into the determining scientific merit or the priority scoring. Investigators should seek guidance from their institutions on issues related to institutional policies, and local IRB rules, as well as local, state and federal laws and regulations, including the Privacy Rule.

Further detail on the requirements for addressing data sharing in applications for NCIPC funding may be obtained by contacting NCIPC program staff or by visiting the NCIPC Internet Web site at: http://www.cdc.gov/ncipc/osp/sharing_policy.htm.

VI.3. Reporting

You must provide CDC with an original, plus two hard copies of the following reports:

1. Interim progress report, (use form PHS 2590, OMB Number 0925-0001, rev. 5/2001 as posted on the CDC Web site) no less than 90 days before the end of the budget period. The progress report will serve as your non-competing continuation application, and must contain the following elements:

- a. Current Budget Period Activities Objectives.
- b. Current Budget Period Financial Progress.
- c. New Budget Period Program Proposed Activity Objectives.
- d. Detailed Line-Item Budget and Justification.
- e. Measures of Effectiveness.
- f. Additional Requested Information.

2. Financial status report, no more than 90 days after the end of the budget period.

3. Final financial and performance reports, no more than 90 days after the end of the project period.

These reports must be mailed to the Grants Management Specialist listed in the "Agency Contacts" section of this announcement.

VII. Agency Contacts

We encourage inquiries concerning this announcement.

For general questions, contact:

Technical Information Management Section, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: 770-488-2700.

For scientific/research issues, contact: Charlene Baker, PhD, Centers for Disease Control and Prevention, 4770 Buford Highway, NE, MS K-60, Atlanta, GA 30341, Telephone: 770-488-1737, E-mail: asu6@cdc.gov.

For questions about peer review, contact: Gwendolyn Cattledge, PhD, Scientific Review Administrator, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop K-02, Telephone: 770-488-1430, E-mail: gxc8@cdc.gov.

For financial, grants management, or budget assistance, contact: James Masone, Grants Management Specialist, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, E-mail: JMasone@cdc.gov.

VIII. Other Information

This and other CDC funding opportunity announcements can be found on the CDC Web site, Internet address: <http://www.cdc.gov>. Click on "Funding" then "Grants and Cooperative Agreements."

Dated: December 23, 2004.

William P. Nichols,

Acting Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28619 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Advisory Council for the Elimination of Tuberculosis Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), the Centers for Disease Control and Prevention (CDC) announces the following council meeting.

Name: Advisory Council for the Elimination of Tuberculosis (ACET).

Times and Dates: 8:30 a.m.-5 p.m., February 16, 2005; 8:30 a.m.-12 p.m., February 17, 2005.

Place: Corporate Square, Building 8, 1st Floor Conference Room, Atlanta, Georgia 30333. Telephone (404) 639-8008.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 100 people.

Purpose: This council advises and makes recommendations to the Secretary, Department of Health and Human Services; the Assistant Secretary for Health; and the Director, CDC, regarding the elimination of tuberculosis (TB). Specifically, the Council makes recommendations regarding policies, strategies, objectives, and priorities; addresses the development and application of new technologies; and reviews the extent to which progress has been made toward eliminating TB.

Matters to be Discussed: Agenda items include issues pertaining to Global TB epidemiology and public health response, nucleic acid amplification testing (NAAT), and other TB related topics.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Paulette Ford-Knights, National Center for HIV, STD, and TB Prevention, 1600 Clifton Road, NE., M/S E-07, Atlanta, Georgia 30333, telephone (404) 639-8008.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: December 20, 2004.

B. Kathy Skipper,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04-28615 Filed 12-29-04; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-2490-N]

CLIA Program; Continued Approval of the American Association of Blood Banks for Deeming Authority

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the re-approval of the American Association of Blood Banks (AABB) as an accrediting organization for clinical laboratories under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) program. The initial exemption

was published in the **Federal Register** on July 21, 1995. We have determined that the accreditation process of this organization provides reasonable assurance that a laboratory accredited by it meets the conditions required by Federal law and regulations. Consequently, laboratories that are voluntarily accredited by the AABB and continue to meet the AABB requirements will be deemed to meet the CLIA condition-level requirements for laboratories and therefore are not subject to routine inspection by State survey agencies to determine their compliance with Federal requirements. They are, however, subject to validation and complaint investigation surveys conducted by us or our designee.

EFFECTIVE DATE: This notice is effective for the period July 21, 2001 through July 21, 2007.

FOR FURTHER INFORMATION CONTACT: Daralyn Hassan, (410) 786-9360.

SUPPLEMENTARY INFORMATION:

I. Background and Legislative Authority

On October 31, 1988, the Congress enacted the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Pub. L. 100-578. CLIA replaced in its entirety section 353(e)(2) of the Public Health Service Act, as enacted by the Clinical Laboratories Improvement Act of 1967. We issued a final rule (57 FR 33992) implementing the accreditation provisions of CLIA on July 31, 1992. Under the CLIA program, we may approve a private, nonprofit organization as an approved accreditation organization to accredit clinical laboratories if the organization meets certain requirements. An organization's requirements for accredited laboratories must be equal to, or more stringent than, the applicable CLIA program requirements in 42 CFR part 493 (Laboratory Requirements).

The regulations listed in subpart E of part 493 (Accreditation by a Private, Nonprofit Accreditation Organization or Exemption Under an Approved State Laboratory Program) specify the requirements an organization must meet to be an approved accreditation organization. We approve an accreditation organization for a period not to exceed 6 years.

In general, the approved accreditation organization must:

- Use inspectors qualified to evaluate laboratory performance and agree to inspect laboratories with the frequency determined by us.
- Apply standards and criteria that are equal to or more stringent than those

condition-level requirements established by us.

- Provide reasonable assurance that its accredited laboratories continually meet these standards and criteria.
- Provide us with the name of any laboratory that has had its accreditation denied, suspended, withdrawn, limited, or revoked within 30 days of the action taken.
- Notify us at least 30 days before implementing any proposed change in its standards.
- If we withdraw our approval, notify the accredited laboratories of the withdrawal within 10 days of the withdrawal.

CLIA requires CMS to perform an annual evaluation by inspecting a sufficient number of laboratories accredited by an approved accreditation organization as well as by any other means that we determine appropriate.

II. Notice of Approval of AABB as an Accrediting Organization

In this notice, we approve AABB as an organization that may continue to accredit laboratories for purposes of establishing their compliance with CLIA requirements. We have examined the AABB application and all subsequent submissions to determine equivalency with our requirements under subpart E of part 493 that an accreditation organization must meet to be approved under CLIA. We have determined that AABB complied with the applicable CLIA requirements and grant AABB approval as an accreditation organization under subpart E, through July 21, 2007, for the following specialties and subspecialty areas:

- Immunohematology.
- General immunology.
- Hematology.
- Routine chemistry.
- Toxicology.

As a result of this determination, any laboratory that is accredited by the AABB during the effective time period for an approved specialty or subspecialty listed above is deemed to meet the CLIA requirements for laboratories found in part 493 of our regulations for that specialty or subspecialty and, therefore, is not subject to routine inspection by a State survey agency to determine its compliance with CLIA requirements. The accredited laboratory, however, is subject to validation and complaint investigation surveys performed by us, or by any other validly authorized agent.

III. Evaluation of the AABB Request for Approval as an Accreditation Organization under CLIA

The AABB formally applied to us for approval as an accreditation

organization under CLIA for the specialties of immunohematology, hematology, general immunology, and the subspecialties of routine chemistry and toxicology. We evaluated the AABB application to determine compliance with our implementing and enforcement regulations, and the deeming/exemption requirements of the CLIA rules.

We evaluated the application to verify assurance of the AABB's compliance with the following subparts of part 493:

- Subpart H, Participation in Proficiency Testing for Laboratories Performing Nonwaived Testing.
- Subpart J, Facility Administration for Nonwaived Testing.
- Subpart K, Quality System for Nonwaived Testing.
- Subpart M, Personnel for Nonwaived Testing.
- Subpart Q, Inspections.
- Subpart R, Enforcement Procedures.

The AABB meets the requirements for subparts H, J, K, M, Q, and R.

We also verified the organization's assurance that it requires the laboratories it accredits to be, and that the organization is, in compliance with the following subparts of part 493 as explained below:

Subpart E—Accreditation by a Private, Nonprofit Accreditation Organization or Exemption Under an Approved State Laboratory Program

The AABB submitted a list of all specialties and subspecialties that it would accredit; a comparison of individual accreditation and condition-level requirements; a description of its inspection process; proficiency testing (PT) monitoring process; its data management and analysis system; a listing of the size, composition, education and experience of its inspection teams; its investigative and complaint response procedures; its notification agreements with CMS; its removal or withdrawal of laboratory accreditation procedures; its current list of accredited laboratories; and its announced or unannounced inspection process.

The AABB has additional requirements pertaining to waived testing. The AABB will routinely inspect laboratories that perform waived tests that are normally associated with blood centers and transfusion services. These laboratories will be inspected for good manufacturing practices and to verify that tests are performed according to manufacturer's instructions. In addition, for waived testing, the AABB requires that there be appropriately qualified personnel that is, director, supervisor, and testing personnel. Section 493.15 of the CLIA regulations

requires only that a laboratory follow manufacturer's instructions and does not require routine inspections of waived testing. Thus, the requirements of the AABB are more stringent than the requirements of the CLIA regulations.

We have determined that the AABB has complied with the requirements under subpart E of part 493 and that the requirements of the AABB are equal to or more stringent than the condition-level requirements in subparts H, J, K, M, Q, and R of part 493.

Subpart H—Participation in Proficiency Testing for Laboratories Performing Nonwaived Testing

The AABB has revised its requirements to be equal to or more stringent than the CLIA requirements at § 493.801 through § 493.865.

Subpart J—Facility Administration for Nonwaived Testing

The AABB has revised its requirements to be equal to or more stringent than the CLIA requirements at § 493.1100 through § 493.1105. For example, the AABB requires laboratories to retain quality assessment records for five years, while the CLIA regulations require laboratories to retain these records for only two years.

Subpart K—Quality System for Nonwaived Testing

The quality control (QC) requirements of the AABB have been evaluated against the requirements of the CLIA regulations. The AABB has modified its survey process and made revisions to its standards encompassing general QC as well as specialty and subspecialty QC requirements in order to reflect the new QC requirements in the CLIA regulations. As such, we have determined that the AABB's requirements are equal to or more stringent than the requirements in the CLIA regulations. The specific requirements that are more stringent than the requirements of the CLIA regulations are the following:

- The requirement that laboratories meet the AABB's QC requirements for all waived testing they perform.
- The requirement for compliance with standards for parentage testing.
- The AABB's requirement that laboratories that perform provider-performed microscopy procedures must meet the same certification requirements as all other laboratories that perform moderate complexity testing.

Subpart M—Personnel for Nonwaived Testing

The AABB has revised its requirements to equal the CLIA requirements at § 493.1403 through § 493.1495 for laboratories that perform moderate and high complexity testing. The AABB personnel standards provide that the laboratory must meet CLIA requirements for personnel qualifications. The CLIA requirements for personnel responsibilities are encompassed in the revisions made to the AABB standards.

Subpart Q—Inspections

We have determined that the AABB's requirements for inspections are equal to or more stringent than the requirements of § 493.1771 through § 493.1780 of this subpart.

Subpart R—Enforcement Procedures

The AABB meets the requirements of subpart R to the extent it applies to accreditation organizations. The AABB policy sets forth the actions the organization takes when laboratories it accredits do not comply with its requirements and standards for accreditation. When appropriate, the AABB will deny, suspend, or revoke accreditation in a laboratory accredited by the AABB and report that action to CMS within 30 days. The AABB also provides an appeals process for laboratories that have had accreditation denied, suspended, or revoked.

We have determined that the AABB's laboratory enforcement and appeal policies are equal to or more stringent than the requirements of this part 493 subpart R as they apply to accreditation organizations.

IV. Federal Validation Inspection and Continuing Oversight

The Federal validation inspections of AABB accredited laboratories may be conducted on a representative sample basis or in response to substantial allegations of noncompliance (that is, complaint inspections). The outcome of those validation inspections, performed by us or our agent, or the State survey agency, will be our principal means for verifying that the laboratories accredited by AABB remain in compliance with CLIA requirements. This Federal monitoring is an ongoing process.

V. Removal of Approval as an Accrediting Organization

Our regulations provide that CMS may rescind the approval of an accreditation organization, such as that of the AABB, for cause, before the end of the effective date of approval. If we determine that the AABB failed to adopt

requirements that are equal to, or more stringent than, the CLIA requirements, or that systemic problems exist in its inspection process, we may give it a probationary period, not to exceed one year, to allow the AABB to adopt comparable requirements.

Should circumstances result in our withdrawal of the AABB's approval, we will publish a notice in the **Federal Register** explaining the basis for removing its approval.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget did not review this notice because our publication of this notice is not a regulatory action under that Executive Order.

Authority: Section 353 of the Public Health Service Act (42 U.S.C.263a).

Dated: November 16, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04-28152 Filed 12-29-04; 8:45 am]

BILLING CODE 3410-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-9024-N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—July 2004 Through September 2004

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from July 2004 through September 2004, relating to the Medicare and Medicaid programs. This notice provides information on national coverage determinations (NCDs) affecting specific medical and health care services under Medicare. Additionally, this notice identifies certain devices with investigational device exemption (IDE) numbers approved by the Food and Drug Administration (FDA) that potentially may be covered under Medicare. Finally, this notice also includes listings of all approval numbers from the Office of Management and Budget for collections of information in CMS regulations.

Section 1871(c) of the Social Security Act requires that we publish a list of

Medicare issuances in the **Federal Register** at least every 3 months.

Although we are not mandated to do so by statute, for the sake of completeness of the listing, and to foster more open and transparent collaboration efforts, we are also including all Medicaid issuances and Medicare and Medicaid substantive and interpretive regulations (proposed and final) published during this 3-month time frame.

FOR FURTHER INFORMATION CONTACT: It is possible that an interested party may have a specific information need and not be able to determine from the listed information whether the issuance or regulation would fulfill that need. Consequently, we are providing information contact persons to answer general questions concerning these items. Copies are not available through the contact persons. (See Section III of this notice for how to obtain listed material.)

Questions concerning items in Addendum III may be addressed to Timothy Jennings, Office of Strategic Operations and Regulatory Affairs, Centers for Medicare & Medicaid Services, C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850, or you can call (410) 786-2134.

Questions concerning Medicare NCDs in Addendum V may be addressed to Patricia Brocato-Simons, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, C1-09-06, 7500 Security Boulevard, Baltimore, MD 21244-1850, or you can call (410) 786-0261.

Questions concerning FDA-approved Category B IDE numbers listed in Addendum VI may be addressed to Eileen Davidson, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, S3-26-10, 7500 Security Boulevard, Baltimore, MD 21244-1850, or you can call (410) 786-6874.

Questions concerning approval numbers for collections of information in Addendum VII may be addressed to Dawn Willingham, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Centers for Medicare & Medicaid Services, C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850, or you can call (410) 786-6141.

Questions concerning all other information may be addressed to Margaret Teeters, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Centers for Medicare & Medicaid Services, C5-13-18, 7500 Security Boulevard, Baltimore, MD 21244-1850, or you can call (410) 786-4678.

SUPPLEMENTARY INFORMATION:

I. Program Issuances

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare and Medicaid programs. These programs pay for health care and related services for 39 million Medicare beneficiaries and 35 million Medicaid recipients. Administration of the two programs involves (1) furnishing information to Medicare beneficiaries and Medicaid recipients, health care providers, and the public and (2) maintaining effective communications with regional offices, State governments, State Medicaid agencies, State survey agencies, various providers of health care, all Medicare contractors that process claims and pay bills, and others. To implement the various statutes on which the programs are based, we issue regulations under the authority granted to the Secretary of the Department of Health and Human Services under sections 1102, 1871, 1902, and related provisions of the Social Security Act (the Act). We also issue various manuals, memoranda, and statements necessary to administer the programs efficiently.

Section 1871(c)(1) of the Act requires that we publish a list of all Medicare manual instructions, interpretive rules, statements of policy, and guidelines of general applicability not issued as regulations at least every 3 months in the **Federal Register**. We published our first notice June 9, 1988 (53 FR 21730). Although we are not mandated to do so by statute, for the sake of completeness of the listing of operational and policy statements, and to foster more open and transparent collaboration, we are continuing our practice of including Medicare substantive and interpretive regulations (proposed and final) published during the respective 3-month time frame.

II. How to Use the Addenda

This notice is organized so that a reader may review the subjects of manual issuances, memoranda, substantive and interpretive regulations, NCDs, and FDA-approved IDEs published during the subject quarter to determine whether any are of particular interest. We expect this notice to be used in concert with previously published notices. Those unfamiliar with a description of our Medicare manuals may wish to review Table I of our first three notices (53 FR 21730, 53 FR 36891, and 53 FR 50577) published in 1988, and the notice published March 31, 1993 (58 FR 16837). Those desiring information on the Medicare NCD Manual (NCMD, formerly the Medicare

Coverage Issues Manual (CIM)) may wish to review the August 21, 1989, publication (54 FR 34555). Those interested in the revised process used in making NCDs under the Medicare program may review the September 26, 2003, publication (68 FR 55634).

To aid the reader, we have organized and divided this current listing into six addenda:

- Addendum I lists the publication dates of the most recent quarterly listings of program issuances.
- Addendum II identifies previous **Federal Register** documents that contain a description of all previously published CMS Medicare and Medicaid manuals and memoranda.
- Addendum III lists a unique CMS transmittal number for each instruction in our manuals or Program Memoranda and its subject matter. A transmittal may consist of a single or multiple instruction(s). Often, it is necessary to use information in a transmittal in conjunction with information currently in the manuals.
- Addendum IV lists all substantive and interpretive Medicare and Medicaid regulations and general notices published in the **Federal Register** during the quarter covered by this notice. For each item, we list the—
 - Date published;
 - **Federal Register** citation;
 - Parts of the Code of Federal Regulations (CFR) that have changed (if applicable);
 - Agency file code number; and
 - Title of the regulation.
- Addendum V includes completed NCDs, or reconsiderations of completed NCDs, from the quarter covered by this notice. Completed decisions are identified by the section of the NCDM in which the decision appears, the title, the date the publication was issued, and the effective date of the decision.
- Addendum VI includes listings of the FDA-approved IDE categorizations, using the IDE numbers the FDA assigns. The listings are organized according to the categories to which the device numbers are assigned (that is, Category A or Category B), and identified by the IDE number.
- Addendum VII includes listings of all approval numbers from the Office of Management and Budget (OMB) for collections of information in CMS regulations in title 42; title 45, subchapter C; and title 20 of the CFR.

III. How to Obtain Listed Material

A. Manuals

Those wishing to subscribe to program manuals should contact either the Government Printing Office (GPO)

or the National Technical Information Service (NTIS) at the following addresses:

Superintendent of Documents,
Government Printing Office, ATTN:
New Orders, P.O. Box 371954,
Pittsburgh, PA 15250-7954,
Telephone (202) 512-1800, Fax
number (202) 512-2250 (for credit
card orders); or

National Technical Information Service,
Department of Commerce, 5825 Port
Royal Road, Springfield, VA 22161,
Telephone (703) 487-4630.

In addition, individual manual transmittals and Program Memoranda listed in this notice can be purchased from NTIS. Interested parties should identify the transmittal(s) they want. GPO or NTIS can give complete details on how to obtain the publications they sell. Additionally, most manuals are available at the following Internet address: <http://cms.hhs.gov/manuals/default.asp>.

B. Regulations and Notices

Regulations and notices are published in the daily **Federal Register**. Interested individuals may purchase individual copies or subscribe to the **Federal Register** by contacting the GPO at the address given above. When ordering individual copies, it is necessary to cite either the date of publication or the volume number and page number.

The **Federal Register** is also available on 24x microfiche and as an online database through *GPO Access*. The online database is updated by 6 a.m. each day the **Federal Register** is published. The database includes both text and graphics from Volume 59, Number 1 (January 2, 1994) forward. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is <http://www.gpoaccess.gov/fr/index.html>, by using local WAIS client software, or by telnet to swais.gpoaccess.gov, then log in as guest (no password required). Dial-in users should use communications software and modem to call (202) 512-1661; type swais, then log in as guest (no password required).

C. Rulings

We publish rulings on an infrequent basis. Interested individuals can obtain

copies from the nearest CMS Regional Office or review them at the nearest regional depository library. We have, on occasion, published rulings in the **Federal Register**. Rulings, beginning with those released in 1995, are available online, through the CMS Home Page. The Internet address is <http://cms.hhs.gov/rulings>.

D. CMS' Compact Disk-Read Only Memory (CD-ROM)

Our laws, regulations, and manuals are also available on CD-ROM and may be purchased from GPO or NTIS on a subscription or single copy basis. The Superintendent of Documents list ID is HCLRM, and the stock number is 717-139-00000-3. The following material is on the CD-ROM disk:

- Titles XI, XVIII, and XIX of the Act.
- CMS-related regulations.
- CMS manuals and monthly revisions.

• CMS program memoranda.
The titles of the Compilation of the Social Security Laws are current as of January 1, 1999. (Updated titles of the Social Security Laws are available on the Internet at http://www.ssa.gov/OP_Home/ssact/comp-toc.htm.) The remaining portions of CD-ROM are updated on a monthly basis.

Because of complaints about the unreadability of the Appendices (Interpretive Guidelines) in the State Operations Manual (SOM), as of March 1995, we deleted these appendices from CD-ROM. We intend to re-visit this issue in the near future and, with the aid of newer technology, we may again be able to include the appendices on CD-ROM.

Any cost report forms incorporated in the manuals are included on the CD-ROM disk as LOTUS files. LOTUS software is needed to view the reports once the files have been copied to a personal computer disk.

IV. How to Review Listed Material

Transmittals or Program Memoranda can be reviewed at a local Federal Depository Library (FDL). Under the FDL program, government publications are sent to approximately 1,400 designated libraries throughout the United States. Some FDLs may have arrangements to transfer material to a local library not designated as an FDL. Contact any library to locate the nearest FDL.

In addition, individuals may contact regional depository libraries that receive

and retain at least one copy of most Federal Government publications, either in printed or microfilm form, for use by the general public. These libraries provide reference services and interlibrary loans; however, they are not sales outlets. Individuals may obtain information about the location of the nearest regional depository library from any library. For each CMS publication listed in Addendum III, CMS publication and transmittal numbers are shown. To help FDLs locate the materials, use the CMS publication and transmittal numbers. For example, to find the Medicare National Coverage Determinations publication titled "Islet Cell Transplantation," use CMS-Pub. 100-03, Transmittal No. 18.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance, Program No. 93.774, Medicare—Supplementary Medical Insurance Program, and Program No. 93.714, Medical Assistance Program)

Dated: December 13, 2004.

Jacquelyn Y. White,

Director, Office of Strategic Operations and Regulatory Affairs.

Addendum I

This addendum lists the publication dates of the most recent quarterly listings of program issuances.

June 28, 2002 (67 FR 43762)
September 27, 2002 (67 FR 61130)
December 27, 2002 (67 FR 79109)
March 28, 2003 (68 FR 15196)
June 27, 2003 (68 FR 38359)
September 26, 2003 (68 FR 55618)
December 24, 2003 (68 FR 74590)
March 26, 2004 (69 FR 15837)
June 25, 2004 (69 FR 35634)
September 24, 2004 (69 FR 57312)

Addendum II—Description of Manuals, Memoranda, and CMS Rulings

An extensive descriptive listing of Medicare manuals and memoranda was published on June 9, 1988, at 53 FR 21730 and supplemented on September 22, 1988, at 53 FR 36891 and December 16, 1988, at 53 FR 50577. Also, a complete description of the former CIM (now the NCDM) was published on August 21, 1989, at 54 FR 34555. A brief description of the various Medicaid manuals and memoranda that we maintain was published on October 16, 1992, at 57 FR 47468.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS JULY THROUGH SEPTEMBER 2004

Transmittal No.	Manual/Subject/Publication Number
Medicare General Information (CMS-Pub. 100-01)	
08	Standard Terminology for Claims Processing Systems Standard Terminology Chart.
09	Transmittal rescinded and replaced with Transmittal 10.
10	Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year 2005. Basis for Determining the Part A Coinsurance Amounts. Part B Annual Deductible.
Medicare Benefit Policy (CMS-Pub. 100-02)	
18	This revision rescinded Transmittal 12.
19	Hospital Services Covered Under Part B Outpatient Observation Services.
20	This revision rescinded Transmittal 17.
21	Medicare Comprehensive Outpatient Rehabilitation Facility Coverage. Comprehensive Outpatient Rehabilitation Facility Services Provided by Medicare. Required Services. Optional Comprehensive Outpatient Rehabilitation Facility Services. Rules for Provision of Services. Physician's Services. Physical Therapy Services. Occupational Therapy Services. Speech-Language Pathology Services. Respiratory Therapy Services. Prosthetic and Orthotic Devices and Supplies. Social Services. Psychological Services. Nursing Services. Drugs and Biologicals. Home Environment Evaluation. Outpatient Mental Health Treatment Limitation.
22	This revision rescinded transmittal 15.
Medicare National Coverage Determinations (CMS-Pub. 100-03)	
17	Manualization of the Negotiated Clinical Diagnostic Laboratory National Coverage Determinations. Urine Culture, Bacterial. Human Immunodeficiency Virus Testing (Prognosis Including Monitoring). Human Immunodeficiency Virus Testing (Diagnosis). Blood Counts. Partial Thromboplastin Time. Prothrombin Time. Serum Iron Studies. Collagen Crosslinks, Any Method. Blood Glucose Testing. Glycated Hemoglobin/Glycated Protein. Thyroid Testing. Lipid Testing. Digoxin Therapeutic Drug Assay. Alpha-fetoprotein. Carcinoembryonic Antigen. Human Chorionic Gonadotropin. Tumor Antigen by Immunoassay. Prostate Specific Antigen. Gamma Glutamyl Transferase. Hepatitis Panel/Acute Hepatitis Panel. Fecal Occult Blood Test.
18	Islet Cell Transplantation. Pancreas Transplants (Effective July 1, 1999). Islet Cell Transplantation in the Context of a Clinical Trial (Effective October 1, 2004).
19	Blood-Derived Products for Chronic Non-Healing Wounds.
20	Issued to a specific audience, not posted to Internet/Intranet due to sensitivity of Instruction.
21	Magnetic Resonance Spectroscopy for Diagnosing Brain Tumors. Magnetic Resonance Imaging. Magnetic Resonance Spectroscopy. Magnetic Resonance Angiography.
Medicare Claims Processing (CMS-Pub. 100-04).	
222	Skilled Nursing Facility Consolidated Billing Requirements for Durable Medical Equipment Prosthetic, Orthotics & Supplies. Skilled Nursing Facility Consolidated Billing and Durable Medical Equipment Provided by Durable Medical Equipment Prosthetic, Orthotics & Supplies Suppliers. General Information.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS JULY THROUGH SEPTEMBER 2004—Continued

Transmittal No.	Manual/Subject/Publication Number
223	Positron Emissions Tomography Scans and Related Claims Processing. Positron Emission Tomography Scans—General Information. Billing Instructions. Use of Gamma Cameras and Full Ring and Partial Ring Positron Emissions Scanners. Positron Emission Tomography Scan Qualifying Conditions and Health. Common Procedure Coding System Code Chart. Positron Emissions Tomography Scans for Imaging of the Perfusion of the Heart Using Rubidium 82. Expanded Coverage of Positron Emission Tomography Scans for Solitary Pulmonary Nodules. Expanded Coverage of Positron Emissions Tomography Scans Effective for Services on or after July 1, 1999. Expanded Coverage of Positron Emissions Tomography Scans Effective for Services on or after July 1, 2001. Expanded Coverage of Positron Emissions Tomography Scans for Breast Cancer Effective for Dates on or after October 1, 2002. Coverage of Positron Emissions Tomography Scans for Myocardial Viability. Coverage of Positron Emissions Tomography Scans for Thyroid Cancer. Coverage of Positron Emissions Tomography Scans for Perfusion of the Heart Using Ammonia N-13.
224	October Quarterly Update to 2004 Annual Update of Health Common Procedure Coding System Codes Used For Skilled Nursing Facility. Consolidated Billing Enforcement.
225	Changes to the Laboratory National Coverage Determination Edit Software for October 2004.
226	Quarterly Update of Health Common Procedure Coding System Codes Used for Home Health Consolidated Billing Enforcement.
227	Home Health Prospective Payment System Consolidated Billing and Primary Home Health Agency. Local Medical Review Policy/Local Coverage Determination Medicare. Summary Notice Message Revision. Medical Necessity. Necesidad Médica.
228	General Policy. Patient and Insured Information.
229	Additional Clarification of Bill Type 22x and 23x Submitted by Skilled Nursing Facilities With Instructions for Involuntarily Moving A Beneficiary Out of the Skilled Nursing Facility and Ending a Benefit Period. Skilled Nursing Facility Prospective Payment System and Consolidated Billing Overview. Consolidated Billing Requirements for Skilled Nursing Facility. Other Excluded Services Beyond the Scope of a Skilled Nursing Facility Part A Benefit. Outpatient Surgery and Related Procedures “Inclusions.” Emergency Services. Dialysis and Dialysis Related Services to a Beneficiary With End Stage Renal Disease. End Stage Renal Disease Services. Coding Applicable to Epoetin Services. Coding for Darbepoetin Alfa. Ambulance Services. Screening and Preventive Services. Therapy Services. Situations that Require a Discharge or Leave of Absence. Billing Procedures for Periodic Interim Payment Method of Payment Ending A Benefit Period. Other Billing Situations. Billing for Outpatient Skilled Nursing Facility Services
230	Update to the Claims Status Codes. Health Care Claims Status Category Codes and Health Care Claims Status Codes for Use with Health Care Claims Status Request and Response.
231	Indian Health Service or Tribal Critical Access Hospital Payment Methodology for Inpatient and Outpatient Services. Payment for Inpatient Services Furnished by an Indian Health Service or Tribal Critical Access Hospital. Payment for Outpatient Services Furnished by an Indian Health Service or Tribal Critical Access Hospital.
232	Issued to a specific audience, not posted to Internet/Intranet due to confidentiality of instruction.
233	Issued to a specific audience, not posted to Internet/Intranet due to confidentiality of instruction.
234	Standardized Responses to Provider Inquiries Regarding the Negotiated Laboratory National Coverage Determinations Edit Software.
235	Instructions for Downloading the Medicare Zip Code File.
236	2005 Durable Medical Equipment Prosthetic, Orthotics & Supplies Pricing. File Record Layout Expansion and New Pricing Procedures for Certain Durable Medical Equipment Prosthetic, Orthotics & Supplies Items Based on Modifiers. Payment of Durable Medical Equipment Prosthetic, Orthotics & Supplies Items based on Modifiers. Intermediary Format for Durable Medical Equipment, Prosthetic, Orthotic and Supply Fee Schedule.
237	Implementation of Patient Status Code 65, Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital.
238	Health Insurance Portability and Accountability Act Institutional Health Care Claim Implementation Guide Additional Updates.
239	Transmittal 239 is Rescinded and replaced with Transmittal 270.
240	Expansion of the Existing Interrupted Stay Policy Under Long Term Care. Hospital Prospective Payment System.
241	Processing Part B Claims for Indian Health Services. General. Services That May Be Paid to Indian Health Service/Tribe/Tribal Organization Facilities.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS JULY THROUGH SEPTEMBER 2004—Continued

Transmittal No.	Manual/Subject/Publication Number
	Services Paid Under the Physician Fee Schedule. Other Part B Services. Durable Medical Equipment. Prosthetics and Orthotics. Prosthetics Devices. Surgical Dressings and Splints and Casts. Therapeutic Shoes. Drugs. Clinical Laboratory Services. Ambulance Services. Claims Processing. Claims Processing Requirements for Benefits, Improvements & Protection Act of 2000 Services. Claims Processing Requirements for Medicare Modernization Act Enrollment and Billing for Durable Medical Equipment, Prosthetic, Orthotics & Supplies. Claims Processing for Durable Medical Equipment, Prosthetic, Orthotics & Supplies. Enrollment for Durable Medical Equipment, Prosthetic, Orthotics & Supplies. Claims Submission for Durable Medical Equipment, Prosthetic, Orthotics & Supplies. Enrollment and Billing for Clinical Laboratory and Ambulance Services Claims Submission and Processing for Clinical Laboratory and Ambulance Service. Enrollment for Clinical Laboratory and Ambulance Services and Part B drugs.
242	Quarterly Update to Correct Coding Initiative edits, Version 10.3, Effective October 1, 2004.
243	Patient Status Code and Reason for Patient Visit for the Hospital Outpatient Prospective Payment System.
	Patient Status Code and Reason for Patient Visit for the Hospital.
244	Transmittal 244 is Rescinded and Replaced with Transmittal 269.
245	Issued to a specific audience, not posted to Internet/Intranet due to confidentiality of instruction.
246	Issued to a specific audience, not posted to Internet/Intranet due to confidentiality of instruction.
247	Issued to a specific audience, not posted to Internet/Intranet due to confidentiality of instruction.
248	Durable Medical Equipment Regional Carrier/Local Carriers/Statistical Analysis Durable Medical Equipment Regional Carrier—Drug Pricing Limits as of January 1, 2005.
	Payment Rules for Drugs and Biologicals.
	Medicare Modernization Act Drug Pricing-Average Sales Price.
	Single Drug Pricer.
	Calculation of the Payment Allowance Limit for Durable Medical Equipment.
	Regional Carrier Drugs.
	Calculation of the Average Wholesale Price.
	Detailed Procedures for Determining Average Wholesale Price and the Drug.
	Payment Allowance Limits.
	Background.
	Review of Sources for Medicare Covered Drugs and Biologicals.
	Use of Generics.
	Find the Strength and Dosage.
	Restrictions.
	Inherent Reasonableness for Drugs and Biologicals.
	Injection Services.
	Injections Furnished to End Stage Renal Disease Beneficiaries.
249	New Medicare Summary Notice Message 31.18.
	Adjustments.
	Ajustes.
250	Coordination of Benefits Agreement Claims Selection Options.
	Consolidated Claims Crossover Process.
	Consolidation of the Claims Crossover Process.
251	Editing Of Hospital And Skilled Nursing Facility Part B Inpatient Services.
	Inpatient Part B Hospital Services.
	Editing of Hospital Part B Inpatient Services. Billing for Inpatient Skilled Nursing Facility Services Paid Under Part B.
	Editing of Skilled Nursing Facilities Part B Inpatient Services.
252	Paper Remittance Advice format change to accommodate the forced balancing Amount to balance at the claim level as well as the provider level, a flat file change, and a change in the companion document for fiscal intermediaries.
253	Fiscal Intermediary Shared System Changes to Allow for Provider Liability Days on Skilled Nursing Facility and Swing Bed Facility Inpatient Bills.
	Billing Skilled Nursing Facility Prospective Payment System Services.
254	October 2004 Outpatient Prospective Payment System Code Editor Specifications Version 5.3.
255	October Update to the Medicare Outpatient Code Editor Version 20.0 for Bills From Hospitals That Are Not Paid Under the Outpatient Prospective Payment System.
256	Use of Group Health Plan Payment System/Medicare Managed Care System To Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 of the Medicare Modernization Act.
257	Shared Systems Changes for Medicare Part B Drugs for End Stage Renal Disease Independent Dialysis Facilities.
258	New Waived Tests—October 1, 2004.
259	Scheduled Release for October Updates to Software Programs and Pricing/Coding Files.
260	Cryosurgery of the Prostate.
	Cryosurgery of the Prostate Gland.
	Coverage Requirements.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS JULY THROUGH SEPTEMBER 2004—Continued

Transmittal No.	Manual/Subject/Publication Number
	Billing Requirements.
	Payment Requirements.
261	Billing and Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health Clinical Trial.
	Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health Clinical Trial.
	Healthcare Common Procedural Coding System Codes for Carriers.
	Applicable Modifier for Islet Cell Transplant Claims for Carriers.
	Special Billing and Payment Requirements for Carriers.
	Special Billing and Payment Requirements for Intermediaries.
	Special Billing and Payment Requirements Medicare Advantage Beneficiaries.
262	Confidential.
263	Inpatient Rehabilitation Facility Annual Update: Prospective Payment System.
	Pricer Changes for Fiscal Year 2005.
	Outlier Payments: Cost-to-Charge Ratios.
264	This Transmittal is Rescinded and Replaced with Transmittal 271.
265	Issued to a specific audience, not posted to Internet/Intranet due to confidentiality of instruction.
266	Revision of Common Working File Editing for Same-Day, Same-Provider Acute Care Readmissions.
	Repeat Admissions.
267	Crossover Patients in New Long Term Care Hospital.
	Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number.
	Crossover Patients in New Long Term Care Hospital.
268	Medicare Part A Skilled Nursing Facility Prospective Payment.
	System Pricer Update Fiscal Year 2005.
	Skilled Nursing Facility Prospective Payment System Pricer Software.
269	This Transmittal Replaces Transmittal 244.
270	This Transmittal Replaces Transmittal 239.
271	This Transmittal Replaces Transmittal 264.
272	October Quarterly Update for 2004 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule.
273	Modification of CMS' Medicare Contingency Plan for Health Insurance Portability & Accountability Act Implementation.
	Receipt Date.
	Payment Ceiling Standards.
	Payment Floor Standards.
	Determining and Paying Interest.
274	Good Cause Waiver of Late Claim Filing Payment Reduction Penalty.
	Extend Time for Good Cause.
	Conditions Which Establish Good Cause.
	Procedure to Establish Good Cause.
	Good Cause Is Not Found.
	Preparing Common Working File Claim Records for Services Subject to 10 Percent Payment Reduction.
275	The Supplemental Security Income/Medicare Beneficiary Data for Fiscal Year 2003 for Inpatient Prospective Payment System Hospitals.
276	Further Information Related to CR 3175, Distinct Part Units of Critical Access Hospitals.
	Requirements for Critical Access Hospital Services, Critical Access Hospital Skilled Nursing Care Services and Distinct Part Units.
	Inpatient Rehabilitation Facility Prospective Payment System.
	Billing Requirements Under Inpatient Rehabilitation Facility Prospective Payment System.
277	Sensitive.
278	This Transmittal is no longer sensitive and can be posted to Internet/Intranet.
279	Issued to a specific audience, not posted to Internet/Intranet due to sensitivity of instruction.
280	Issued to a specific audience, not posted to Internet/Intranet due to sensitivity of instruction.
281	Issued to a specific audience, not posted to Internet/Intranet due to confidentiality of instruction.
282	This Transmittal replaces Transmittal 274.
283	2005 Healthcare Common Procedure Coding System Annual Update Reminder.
	Health Care Common Procedure Coding System Annual Update Reminder.
284	Durable Medical Equipment Regional Carriers Only—Appeals of Duplicate Claims.
285	Addition of Physician Assistants, Nurse Practitioners and Clinical Nurse.
	Specialists as Emergency On-Call Providers for Critical Access Hospitals.
	Costs of Emergency Room On-Call Providers.
286	Medicare Physician Fee Schedule Database 2005 File Layout.
	Addendum.
287	Schedule for Completing the Calendar Year 2005 Fee Schedule Updates and the Participating Physician Enrollment Procedures.
288	Fiscal Year 2005 Payment for Services Furnished in Ambulatory Surgical Centers.
289	File Descriptions and Instructions for Retrieving the 2005 Pricing Files Through CMS' Mainframe Telecommunications System.
	Recurring Update Notification Containing New Pricing File Names and Retrieval Dates for 2005.
290	October 2004 Update of the Hospital Outpatient Prospective Payment System.
291	Use of Transmission Date in the Service Date/Assessment Date Field for Inpatient Rehabilitation Facility Prospective Payment System Claims.
	Payment Adjustment for Late Transmission of Patient Assessment Data.
292	Confidential.
293	Confidential.
294	Sensitive/Controversial.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS JULY THROUGH SEPTEMBER 2004—Continued

Transmittal No.	Manual/Subject/Publication Number
295	Transmittal 214 is Rescinded and Replaced with Transmittal 295.
296	This Transmittal replaces Transmittal 196.
297	Reasonable Charge Update for 2005 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, Therapeutic Shoes, and Certain Intraocular Lenses.
298	This Transmittal replaces Transmittal 295.
299	Use of Condition Code 44, "Inpatient Admission Changed to Outpatient".
300	Payment For Outpatient End Stage Renal Disease-Related Services.
301	Transmittal 301 Replaces Transmittal 251.
302	Nursing Facility Visits (Codes 99301–99313).
303	Instructions for Completion of Form CMS–1450.
304	Transmittal 304 Replaces Transmittal 205.
Medicare Secondary Payer (CMS-Pub. 100–05)	
17	Clarification of CR 3064. General Policy.
18	Application of the Medicare Secondary Payer for the Working Aged Provision and the Medicare Secondary for the Disabled Provision to Former Spouses and Certain Family Members With Coverage Under the Federal Employees Health Benefits Program. Individuals Not Subject to the Limitation on Payment. Individuals Not Subject to Medicare Secondary Payer Provision.
19	Clarification of Medicare Secondary Payer Rules in Relation to a Temporary Leave of Absence. Rules Defining Employees Covered by Group Health Plans and Large Group Health Plans.
Medicare Financial Management (CMS-Pub. 100–06)	
49	Procedures For Re-Issuance and Stale Dating of Medicare Checks
50	Unsolicited/Voluntary Refunds General Information. Office of Inspector General Initiatives. Unsolicited/Voluntary Refund Accounts. Receiving and Processing Unsolicited/Voluntary Refund Checks When Identifying Information Is Provided.
51	This transmittal is rescinded and replaced with Transmittal 52.
52	Notice of New Interest Rate for Medicare Overpayments and Underpayments.
53	Change Request 3367, Debt Collection System, replaces Change Request 2952, Debt Collection System
54	Notification to Providers of Intent to Complete a Post-Payment Audit. Contractor's Responsibility Prior to Submission of Cost Reports.
Medicare State Operations Manual (Pub. 100–07)	
02	Provider Identification Number.
Medicare Program Integrity (CMS-Pub. 100–08)	
79	Local Medical Review Policy/Local Coverage Determination Medicare Summary. Notice Message Revision. Prepayment Edits.
80	Program Integrity Management Fraud and Abuse Complaint Screening Revisions. Complaint Screening.
81	Implementation of the Quarterly Strategy Analysis. The Quarterly Strategy Analysis. The Quarterly Strategy Analysis Format. Executive Summary. Problem Specific Activities. Problem Specific Activity Definitions. Narrative.
82	Home Health Demand Bills. Home Health. Effectuating Favorable Final Appellate. Decisions That a Beneficiary Is "Confined to Home" . Medical Review of Home Health Demand Bills.
83	Program Integrity Management Revisions for Chapter 4. Program Safeguard Contractor and Medicare Contractor Benefit Integrity Unit. Benefit Integrity Security Requirements. Medical Review for Benefit Integrity Purposes. Requests for Information from Outside Organizations. Conducting Investigations. Disposition of Cases. Types of Fraud Alerts. Background. Investigation, Case, and Suspension Entries. Initial Entry Requirements for Investigations. Referral of Cases to the Office of the Inspector General/Office of Investigations.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS JULY THROUGH SEPTEMBER 2004—Continued

Transmittal No.	Manual/Subject/Publication Number
	Suspension. Referral to Quality Improvement Organizations Exceptions.
Medicare Contractor Beneficiary and Provider Communications (CMS-Pub. 100–09)	
07	Confidential.
Medicare Managed Care (CMS-Pub. 100–16)	
56	Administrative Contracting Requirements.
57	Coverage of Clinical Trials. Hospital Inpatient Data. Diagnostic Coding and Guidelines for Data Collection From Provider Network.
58	Terminology.
59	State and County Code Corrections. Completion of Enrollment Form. Passive Elections. Eligibility Requirements for Medicare Medical Savings Account Plans. Annual Elective Period. Open Enrollment Period. Open Enrollment Period Through 2005. Open Enrollment Period in 2006. Open Enrollment Period in 2007 and Beyond. Open Enrollment for Newly Eligible Individuals in 2006 and Beyond. Open Enrollment Period for Institutionalized Individuals in 2006 and Beyond. Special Enrollment Period for Beneficiaries Age 65.
60	Streamlined Marketing Review Process. File and Use. Guidelines for Advertising and Pre-Enrollment Materials. Guidelines for Advertising Materials. Guidelines for Pre-Enrollment Materials.
61	Emergency and Urgently Needed Services.
62	Revisions to Chapter 13—Medicare+Choice Beneficiary Grievances, Organization Determinations and Appeals.
Demonstrations (CMS-Pub. 100–19)	
05	Use of Group Health Plan Payment System to Pay Capitated Payments to Non-Health Plan Demonstration/Program Sites Serving Medicare Fee For Service Beneficiaries—Updated List of Plan Numbers.
06	Revision of CR 3269 for the Demonstration Project to Clarify the Definition of Homebound (Homebound Demonstration).
One Time Notification (CMS-Pub. 100–20)	
92	Additional Instructions Related to the “Redistribution of Unused Resident Positions,” Section 422 of the Medicare Modernization Act of 2003 P.L. 108–173, for Purposes of Graduate Medical Education Payments.
93	Temporary Skilled Nursing Facility Extension.
94	Shared System Maintainer Hours for Resolution of Problems Detected During Health Insurance Portability and Accountability Act. Transaction Release Testing.
95	Modifications to Post-payment Adjustment Process for Home Health Prospective Payment System Claims Failing to Report Prior Inpatient Discharges.
96	Annual Changes to the Amount in Controversy Thresholds For the Administrative Law Judge and Judicial Review. Levels of the Claim Appeals Process as Required by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
97	Implementation of the Business Segment Identifier in the Healthcare Integrated General Ledger Accounting System.
98	Change to Previous Transmittal Regarding the Discounted Use of Revenue Code 0910.
99	This One-Time Notification is a full replacement for Transmittal 86.
100	This Transmittal is Rescinded and Replaced with Transmittal 103.
101	Change of the Premera Blue Cross Medicare Part A Plan Under Contract to BCBSA to a Part A Fiscal Intermediary Contract with Noridian Mutual Insurance Company in the States of Washington and Alaska.
102	Update to the Healthcare Provider Taxonomy Codes/Medicare Specialty Code Crosswalk.
103	This Transmittal replaces Transmittal 100.
104	Confidential.
105	Confidential.
106	Medicare Modernization Act Drug Pricing Update—Payment Limits for J9045 (Carboplatin Injection) and (Rituximab Cancer Treatment).
107	Common Working File Analysis to Process Claims Per the Renovated Override Code Processing (re: CR3190) and Common Working File Analysis to Review System Edits for Additional 2-byte Modifiers Added in CR3190 (Phase 2).
108	New Remark Code Message for Use With Claims for Parental Pumps-Durable Medical Equipment Regional Carrier Only.
109	Billing Instructions for ADVATE rAHF-PFM on Medicare Claims.
110	Medicare Modernization Act Drug Pricing Update—Payment Limits for J100 (Depo-estradiol cypionate inj).
111	Creation of Common Working File Auxilliary File and Associated Logic to Property.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS JULY THROUGH SEPTEMBER 2004—Continued

Transmittal No.	Manual/Subject/Publication Number
112	Calculate Medicare-Equivalent Deductibles for Department of Veteran Affairs Claims. This Transmittal replaces Transmittal 109.
113	Implementation of § 921 of the Medicare Modernization Act Provider Customer Program.
114	Sensitive.
115	Instructions for Fiscal Intermediary Standard System and Multi-Carrier System Healthcare Integrated General Ledger Accounting System Changes.
116	Notification of Medlearn Matters Article for Confidential Change Request (CR) 3301.

ADDENDUM IV.—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER

[July 2004 Through September 2004]

Publication date	FR Vol. 69 page No.	CFR parts affected	File code	Title of regulation
July 1, 2004	40288	42 CFR Part 414	CMS-1492- IFC	Medicare Program; Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004.
July 23, 2004	44036	.....	CMS-1334- N	Medicare Program; Public Meeting in Calendar Year 2004 for Coding and Payment Determinations for Power Wheelchairs.
July 23, 2004	44035	.....	CMS-1364- N	Medicare Program; August 30, 2004, Meeting of the Practicing Physicians Advisory Council and Request for Nominations.
July 23, 2004	44034	.....	CMS-4074- N	Medicare Program; Meeting of the Advisory Panel on Medicare Education—September 9, 2004.
July 23, 2004	44031	.....	CMS-3142- NC	Medicare Program; Evaluation Criteria and Standards for Quality Improvement Program Contracts.
July 23, 2004	44029	.....	CMS-3112- NC2	Medicare Program; Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers.
July 23, 2004	44027	.....	CMS-2202- PN	Medicare and Medicaid Programs; Application by the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., for Continued Deeming Authority for Ambulatory Surgical Centers.
July 23, 2004	44013	.....	CMS-2187- N	State Children's Health Insurance Program (SCHIP); Extended Availability of Unexpended SCHIP Funds From the Appropriation for Fiscal Years 1998 Through 2001; and Provision of Authority for Qualifying States To Use a Portion of SCHIP Funds for Medicaid Expenditures.
July 23, 2004	43956	42 CFR Part 402	CMS-6146- P	Medicare Program; Revised Civil Money Penalties, Assessments, Exclusions, and Related Appeals Procedures.
July 23, 2004	43926	45 CFR Part 146	CMS-2033- F	Requirements for the Group Health Insurance Market; Non-Federal Governmental Plans Exempt From HIPAA Title I Requirements.
July 23, 2004	43924	45 CFR Part 146	CMS-2152- F2	Amendment to the Interim Final Regulation for Mental Health Parity.
July 30, 2004	45822	.....	CMS-4068- N	Medicare Program; Open Public Meeting Regarding the Development of the Model Guidelines for Categories and Classes of Drugs.
July 30, 2004	45775	.....	CMS-1249- N	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update.
July 30, 2004	45721	.....	CMS-1360- N	Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2005.
July 30, 2004	45640	42 CFR Part 484	CMS-1265- CN	Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2005; Correction Notice.
July 30, 2004	45604	42 CFR Parts 405 and 411	CMS-6014- F	Medicare Program; Interest Calculation.
August 3, 2004	46866	42 CFR Parts 417 and 422	CMS-4069- P	Medicare Program; Establishment of the Medicare Advantage Program.
August 3, 2004	46632	42 CFR Parts 403, 411, 417, and 423.	CMS-4068- P	Medicare Program; Medicare Prescription Drug Benefit.
August 5, 2004	47488	42 CFR Parts 405, 410, 411, 414, 418, 424, 484, and 486.	CMS-1429- P	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.
August 5, 2004	47446	.....	CMS-1275- N	Medicare Program; Meeting of the Advisory Panel on Ambulatory Payment Classification Groups—September 1, 2, and 3, 2004.

ADDENDUM IV.—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER—Continued
[July 2004 Through September 2004]

Publication date	FR Vol. 69 page No.	CFR parts affected	File code	Title of regulation
August 11, 2004	48916	42 CFR Parts 403, 412, 413, 418, 460, 480, 482, 483, 485, and 489.	CMS-1428-F	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates.
August 16, 2004	50448	42 CFR Parts 410, 411, 419.	CMS-1427-P	Medicare Program; Proposed Changes to the Hospital Outpatient and Prospective Payment System and Calendar Year 2005 Payment Rates.
August 27, 2004	52723	.....	CMS-1279-N2	Medicare Program; Public Meeting of the Program Advisory and Oversight Committee (PAOC) for Quality Standards and Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
August 27, 2004	52722	.....	CMS-3136-N	Medicare Program; Meeting of the Medicare Coverage Advisory Committee—September 28, 2004.
August 27, 2004	52721	.....	CMS-5025-CN	Medicare Program; Medicare Replacement Drug Demonstration; Correction.
August 27, 2004	52710	.....	CMS-1264-N	Medicare Program; Hospice Wage Index for Fiscal Year 2005.
August 27, 2004	52706	.....	CMS-4067-PN	Medicare and Medicaid Programs; Application by the Utilization Review Accreditation Commission (URAC) for Deeming Authority for Medicare Advantage.
August 27, 2004	52700	.....	CMS-2201-N	State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2005.
August 27, 2004	52699	.....	CMS-1269-N2	Medicare Program; Second Request for Nominations for Two Specific Categories of Members of the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG).
August 27, 2004	52620	42 CFR Parts 431 and 457	CMS-6026-P	Medicaid Program and State Children's Health Insurance Program (SCHIP): Payment Error Rate Measurement.
August 27, 2004	52620	42 CFR Part 402	CMS-6146-CN	Medicare Program; Revised Civil Money Penalties, Assessments, Exclusions, and Related Appeals Procedures.
September 9, 2004	54674	.....	CMS-8020-N	Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2005.
September 9, 2004	54673	.....	CMS-8022-N	Medicare Program; Part A Premium for 2005 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement, Thursday, September 9, 2004.
September 9, 2004	54671	.....	CMS-8021-N	Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2005, Thursday, September 9, 2004.
September 14, 2004 ..	55440	.....	CMS-6027-N	Medicare Program; September 30, 2004 Open Door Forum: Requirements for Coordination Between Plans Primary or Secondary to Medicare Part D Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
September 16, 2004 ..	55763	42 CFR Part 414	CMS-1380-F	Medicare Program; Manufacturer Submission of Manufacturer's Average Sales Price (ASP) Data for Medicare Part B Drugs and Biologicals.
September 24, 2004 ..	57325	.....	CMS-3141-N	Procedure for Producing Guidance Documents Describing Medicare's Coverage Process.
September 24, 2004 ..	57325	.....	CMS-3137-N	Medicare Program; Meeting of the Medicare Coverage Advisory Committee—November 4, 2004.
September 24, 2004 ..	57324	.....	CMS-2200-N4	Medicare Program; Meeting of the State Pharmaceutical Assistance Transition Commission—October 14, 2004.
September 24, 2004 ..	57312	.....	CMS-9023-N	Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—April 2004 Through June 2004.
September 24, 2004 ..	57310	.....	CMS-4077-PN	Medicare and Medicaid Programs; Application by the National Committee for Quality Assurance Preferred Provider Organization for Deeming Authority for Medicare Advantage.
September 24, 2004 ..	57308	.....	CMS-2208-PN	Medicare and Medicaid Programs; Application by the American Osteopathic Association for Continued Approval of Deeming Authority for Hospitals.
September 24, 2004 ..	57307	.....	CMS-2256-PN	Medicare and Medicaid Programs; Application by the Community Health Accreditation Program (CHAP) for Home Health Agencies.

ADDENDUM IV.—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER—Continued
[July 2004 Through September 2004]

Publication date	FR Vol. 69 page No.	CFR parts affected	File code	Title of regulation
September 24, 2004 ..	57305	.....	CMS-2204- PN	Medicare and Medicaid Programs; Application by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for Home Health Agencies.
September 24, 2004 ..	57304	.....	CMS-3154- N	Medicare Program; Request for Nominations for Members for the Medicare Coverage Advisory Committee.
September 24, 2004 ..	57244	42 CFR Parts 431 and 457	CMS-6026- CN	Medicaid Program and State Children's Health Insurance Program (SCHIP); Payment Error Rate Measurement; Correction.
September 24, 2004 ..	57226	42 CFR Part 411	CMS-1810- IFC2	Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II); Correcting Amendment.
September 24, 2004 ..	57224	42 CFR Part 406	CMS-4018- F	Medicare Program; Continuation of Medicare Entitlement When Disability Benefit Entitlement Ends Because of Substantial Gainful Activity.
September 24, 2004 ..	57859	42 CFR Part 493		Laboratory Requirements; OFR Correction.
September 30, 2004 ..	58596	42 CFR Parts 431 and 457	CMS-6026- CN	Medicaid Program and State Children's Health Insurance Program (SCHIP); Payment Error Rate Measurement; OFR Correction.

Addendum V—National Coverage Determinations [July 2004 Through September 2004]

A national coverage determination (NCD) is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under Title XVIII of the Social Security Act, but does not include a determination of what code, if any, is assigned to a particular item or

service covered under this title, or determination with respect to the amount of payment made for a particular item or service so covered. We include below all of the NCDs that were issued during the quarter covered by this notice. The entries below include information concerning completed decisions as well as sections on program and decision memoranda, which also announce pending decisions

or, in some cases, explain why it was not appropriate to issue an NCD. We identify completed decisions by the section of the NCDM in which the decision appears, the title, the date the publication was issued, and the effective date of the decision. Information on completed decisions as well as pending decisions has also been posted on the CMS website at <http://cms.hhs.gov/coverage>.

NATIONAL COVERAGE DETERMINATIONS
[July 2004 Through September 2004]

Title	NCDM section	TN#	Issue date	Effective date
Manualization of Negotiated Clinical Diagnostic Laboratory NCDs	N/A	R17NCD ..	07/02/2004	07/02/2004
Changes to the Laboratory NCD Edit Software for October 2004	N/A	R225CP ...	04/09/2004	10/04/2004
Blood-Derived Products for Chronic Non-Healing Wounds	270.3	R19NCD ..	07/30/2004	07/23/2004
Islet Cell Transplantation	260.3.1	R18NCD ..	07/30/2004	10/04/2004
MRS for Diagnosing Brain Tumors	220.2.1	R21NCD ..	09/10/2004	09/10/2004

Addendum VI—FDA-Approved Category B IDEs

Under the Food, Drug, and Cosmetic Act (21 U.S.C. 360c) devices fall into one of three classes. To assist CMS under this categorization process, the FDA assigns one of two categories to each FDA-approved IDE. Category A refers to experimental IDEs, and Category B refers to non-experimental IDEs. To obtain more information about the classes or categories, please refer to the **Federal Register** notice published on April 21, 1997 (62 FR 19328).

The following list includes all Category B IDEs approved by FDA during the 2nd quarter, July 2004 Through September 2004.

IDE Category

G030093
G030237
G040049
G040052
G040057
G040091
G040092
G040094
G040096
G040098
G040099
G040100
G040102
G040103
G040104
G040105
G040109
G040111

G040112
G040113
G040119
G040122
G040124
G040126
G040128
G040129
G040130
G040134
G040137
G040142
G040143
G040144
G040145
G040146
G040147
G040148
G040149
G040150

G040153	Addendum VII—Approval Numbers for Collections of Information Below we list all approval numbers for collections of information in the referenced sections of CMS regulations	in Title 42; Title 45, Subchapter C; and Title 20 of the Code of Federal Regulations, which have been approved by the Office of Management and Budget:
G040154		
G040160		
G980099		

OMB control numbers	Approved CFR Sections in Title 42, Title 45, and Title 20 (Note: Sections in Title 45 are preceded by “45 CFR,” and sections in Title 20 are preceded by “20 CFR”)
0938–0008	414.40, 424.32, 424.44
0938–0022	413.20, 413.24, 413.106
0938–0023	424.103
0938–0025	406.28, 407.27
0938–0027	486.100–486.110
0938–0033	405.807
0938–0035	407.40
0938–0037	413.20, 413.24
0938–0041	408.6, 408.22
0938–0042	410.40, 424.124
0938–0045	405.711
0938–0046	405.2133
0938–0050	413.20, 413.24
0938–0062	431.151, 435.1009, 440.220, 440.250, 442.1, 442.10–442.16, 442.30, 442.40, 442.42, 442.100–442.119, 483.400–483.480, 488.332, 488.400, 498.3–498.5
0938–0065	485.701–485.729
0938–0074	491.1–491.11
0938–0080	406.7, 406.13
0938–0086	420.200–420.206, 455.100–455.106
0938–0101	430.30
0938–0102	413.20, 413.24
0938–0107	413.20, 413.24
0938–0146	431.800–431.865
0938–0147	431.800–431.865
0938–0151	493.1405, 493.1411, 493.1417, 493.1423, 493.1443, 493.1449, 493.1455, 493.1461, 493.1469, 493.1483, 493.1489
0938–0155	405.2470
0938–0170	493.1269–493.1285
0938–0193	430.10–430.20, 440.167
0938–0202	413.17, 413.20
0938–0214	411.25, 489.2, 489.20
0938–0236	413.20, 413.24
0938–0242	488.26, 442.30
0938–0245	407.10, 407.11
0938–0246	431.800–431.865
0938–0251	406.7
0938–0266	416.41, 416.47, 416.48, 416.83
0938–0267	410.65, 485.56, 485.58, 485.60, 485.64, 485.66
0938–0269	412.116, 412.632, 413.64, 413.350, 484.245
0938–0270	405.376
0938–0272	440.180, 441.300–441.305
0938–0273	485.701–485.729
0938–0279	424.5
0938–0287	447.31
0938–0296	413.170, 413.184
0938–0301	413.20, 413.24
0938–0302	418.22, 418.24, 418.28, 418.56, 418.58, 418.70, 418.74, 418.83, 418.96, 418.100
0938–0313	489.11, 489.20
0938–0328	482.12, 482.13, 482.21, 482.22, 482.27, 482.30, 482.41, 482.43, 482.45, 482.53, 482.56, 482.57, 482.60, 482.61, 482.62, 482.66, 485.618, 485.631
0938–0334	491.9, 491.10
0938–0338	486.104, 486.106, 486.110
0938–0354	441.60
0938–0355	488.26, 442.30
0938–0358	412.20–412.30
0938–0359	412.40–412.52
0938–0360	488.60
0938–0365	484.10, 484.11, 484.12, 484.14, 484.16, 484.18, 484.20, 484.36, 484.48, 484.52
0938–0372	414.330
0938–0378	482.60–482.62
0938–0379	488.26, 442.30
0938–0382	488.26, 442.30
0938–0386	405.2100–405.2171
0938–0391	488.18, 488.26, 488.28
0938–0426	476.104, 476.105, 476.116, 476.134
0938–0429	447.53
0938–0443	473.18, 473.34, 473.36, 473.42

OMB control numbers	Approved CFR Sections in Title 42, Title 45, and Title 20 (Note: Sections in Title 45 are preceded by "45 CFR," and sections in Title 20 are preceded by "20 CFR")
0938-0444	1004.40, 1004.50, 1004.60, 1004.70
0938-0445	412.44, 412.46, 431.630, 456.654, 466.71, 466.73, 466.74, 466.78
0938-0447	405.2133
0938-0448	405.2133, 45 CFR 5, 5b; 20 CFR Parts 401, 422E
0938-0449	440.180, 441.300-441.310
0938-0454	424.20
0938-0456	412.105
0938-0463	413.20, 413.24, 413.106
0938-0467	431.17, 431.306, 435.910, 435.920, 435.940-435.960
0938-0469	417.126, 422.502, 422.516
0938-0470	417.143, 417.800-417.840, 422.6
0938-0477	412.92
0938-0484	424.123
0938-0501	406.15
0938-0502	433.138
0938-0512	486.304, 486.306, 486.307
0938-0526	475.102, 475.103, 475.104, 475.105, 475.106
0938-0534	410.38, 424.5
0938-0544	493.1-493.2001
0938-0564	411.32
0938-0565	411.20-411.206
0938-0566	411.404, 411.406, 411.408
0938-0573	412.230, 412.256
0938-0578	447.534
0938-0581	493.1-493.2001
0938-0599	493.1-493.2001
0938-0600	405.371, 405.378, 413.20
0938-0610	417.436, 417.801, 422.128, 430.12, 431.20, 431.107, 434.28, 483.10, 484.10, 489.102
0938-0612	493.801, 493.803, 493.1232, 493.1233, 493.1234, 493.1235, 493.1236, 493.1239, 493.1241, 493.1242, 493.1249, 493.1251, 493.1252, 493.1253, 493.1254, 493.1255, 493.1256, 493.1261, 493.1262, 493.1263, 493.1269, 493.1273, 493.1274, 493.1278, 493.1283, 493.1289, 493.1291, 493.1299
0938-0618	433.68, 433.74, 447.272
0938-0653	493.1771, 493.1773, 493.1777
0938-0657	405.2110, 405.2112
0938-0658	405.2110, 405.2112
0938-0667	482.12, 488.18, 489.20, 489.24
0938-0679	410.38
0938-0685	410.32, 410.71, 413.17, 424.57, 424.73, 424.80, 440.30, 484.12
0938-0686	493.551-493.557
0938-0688	486.304, 486.306, 486.307, 486.310, 486.316, 486.318, 486.325
0938-0690	488.4-488.9, 488.201
0938-0691	412.106
0938-0692	466.78, 489.20, 489.27
0938-0701	422.152
0938-0702	45 CFR 146.111, 146.115, 146.117, 146.150, 146.152, 146.160, 146.180
0938-0703	45 CFR 148.120, 148.124, 148.126, 148.128
0938-0714	411.370-411.389
0938-0717	424.57
0938-0721	410.33
0938-0723	421.300-421.318
0938-0730	405.410, 405.430, 405.435, 405.440, 405.445, 405.455, 410.61, 415.110, 424.24
0938-0732	417.126, 417.470
0938-0734	45 CFR 5b
0938-0739	413.337, 413.343, 424.32, 483.20
0938-0742	422.300-422.312
0938-0749	424.57
0938-0753	422.000-422.700
0938-0754	441.152
0938-0758	413.20, 413.24
0938-0760	484 Subpart E, 484.55
0938-0761	484.11, 484.20
0938-0763	422.1-422.10, 422.50-422.80, 422.100-422.132, 422.300-422.312, 422.400-422.404, 422.560-422.622
0938-0770	410.2
0938-0778	422.111, 422.64
0938-0779	417.470, 417.126, 422.210, 422.64
0938-0781	411.404-411.406, 484.10
0938-0786	438.352, 438.360, 438.362, 438.364
0938-0787	406.28, 407.27
0938-0790	460.12, 460.22, 460.26, 460.30, 460.32, 460.52, 460.60, 460.70, 460.71, 460.72, 460.74, 460.80, 460.82, 460.98, 460.100, 460.102, 460.104, 460.106, 460.110, 460.112, 460.116, 460.118, 460.120, 460.122, 460.124, 460.132, 460.152, 460.154, 460.156, 460.160, 460.164, 460.168, 460.172, 460.190, 460.196, 460.200, 460.202, 460.204, 460.208, 460.210
0938-0792	491.8, 491.11
0938-0798	413.24, 413.65, 419.42

OMB control numbers	Approved CFR Sections in Title 42, Title 45, and Title 20 (Note: Sections in Title 45 are preceded by "45 CFR," and sections in Title 20 are preceded by "20 CFR")
0938-0802	419.43
0938-0818	410.141, 410.142, 410.143, 410.144, 410.145, 410.146, 414.63
0938-0829	422.568
0938-0832	489 and 491
0938-0833	483.350-483.376
0938-0841	431.636, 457.50, 457.60, 457.70, 457.340, 457.350, 457.431, 457.440, 457.525, 457.560, 457.570, 457.740, 457.750, 457.810, 457.940, 457.945, 457.965, 457.985, 457.1005, 457.1015, 457.1180
0938-0842	412.23, 412.604, 412.606, 412.608, 412.610, 412.614, 412.618, 412.626, 413.64
0938-0846	411.352-411.361
0938-0857	419
0938-0860	419
0938-0866	45 CFR Part 162
0938-0872	413.337, 483.20
0938-0873	422.152
0938-0874	45 CFR Parts 160 and 162
0938-0878	422 Subpart F & G
0938-0883	45 CFR Parts 160 and 164
0938-0884	405.940
0938-0887	45 CFR 148.316, 148.318, 148.320
0938-0897	412.22, 412.533
0938-0907	412.230, 412.304, 413.65
0938-0910	422.624, 422.626, 422.620
0938-0911	426.400, 426.500
0938-0916	483.16
0938-0920	438.6, 438.8, 438.10, 438.12, 438.50, 438.56, 438.102, 438.114, 438.202, 438.206, 438.207, 438.240, 438.242, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.710, 438.722, 438.724, 438.810
0938-0921	414.804

[FR Doc. 04-28156 Filed 12-29-04; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-9026-N]

RIN 0938-AN112

Medicare Program; Timeline for Publication of Medicare Final Regulations After Proposed or Interim Final Regulations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice implements section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which establishes a general 3-year timeline for publishing a Medicare final regulation after a proposed regulation or an interim final regulation has been published. In accordance with the statute, this notice permits an extension of a published timeline under exceptional circumstances. The notice also establishes a transition period for publishing Medicare final regulations for previously published interim final regulations.

EFFECTIVE DATE: This notice is effective on December 30, 2004.

FOR FURTHER INFORMATION CONTACT:

Renee Swann, (410) 786-4492.

SUPPLEMENTARY INFORMATION:

I. Background and Legislative Authority

The general statutory authority for the Department to issue Medicare regulations is found in section 1871 of the Social Security Act (the Act). Specifically, section 1871(a)(1) of the Act authorizes us to publish regulations to administer the Medicare program. Section 1871(a)(2) of the Act states that, with the exception of national coverage determinations, we must publish a regulation "that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits* * *"

Before issuing a final regulation, section 1871(b)(1) of the Act generally requires us to publish a proposed regulation that solicits comments (for at least 60 days) from the public. There are, however, several exceptions that permit the Secretary to issue final regulations or interim final regulations without first obtaining advance public comments.

Executive Order 12866 (issued on September 20, 1993) requires that all Federal agencies prepare an agenda of all regulations under development or review, at a time and in a manner specified by the Administrator of the Office of Information and Regulatory

Affairs, of the Office of Management and Budget.

We announce in the Semi-Annual Unified Regulations Agenda the regulations we plan to publish during the 12-month period following publication of the Agenda in the **Federal Register**. The Agenda is generally published in April and October each year.

In October 2001, to better serve all of our constituencies, including our health care providers, we began publishing regulations on the fourth Friday of every month (except when a statutory deadline demands otherwise), and we began issuing a quarterly publication called the *Quarterly Provider Update* (QPU). The QPU is publicly available on the Internet and lists all of the regulations that we plan to publish in the coming quarter, as well as the publication date and page reference to all regulations published in the previous quarter. The QPU is published on the CMS web site at <http://qa.cms.hhs.gov/providerupdate/main.asp>.

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Pub. L. 108-173) was enacted. Section 902 of the MMA added a new paragraph (a)(3) to section 1871 of the Act. New section 1871(a)(3)(A) of the Act requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish a standardized timeline for the publication of a Medicare final regulation after the

publication of a proposed or an interim final regulation. Section 1871(a)(3)(B) of the Act allows the timeline for publishing Medicare final regulations to vary based on the complexity of the regulation, the number and scope of comments received, and other related factors. The timeline for publishing the final regulation, however, cannot exceed 3 years from the date of publishing the proposed regulation or interim final regulation, unless there are exceptional circumstances. The Secretary may extend the initial targeted publication date of the final regulation, if the Secretary provides public notice including a brief explanation of the justification for the variation no later than the regulation's previously established proposed publication date.

Section 1871(a)(3)(C) of the Act states that a Medicare interim final regulation will not continue in effect if the final regulation is not published before the expiration of the regular timeline, unless a notice of continuation (for a 1-year period) is published in the **Federal Register** before the proposed publication date for the final regulation. The notice of continuation must establish a new timeline and provide an explanation for missing the previous timeline. If the notice is published before the end of the previous timeline, the timeline for publishing the final regulation will be extended for 1 additional year. The statute allows for additional extensions if this process is followed for additional continuation notices.

Section 1871(a)(3)(D) of the Act requires the Secretary to report annually to the Congress on all instances when the Secretary failed to publish a Medicare final regulation within the applicable timeline and to provide an explanation for failing to meet the timeline.

The provisions of section 902 of the MMA were effective on the date of enactment of the MMA (that is, December 8, 2003). Section 902 of the MMA instructs the Secretary to provide an appropriate transition for previously published Medicare interim final regulations.

II. Timeline of Regulatory Documents

A. Medicare Final Regulations for Proposed Regulations and Interim Final Regulations

We are continuing to improve our efforts to be more responsive to Medicare beneficiaries. Thus, we are establishing a timeline for publishing Medicare final regulations. We believe these changes will enhance our ability to better serve Medicare beneficiaries

and to be better business partners with the health care community.

In accordance with section 902(a) of the MMA, we will publish all future Medicare final regulations within 3 years from the publication date of the proposed regulation or interim final regulation, unless there is good cause or there are exceptional circumstances. We will consult with the Office of Management and Budget and set regulation-specific timelines for publishing Medicare final regulations on a case-by-case basis within the 3-year standardized timeline. We will continue to use the QPU to announce all CMS regulations that we will publish during the quarter.

We will continue to announce the timelines for all CMS regulations in the Semi-Annual Unified Regulations Agenda for the period covered by the Agenda. Except for certain Medicare payment regulations and certain other statutorily-mandated regulations, we scheduled all Medicare final regulations for publication within the 3-year standardized time limit in the current Unified Agenda. We do not intend to delay publishing a Medicare final regulation for 3 years if we are able to publish it sooner.

If it appears likely that we will miss the applicable timeline for finalizing a Medicare interim final regulation, we will publish a notice of continuation announcing the extended timeline and furnish a brief explanation for the delay.

Although we do not believe that section 902 of the MMA prohibits the Secretary from finalizing every proposed regulation that was published more than 3 years before December 8, 2003, we recognize that section 902 of the MMA may be susceptible to more than one interpretation. Accordingly, out of an abundance of caution, we are interpreting section 902 of the MMA as rendering ineffective most Medicare proposed regulations that have not been finalized within 3 years of the proposed regulation publication dates. This also includes proposed regulations published before December 8, 2003, unless there is good cause. In those limited cases when we believe there is good cause, that is, when the agency finds that the notice and comment procedure is impracticable, unnecessary, or contrary to the public interest, we will publish the proposed regulation as an interim final regulation. The interim final regulation will be subject to the 3-year standard timeline set by section 902 of the MMA. Otherwise, if we believe that the substance of a proposed regulation rendered ineffective by the statute should move forward, we will publish

the proposed regulation with an appropriate timeline, not to exceed 3 years.

B. Appropriate Transition for Previously Published Medicare Interim Final Regulations

The enactment of the MMA brought about the most extensive revisions to the Medicare program since its inception in 1965. As a result, we must develop and publish numerous regulations by specific statutory effective dates. In addition to this new priority workload, we must annually publish numerous proposed and final regulations that are required by the statute to update the various Medicare payment systems. Section 902 of the MMA recognizes the need for a transition period to allow for the publication of Medicare final regulations for those interim final regulations that were published before the enactment of the MMA (that is, December 8, 2003). It is our intention to publish these Medicare final regulations as time allows while publishing other regulations required by the statute, but no later than December 8, 2006.

In accordance with the Congress' instruction to devise an appropriate transition for existing interim final regulations, we will be extending all Medicare interim final regulations that have not been finalized for 3 years from the date of passage of the MMA until December 8, 2006. Over the course of the 3 years, we will be reviewing the Medicare interim final regulations to determine the basis for finalizing the regulation and the possible impact of not implementing a final regulation. If we determine that a regulation needs to be repealed, we will issue a separate rulemaking document. For those Medicare interim final regulations that we do not finalize within 3 years, the regulation will expire in accordance with the statute, and we will take the appropriate actions to amend the Code of Federal Regulations.

In accordance with the provisions of Executive Order 12866, this notice has been reviewed by the Office of Management and Budget.

Authority: Section 1871 of the Social Security Act (42 U.S.C. 1395hh). (Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 31, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: August 6, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04-28158 Filed 12-29-04; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4077-FN]

RIN 0928-ZA59

Medicare Program; Approval of the National Committee for Quality Assurance Deeming Authority for Medicare Advantage Local Preferred Provider Organizations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final notice.

SUMMARY: This final notice announces the approval of the National Committee for Quality Assurance for deeming authority as a national accreditation program for local preferred provider organizations that wish to participate in the Medicare Advantage program.

FOR FURTHER INFORMATION CONTACT: Gwyneveyre Pasquale, (410) 786-7701.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization (MCO) that has a Medicare Advantage (MA) (formerly, Medicare+Choice) contract with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met in order for an MCO to enter into an MA contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MCO must provide and the requirements that the organization must meet to be an MA contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of services by Medicare certified providers and suppliers.

Generally, for an organization to enter into an MA contract, the organization must be licensed by the State as a risk bearing organization as set forth in part 422 of our regulations. Additionally, the

organization must file an application demonstrating that it meets other Medicare requirements in part 422 of our regulations. Following approval of the contract, we engage in routine monitoring and oversight audits of the MA organization to ensure continuing compliance. The monitoring and oversight audit process is comprehensive and incorporates ongoing analysis of various performance data in addition to biennial audits by CMS staff who use a written protocol that itemizes the Medicare requirements the MA organization must meet.

As an alternative for some Medicare requirements, an MA organization may be exempt from CMS monitoring of certain requirements in subsets listed in section 1852(e)(4)(B) of the Act as a result of an MA organization's accreditation by a CMS-approved accrediting organization (AO); that is, the Secretary deems that the Medicare requirements are met based on a determination that the AO's standards are at least as stringent as Medicare requirements. As we specify at § 422.157(b)(2) of our regulations, the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must re-apply to CMS.

The applicant organization is generally recognized as an entity that accredits MCOs that are licensed as a health maintenance organization (HMO) or a preferred provider organization (PPO).

II. Deeming Application Approval Process

Section 1852(e)(4)(C) of the Act requires that within 210 days of receipt of an application, the Secretary shall determine whether the applicant meets criteria specified in section 1865(b)(2) of the Act. Under these criteria, the Secretary will consider for a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

Section 1865(b)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accreditation body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We must publish a finding of approval

or denial of the application within 210 days from the receipt of the completed application.

III. Provisions of the Proposed Notice

On September 24, 2004, we published a proposed notice in the **Federal Register** (69 FR 57310) announcing the National Committee for Quality Assurance's (NCQA's) request for recognition as a national accreditation program for PPOs that wish to participate in the MA program. This notice informed the public of our consideration of NCQA's application for approval as a deeming authority for MA organizations that are licensed as a PPO for the following six categories:

- Quality improvement.
- Access to services.
- Antidiscrimination.
- Information on advance directives.
- Provider participation rules.
- Confidentiality and accuracy of enrollees' records.

In the notice, we described our evaluation criteria. Under § 422.158(a), we conducted a review of NCQA's application in accordance with the criteria specified by our regulations, which include, but are not limited to, the following:

- The equivalency of NCQA's requirements for PPOs to CMS' comparable MA organization requirements.
- NCQA's survey process, to determine the following:
 - + The frequency of surveys.
 - + The types of forms, guidelines, and instructions used by surveyors.
 - + Descriptions of the accreditation decision making process, deficiency notification and monitoring process, and compliance enforcement process.
 - Detailed information about individuals who perform accreditation surveys including—
 - + Size and composition of the survey team;
 - + Education and experience requirements for the surveyors;
 - + In-service training required for surveyor personnel;
 - + Surveyor performance evaluation systems; and
 - + Conflict of interest policies relating to individuals in the survey and accreditation decision process.
 - Descriptions of the organization's—
 - + Data management and analysis system;
 - + Policies and procedures for investigating and responding to complaints against accredited organizations; and
 - + Types and categories of accreditation offered and MA organizations currently accredited within those types and categories.

In accordance with § 422.158(b) of our regulations, the applicant must provide documentation relating to—

- Its ability to provide data in a CMS-compatible format;
- The adequacy of personnel and other resources necessary to perform the required surveys and other activities; and
- Assurances that it will comply with ongoing responsibility requirements specified in § 422.157(c) of our regulations.

In accordance with section 1865(b)(3)(A) of the Act, the proposed notice also solicited public comment on the ability of the NCQA's accreditation program to meet or exceed the Medicare requirements for which it seeks authority to deem. We did not receive any public comment in response to the proposed notice.

IV. Provisions of the Final Notice

On August 4, 2004, NCQA submitted all the necessary information to permit us to make a determination concerning its request for approval as a deeming authority for MA organizations that are licensed as a PPO.

We compared the standards contained in NCQA's PPO crosswalk and its survey process with the Medicare regulations and the PPO survey monitoring guide. Our review and evaluation of NCQA's deeming application determined that the NCQA standards meet or exceed those established by the Medicare program. Therefore, we recognize NCQA as a national accreditation organization for local preferred provider organizations that wish to participate in the Medicare Advantage program, effective October 20, 2004 through October 20, 2010.

V. Collection of Information Requirements

This final notice does not impose any information collection and record keeping requirements subject to the Paperwork Reduction Act (PRA). Consequently, it does not need to be reviewed by the Office of Management and Budget (OMB) under the authority of the PRA.

VI. Executive Order 12866 Statement

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

Authority: Sections 1852 and 1865 of the Social Security Act (42 U.S.C. 1395w-23 and

1395bb) (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 24, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04-28154 Filed 12-29-04; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-1249-CN2]

RIN 0938-AM46

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Corrections

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Correction notice.

SUMMARY: This document corrects technical errors that appeared in the July 30, 2004 **Federal Register**, entitled "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update—Notice."

EFFECTIVE DATE: This correction is effective October 1, 2004, except for certain wage index corrections that are effective January 1, 2005.

FOR FURTHER INFORMATION CONTACT: Jeanette Kranacs, (410) 786-9385, Bill Ullman, (410) 786-5667, or Sheila Lambowitz, (410) 786-7605.

SUPPLEMENTARY INFORMATION:

I. Background

On October 7, 2004, we published a correction notice (FR Doc. 04-22399, 69 FR 60158) to correct a number of technical errors that had appeared in the FY 2005 SNF PPS update notice published on July 30, 2004 (FR Doc. 04-17443, 69 FR 45775). In that notice we indicated that the corrected wage tables and other tables were being posted on the CMS Web site at <http://www.cms.hhs.gov/providers/snfpps>, and we also expressed our intent to publish them in a forthcoming **Federal Register** notice. In this notice we are fulfilling that intent, as well as correcting certain

additional technical errors in wage index values that have been recently identified. The corrections appear in this document under the heading "Correction of Errors." The provisions in this correction notice are effective as if they had been included in the document published in the **Federal Register** on July 30, 2004, that is, as of October 1, 2004, except for those wage index value corrections that we specifically note to be effective as of January 1, 2005.

In this notice, we hereby set forth the corrected versions of Tables 8, 9, 10, and 12 that were referenced in FR Doc. 04-22399 (69 FR 60158).

In addition, Table 8 is further revised to reflect the following additional corrections, which become effective as of January 1, 2005:

1. The entry of "0.7959" for Metropolitan Statistical Area (MSA) 3960 (Lake Charles, LA) is revised by adding "(0.7972, effective January 1, 2005)".
2. The entry of "0.8053" for MSA 4280 (Lexington, KY) is revised by adding "(0.9219, effective January 1, 2005)".
3. The entry of "1.0025" for MSA 5000 (Miami, FL) is revised by adding "(0.9870, effective January 1, 2005)".
4. The entry of "1.2921" for MSA 5380 (Nassau-Suffolk, NY) is revised by adding "(1.2907, effective January 1, 2005)".
5. The entry of "1.3587" for MSA 5600 (New York, NY) is revised by adding "(1.3586, effective January 1, 2005)".
6. The entry of "1.0975" for MSA 6780 (Riverside-San Bernardino, CA) is revised by adding "(1.0970, effective January 1, 2005)".
7. The entry of "0.9964" for MSA 8780 (Visalia-Tulare-Porterville, CA) is revised by adding "(0.9975, effective January 1, 2005)".
8. The entry of "1.0059" for MSA 8960 (West Palm Beach-Boca Raton, FL) is revised by adding "(1.0362, effective January 1, 2005)".
9. The entry of "0.9472" for MSA 9040 (Wichita, KS) is revised by adding "(0.9468, effective January 1, 2005)".

II. Correction of Errors

In FR Doc. 04-17443 (69 FR 45775), make the following corrections:

1. On pages 45787 through 45814, in Table 8—Wage Index for Rural Areas the table is corrected to read as follows:

TABLE 8.—WAGE INDEX FOR URBAN AREAS

MSA	Urban area (constituent counties or county equivalents)	Wage index
0040	Abilene, TX	0.8009
	Taylor, TX	
0060	Aguadilla, PR	0.4294
	Aguada, PR	
	Aguadilla, PR	
	Moca, PR	
0080	Akron, OH	0.9055
	Portage, OH	
	Summit, OH	
0120	Albany, GA	1.1266
	Dougherty, GA	
	Lee, GA	
0160	Albany-Schenectady-Troy, NY	0.8570
	Albany, NY	
	Montgomery, NY	
	Rensselaer, NY	
	Saratoga, NY	
	Schenectady, NY	
	Schoharie, NY	
0200	Albuquerque, NM	1.0485
	Bernalillo, NM	
	Sandoval, NM	
	Valencia, NM	
0220	Alexandria, LA	0.8171
	Rapides, LA	
0240	Allentown-Bethlehem-Easton, PA	0.9536
	Carbon, PA	
	Lehigh, PA	
	Northampton, PA	
0280	Altoona, PA	0.8462
	Blair, PA	
0320	Amarillo, TX	0.9178
	Potter, TX	
	Randall, TX	
0380	Anchorage, AK	1.2109
	Anchorage, AK	
0440	Ann Arbor, MI	1.0816
	Lenawee, MI	
	Livingston, MI	
	Washtenaw, MI	
0450	Anniston, AL	0.7881
	Calhoun, AL	
0460	Appleton-Oshkosh-Neenah, WI	0.9115
	Calumet, WI	
	Outagamie, WI	
	Winnebago, WI	
0470	Arecibo, PR	0.3757
	Arecibo, PR	
	Camuy, PR	
	Hatillo, PR	
0480	Asheville, NC	0.9501
	Buncombe, NC	
	Madison, NC	
0500	Athens, GA	1.0202
	Clarke, GA	
	Madison, GA	
	Oconee, GA	
0520	Atlanta, GA	0.9971
	Barrow, GA	
	Bartow, GA	
	Carroll, GA	
	Cherokee, GA	
	Clayton, GA	
	Cobb, GA	
	Coweta, GA	
	De Kalb, GA	
	Douglas, GA	
	Fayette, GA	
	Forsyth, GA	
	Fulton, GA	
	Gwinnett, GA	
	Henry, GA	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Newton, GA	
	Paulding, GA	
	Pickens, GA	
	Rockdale, GA	
	Spalding, GA	
	Walton, GA	
0560	Atlantic City-Cape May, NJ	1.0907
	Atlantic City, NJ	
	Cape May, NJ	
0580	Auburn-Opelika, AL	0.8215
	Lee, AL	
0600	Augusta-Aiken, GA-SC	0.9208
	Columbia, GA	
	McDuffie, GA	
	Richmond, GA	
	Aiken, SC	
	Edgefield, SC	
0640	Austin-San Marcos, TX	0.9595
	Bastrop, TX	
	Caldwell, TX	
	Hays, TX	
	Travis, TX	
	Williamson, TX	
0680	Bakersfield, CA	1.0036
	Kern, CA	
0720	Baltimore, MD	0.9907
	Anne Arundel, MD	
	Baltimore, MD	
	Baltimore City, MD	
	Carroll, MD	
	Harford, MD	
	Howard, MD	
	Queen Annes, MD	
0733	Bangor, ME	0.9955
	Penobscot, ME	
0743	Barnstable-Yarmouth, MA	1.2335
	Barnstable, MA	
0760	Baton Rouge, LA	0.8354
	Ascension, LA	
	East Baton Rouge	
	Livingston, LA	
	West Baton Rouge, LA	
0840	Beaumont-Port Arthur, TX	0.8616
	Hardin, TX	
	Jefferson, TX	
	Orange, TX	
0860	Bellingham, WA	1.1642
	Whatcom, WA	
0870	Benton Harbor, MI	0.8847
	Berrien, MI	
0875	Bergen-Passaic, NJ	1.1967
	Bergen, NJ	
	Passaic, NJ	
0880	Billings, MT	0.8961
	Yellowstone, MT	
0920	Biloxi-Gulfport-Pascagoula, MS	0.8649
	Hancock, MS	
	Harrison, MS	
	Jackson, MS	
0960	Binghamton, NY	0.8447
	Broome, NY	
	Tioga, NY	
1000	Birmingham, AL	0.9198
	Blount, AL	
	Jefferson, AL	
	St. Clair, AL	
	Shelby, AL	
1010	Bismarck, ND	0.7505
	Burleigh, ND	
	Morton, ND	
1020	Bloomington, IN	0.8587
	Monroe, IN	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
1040	Bloomington-Normal, IL	0.9111
	McLean, IL	
1080	Boise City, ID	0.9352
	Ada, ID	
	Canyon, ID	
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1290
	Bristol, MA	
	Essex, MA	
	Middlesex, MA	
	Norfolk, MA	
	Plymouth, MA	
	Suffolk, MA	
	Worcester, MA	
	Hillsborough, NH	
	Merrimack, NH	
	Rockingham, NH	
	Strafford, NH	
1125	Boulder-Longmont, CO	1.0046
	Boulder, CO	
1145	Brazoria, TX	0.8524
	Brazoria, TX	
1150	Bremerton, WA	1.0614
	Kitsap, WA	
1240	Brownsville-Harlingen-San Benito, TX	1.0125
	Cameron, TX	
1260	Bryan-College Station, TX	0.9243
	Brazos, TX	
1280	Buffalo-Niagara Falls, NY	0.9339
	Erie, NY	
	Niagara, NY	
1303	Burlington, VT	0.9322
	Chittenden, VT	
	Franklin, VT	
	Grand Isle, VT	
1310	Caguas, PR	0.4061
	Caguas, PR	
	Cayey, PR	
	Cidra, PR	
	Gurabo, PR	
	San Lorenzo, PR	
1320	Canton-Massillon, OH	0.8895
	Carroll, OH	
	Stark, OH	
1350	Casper, WY	0.9243
	Natrona, WY	
1360	Cedar Rapids, IA	0.8975
	Linn, IA	
1400	Champaign-Urbana, IL	0.9527
	Champaign, IL	
1440	Charleston-North Charleston, SC	0.9420
	Berkeley, SC	
	Charleston, SC	
	Dorchester, SC	
1480	Charleston, WV	0.8876
	Kanawha, WV	
	Putnam, WV	
1520	Charlotte-Gastonia-Rock Hill, NC-SC	0.9711
	Cabarrus, NC	
	Gaston, NC	
	Lincoln, NC	
	Mecklenburg, NC	
	Rowan, NC	
	Union, NC	
	York, SC	
1540	Charlottesville, VA	1.0294
	Albemarle, VA	
	Charlottesville City, VA	
	Fluvanna, VA	
	Greene, VA	
1560	Chattanooga, TN-GA	0.9207
	Catoosa, GA	
	Dade, GA	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
1580	Walker, GA Hamilton, TN Marion, TN Cheyenne, WY	0.8980
1600	Laramie, WY Chicago, IL Cook, IL De Kalb, IL Du Page, IL Grundy, IL Kane, IL Kendall, IL Lake, IL McHenry, IL Will, IL	1.0851
1620	Chico-Paradise, CA	1.0542
1640	Butte, CA Cincinnati, OH-KY-IN Dearborn, IN Ohio, IN Boone, KY Campbell, KY Gallatin, KY Grant, KY Kenton, KY Pendleton, KY Brown, OH Clermont, OH Hamilton, OH Warren, OH	0.9595
1660	Clarksville-Hopkinsville, TN-KY Christian, KY Montgomery, TN	0.8022
1680	Cleveland-Lorain-Elyria, OH Ashtabula, OH Geauga, OH Cuyahoga, OH Lake, OH Lorain, OH Medina, OH	0.9626
1720	Colorado Springs, CO	0.9792
1740	El Paso, CO	0.8396
1760	Columbia MO Boone, MO	0.9450
1800	Columbia, SC Lexington, SC Richland, SC	0.8690
1840	Columbus, GA-AL Russell, AL Chattanooga, GA Harris, GA Muscogee, GA	0.9753
1880	Columbus, OH Delaware, OH Fairfield, OH Franklin, OH Licking, OH Madison, OH Pickaway, OH	0.8647
1890	Corpus Christi, TX Nueces, TX San Patricio, TX	1.0545
1900	Corvallis, OR Benton, OR	0.8662
1920	Cumberland, MD-WV Allegany MD Mineral WV Dallas, TX Collin, TX Dallas, TX Denton, TX Ellis, TX	1.0054

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Henderson, TX	
	Hunt, TX	
	Kaufman, TX	
	Rockwall, TX	
1950	Danville, VA	0.8643
	Danville City, VA	
	Pittsylvania, VA	
1960	Davenport-Moline-Rock Island, IA-IL	0.8773
	Scott, IA	
	Henry, IL	
	Rock Island, IL	
2000	Dayton-Springfield, OH	0.9231
	Clark, OH	
	Greene, OH	
	Miami, OH	
	Montgomery, OH	
2020	Daytona Beach, FL	0.8900
	Flagler, FL	
	Volusia, FL	
2030	Decatur, AL	0.8894
	Lawrence, AL	
	Morgan, AL	
2040	Decatur, IL	0.8122
	Macon, IL	
2080	Denver, CO	1.0904
	Adams, CO	
	Arapahoe, CO	
	Broomfield, CO	
	Denver, CO	
	Douglas, CO	
	Jefferson, CO	
2120	Des Moines, IA	0.9266
	Dallas, IA	
	Polk, IA	
	Warren, IA	
2160	Detroit, MI	1.0227
	Lapeer, MI	
	Macomb, MI	
	Monroe, MI	
	Oakland, MI	
	St. Clair, MI	
	Wayne, MI	
2180	Dothan, AL	0.7596
	Dale, AL	
	Houston, AL	
2190	Dover, DE	0.9825
	Kent, DE	
2200	Dubuque, IA	0.8748
	Dubuque, IA	
2240	Duluth-Superior, MN-WI	1.0356
	St. Louis, MN	
	Douglas, WI	
2281	Dutchess County, NY	1.1657
	Dutchess, NY	
2290	Eau Claire, WI	0.9139
	Chippewa, WI	
	Eau Claire, WI	
2320	El Paso, TX	0.9181
	El Paso, TX	
2330	Elkhart-Goshen, IN	0.9278
	Elkhart, IN	
2335	Elmira, NY	0.8445
	Chemung, NY	
2340	Enid, OK	0.9001
	Garfield, OK	
2360	Erie, PA	0.8699
	Erie, PA	
2400	Eugene-Springfield, OR	1.0940
	Lane, OR	
2440	Evansville-Henderson, IN-KY	0.8395
	Posey, IN	
	Vanderburgh, IN	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
2520	Warrick, IN Henderson, KY Fargo-Moorhead, ND-MN Clay, MN Cass, ND	0.9114
2560	Fayetteville, NC Cumberland, NC	0.9363
2580	Fayetteville-Springdale-Rogers, AR Benton, AR Washington, AR	0.8636
2620	Flagstaff, AZ-UT Coconino, AZ Kane, UT	1.0611
2640	Flint, MI	1.1178
2650	Genesee, MI Florence, AL Colbert, AL Lauderdale, AL	0.7883
2655	Florence, SC	0.8960
2670	Florence, SC Fort Collins-Loveland, CO Larimer, CO	1.0218
2680	Ft. Lauderdale, FL Broward, FL	1.0165
2700	Fort Myers-Cape Coral, FL Lee, FL	0.9371
2710	Fort Pierce-Port St. Lucie, FL Martin, FL St. Lucie, FL	1.0046
2720	Fort Smith, AR-OK Crawford, AR Sebastian, AR Sequoyah, OK	0.8303
2750	Fort Walton Beach, FL Okaloosa, FL	0.8786
2760	Fort Wayne, IN Adams, IN Allen, IN De Kalb, IN Huntington, IN Wells, IN Whitley, IN	0.9737
2800	Forth Worth-Arlington, TX Hood, TX Johnson, TX Parker, TX Tarrant, TX	0.9520
2840	Fresno, CA Fresno, CA Madera, CA	1.0407
2880	Gadsden, AL	0.8049
2900	Etowah, AL Gainesville, FL Alachua, FL	0.9459
2920	Galveston-Texas City, TX Galveston, TX	0.9403
2960	Gary, IN Lake, IN Porter, IN	0.9342
2975	Glens Falls, NY Warren, NY Washington, NY	0.8467
2980	Goldsboro, NC Wayne, NC	0.8778
2985	Grand Forks, ND-MN Polk, MN	0.9091
2995	Grand Forks, ND Grand Junction, CO Mesa, CO	0.9900
3000	Grand Rapids-Muskegon-Holland, MI Allegan, MI Kent, MI	0.9519

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Muskegon, MI	
	Ottawa, MI	
3040	Great Falls, MT	0.8810
	Cascade, MT	
3060	Greeley, CO	0.9444
	Weld, CO	
3080	Green Bay, WI	0.9586
	Brown, WI	
3120	Greensboro-Winston-Salem-High Point, NC	0.9312
	Alamance, NC	
	Davidson, NC	
	Davie, NC	
	Forsyth, NC	
	Guilford, NC	
	Randolph, NC	
	Stokes, NC	
	Yadkin, NC	
3150	Greenville, NC	0.9183
	Pitt, NC	
3160	Greenville-Spartanburg-Anderson, SC	0.9400
	Anderson, SC	
	Cherokee, SC	
	Greenville, SC	
	Pickens, SC	
	Spartanburg, SC	
3180	Hagerstown, MD	0.9940
	Washington, MD	
3200	Hamilton-Middletown, OH	0.9066
	Butler, OH	
3240	Harrisburg-Lebanon-Carlisle, PA	0.9286
	Cumberland, PA	
	Dauphin, PA	
	Lebanon, PA	
	Perry, PA	
3283	Hartford, CT	1.1054
	Hartford, CT	
	Litchfield, CT	
	Middlesex, CT	
	Tolland, CT	
3285	Hattiesburg, MS	0.7362
	Forrest, MS	
	Lamar, MS	
3290	Hickory-Morganton-Lenoir, NC	0.9502
	Alexander, NC	
	Burke, NC	
	Caldwell, NC	
	Catawba, NC	
3320	Honolulu, HI	1.1013
	Honolulu, HI	
3350	Houma, LA	0.7721
	Lafourche, LA	
	Terrebonne, LA	
3360	Houston, TX	1.0117
	Chambers, TX	
	Fort Bend, TX	
	Harris, TX	
	Liberty, TX	
	Montgomery, TX	
	Waller, TX	
3400	Huntington-Ashland, WV-KY-OH	0.9564
	Boyd, KY	
	Carter, KY	
	Greenup, KY	
	Lawrence, OH	
	Cabell, WV	
	Wayne, WV	
3440	Huntsville, AL	0.8851
	Limestone, AL	
	Madison, AL	
3480	Indianapolis, IN	1.0039
	Boone, IN	
	Hamilton, IN	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Hancock, IN	
	Hendricks, IN	
	Johnson, IN	
	Madison, IN	
	Marion, IN	
	Morgan, IN	
	Shelby, IN	
3500	Iowa City, IA	0.9654
	Johnson, IA	
3520	Jackson, MI	0.9146
	Jackson, MI	
3560	Jackson, MS	0.8406
	Hinds, MS	
	Madison, MS	
	Rankin, MS	
3580	Jackson, TN	0.8900
	Chester, TN	
	Madison, TN	
3600	Jacksonville, FL	0.9548
	Clay, FL	
	Duval, FL	
	Nassau, FL	
	St. Johns, FL	
3605	Jacksonville, NC	0.8401
	Onslow, NC	
3610	Jamestown, NY	0.7589
	Chautauqua, NY	
3620	Janesville-Beloit, WI	0.9583
	Rock, WI	
3640	Jersey City, NJ	1.0923
	Hudson, NJ	
3660	Johnson City-Kingsport-Bristol, TN-VA	0.8202
	Carter, TN	
	Hawkins, TN	
	Sullivan, TN	
	Unicoi, TN	
	Washington, TN	
	Bristol City, VA	
	Scott, VA	
	Washington, VA	
3680	Johnstown, PA	0.7980
	Cambria, PA	
	Somerset, PA	
3700	Jonesboro, AR	0.8144
	Craighead, AR	
3710	Joplin, MO	0.8721
	Jasper, MO	
	Newton, MO	
3720	Kalamazoo-Battlecreek, MI	1.0350
	Calhoun, MI	
	Kalamazoo, MI	
	Van Buren, MI	
3740	Kankakee, IL	1.0603
	Kankakee, IL	
3760	Kansas City, KS-MO	0.9641
	Johnson, KS	
	Leavenworth, KS	
	Miami, KS	
	Wyandotte, KS	
	Cass, MO	
	Clay, MO	
	Clinton, MO	
	Jackson, MO	
	Lafayette, MO	
	Platte, MO	
	Ray, MO	
3800	Kenosha, WI	0.9772
	Kenosha, WI	
3810	Killeen-Temple, TX	0.9242
	Bell, TX	
	Coryell, TX	
3840	Knoxville, TN	0.8508

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Anderson, TN	
	Blount, TN	
	Knox, TN	
	Loudon, TN	
	Sevier, TN	
	Union, TN	
3850	Kokomo, IN	0.8986
	Howard, IN	
	Tipton, IN	
3870	La Crosse, WI-MN	0.9289
	Houston, MN	
	La Crosse, WI	
3880	Lafayette, LA	0.8105
	Acadia, LA	
	Lafayette, LA	
	St. Landry, LA	
	St. Martin, LA	
3920	Lafayette, IN	0.9067
	Clinton, IN	
	Tippecanoe, IN	
3960	Lake Charles, LA	0.7959 (0.7972**)
	Calcasieu, LA	
3980	Lakeland-Winter Haven, FL	0.8930
	Polk, FL	
4000	Lancaster, PA	0.9883
	Lancaster, PA	
4040	Lansing-East Lansing, MI	0.9658
	Clinton, MI	
	Eaton, MI	
	Ingham, MI	
4080	Laredo, TX	0.8747
	Webb, TX	
4100	Las Cruces, NM	0.8784
	Dona Ana, NM	
4120	Las Vegas, NV-AZ	1.1121
	Mohave, AZ	
	Clark, NV	
	Nye, NV	
4150	Lawrence, KS	0.8644
	Douglas, KS	
4200	Lawton, OK	0.8212
	Comanche, OK	
4243	Lewiston-Auburn, ME	0.9562
	Androscoggin, ME	
4280	Lexington, KY	0.8053 (0.9219**)
	Bourbon, KY	
	Clark, KY	
	Fayette, KY	
	Jessamine, KY	
	Madison, KY	
	Scott, KY	
	Woodford, KY	
4320	Lima, OH	0.9258
	Allen, OH	
	Auglaize, OH	
4360	Lincoln, NE	1.0208
	Lancaster, NE	
4400	Little Rock-North Little, AR	0.8826
	Faulkner, AR	
	Lonoke, AR	
	Pulaski, AR	
	Saline, AR	
4420	Longview-Marshall, TX	0.8739
	Gregg, TX	
	Harrison, TX	
	Upshur, TX	
4480	Los Angeles-Long Beach, CA	1.1732
	Los Angeles, CA	
4520	Louisville, KY-IN	0.9162
	Clark, IN	
	Floyd, IN	
	Harrison, IN	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Scott, IN	
	Bullitt, KY	
	Jefferson, KY	
	Oldham, KY	
4600	Lubbock, TX	0.8777
	Lubbock, TX	
4640	Lynchburg, VA	0.9017
	Amherst, VA	
	Bedford City, VA	
	Bedford, VA	
	Campbell, VA	
	Lynchburg City, VA	
4680	Macon, GA	0.9596
	Bibb, GA	
	Houston, GA	
	Jones, GA	
	Peach, GA	
	Twiggs, GA	
4720	Madison, WI	1.0395
	Dane, WI	
4800	Mansfield, OH	0.9105
	Crawford, OH	
	Richland, OH	
4840	Mayaguez, PR	0.4769
	Anasco, PR	
	Cabo Rojo, PR	
	Hormigueros, PR	
	Mayaguez, PR	
	Sabana Grande, PR	
	San German, PR	
4880	McAllen-Edinburg-Mission, TX	0.8602
	Hidalgo, TX	
4890	Medford-Ashland, OR	1.0534
	Jackson, OR	
4900	Melbourne-Titusville-Palm Bay, FL	0.9633
	Brevard, FL	
4920	Memphis, TN-AR-MS	0.9234
	Crittenden, AR	
	De Soto, MS	
	Fayette, TN	
	Shelby, TN	
	Tipton, TN	
4940	Merced, CA	1.0575
	Merced, CA	
5000	Miami, FL	1.0025 (0.9870**)
	Dade, FL	
5015	Middlesex-Somerset-Hunterdon, NJ	1.1360
	Hunterdon, NJ	
	Middlesex, NJ	
	Somerset, NJ	
5080	Milwaukee-Waukesha, WI	1.0076
	Milwaukee, WI	
	Ozaukee, WI	
	Washington, WI	
	Waukesha, WI	
5120	Minneapolis-St. Paul, MN-WI	1.1066
	Anoka, MN	
	Carver, MN	
	Chisago, MN	
	Dakota, MN	
	Hennepin, MN	
	Isanti, MN	
	Ramsey, MN	
	Scott, MN	
	Sherburne, MN	
	Washington, MN	
	Wright, MN	
	Pierce, WI	
	St. Croix, WI	
5140	Missoula, MT	0.9618
	Missoula, MT	
5160	Mobile, AL	0.7932

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
5170	Baldwin, AL Mobile, AL Modesto, CA	1.1966
5190	Stanislaus, CA Monmouth-Ocean, NJ	1.0888
5200	Monmouth, NJ Ocean, NJ Monroe, LA	0.7913
5240	Ouachita, LA Montgomery, AL	0.8300
5280	Autauga, AL Elmore, AL Montgomery, AL Muncie, IN	0.8580
5330	Delaware, IN Myrtle Beach, SC	0.9022
5345	Horry, SC Naples, FL	1.0558
5360	Collier, FL Nashville, TN	1.0108
5380	Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford, TN Sumner, TN Williamson, TN Wilson, TN Nassau-Suffolk, NY	1.2921 (1.2907**)
5483	Nassau, NY Suffolk, NY New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2254
5523	Fairfield, CT New Haven, CT New London-Norwich, CT	1.1596
5560	New London, CT New Orleans, LA	0.9103
5600	Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA St. Charles, LA St. James, LA St. John The Baptist, LA St. Tammany, LA New York, NY	1.3587 (1.3586**)
5640	Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY Newark, NJ	1.1625
5660	Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ Newburgh, NY-PA	1.1170
5720	Orange, NY Pike, PA Norfolk-Virginia Beach-Newport News, VA-NC	0.8894
	Currituck, NC Chesapeake City, VA Gloucester, VA Hampton City, VA Isle of Wight, VA James City, VA Mathews, VA Newport News City, VA	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA York, VA	
5775	Oakland, CA	1.5220
	Alameda, CA Contra Costa, CA	
5790	Ocala, FL	0.9153
	Marion, FL	
5800	Odessa-Midland, TX	0.9632
	Ector, TX Midland, TX	
5880	Oklahoma City, OK	0.8966
	Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	
5910	Olympia, WA	1.1006
	Thurston, WA	
5920	Omaha, NE-IA	0.9754
	Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	
5945	Orange County, CA	1.1611
	Orange, CA	
5960	Orlando, FL	0.9742
	Lake, FL Orange, FL Osceola, FL Seminole, FL	
5990	Owensboro, KY	0.8434
	Daviess, KY	
6015	Panama City, FL	0.8124
	Bay, FL	
6020	Parkersburg-Marietta, WV-OH	0.8288
	Washington, OH Wood, WV	
6080	Pensacola, FL	0.8306
	Escambia, FL Santa Rosa, FL	
6120	Peoria-Pekin, IL	0.8886
	Peoria, IL Tazewell, IL Woodford, IL	
6160	Philadelphia, PA-NJ	1.0824
	Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	
6200	Phoenix-Mesa, AZ	0.9982
	Maricopa, AZ Pinal, AZ	
6240	Pine Bluff, AR	0.8673
	Jefferson, AR	
6280	Pittsburgh, PA	0.8756
	Allegheny, PA Beaver, PA Butler, PA Fayette, PA Washington, PA	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
6323	Westmoreland, PA	
6323	Pittsfield, MA	1.0439
6340	Berkshire, MA	
6340	Pocatello, ID	0.9601
6360	Bannock, ID	
6360	Ponce, PR	0.4954
	Guayanilla, PR	
	Juana Diaz, PR	
	Penuelas, PR	
	Ponce, PR	
	Villalba, PR	
	Yauco, PR	
6403	Portland, ME	1.0112
	Cumberland, ME	
	Sagadahoc, ME	
	York, ME	
6440	Portland-Vancouver, OR-WA	1.1403
	Clackamas, OR	
	Columbia, OR	
	Multnomah, OR	
	Washington, OR	
	Yamhill, OR	
	Clark, WA	
6483	Providence-Warwick-Pawtucket, RI	1.1061
	Bristol, RI	
	Kent, RI	
	Newport, RI	
	Providence, RI	
	Washington, RI	
6520	Provo-Orem, UT	0.9613
	Utah, UT	
6560	Pueblo, CO	0.8752
	Pueblo, CO	
6580	Punta Gorda, FL	0.9441
	Charlotte, FL	
6600	Racine, WI	0.9045
	Racine, WI	
6640	Raleigh-Durham-Chapel Hill, NC	1.0258
	Chatham, NC	
	Durham, NC	
	Franklin, NC	
	Johnston, NC	
	Orange, NC	
	Wake, NC	
6660	Rapid City, SD	0.8912
	Pennington, SD	
6680	Reading, PA	0.9215
	Berks, PA	
6690	Redding, CA	1.1835
	Shasta, CA	
6720	Reno, NV	1.0456
	Washoe, NV	
6740	Richland-Kennewick-Pasco, WA	1.0520
	Benton, WA	
	Franklin, WA	
6760	Richmond-Petersburg, VA	0.9397
	Charles City County, VA	
	Chesterfield, VA	
	Colonial Heights City, VA	
	Dinwiddie, VA	
	Goochland, VA	
	Hanover, VA	
	Henrico, VA	
	Hopewell City, VA	
	New Kent, VA	
	Petersburg City, VA	
	Powhatan, VA	
	Prince George, VA	
	Richmond City, VA	
6780	Riverside-San Bernardino, CA	1.0975 (1.0970**)
	Riverside, CA	
	San Bernardino, CA	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
6800	Roanoke, VA	0.8428
	Botetourt, VA	
	Roanoke, VA	
	Roanoke City, VA	
	Salem City, VA	
6820	Rochester, MN	1.1504
	Olmsted, MN	
6840	Rochester, NY	0.9196
	Genesee, NY	
	Livingston, NY	
	Monroe, NY	
	Ontario, NY	
	Orleans, NY	
	Wayne, NY	
6880	Rockford, IL	0.9626
	Boone, IL	
	Ogle, IL	
	Winnebago, IL	
6895	Rocky Mount, NC	0.8998
	Edgecombe, NC	
	Nash, NC	
6920	Sacramento, CA	1.1848
	El Dorado, CA	
	Placer, CA	
	Sacramento, CA	
6960	Saginaw-Bay City-Midland, MI	0.9696
	Bay, MI	
	Midland, MI	
	Saginaw, MI	
6980	St. Cloud, MN	1.0215
	Benton, MN	
	Stearns, MN	
7000	St. Joseph, MO	1.0013
	Andrews, MO	
	Buchanan, MO	
7040	St. Louis, MO-IL	0.9081
	Clinton, IL	
	Jersey, IL	
	Madison, IL	
	Monroe, IL	
	St. Clair, IL	
	Franklin, MO	
	Jefferson, MO	
	Lincoln, MO	
	St. Charles, MO	
	St. Louis, MO	
	St. Louis City, MO	
	Warren, MO	
	Sullivan City, MO	
7080	Salem, OR	1.0556
	Marion, OR	
	Polk, OR	
7120	Salinas, CA	1.3823
	Monterey, CA	
7160	Salt Lake City-Ogden, UT	0.9487
	Davis, UT	
	Salt Lake, UT	
	Weber, UT	
7200	San Angelo, TX	0.8167
	Tom Green, TX	
7240	San Antonio, TX	0.9023
	Bexar, TX	
	Cornal, TX	
	Guadalupe, TX	
	Wilson, TX	
7320	San Diego, CA	1.1267
	San Diego, CA	
7360	San Francisco, CA	1.4712
	Marin, CA	
	San Francisco, CA	
	San Mateo, CA	
7400	San Jose, CA	1.4744

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
7440	Santa Clara, CA San Juan-Bayamon, PR	0.4802
	Agua Buenas, PR Barceloneta, PR Bayamon, PR Canovanas, PR Carolina, PR Catano, PR Ceiba, PR Comerio, PR Corozal, PR Dorado, PR Fajardo, PR Florida, PR Guaynabo, PR Humacao, PR Juncos, PR Los Piedras, PR Loiza, PR Luguillo, PR Manati, PR Morovis, PR Naguabo, PR Naranjito, PR Rio Grande, PR San Juan, PR Toa Alta, PR Toa Baja, PR Trujillo Alto, PR Vega Alta, PR Vega Baja, PR Yabucoa, PR	
7460	San Luis Obispo-Atascadero-Paso Robles, CA	1.1118
	San Luis Obispo, CA	
7480	Santa Barbara-Santa Maria-Lompoc, CA	1.0771
	Santa Barbara, CA	
7485	Santa Cruz-Watsonville, CA	1.4779
	Santa Cruz, CA	
7490	Santa Fe, NM	1.0590
	Los Alamos, NM Santa Fe, NM	
7500	Santa Rosa, CA	1.2961
	Sonoma, CA	
7510	Sarasota-Bradenton, FL	0.9629
	Manatee, FL Sarasota, FL	
7520	Savannah, GA	0.9460
	Bryan, GA Chatham, GA Effingham, GA	
7560	Scranton--Wilkes-Barre--Hazleton, PA	0.8522
	Columbia, PA Lackawanna, PA Luzerne, PA Wyoming, PA	
7600	Seattle-Bellevue-Everett, WA	1.1479
	Island, WA King, WA Snohomish, WA	
7610	Sharon, PA	0.7881
	Mercer, PA	
7620	Sheboygan, WI	0.8948
	Sheboygan, WI	
7640	Sherman-Denison, TX	0.9617
	Grayson, TX	
7680	Shreveport-Bossier City, LA	0.9111
	Bossier, LA Caddo, LA Webster, LA	
7720	Sioux City, IA-NE	0.9094
	Woodbury, IA Dakota, NE	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
7760	Sioux Falls, SD	0.9441
	Lincoln, SD	
	Minnehaha, SD	
7800	South Bend, IN	0.9447
	St. Joseph, IN	
7840	Spokane, WA	1.0660
	Spokane, WA	
7880	Springfield, IL	0.8738
	Menard, IL	
	Sangamon, IL	
7920	Springfield, MO	0.8597
	Christian, MO	
	Greene, MO	
	Webster, MO	
8003	Springfield, MA	1.0173
	Hampden, MA	
	Hampshire, MA	
8050	State College, PA	0.8461
	Centre, PA	
8080	Steubenville-Weirton, OH-WV	0.8280
	Jefferson, OH	
	Brooke, WV	
	Hancock, WV	
8120	Stockton-Lodi, CA	1.0564
	San Joaquin, CA	
8140	Sumter, SC	0.8520
	Sumter, SC	
8160	Syracuse, NY	0.9394
	Cayuga, NY	
	Madison, NY	
	Onondaga, NY	
	Oswego, NY	
8200	Tacoma, WA	1.1078
	Pierce, WA	
8240	Tallahassee, FL	0.8655
	Gadsden, FL	
	Leon, FL	
8280	Tampa-St. Petersburg-Clearwater, FL	0.9024
	Hernando, FL	
	Hillsborough, FL	
	Pasco, FL	
	Pinellas, FL	
8320	Terre Haute, IN	0.8582
	Clay, IN	
	Vermillion, IN	
	Vigo, IN	
8360	Texarkana, AR-Texarkana, TX	0.8413
	Miller, AR	
	Bowie, TX	
8400	Toledo, OH	0.9524
	Fulton, OH	
	Lucas, OH	
	Wood, OH	
8440	Topeka, KS	0.8904
	Shawnee, KS	
8480	Trenton, NJ	1.0276
	Mercer, NJ	
8520	Tucson, AZ	0.8926
	Pima, AZ	
8560	Tulsa, OK	0.8729
	Creek, OK	
	Osage, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
8600	Tuscaloosa, AL	0.8440
	Tuscaloosa, AL	
8640	Tyler, TX	0.9502
	Smith, TX	
8680	Utica-Rome, NY	0.8295
	Herkimer, NY	
	Oneida, NY	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
8720	Vallejo-Fairfield-Napa, CA	1.3517
	Napa, CA	
	Solano, CA	
8735	Ventura, CA	1.1105
	Ventura, CA	
8750	Victoria, TX	0.8469
	Victoria, TX	
8760	Vineland-Millville-Bridgeton, NJ	1.0573
	Cumberland, NJ	
8780	Visalia-Tulare-Porterville, CA	0.9964 (0.9975**)
	Tulare, CA	
8800	Waco, TX	0.8146
	McLennan, TX	
8840	Washington, DC-MD-VA-WV	1.0971
	District of Columbia, DC	
	Calvert, MD	
	Charles, MD	
	Frederick, MD	
	Montgomery, MD	
	Prince Georges, MD	
	Alexandria City, VA	
	Arlington, VA	
	Clarke, VA	
	Culpepper, VA	
	Fairfax, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fauquier, VA	
	Fredericksburg City, VA	
	King George, VA	
	Loudoun, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Prince William, VA	
	Spotsylvania, VA	
	Stafford, VA	
	Warren, VA	
	Berkeley, WV	
	Jefferson, WV	
8920	Waterloo-Cedar Falls, IA	0.8633
	Black Hawk, IA	
8940	Wausau, WI	0.9570
	Marathon, WI	
8960	West Palm Beach-Boca Raton, FL	1.0059 (1.0362**)
	Palm Beach, FL	
9000	Wheeling, OH-WV	0.7449
	Belmont, OH	
	Marshall, WV	
	Ohio, WV	
9040	Wichita, KS	0.9472 (0.9468**)
	Butler, KS	
	Harvey, KS	
	Sedgwick, KS	
9080	Wichita Falls, TX	0.8395
	Archer, TX	
	Wichita, TX	
9140	Williamsport, PA	0.8485
	Lycoming, PA	
9160	Wilmington-Newark, DE-MD	1.1121
	New Castle, DE	
	Cecil, MD	
9200	Wilmington, NC	0.9237
	New Hanover, NC	
	Brunswick, NC	
9260	Yakima, WA	1.0322
	Yakima, WA	
9270	Yolo, CA	0.9378
	Yolo, CA	
9280	York, PA	0.9150
	York, PA	
9320	Youngstown-Warren, OH	0.9517
	Columbiana, OH	

TABLE 8.—WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
9340	Mahoning, OH Trumbull, OH Yuba City, CA	1.0363
9360	Sutter, CA Yuba, CA Yuma, AZ	0.8871
	Yuma, AZ	

**Effective January 1, 2005

2. On page 45815, Table 9 is revised to read as follows:

TABLE 9.—WAGE INDEX FOR RURAL AREAS—Continued

TABLE 9.—WAGE INDEX FOR RURAL AREAS—Continued

TABLE 9.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7637
Alaska	1.1637
Arizona	0.9140
Arkansas	0.7703
California	1.0297
Colorado	0.9368
Connecticut	1.1917
Delaware	0.9503
Florida	0.8721
Georgia	0.8247
Guam	0.9611
Hawaii	1.0522
Idaho	0.8826
Illinois	0.8340
Indiana	0.8736
Iowa	0.8550
Kansas	0.8087

Nonurban area	Wage index
Kentucky	0.7844
Louisiana	0.7290
Maine	0.9039
Maryland	0.9179
Massachusetts	1.0216
Michigan	0.8740
Minnesota	0.9339
Mississippi	0.7583
Missouri	0.7829
Montana	0.8701
Nebraska	0.9035
Nevada	0.9832
New Hampshire	0.9940
New Jersey ¹	0.8529
New Mexico	0.8403
New York	0.8500
North Carolina	0.7743
North Dakota	0.8759
Ohio	0.7537
Oklahoma	1.0049
Oregon	

Nonurban area	Wage index
Pennsylvania	0.8348
Puerto Rico	0.4047
Rhode Island ¹	
South Carolina	0.8640
South Dakota	0.8393
Tennessee	0.7876
Texas	0.7910
Utah	0.8843
Vermont	0.9375
Virginia	0.8479
Virgin Islands	0.7456
Washington	1.0072
West Virginia	0.8083
Wisconsin	0.9498
Wyoming	0.9182

¹ All counties within the State are classified urban.

3. On page 45817, Table 10 is revised to read as follows:

TABLE 10.—SNF XYZ: LOCATED IN STATE COLLEGE, PA

[Wage Index: 0.8461]

RUG Group	Labor	Wage index	Adj. labor	Non-labor	Adj. rate	Percent adjustment	Medicare days	Payment
RVC	\$274.56	0.8461	\$232.31	\$85.65	\$317.96	*\$339.26	14	\$4,750
RHA	\$212.18	0.8461	\$179.53	\$66.19	\$245.72	*\$262.18	16	\$4,195
CC2	\$175.71	0.8461	\$148.67	\$54.82	\$203.49	**\$463.96	10	\$4,640
SSC	\$176.74	0.8461	\$149.54	\$55.13	\$204.67	***\$245.60	30	\$7,368
IA2	\$119.84	0.8461	\$101.40	\$37.39	\$138.79	\$138.79	30	\$4,164
Total							100	\$25,117

*Reflects a 6.7 percent adjustment from section 314 of the BIPA.

**Reflects a 128 percent adjustment from section 511 of the MMA. Section 101(a) of the BBRA no longer applies because of the MMA section 511 adjustment.

***Reflects a 20 percent adjustment from section 101(a) of the BBRA.

4. On page 45821, Table 12 is revised to read as follows:

TABLE 12.—PROJECTED IMPACT OF FY 2005 UPDATE TO THE SNF PPS

	Number of facilities	Wage index change	Total FY 2005 change
Total	15,252	0.0%	2.8%
Urban	10,016	0.0%	2.8%
Rural	5,236	0.0%	2.8%
Hospital based urban	984	0.1%	2.9%

TABLE 12.—PROJECTED IMPACT OF FY 2005 UPDATE TO THE SNF PPS—Continued

	Number of facilities	Wage index change	Total FY 2005 change
Freestanding urban	8,466	0.0%	2.8%
Hospital based rural	640	0.1%	2.9%
Freestanding rural	3,708	0.0%	2.8%
Urban by region:			
New England	913	−0.6%	2.2%
Middle Atlantic	1,526	−0.7%	2.1%
South Atlantic	1,610	0.3%	3.1%
East North Central	1,943	0.2%	3.0%
East South Central	456	0.0%	2.8%
West North Central	691	0.4%	3.2%
West South Central	965	0.8%	3.6%
Mountain	432	−0.4%	2.4%
Pacific	1,473	0.4%	3.2%
Rural by region:			
New England	149	0.4%	3.2%
Middle Atlantic	254	−0.4%	2.4%
South Atlantic	715	−0.3%	2.5%
East North Central	948	0.1%	2.9%
Central East South	595	−0.4%	2.4%
West North Central	1,220	0.5%	3.3%
West South Central	817	0.4%	3.2%
Mountain	330	−0.2%	2.6%
Pacific	208	0.0%	2.8%
Ownership:			
Government	712	0.0%	2.8%
Proprietary	9,457	0.0%	2.8%
Voluntary	3605	0.0%	2.8%

III. Waiver of Proposed Rulemaking and Delayed Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice such as this take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). We also ordinarily provide a 30-day delay in the effective date of the provisions of a notice in accordance with section 553(d) of the APA (5 U.S.C. 553(d)). However, we can waive both the notice and comment procedure and the 30-day delay in effective date if the Secretary finds, for good cause, that a notice and comment process is impracticable, unnecessary or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

We find it unnecessary to undertake notice-and-comment rulemaking because this notice merely provides technical corrections to the regulations. We are not changing our payment methodology, but rather, are simply implementing correctly the payment methodology that we previously proposed, received comment on, and subsequently finalized. Thus, because the public has already had the opportunity to comment on the payment methodology being used to calculate

wage indexes, additional comment would be unnecessary.

Further, we believe a delayed effective date is unnecessary because this correction notice merely corrects inadvertent technical errors. Further, we believe imposing a 30-day delay in the effective date would be contrary to the public interest for SNF providers in the affected MSAs. We believe that it is imperative that these providers receive appropriate SNF PPS payments in as timely a manner as possible, and any delay in applying the appropriate wage index would be contrary to the public interest. Further, the changes noted above do not make any substantive changes to the SNF PPS payment methodology or underlying payment policies. Therefore, we find good cause to waive notice-and-comment procedures, as well as the 30-day delay in effective date.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 15, 2004.

Ann Agnew,

Executive Secretary to the Department.

[FR Doc. 04–28157 Filed 12–29–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1285–N]

Medicare Program: Meeting of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (Panel)—February 23, 24, and 25, 2005, and Re-chartering of APC Panel on November 8, 2004

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (DHHS).

ACTION: Notice of meeting and re-chartering of Panel.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act (FACA) (5 U.S.C. Appendix 2), this notice announces the first biannual meeting of the Ambulatory Payment Classification (APC) Panel for 2005.

The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare and Medicaid Services concerning the clinical integrity of the APC groups and their associated weights. The advice provided by the Panel will be considered as CMS prepares its annual updates of the

hospital Outpatient Prospective Payment System (OPPS) through rulemaking.

DATES: *Meeting Dates:* The first biannual meeting for 2005 is scheduled for the following dates and times:

- Wednesday, February 23, 2005, 1 p.m. to 5 p.m. (e.s.t.)
- Thursday, February 24, 2005, 8 a.m. to 5 p.m. (e.s.t.)
- Friday, February 25, 2005, 8 a.m. to 12 noon (e.s.t.)

DEADLINES:

Deadline for Hardcopy Comments/Suggested Agenda Topics—

- 5 p.m. (e.s.t.), Wednesday, January 26, 2005

Deadline for Hardcopy Presentations—

- 5 p.m. (e.s.t.), Wednesday, January 26, 2005

Deadline for Attendance Registration—

- 5 p.m. (e.s.t.), Wednesday, February 9, 2005.

Deadline for Special Accommodations—

- 5 p.m. (e.s.t.), Wednesday, February 9, 2005.

SUBMITTAL OF MATERIALS TO THE DESIGNATED FEDERAL OFFICER (DFO):

Because of staffing and resource limitations, we cannot accept written comments and presentations by FAX, nor can we print written comments and presentations received electronically for dissemination at the meeting.

Only hardcopy comments and presentations will be accepted for placement in the meeting booklets. All hardcopy presentations *must be accompanied by Form CMS-20017*. The form is now available through the CMS Forms Web site. The URL for linking to this form is (<http://www.cms.hhs.gov/forms/cms20017.pdf>).

We are also requiring electronic versions of the written comments and presentations (in addition to the hardcopies), so we can send them to the Panel members for their review prior to the meeting.

You must send BOTH electronic and hardcopy versions of your presentations and written comments by the prescribed deadlines. (Electronic transmission must be sent to the e-mail address, and hardcopies (accompanied by Form CMS-20017) must be mailed to the Designated Federal Officer [DFO], as specified in the **FOR FURTHER INFORMATION CONTACT** section of this notice.)

ADDRESS: The meeting will be held in the Multipurpose Room, 1st Floor, at the CMS Central Office, 7500 Security

Boulevard, Baltimore, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: For inquiries regarding the meeting; meeting registration; and hardcopy submissions of oral presentations, agenda items, and comments, please contact the DFO: Shirl Ackerman-Ross, DFO, CMS, CMM, HAPG, DOC, 7500 Security Boulevard, Mail Stop C4–05–17, Baltimore, MD 21244–1850. Phone (410) 786–4474.

• E-mail Address for comments, presentations, and registration requests APCPanel@cms.hhs.gov

• News media representatives must contact our Public Affairs Office at (202) 690–6145.

ADVISORY COMMITTEES' INFORMATION LINES:

The CMS Advisory Committees' Information Line is 1–877–449–5659 (toll free) and (410) 786–9379 (local).

WEB SITES:

• For additional information on the APC meeting agenda topics and updates to the Panel's activities, search our Web site at: <http://www.cms.hhs.gov/faca/apc/default.asp>.

• To obtain Charter copies, search our Web site at <http://www.cms.hhs.gov/faca> or e-mail the Panel DFO.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary is required by section 1833(t)(9)(A) of the Act, as amended and redesignated by sections 201(h) and 202(a)(2) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), respectively, to establish and consult with an expert, outside advisory panel on APC groups. The Panel meets up to three times annually to review the APC groups and to provide technical advice to the Secretary and the Administrator concerning the clinical integrity of the groups and their associated weights. All members must have technical expertise that shall enable them to participate fully in the work of the Panel. Such expertise encompasses hospital payment systems, hospital medical-care delivery systems, outpatient payment requirements, APCs, Physicians' Current Procedural Terminology Codes (CPTs), the use and payment of drugs and medical devices in the outpatient setting, and other forms of relevant expertise. It is not necessary that any member be an expert on all areas.

We will consider the technical advice provided by the Panel as we prepare the proposed rule that proposes changes to the OPPS for the next calendar year. The Secretary recently re-chartered the Panel on November 8, 2004.

The Panel may consist of up to 15 representatives who are full-time

employees (not consultants) of Medicare providers, which are subject to the OPPS, and a Chair.

The Administrator selected the Panel membership based upon either self-nominations or nominations submitted by providers or interested organizations. The Panel presently consists of the following members and a Chair:

- Edith Hambrick, M.D., J.D., Chair
 - Marilyn Bedell, M.S., R.N., O.C.N.
 - Albert Brooks Einstein, Jr., M.D.
 - Lee H. Hilborne, M.D., M.P.H.
 - Stephen T. House, M.D.
 - Kathleen Kinslow, C.R.N.A., Ed.D.
 - Mike Metro, R.N., B.S.
 - Sandra J. Metzler, M.B.A., R.H.I.A., C.P.H.Q.
 - Gerald V. Naccarelli, M.D.
 - Frank G. Opelka, M.D., F.A.C.S.
 - Louis Potters, M.D., F.A.C.R.*
 - Lou Ann Schraffenberger, M.B.A., R.H.I.A., C.C.S.-P.
 - Judie S. Snipes, R.N., M.B.A., C.H.E.*
 - Lynn R. Tomascik, R.N., M.S.N., C.N.A.A.
 - Timothy Gene Tyler, Pharm.D.
 - William Van Decker, M.D.
- (*New member as of 10/1/2004)

II. Agenda

The agenda for the February 2005 meeting will provide for discussion and comment on the following topics as designated in the Panel's Charter:

- Reconfiguration of APCs (for example, splitting of APCs, moving Healthcare Common Procedure Coding System (HCPCS) codes from one APC to another and moving HCPCS codes from new technology APCs to clinical APCs).
- Evaluation of APC weights.
- Packaging devices and drug costs into APCs: Methodology, effect on APCs, and need for reconfiguring APCs based upon device and drug packaging.
- Removal of procedures from the inpatient list for payment under the OPPS.
- Use of single and multiple procedure claims data.
- Packaging of HCPCS codes.
- Other technical issues concerning APC structure.

III. Written Comments and Suggested Agenda Topics

Hardcopy written comments and suggested agenda topics should be sent to the DFO. Such items must be received by the DFO 5 p.m. (e.s.t.), Wednesday, January 26, 2005.

Additionally, the written comments and suggested agenda topics must fall within the subject categories outlined in the Panel's Charter listed in the Agenda section of this notice.

IV. Oral Presentations

Individuals or organizations wishing to make 5-minute oral presentations must contact the DFO. The DFO must receive hardcopy presentations by 5 p.m. (e.s.t.), on Wednesday, January 26, 2005, in order to be scheduled.

The number of oral presentations may be limited by the time available. Oral presentations should not exceed 5 minutes in length.

The Chair may further limit time allowed for presentations due to the number of oral presentations, if necessary.

V. Presenter and Presentation Criteria

The additional criteria below must be supplied to the DFO by the January 26, 2005 deadline (along with hardcopies of presentations).

- Required personal information regarding presenter(s):
 - + Name of presenter(s);
 - + Title(s);
 - + Organizational affiliation;
 - + Address;
 - + E-mail address, and
 - + Telephone number(s).
- All presentations must contain, at a minimum, the following supporting information and data:
 - + Financial relationship(s) of presenter(s), if any, with any company whose products, services, or procedures that are under consideration;
 - + Physicians' Current Procedural Terminology (CPT) codes involved;
 - + APC(s) affected;
 - + Description of the issue(s);
 - + Clinical description of the service under discussion (with comparison to other services within the APC);
 - + Recommendations and rationale for change;
 - + Expected outcome of change; and
 - + Potential consequences of not making the change(s).

VI. Oral Comments

In addition to formal oral presentations, there will be opportunity during the meeting for public oral comments that will be limited to 1 minute for each individual and a total of 5 minutes per organization.

VII. Meeting Attendance

The meeting is open to the public; however, attendance is limited to space available. Attendance will be determined on a first-come, first-served basis.

Persons wishing to attend this meeting, which is located on Federal property, must call or e-mail the Panel DFO to register in advance no later than 5 p.m. (e.s.t.), Wednesday, February 9, 2005.

The following information must be e-mailed or telephoned to the DFO by the date and time above:

- Name(s) of attendee(s);
- Title(s);
- Organization;
- E-mail address(es); and
- Telephone number(s).

VIII. Security, Building, and Parking Guidelines

Persons attending the meeting must present photographic identification to the Federal Protective Service or Guard Service personnel before they will be allowed to enter the building.

Individuals who are not registered in advance will not be permitted to enter the building and will be unable to attend the meeting. The public may not enter the building earlier than 30–45 minutes prior to the convening of the meeting each day. (Please note that the meeting on Wednesday, February 23, 2005 does not convene until 1 p.m.)

All visitors must be escorted in areas other than the lower and first-floor levels in the Central Building.

Parking permits and instructions are issued upon arrival by the guards at the main entrance.

IX. Special Accommodations

Individuals requiring sign-language interpretation or other special accommodations must send a request for these services to the DFO by 5 p.m. (e.s.t.), Wednesday, February 9, 2005.

Authority: Section 1833(t) of the Act (42 U.S.C. 1395l(t), as amended by section 201(h) of the BBRA of 1999 (Pub. L. 106–113). The Panel is governed by the provisions of Pub. L. 92–463, as amended (5 U.S.C. Appendix 2).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program).

Dated: December 9, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–28151 Filed 12–29–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1292–N]

Medicare Program; Town Hall Meeting on the Fiscal Year 2006 Applications for New Medical Services and Technologies Add-on Payments Under the Hospital Inpatient Prospective Payment System Scheduled for February 23, 2005

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of meeting.

SUMMARY: This notice, in accordance with section 503 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), announces a Town Hall meeting to discuss fiscal year (FY) 2006 applications for add-on payments for new medical services and technologies under the hospital inpatient prospective payment system (IPPS). Applicants, supporters, opponents, and other interested parties are invited to this meeting to present their comments, recommendations, and data regarding whether the FY 2006 new medical services and technologies applications meet the substantial clinical improvement criteria.

DATES: *Meeting Date:* The Town Hall meeting announced in this notice will be held on Wednesday, February 23, 2005 at 9 a.m. and check-in will begin at 8:30 a.m. EST.

Registration Deadline for Presenters: All presenters, whether attending in person or by phone, must register and submit their agenda item(s) by February 15, 2005.

Registration Deadline for All Other Participants: All other participants must register by February 17, 2005.

Comment Deadline: Written comments for discussion at the meeting must be received by February 15, 2005. All other written comments for consideration before publication of the IPPS proposed rule must be received by March 15, 2005.

ADDRESSES: The Town Hall meeting will be held in the Auditorium in the central building of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Agenda Items or Written Comments: Agenda items and written comments regarding whether a FY 2006 application meets the substantial clinical improvement criterion may be sent by mail, fax, or electronically.

Agenda items must be received by February 15, 2005. We will accept written questions or other statements, not to exceed three single-spaced, typed pages that are received by March 15, 2005. Send written comments, questions, or other statements to—

Division of Acute Care, Mail stop C4-07-05, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Attention: Meredith Walz or Michael Treitel, Fax: (410) 786-0169. E-mail: newtech@cms.hhs.gov

FOR FURTHER INFORMATION CONTACT:

Meredith Walz, (410) 786-9421, mwalz@cms.hhs.gov; Michael Treitel, (410) 786-4552, mtreitel@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. Background

Sections 1886(d)(5)(K) and (L) of the Social Security Act (the Act) require the Secretary to establish a process of identifying and ensuring adequate payments for new medical services and technologies under Medicare. Effective for discharges beginning on or after October 1, 2001, section 1886(d)(5)(K)(i) required the Secretary to establish (after notice and opportunity for public comment) a mechanism to recognize the costs of new services and technologies under the inpatient hospital prospective payment system (IPPS). In addition, section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered “new” if it meets criteria established by the Secretary (after notice and opportunity for public comment). (See the May 4, 2001 proposed rule (66 FR 22693) and the September 7, 2001 final rule (66 FR 46912) for a more detailed discussion.)

In the September 7, 2001 final rule (66 FR 46914), we noted that we evaluate a request for special payment for a new medical service or technology against the following criteria in order to determine if the new technology meets the substantial clinical improvement requirement:

- The device offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments.
- The device offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods. There must also be evidence that use of the device to make a diagnosis affects the management of the patient.

- Use of the device significantly improves clinical outcomes for a patient population as compared to currently available treatments. Some examples of outcomes that are frequently evaluated in studies of medical devices are the following:

- ++ Reduced mortality rate with use of the device.
- ++ Reduced rate of device-related complications.
- ++ Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
- ++ Decreased number of future hospitalizations or physician visits.
- ++ More rapid beneficial resolution of the disease process treatment because of the use of the device.
- ++ Decreased pain, bleeding, or other quantifiable symptom.
- ++ Reduced recovery time.

In addition, we indicated that the requester is required to submit evidence that the technology meets one or more of these criteria.

Section 503 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) revised the process for evaluating new medical services and technology applications by requiring the Secretary to do the following:

- Before publication of a proposed rule, provide for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of Medicare beneficiaries.
- Make public and periodically update a list of all the services and technologies for which an application is pending.
- Accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.
- Before publication of a proposed rule, provide for a meeting at which organizations representing hospitals, physicians, manufacturers and any other interested party may present comments, recommendations, and data to the clinical staff of CMS.

The opinions and alternatives provided during this meeting will assist us as we evaluate the new medical services and technology applications for FY 2006. In addition, they will help us to evaluate our policy on the IPPS new technology add-on payment process before the publication of the FY 2006 IPPS proposed rule.

II. Meeting Format

This meeting will allow for a discussion of the substantial clinical

improvement criteria for each of the FY 2006 new medical services and technology add-on payment applications. Information regarding the applications can be found on our Web site at <http://www.cms.hhs.gov/providers/hipps/newtech.asp>. In addition, we believe some of the issues raised in public comments during the FY 2005 rulemaking cycle warrant further investigation to determine whether our definition of “substantial clinical improvement” should be revised (69 FR 49001 through 49006). We also believe that the definition of “substantial similarity” may need to be revisited. (See the IPPS FY 2005 final rule (69 FR 49011) and the September 7, 2001 (66 FR 46915) final rule). Although we do not expect to have a general discussion of these topics during the timeframe of the town hall meeting, we are inviting comment as part of this town hall meeting notice. So that we can consider these comments in development of our proposed rule, we will accept comments through the deadline for other written comments specified in the **DATES** section of this notice. We will also solicit comments during the rulemaking process.

The majority of the meeting will be reserved for comments, recommendations, and data from registered presenters. The time for each presenter's comments will be approximately 10 minutes and will be based on the number of registered presenters. Presenters will be scheduled to speak in the order in which they register and grouped by new technology applicant. Therefore, individuals who want to be presenters must register and submit their agenda items by Tuesday, February 15, 2005. Once the agenda is completed, it will be posted on the IPPS Web site at <http://www.cms.hhs.gov/providers/hipps/newtech.asp>. Comments from participants will be heard (time permitting) after the completion of the presentations.

For presenters or participants that cannot come to CMS for the meeting, an open toll-free phone line, (877) 357-7851, has been made available. If you are calling in, you will be prompted to enter the conference identification number, 2940111, or the name of the meeting. In addition, written comments will also be accepted and presented at the meeting if they are received by February 15, 2005. Written comments may also be submitted after the meeting. If the comments are to be considered before the publication of the proposed rule, the comments must be received by March 15, 2005.

III. Registration Instructions

The Division of Acute Care is coordinating meeting registration. While there is no registration fee, individuals must register to attend. Individuals may present their comments either in person or by phone. These individuals must register and submit their agenda item(s) by February 15, 2005. All other participants must register by February 17, 2005. All registrants will receive confirmation with instructions for arrival at the CMS complex (persons who register on-line will receive this confirmation upon completion of the registration process and should print the confirmation and bring it with them to the meeting). Because of limited meeting space and our desire to maintain an accurate count of registrants that plan to come to CMS, we prefer that these persons register on-line. In addition, we would prefer that registrants that plan to participate by phone, register by phone or fax.

On-line Registration: Registration may be completed on-line at the following web address: <http://www.cms.hhs.gov/providers/hipps/newtech.asp>. Select the link "Register to Attend the New Technology Town Hall Meeting" and then select "New Technology Town Hall Meeting" from the drop down menu and follow the instructions. After completing registration, on-line registrants should print the confirmation page and bring it with them to the meeting.

Registration by Phone or Fax: Registration may be completed by contacting Meredith Walz at (410) 786-9421 or Michael Treitel at (410) 786-4552. Registration may also be completed by fax to the attention of Meredith Walz or Michael Treitel at (410) 786-0169. If registration is completed by phone or fax, please provide your name, address, telephone number, and, if available, e-mail address and fax number.

IV. Security Information

Since this meeting will be held in a Federal government building, Federal security measures are applicable. In planning your arrival time, we recommend allowing additional time to clear security. In order to gain access to the building and grounds, participants must bring a government-issued photo identification and a copy of their confirmation of registration for the meeting. Access may be denied to persons without proper identification. For security reasons, no additional meeting registrations will be accepted after the close of the registration period.

Security measures also include inspection of vehicles, inside and out, at the entrance to the grounds. In addition, all persons entering the building must pass through a metal detector. All items brought to CMS, whether personal or for the purpose of demonstration or to support a presentation, are subject to inspection. Laptops and other computer equipment must be registered with the security desk upon entry. CMS cannot assume responsibility for coordinating the receipt, transfer, transport, storage, set-up, safety, or timely arrival of any personal belongings or items used for demonstration or to support a presentation. Participants should e-mail presentations to CMS prior to the meeting to ensure that CMS has a back-up copy in the event of computer problems or lack of software or memory card compatibility. Please note that CMS headquarters is a smoke-free facility.

Authority: Section 503 of Public Law 108-173.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 16, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04-28153 Filed 12-29-04; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 2004N-0545]

Nonclinical and Clinical Datasets; Notice of Pilot Project

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA), Center for Biologics Evaluation and Research (CBER), is seeking volunteers to participate in a pilot project involving the evaluation of various analysis tools to facilitate the use of electronic datasets for analysis of animal and human data submitted to FDA by applicants of biologics license applications (BLAs). These analysis tools will allow a reviewer to more efficiently capture and evaluate nonclinical and clinical datasets submitted in electronic format.

DATES: Submit written requests to participate in the pilot project by

February 28, 2005. Comments on this pilot project may be submitted at any time.

ADDRESSES: Submit written requests to participate and comments regarding the pilot project to the Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to <http://www.fda.gov/dockets/ecomments>.

FOR FURTHER INFORMATION CONTACT: Richard Diamond, Center for Biologics Evaluation and Research (HFM-6), Food and Drug Administration, 1401 Rockville Pike, suite 200N, Rockville, MD 20852-1448, 301-827-0372.

SUPPLEMENTARY INFORMATION:

I. Background

Under current FDA regulations (21 CFR 601.2), applicants must provide nonclinical and clinical data in BLAs. CBER provided recommendations for the electronic submission of BLAs, as well as new drug applications (NDAs), in the "Guidance for Industry: Providing Regulatory Submissions to the Center for Biologics Evaluation and Research (CBER) in Electronic Format—Biologics Marketing Applications" dated November 1999. A joint CBER and Center for Drug Evaluation and Research (CDER) document entitled "Guidance for Industry: Providing Regulatory Submissions in Electronic Format—General Considerations" dated January 1999 provided recommendations for the file formats for nonclinical and clinical datasets.

FDA announced on July 21, 2004, a standard format, called the Study Data Tabulation Model (SDTM) developed by the Clinical Data Interchange Standards Consortium (CDISC), that sponsors of human drug clinical trials can use to submit data to the agency. It is expected that this step will lead to greater efficiencies in clinical research and FDA reviews of NDAs and BLAs. CDISC is an open, multidisciplinary, nonprofit organization including members from pharmaceutical companies, biotechnology companies, contract research organizations, and software vendors. CDISC committed to the development of industry standards to support the electronic acquisition, exchange, submission and archiving of clinical trials data and metadata for medical and biopharmaceutical product development. CDISC is currently facilitating the work on similar standards for nonclinical and clinical datasets. Where possible, the standards developed for clinical datasets and metadata should be used in the development of standardized

presentations of the datasets for routine toxicology studies (e.g., chronic toxicology and carcinogenicity studies). Version 3.1 (V3.1) of the CDISC Submission Data Domain Standards was officially released on June 25, 2004. These standards and the accompanying Implementation Guide can be viewed on the CDISC Web site at www.cdisc.org.¹

FDA has performed some initial pilot testing of nonclinical and clinical data applicable to drugs. The purpose of this pilot project is to evaluate the Version 3.1 of the CDISC SDTM and the Implementation Guide to determine applicability to clinical and nonclinical data required for submission of CBER regulated BLAs, to help in the refinement of analysis tools designed to facilitate the review and evaluation of electronic nonclinical and clinical datasets, and to obtain feedback from reviewers and pharmaceutical companies on the creation and use of standardized nonclinical and clinical data and metadata in a format that is applicable to BLA submissions.

II. Pilot Project Description

This pilot project is part of an effort to improve the process for submitting nonclinical and clinical data. Eventually, FDA expects to recommend detailed data standards for the submission of nonclinical and clinical data. Participants in this pilot project will have the opportunity not only to assist the agency in testing the use of various analysis tools and standardized nonclinical and clinical data and metadata, but would also be able to familiarize themselves with the process at an early stage of development. Only a few participants are needed for this pilot.

A. Initial Approach

Because a limited group of voluntary participants are needed, the agency will use its discretion in choosing volunteers, based on their having previously submitted nonclinical and clinical datasets to FDA and having demonstrated familiarity with our recommendations for creating nonclinical and clinical datasets as presented in the "Guidance for Industry: Providing Regulatory Submissions to the Center for Biologics Evaluation and Research (CBER) in Electronic Format—Biologics Marketing Applications." During the pilot project, specific technical instructions for providing the nonclinical and clinical data for testing will be made available to pilot

participants. Participants in the pilot project will be asked to provide nonclinical and clinical datasets as described in the technical instructions and to provide technical feedback.

B. Scope

Existing requirements for the submission of CBER nonclinical and clinical data will not be waived, suspended, or modified for purposes of this pilot project. The pilot project will test the preparation and use of the submitted nonclinical and clinical electronic datasets.

C. How to Participate

Written requests to volunteer should be submitted to the Division of Dockets Management (see **ADDRESSES**). Requests are to be identified with the docket number found in brackets in the heading of this document.

III. Comments

Interested persons may submit to the Division of Dockets Management (see **ADDRESSES**) written or electronic comments regarding this pilot project. Submit a single copy of electronic comments or two paper copies of any mailed comments, except that individuals may submit one paper copy. Comments are to be identified with the docket number found in brackets in the heading of this document. We will consider all received comments in making a determination on electronic filing and when drafting a guidance document for submitting CBER nonclinical and clinical study data as electronic datasets. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

Dated: December 16, 2004.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. 04-28579 Filed 12-29-04; 8:45 am]

BILLING CODE 4160-01-S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 2003N-0232]

Universal Reagents, Inc.; Revocation of U.S. License No. 0887

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the revocation of the biologics license (U.S. License No. 0887) issued to Universal

Reagents, Inc., (URI) for the manufacture of Source Plasma. A notice of opportunity for a hearing on a proposal to revoke the license was published in the **Federal Register** of July 10, 2003. URI requested a hearing by letter dated August 11, 2003. Subsequently, the authorized official of URI voluntarily requested revocation of its biologics license (U.S. License No. 0887) by letter dated December 29, 2003. In light of URI's request for revocation of its license, the firm's request for an opportunity for a hearing on the issue of license revocation became unnecessary. FDA, therefore, proceeded to revoke the license.

DATES: The revocation of U.S. License No. 0887 became effective March 2, 2004.

FOR FURTHER INFORMATION CONTACT:

Nathaniel L. Geary, Center for Biologics Evaluation and Research (HFM-17), Food and Drug Administration, suite 200N, 1401 Rockville Pike, Rockville, MD 20852-1448, 301-827-6210.

SUPPLEMENTARY INFORMATION: FDA has revoked the biologics license (U.S. License No. 0887) for the manufacture of Source Plasma issued to URI, 2858 North Pennsylvania St., Indianapolis, IN 46205.

By certified return receipt letter, dated October 23, 2002, issued under § 601.5(b) (21 CFR 601.5(b)), FDA notified the firm of FDA's intent to revoke U.S. License No. 0887 and announced its intent to offer an opportunity for a hearing. Because URI did not submit a response to FDA's letter dated October 23, 2002, and did not waive an opportunity for hearing under 21 CFR 12.21(b), FDA issued a notice of opportunity for a hearing in the **Federal Register** of July 10, 2003 (68 FR 41162), on the proposal to revoke the biologics license (U.S. License No. 0887) issued to URI for the manufacture of Source Plasma. As described in the notice of opportunity for a hearing, the grounds for the proposed license revocation included the following: (1) The results of an FDA inspection of the firm conducted between May 29 and June 3, 2002; as well as from the inspection on June 7, 2002, of Central Indiana Regional Blood Center, Inc. (CIRBC), Indianapolis, IN, which performed infectious disease testing for URI under a contract agreement; (2) FDA's determination through its investigation and inspections of both URI and CIRBC, that URI had significant deviations from the standards established in its license as well as in the applicable Federal regulations; and (3) documentation that URI had willfully engaged in violative

¹FDA has verified the Web site address, but is not responsible for subsequent changes to the Web site after this document publishes in the **Federal Register**.

recordkeeping practices and falsified records it submitted to FDA. In support of the proposed revocation, FDA had placed documentation on file for public examination with the Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

Following publication of the notice of opportunity for a hearing on July 10, 2003, FDA's Division of Dockets Management received a letter (via electronic transmission), dated August 11, 2003. In the letter, URI requested a hearing on the proposed license revocation and set forth information to support its request.

While the request for hearing was pending, the authorized official of the firm voluntarily requested revocation of U.S. License No. 0887 by letter dated December 29, 2003. FDA notified URI by letter of March 2, 2004, that the license had been revoked. Based on the voluntary request for revocation of U.S. License No. 0887, URI's request for a hearing on the issue of license revocation became unnecessary.

Accordingly, under § 601.5, section 351 of the Public Health Service Act (42 U.S.C. 262), and under authority delegated to the Commissioner of Food and Drugs (FDA Staff Manual Guides (SMG) 1410.10)) <http://www.fda.gov/smg/default.htm> and redelegated to the Director, Center for Biologics Evaluation and Research (SMG 1410.204), the biologics license (U.S. License No. 0887) for the manufacture of Source Plasma issued to URI was revoked, effective March 2, 2004.

This notice is issued and published under § 601.8 and the redelegation at SMG 1410.203.

Dated: November 29, 2004.

Jesse Goodman,

Director, Center for Biologics Evaluation and Research.

[FR Doc. 04-28580 Filed 12-29-04; 8:45 am]

BILLING CODE 4160-01-S

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[CGD08-04-044]

Houston/Galveston Navigation Safety Advisory Committee

AGENCY: Coast Guard, DHS.

ACTION: Notice of meetings.

SUMMARY: The Houston/Galveston Navigation Safety Advisory Committee (HOGANSAC) and its working groups will meet to discuss waterway

improvements, aids to navigation, area projects impacting safety on the Houston Ship Channel, and various other navigation safety matters in the Galveston Bay area. All meetings will be open to the public.

DATES: The next meeting of HOGANSAC will be held on Thursday, February 10, 2005 at 9 a.m. The meeting of the Committee's working groups will be held on Tuesday, January 18, 2005 at 9 a.m.

ADDRESSES: The full Committee meeting will be held at the Barbour's Cut Cruise Terminal, 820 North L Street, Morgan's Point, TX 77572, (281-470-1800). The working groups meeting will be held at the Port of Texas City office building, 2425 Highway 146 North, Texas City, TX 77552 (409-945-4461).

FOR FURTHER INFORMATION CONTACT:

Captain (CAPT) Richard Kaser, Executive Director of HOGANSAC, telephone (713) 671-5199, Commander (CDR) Tom Marian, Executive Secretary of HOGANSAC, telephone (713) 671-5164, or Lieutenant Junior (LTJG) Grade Brandon Finley, Assistant to the Executive Secretary of HOGANSAC, telephone (713) 671-5103, e-mail rfinley@vtshouston.uscg.mil. Written materials and requests to make presentations should be sent to Commanding Officer, VTS Houston/Galveston, Attn: LTJG Finley, 9640 Clinton Drive, Floor 2, Houston, TX 77029.

SUPPLEMENTARY INFORMATION: Notice of this meeting is given pursuant to the Federal Advisory Committee Act, 5 U.S.C. App. 2.

Agenda of the Meetings

Houston/Galveston Navigation Safety Advisory Committee (HOGANSAC). The tentative agenda includes the following:

(1) Opening remarks by the Committee Sponsor (RADM Duncan) or the Committee Sponsor's representative, Executive Director (CAPT Kaser) and Chairperson (Mr. Tim Leitzell).

(2) Approval of the October 5, 2004 minutes.

(3) Old Business:

(a) Dredging projects; (b) AtoN Knockdown Working Group; (c) Navigation Operations subcommittee report; (d) Education and Outreach subcommittee report; (e) Area Maritime Security Committee Liaison's report; (f) Technology subcommittee report; (g) Safe Harbor Working Group; (h) Deepdraft Entry Facilitation Working Group; (i) Galveston Causeway Construction Working Group.

(4) New Business: (a) State of the Waterway presentation; (b) Renewal of HOGANSAC charter (2004-2006); (c)

Recognition of new membership; (d) 2005 Harbor Safety Conference; (e) Public Service Awards.

Working Groups Meeting. The tentative agenda for the working groups meeting includes the following:

(1) Presentation by each working group of its accomplishments and plans for the future.

(2) Review and discuss the work completed by each working group.

Procedural

Working groups have been formed to examine the following issues: Dredging and related issues, electronic navigation systems, AtoN knockdowns, impact of passing vessels on moored ships, boater education issues, facilitating deep draft movements and mooring infrastructure. Not all working groups will provide a report at this session. Further, working group reports may not necessarily include discussions on all issues within the particular working group's area of responsibility. All meetings are open to the public. Please note that the meetings may adjourn early if all business is finished. Members of the public may make presentations, oral or written, at either meeting. Requests to make oral or written presentations should reach the Coast Guard five (5) working days before the meeting at which the presentation will be made. If you would like to have written materials distributed to each member of the committee in advance of the meeting, you should send your request along with fifteen (15) copies of the materials to the Coast Guard at least ten (10) working days before the meeting at which the presentation will be made.

Information on Services for the Handicapped

For information on facilities or services for the handicapped or to request special assistance at the meetings, contact the Executive Director, Executive Secretary, or Assistant to the Executive Secretary as soon as possible.

Dated: December 16, 2004.

R.F. Duncan,

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

[FR Doc. 04-28551 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-15-P

DEPARTMENT OF HOMELAND SECURITY**Coast Guard****[USCG-2004-19977]****Inspection of Towing Vessels****AGENCY:** Coast Guard, DHS.**ACTION:** Notice; request for comments, and notice of public meetings.

SUMMARY: In the recently enacted Coast Guard and Maritime Transportation Act of 2004, the Congress directed the Coast Guard to add towing vessels to the list of vessels subject to inspections, and to consider the establishment of a safety management system appropriate for towing vessels. With this notice, we are seeking public and industry involvement as we consider how to proceed. The rulemaking process and its associated opportunity for public input will provide us with information on the extent of items to be considered for inclusion in any towing vessel inspection/safety management program(s).

DATES: Comments and related material must reach the Docket Management Facility on or before March 23, 2005. Public meetings will be held on the following dates in the following cities:

- January 26, 2005, 9 a.m. to 12 p.m. (noon), in Washington, DC; and
- February 2, 2005, 9 a.m. to 12 p.m. (noon), in Oakland, CA;
- February 10, 2005, 9 a.m. to 12 p.m. (noon), in New Orleans, LA;
- February 17, 2005, 9 a.m. to 12 p.m. (noon), in St. Louis, MO.

ADDRESSES: *Comments.* You may submit comments identified by Coast Guard docket number USCG-2004-19977 to the Docket Management Facility at the U.S. Department of Transportation. To avoid duplication, please use only one of the following methods:

- (1) Web site: <http://dms.dot.gov>.
- (2) Mail: Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street SW., Washington, DC 20590-0001.
- (3) Fax: 202-493-2251.
- (4) Delivery: Room PL-401 on the Plaza level of the Nassif Building, 400 Seventh Street SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202-366-9329.
- (5) Federal eRulemaking Portal: <http://www.regulations.gov>.

Meetings. The meetings will be held at the following locations:

Washington, DC—DOT/Nassif Building, 400 Seventh Street SW., Room 2230, Washington, DC 20590.

Oakland, CA—Ronald V. Dellums Federal Building, 1301 Clay Street, Third-Floor North-Tower Auditorium, Oakland, CA 94612.

New Orleans, LA—8th Coast Guard District, Hale Boggs Federal Building, 500 Poydras Street, Basement Conference Room, New Orleans, LA 70130.

St. Louis, MO—Robert A. Young Building, 1222 Spruce Street, Room 2.308 (Auditorium), St. Louis, MO 63103.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, contact Thomas Scott Kuhaneck, Domestic Vessel Compliance Division (G-MOC-1), U.S. Coast Guard, telephone 202-267-0240, or e-mail: TKuhaneck@comdt.uscg.mil. If you have questions on viewing or submitting material to the docket, call Andrea M. Jenkins, Program Manager, Docket Operations, telephone 202-366-0271.

SUPPLEMENTARY INFORMATION:**Public Participation and Request for Comments**

We encourage you to respond to our request for comments, by submitting comments and related materials. All comments received will be posted, without change, to <http://dms.dot.gov> and will include any personal information you have provided. We have an agreement with the Department of Transportation (DOT) to use the Docket Management Facility. Please see DOT's "Privacy Act" three paragraphs below.

Submitting comments: If you submit a comment, please include your name and address, identify docket number (USCG-2004-19977), indicate the specific question, and give the reason for each comment. You may submit your comments and material by electronic means, mail, fax, or delivery to the Docket Management Facility at the address under **ADDRESSES**; but please submit your comments and material by only one means. If you submit them by mail or delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit them 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.

Viewing comments and documents: To view comments, as well as documents mentioned in this notice as being available in the docket, go to <http://dms.dot.gov> at any time and conduct a simple search using the

docket number. You may also visit the Docket Management Facility in room PL-401 on the Plaza level of the Nassif Building, 400 Seventh Street SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Privacy Act: Anyone can 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 the Department of Transportation's Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477), or you may visit <http://dms.dot.gov>.

Public Meetings

We are intending to hold at least four public meetings regarding this notice on the inspection of towing vessels. The four scheduled meetings will be held—

- January 26, 2005, 9 a.m. to 12 p.m., at Nassif Building, 400 Seventh Street SW., Room 2230, Washington, DC 20590.
- February 2, 2005, 9 a.m. to 12 p.m., at Ronald V. Dellums Federal Building, 1301 Clay Street, Third Floor, North Tower Auditorium, Oakland, CA 94612.
- February 10, 2005, 9 a.m. to 12 p.m., at 8th Coast Guard District, Hale Boggs Federal Building, 500 Poydras Street, Basement Conference Room, New Orleans, LA 70130.
- February 17, 2005, 9 a.m. to 12 p.m., at Robert A. Young Building, 1222 Spruce Street, Room 2.308 (and 2.206—Auditorium), St. Louis, MO 63103.

To facilitate entry at a meeting site, provide the names of persons planning to attend the meeting and the company or organizations they represent to Thomas Scott Kuhaneck at the address under **FOR FURTHER INFORMATION CONTACT** at least two days before the meeting.

Questions

We need the public's assistance in answering the following questions, and any additional information provided on this topic is welcome.

In responding to each question, please explain your reasons for each answer as specifically as possible so that we can carefully weigh the consequences and impacts of any future actions we may take.

(1) Towing vessels of a certain size (300 or more gross register tons) are already inspected vessels and are subject to a variety of existing requirements. Should the Coast Guard use any of these existing standards (or standards for other types of inspected

vessels) for incorporation into the new regulations regarding the inspection of towing vessels? If so, which regulations or standards should be incorporated into these new regulations?

(2) Title 46, United States Code, specifies the items covered with regard to inspected vessels including lifesaving, firefighting, hull, propulsion equipment, machinery and vessel equipment. However, the legislation that added towing vessels to the list of inspected vessels, authorized that the Coast Guard may prescribe different standards for towing vessels than for other types of inspected vessels. What, if any, different standards should be considered with regard to inspected towing vessel requirements from other inspected vessels?

(3) Towing vessels vary widely in terms of size, horsepower, areas of operation, and type of operation. Under what circumstances, if any, should a towing vessel be exempt from the requirements as an inspected vessel?

(4) Should existing towing vessels be given time to implement requirements, be "grandfathered" altogether from them, or should this practice vary from requirement to requirement?

(5) Should existing towing vessels be treated differently from towing vessels yet to be built?

(6) The same act that requires inspection of towing vessels authorizes the Coast Guard to develop a safety management system appropriate for the towing vessels. If such a system is developed, should its use be required for all inspected towing vessels?

(7) Examples of existing safety management systems include the international safety management (ISM) code and the American Waterways Operators Responsible Carrier Program. If a safety management system is used, what elements should be included in such a system?

Procedural

The meetings are open to the public. Security staff will compare the visitor's photo identification card with the names on the list of meeting attendees. Visitors will be escorted to and from the meeting rooms. Attendees may make oral presentations during the meeting. Please note that the meeting may close early if all business is finished.

Information on Services for Individuals With Disabilities

For information on facilities or services for individuals with disabilities or to request special assistance at the meeting, contact Thomas Scott Kuhaneck at the address under **FOR**

FURTHER INFORMATION CONTACT as soon as possible.

Dated: December 27, 2004.

Joseph J. Angelo,

Director of Standards, Marine Safety, Security, and Environmental Protection, U.S. Coast Guard.

[FR Doc. 04-28614 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-15-P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR-4901-N-53]

Federal Property Suitable as Facilities to Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

EFFECTIVE DATE: December 30, 2004.

FOR FURTHER INFORMATION CONTACT:

Kathy Ezzell, Department of Housing and Urban Development, Room 7262, 451 Seventh Street SW., Washington, DC 20410; telephone (202) 708-1234; TTY number for the hearing- and speech-impaired (202) 708-2565, (these telephone numbers are not toll-free), or call the toll-free Title V information line at 1-800-927-7588.

SUPPLEMENTARY INFORMATION:

In accordance with the December 12, 1988 court order in *National Coalition for the Homeless v. Veterans Administration*, No. 88-2503-OG (D.D.C.), HUD publishes a Notice, on a weekly basis, identifying unutilized, underutilized, excess and surplus Federal buildings and real property that HUD has reviewed for suitability for use to assist the homeless. Today's Notice is for the purpose of announcing that no additional properties have been determined suitable or unsuitable this week.

Dated: December 22, 2004.

Mark R. Johnston,

Director, Office of Special Needs Assistance Programs.

[FR Doc. 04-28440 Filed 12-29-04; 8:45 am]

BILLING CODE 4210-29-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[WY-100-05-1310-DB]

Notice of Meeting of the Pinedale Anticline Working Group's SocioEconomic Task Group

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of public meeting.

SUMMARY: In accordance with the Federal Land Policy and Management Act (1976) and the Federal Advisory Committee Act (1972), the U.S. Department of the Interior, Bureau of Land Management (BLM) Pinedale Anticline Working Group (PAWG) Socioeconomic Task Group (subcommittee) will meet in Pinedale, Wyoming, for a business meeting. Task Group meetings are open to the public. **DATES:** A PAWG Socioeconomic Task Group meeting is scheduled for February 10, 2005, from 10 a.m. until 5 p.m.

ADDRESSES: The PAWG Socioeconomic Task Group meeting will be held in the Lovatt room of the Pinedale Library at 155 S. Tyler Ave., Pinedale, WY.

FOR FURTHER INFORMATION CONTACT: Roy Allen, BLM/Socioeconomic TG Liaison, Bureau of Land Management, Wyoming State Office, 5353 Yellowstone Rd., Cheyenne, WY 82009, or P.O. Box 1828, Cheyenne, WY 82003; 307-775-6031.

SUPPLEMENTARY INFORMATION: The Pinedale Anticline Working Group (PAWG) was authorized and established with release of the Record of Decision (ROD) for the Pinedale Anticline Oil and Gas Exploration and Development Project on July 27, 2000. The PAWG advises the BLM on the development and implementation of monitoring plans and adaptive management decisions as development of the Pinedale Anticline Natural Gas Field (PAPA) proceeds for the life of the field.

After the ROD was issued, Interior determined that a Federal Advisory Committees Act (FACA) charter was required for this group. The charter was signed by Secretary of the Interior, Gale Norton, on August 15, 2002, and renewed on August 13, 2004. An announcement of committee initiation and call for nominations was published in the **Federal Register** on February 21, 2003, (68 FR 8522). PAWG members were appointed by Secretary Norton on May 4, 2004.

At their second business meeting, the PAWG established seven resource- or activity-specific Task Groups, including one for Socioeconomics. Public

participation on the Task Groups was solicited through the media, letters, and word-of-mouth.

The agenda for this meeting will include information gathering and discussion related to developing a socioeconomic monitoring plan to assess the impacts of development in the Pinedale Anticline gas field, and identifying who will do and who will pay for the monitoring. Task Group recommendations are due to the PAWG in February, 2005. At a minimum, public comments will be heard just prior to adjournment of the meeting.

Dated: December 20, 2004.

Priscilla E. Mecham,
Field Office Manager.

[FR Doc. 04-28589 Filed 12-29-04; 8:45 am]

BILLING CODE 4310-22-P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[WY-100-05-1310-DB]

Notice of Meeting of the Pinedale Anticline Working Group's Air Quality Task Group

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of public meeting.

SUMMARY: In accordance with the Federal Land Policy and Management Act (1976) and the Federal Advisory Committee Act (1972), the U.S. Department of the Interior, Bureau of Land Management (BLM) Pinedale Anticline Working Group (PAWG) Air Quality Task Group (subcommittee) will meet in Pinedale, Wyoming, for a business meeting. Task Group meetings are open to the public.

DATES: A PAWG Air Quality Task Group meeting is scheduled for February 17, 2005, from 8 a.m. until 12 p.m.

ADDRESSES: The PAWG Air Quality Task Group meeting will be held in the U.S. Forest Service office at 29 E. Fremont Lake Rd., Pinedale, WY.

FOR FURTHER INFORMATION CONTACT: Susan Caplan, BLM/Air Quality TG Liaison, Bureau of Land Management, Wyoming State Office, 5353 Yellowstone Rd., Cheyenne, WY 82009, or P.O. Box 1828, Cheyenne, WY 82003; 307-775-6031.

SUPPLEMENTARY INFORMATION: The Pinedale Anticline Working Group (PAWG) was authorized and established with release of the Record of Decision (ROD) for the Pinedale Anticline Oil and Gas Exploration and Development Project on July 27, 2000. The PAWG advises the BLM on the development

and implementation of monitoring plans and adaptive management decisions as development of the Pinedale Anticline Natural Gas Field (PAPA) proceeds for the life of the field.

After the ROD was issued, Interior determined that a Federal Advisory Committees Act (FACA) charter was required for this group. The charter was signed by Secretary of the Interior, Gale Norton, on August 15, 2002, and renewed on August 13, 2004. An announcement of committee initiation and call for nominations was published in the **Federal Register** on February 21, 2003, (68 FR 8522). PAWG members were appointed by Secretary Norton on May 4, 2004.

At their second business meeting, the PAWG established seven resource or activity-specific Task Groups, including one for Air Quality. Public participation on the Task Groups was solicited through the media, letters, and word-of-mouth.

The agenda for this meeting will include information gathering and discussion related to developing an air quality monitoring plan to assess the impacts of development in the Pinedale Anticline gas field, and identifying who will do and who will pay for the monitoring. Task Group recommendations are due to the PAWG in February, 2005. At a minimum, public comments will be heard just prior to adjournment of the meeting.

Dated: December 20, 2004.

Priscilla E. Mecham,
Field Office Manager.

[FR Doc. 04-28590 Filed 12-29-04; 8:45 am]

BILLING CODE 4310-22-P

INTERNATIONAL TRADE COMMISSION

[Inv. No. 337-TA-511]

In the Matter of Certain Pet Food Treats; Notice of Decision Not To Review an Initial Determination Terminating the Investigation as to Respondent TsingTao U.S.

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade Commission has determined not to review an initial determination (ID) issued by the presiding administrative law judge (ALJ) in the above-captioned investigation terminating the investigation as to respondent TsingTao ShengRong Seafood, Inc. of Columbus, Ohio ("TsingTao U.S.").

FOR FURTHER INFORMATION CONTACT:

Andrea Casson, Esq., Office of the General Counsel, U.S. International Trade Commission, 500 E Street, SW., Washington, DC 20436, telephone 202-205-3105. Copies of all nonconfidential documents filed in connection with this investigation are or will be available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436, telephone 202-205-2000. General information concerning the Commission may also be obtained by accessing its Internet server (<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: The Commission instituted this investigation on June 8, 2004, based on a complaint filed by Thomas J. Baumgartner and Hillbilly Smokehouse, Inc., both of Rogers, Arkansas. 69 FR 32044. The complaint alleges violations of section 337 in the importation into the United States, sale for importation, or sale within the United States after importation of certain pet food treats that infringe U.S. Design Patent No. 383,886. The notice of investigation lists six companies as respondents, including TsingTao U.S.

On August 18, 2004, complainants moved for issuance of an order directing several respondents, including TsingTao U.S., to show cause why they should not be found in default. On August 30, 2004, the Commission investigative attorney filed a response, noting, *inter alia*, that the complaint and notice of investigation sent to TsingTao U.S. were returned as undeliverable, and that it therefore appeared that TsingTao U.S. had not been served with those documents as required by section 337(g)(1)(B), 19 U.S.C. 1337(g)(1)(B).

On October 5, 2004, the ALJ issued Order No. 6, in which find that service had not been effectuated on Tsing Tao U.S. For this reason, he found that a show cause order against TsingTao U.S. would be inappropriate at that time. He granted leave to complainants to attempt personal service on TsingTao U.S., pursuant to Commission rule 210.11(b).

Because complainants did not thereafter establish successful service or show any attempts to personally serve TsingTao U.S., the ALJ, on November

17, 2004, issued an order (Order No. 9), requiring complainants to show cause why the investigation should not be terminated as to TsingTao U.S. due to a failure to prosecute. On November 19, 2004, complainants responded to Order No. 9, stating that their efforts to locate TsingTao U.S. have proven unsuccessful, and that they therefore do not oppose termination of the investigation as to that respondent. On December 2, 2004, the ALJ issued an ID (Order No. 11), terminating the investigation as to TsingTao U.S. No petitions for review of the ID were filed.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in § 210.42 of the Commission's Rules of Practice and Procedure (19 CFR 210.42).

By order of the Commission.

Issued: December 27, 2004.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. 04-28634 Filed 12-29-04; 8:45 am]

BILLING CODE 7020-02-P

INTERNATIONAL TRADE COMMISSION

[Investigation No. AA1921-129 (Second Review)]

Polychloroprene Rubber From Japan

AGENCY: United States International Trade Commission.

ACTION: Scheduling of a full five-year review concerning the antidumping duty order on polychloroprene rubber from Japan.

SUMMARY: The Commission hereby gives notice of the scheduling of a full review pursuant to section 751(c)(5) of the Tariff Act of 1930 (19 U.S.C. 1675(c)(5)) (the Act) to determine whether revocation of the antidumping duty order on polychloroprene rubber from Japan would be likely to lead to continuation or recurrence of material injury within a reasonably foreseeable time. For further information concerning the conduct of this review 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).

EFFECTIVE DATE: December 22, 2004.

FOR FURTHER INFORMATION CONTACT: John Kitzmiller (202-205-3387), 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 this review may be viewed on the Commission's electronic docket (EDIS) at <http://edis.usitc.gov>.

SUPPLEMENTARY INFORMATION:

Background. On October 4, 2004, the Commission determined that it should proceed to a full review in the subject five-year review pursuant to section 751(c)(5) of the Act. The Commission found that the domestic interested party group response to its notice of institution (69 FR 39905, July 1, 2004) was adequate and that the respondent interested party group response to its notice of institution was inadequate. The Commission also found that other circumstances warranted conducting a full review.¹ A record of the Commissioners' votes, the Commission's statement on adequacy, and any individual Commissioner's statements are available from the Office of the Secretary and at the Commission's Web site.

Participation in the review and public service list. Persons, including industrial users of the subject merchandise and, if the merchandise is sold at the retail level, representative consumer organizations, wishing to participate in this review as parties must file an entry of appearance with the Secretary to the Commission, as provided in section 201.11 of the Commission's rules, by 45 days after publication of this notice. A party that filed a notice of appearance following publication of the Commission's notice of institution of the review need not file an additional notice of appearance. The Secretary will maintain a public service list containing the names and addresses of all persons, or their representatives, who are parties to the review.

Limited disclosure of business proprietary information (BPI) under an administrative protective order (APO) and BPI service list. Pursuant to section 207.7(a) of the Commission's rules, the Secretary will make BPI gathered in this review available to authorized applicants under the APO issued in the review, provided that the application is made by 45 days after publication of this notice. Authorized applicants must represent interested parties, as defined

by 19 U.S.C. 1677(9), who are parties to the review. A party granted access to BPI following publication of the Commission's notice of institution of the review need not reapply for such access. A separate service list will be maintained by the Secretary for those parties authorized to receive BPI under the APO.

Staff report. The prehearing staff report in the review will be placed in the nonpublic record on April 13, 2005, and a public version will be issued thereafter, pursuant to section 207.64 of the Commission's rules.

Hearing. The Commission will hold a hearing in connection with the review beginning at 9:30 a.m. on May 3, 2005, at the U.S. International Trade Commission Building. Requests to appear at the hearing should be filed in writing with the Secretary to the Commission on or before April 26, 2005. A nonparty who has testimony that may aid the Commission's deliberations may request permission to present a short statement at the hearing. All parties and nonparties desiring to appear at the hearing and make oral presentations should attend a prehearing conference to be held at 9:30 a.m. on April 28, 2005, at the U.S. International Trade Commission Building. Oral testimony and written materials to be submitted at the public hearing are governed by sections 201.6(b)(2), 201.13(f), 207.24, and 207.66 of the Commission's rules. Parties must submit any request to present a portion of their hearing testimony *in camera* no later than 7 days prior to the date of the hearing.

Written submissions. Each party to the review may submit a prehearing brief to the Commission. Prehearing briefs must conform with the provisions of section 207.65 of the Commission's rules; the deadline for filing is April 22, 2005. Parties may also file written testimony in connection with their presentation at the hearing, as provided in section 207.24 of the Commission's rules, and posthearing briefs, which must conform with the provisions of section 207.67 of the Commission's rules. The deadline for filing posthearing briefs is May 12, 2005; witness testimony must be filed no later than three days before the hearing. In addition, any person who has not entered an appearance as a party to the review may submit a written statement of information pertinent to the subject of the review on or before May 12, 2005. On June 3, 2005, the Commission will make available to parties all information on which they have not had an opportunity to comment. Parties may submit final comments on this information on or before June 7, 2005, but such final

¹ Chairman Stephen Koplan dissenting.

comments must not contain new factual information and must otherwise comply with section 207.68 of the Commission's rules. All written submissions must conform with the provisions of section 201.8 of the Commission's rules; any submissions that contain BPI must also conform with the requirements of sections 201.6, 207.3, and 207.7 of the Commission's rules. The Commission's rules do not authorize filing of submissions with the Secretary by facsimile or electronic means, except to the extent permitted by section 201.8 of the Commission's rules, as amended, 67 FR 68036 (November 8, 2002).

Additional written submissions to the Commission, including requests pursuant to section 201.12 of the Commission's rules, shall not be accepted unless good cause is shown for accepting such submissions, or unless the submission is pursuant to a specific request by a Commissioner or Commission staff.

In accordance with sections 201.16(c) and 207.3 of the Commission's rules, each document filed by a party to the review must be served on all other parties to the review (as identified by either the public or BPI service list), and a certificate of service must be timely filed. The Secretary will not accept a document for filing without a certificate of service.

Authority: This review is 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: December 23, 2004.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. 04-28588 Filed 12-29-04; 8:45 am]

BILLING CODE 7020-02-P

DEPARTMENT OF LABOR

Office of the Solicitor; Agency Information Collection Activities: Proposed Collection; Comment Request; Equal Access to Justice Act

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a pre-clearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995. See 44 U.S.C. 3506(c)(2)(A). The program helps to ensure that requested data can be provided in the desired format,

reporting burden (time and financial resources) is minimized, collection instruments are understood clearly, and the impact of the collection requirements on respondents can be assessed properly. Currently the Office of the Solicitor is soliciting comments concerning the proposed extension of the information collection required in applications to obtain awards in administrative proceedings subject to the Equal Access to Justice Act.

DATES: Written comments must be submitted by February 28, 2005.

ADDRESSES: Comments are to be submitted to the Department of Labor, Office of Solicitor, Attn: April Nelson, 200 Constitution Avenue, NW., (Room N-2428), Washington, DC 20210. Written comments limited to 10 pages or fewer may be transmitted by facsimile to (202) 693-5539.

FOR FURTHER INFORMATION CONTACT: Contact April Nelson, Office of Solicitor, telephone (202) 693-5782. Copies of the referenced information collection request are available in room N-1301, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. The collection request and applicable supporting documentation may be obtained by contacting Darrin King by telephone at (202) 693-4129 or by e-mail at king.darrin@dol.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Equal Access to Justice Act (EAJA) provides for the award of fees and expenses, under certain circumstances, to parties involved in adversary adjudications with the United States. 5 U.S.C. 504. The statute, at 5 U.S.C. 504(a)(2), requires that a party seeking an award of fees and expenses in a covered proceeding must submit to the agency "an application which shows that the party is the prevailing party and is eligible to receive an award" under EAJA.

The Department of Labor's regulations at 29 CFR Part 16 implement EAJA, and 29 CFR 16.201 sets forth the required elements of an EAJA award application. Under this regulation, EAJA award applications must include information regarding the following: The identity of the applicant, the proceeding for which an award is sought, the fact that the applicant has prevailed, the agency position alleged not to be substantially justified, the number of employees of the applicant at the time the proceeding was instituted (if the applicant is other than an individual), the type and purpose of the applicant's organization or business (if applicable), net worth and/or other designated information,

and amounts requested. Certain certifications, affidavits and other documents also are required. See 29 CFR 16.201-16.204 for a complete description of information required from applicants.

II. Desired Focus of Comments

The Department of Labor is interested in comments particularly in order to:

- 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 agency's 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.

III. Current Action

This notice requests an extension of the current Office of Management and Budget (OMB) approval of the paperwork requirements for the contents of applications for an award under the Equal Access to Justice Act.

Type of Review: Extension of a currently approved collection of information.

Agency: Office of the Solicitor.

Title: Equal Access to Justice Act.

OMB Number: 1225-0013.

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Federal government; State, local or tribal government.

Number of Respondents: 10.

Frequency: On occasion.

Total Responses: 10.

Average Time per Response: 5 hours.

Estimated Total Burden Hours: 50 hours.

Total annualized capital/startup costs: \$0.

Total Annualized costs (operation and maintenance): \$0.

Comments submitted in response to this notice will be summarized and may be included in the request for OMB approval of the final information collection request. The comments will become a matter of public record.

Signed at Washington, DC, this 23rd day of December, 2004.

Robert A. Shapiro,

Associate Solicitor for Legislation and Legal Counsel.

[FR Doc. 04-28620 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-23-P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA-W-55,427]

Alexvale/Kincaid Furniture, a Subsidiary of La-Z-Boy, Administrative Offices, Taylorsville, NC; Notice of Revised Determination on Reopening

On November 9, 2004, the Department, on its own motion, reopened its investigation for the former workers of the subject facility.

The initial investigation for workers of Kincaid Furniture, Taylorsville, North Carolina resulted in a negative determination issued on September 8, 2004 and published in the **Federal Register** on September 23, 2004 (69 FR 57093). The petition was denied because criterion (1) was not met. The investigation revealed no decline in employment during the relevant time period.

By application of September 23, 2004, a petitioner requested administrative reconsideration of the Department's negative determination regarding eligibility for workers and former workers of the subject facility to apply for Trade Adjustment Assistance (TAA).

On October 27, 2004, the Department issued a Negative Determination Regarding Application for Reconsideration applicable to workers and former workers of the subject facility on the grounds that the application did not contain any new substantial information that would bear importantly on the Department's determination denying certification because the subject facility did not have a "significant number or proportion" of workers who were separated or threatened with separation to meet the requirement of Section 222(a)(1) of the Trade Act of 1974, as amended. The Notice of the determination was published in the **Federal Register** on November 5, 2004 (69 FR 64592).

Upon further consultation with the petitioner, new information revealed the petitioner intended to apply on behalf of the Administrative Offices supporting production at the subject facility, rather than the facility as a whole.

A company official was contacted in regards to the Administrative Offices at

the Taylorsville facility. It was revealed that the workers of the Administrative Offices are separately identifiable from the rest of the workers at the subject facility, and there were significant declines in employment within the Administrative Offices between December 2003 and August 2004.

Furthermore, the Administrative Offices of the subject facility provide accounting, human resources, IT, purchasing, and general clerical support of the production which occurs at the subject facility. Furthermore, production of upholstered furniture at the subject facility declined during the period of January through August 2004, when compared to the same period in 2003. Company imports of upholstered furniture increased during the same period.

It was further revealed that the subject facility was originally a privately owned company known as Alexvale Furniture. The subject facility was purchased by La-Z-Boy, and is now managed by Kincaid Furniture (also a subsidiary of La-Z-Boy). Although the subject facility is now often referred to as a Kincaid facility, the company is registered in the State of North Carolina as Alexvale Furniture, and has a separate employer identification number.

In accordance with Section 246 of the Trade Act of 1974 (26 U.S.C. 2813), as amended, the Department of Labor herein presents the results of its investigation regarding certification of eligibility to apply for alternative trade adjustment assistance (ATAA) for older workers.

In order for the Department to issue a certification of eligibility to apply for ATAA, the group eligibility requirements of Section 246 of the Trade Act must be met. The Department has determined in this case that the requirements of Section 246 have been met.

A significant number of workers at the subject division are age 50 or over and possess skills that are not easily transferable. Competitive conditions within the industry are adverse.

Conclusion

After careful review of the additional facts obtained on reopening, I determine that increases of imports of articles like or directly competitive with upholstered furniture produced by Alexvale/Kincaid Furniture, a subsidiary of La-Z-Boy, Taylorsville, North Carolina, contributed importantly to the total or partial separation of workers from the Administrative Offices of that facility. In accordance with the provisions of the Act, I make the following certification:

"All workers of Alexvale/Kincaid Furniture, a subsidiary of La-Z-Boy, Administrative Offices, Taylorsville, North Carolina, who became totally or partially separated from employment on or after August 11, 2003 through two years from the date of certification are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974, and are eligible to apply for alternative trade adjustment assistance under Section 246 of the Trade Act of 1974."

Signed in Washington, DC, this 29th day of November 2004.

Elliott S. Kushner,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 04-28568 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-30-P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA-W-56,030]

Arista Beaver Brook Circuits, Bethel, CT, Notice of Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, as amended, an investigation was initiated on November 17, 2004 in response to a petition filed on behalf of workers of Arista Beaver Brook Circuits, Bethel, Connecticut.

All but two workers were separated from the subject firm more than one year before the date of the petition. Section 223(b) of the Act specifies that no certification may apply to any worker whose last separation occurred more than one year before the date of the petition.

The remaining two workers were separated in December 2003, and did not represent a significant number or proportion of workers as required by Section 222 of the Trade Act of 1974. Significant number or proportion of the workers means that at least three workers in a firm with a workforce of fewer than 50 workers would have to be affected. Separations by the subject firm did not meet this threshold level in the relevant time period. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC, this 30th day of November 2004.

Richard Church,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 04-28572 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-30-P

DEPARTMENT OF LABOR**Employment and Training
Administration**

[TA-W-55,897]

**Arrow Electronics, Inc., Sun Valley,
CA; Notice of Termination of
Investigation**

Pursuant to Section 221 of the Trade Act of 1974, as amended, an investigation was initiated on November 1, 2004 in response to a petition filed by a company official on behalf of workers at Arrow Electronics, Inc., Sun Valley, California.

The petitioner requested that the petition be withdrawn. Consequently, further investigation would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC this 29th day of November 2004.

Linda G. Poole,

*Certifying Officer, Division of Trade
Adjustment Assistance.*

[FR Doc. 04-28571 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-30-P

DEPARTMENT OF LABOR**Employment and Training
Administration**

[TA-W-55,601]

**California Cedar Products Company,
Stockton, CA; Notice of Negative
Determination on Reconsideration**

On October 28, 2004, the Department issued an Affirmative Determination Regarding Application for Reconsideration for the workers and former workers of the subject firm. The notice was published in the **Federal Register** on November 12, 2004 (69 FR 65456).

The Department initially denied Trade Adjustment Assistance (TAA) and Alternate Trade Adjustment Assistance (ATAA) to workers of California Cedar Products Company, Stockton, California because production ceased at the subject facility more than a year prior to the petition date (August 31, 2004).

Subsequent to the issuance of the initial determination, the Department received new information that seemed to indicate that production may have occurred at the subject facility during the relevant period (September 1, 2003 through August 31, 2004).

During the reconsideration investigation, the Department requested more information from the subject company regarding production at the subject facility during the relevant period.

The reconsideration investigation revealed that the subject company did not produce pencil slats during the relevant period and that company sales were from existing inventory.

Conclusion

After reconsideration, I affirm the original notice of negative determination of eligibility to apply for worker adjustment assistance for workers and former workers of California Cedar Products Company, Stockton, California.

Signed at Washington, DC, this 30th day of November 2004.

Elliott S. Kushner,

*Certifying Officer, Division of Trade
Adjustment Assistance.*

[FR Doc. 04-28569 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-30-P

DEPARTMENT OF LABOR**Employment and Training
Administration**

[TA-W-55,819, TA-W-55,819A, TA-W-55,819B, and TA-W-55,819C]

**Coats American, Inc., Sevier Plant,
Marion, NC, El Paso Distribution
Center & Customer Service Center, El
Paso, TX, Sparks Distribution Center,
Sparks, NV, and Old Fort
Transportation & Distribution Center,
Old Fort, NC; Notice of Termination of
Investigation**

Pursuant to Section 221 of the Trade Act of 1974, as amended, an investigation was initiated on October 19, 2004 in response to a petition filed by a company official on behalf of workers at Coats American, Inc. located at the above named facilities in North Carolina, Texas and Nevada.

The petitioner has requested that the petition be withdrawn. Consequently, the investigation has been terminated.

Signed at Washington, DC, this 29th day of November 2004.

Richard Church,

*Certifying Officer, Division of Trade
Adjustment Assistance.*

[FR Doc. 04-28570 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-30-P

DEPARTMENT OF LABOR**Employment and Training
Administration****Investigations Regarding Certifications
of Eligibility To Apply for Worker
Adjustment Assistance**

Petitions have been filed with the Secretary of Labor under Section 221(a) of the Trade Act of 1974 ("the Act") and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Division of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to Section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than January 10, 2005.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than January 10, 2005.

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Room C-5311, 200 Constitution Avenue, NW., Washington, DC 20210.

Signed at Washington, DC this 22nd day of December 2004.

Timothy Sullivan,

*Director, Division of Trade Adjustment
Assistance.*

Appendix

[Petitions instituted between 12/06/2004 and 12/10/2004]

TA-W	Subject firm (petitioners)	Location	Date of institution	Date of petition
56,139	Interdynamics, Inc. (Comp)	Brooklyn, NY	12/06/2004	12/03/2004.
56,140	Woodbridge Corp. (State)	Whitmore Lake, MI	12/06/2004	12/02/2004.
56,141	Acme-McCrary Corp. (Comp)	Wilkesboro, NC	12/06/2004	11/23/2004.
56,142	Valenite, Inc. Materials R and D (State)	Troy, MI	12/06/2004	12/03/2004.
56,143	Tee Jays Manufacturing Co., Inc. (Comp)	Florence, AL	12/06/2004	12/02/2004.
56,144	Heller Industries (Wkrs)	Florham Park, NJ	12/06/2004	12/05/2004.
56,145	Corning, Inc. (Wkrs)	Corning, NY	12/06/2004	12/02/2004.
56,146	Southern Ohio Fabricators (Wkrs)	Batavia, OH	12/06/2004	11/20/2004.
56,147	Innovex, Inc. (State)	Maple Plain, MN	12/06/2004	12/02/2004.
56,148	Ozark Elec. Repair, Inc. (Wkrs)	Cullman, AL	12/06/2004	12/02/2004.
56,149	Honeywell International (Comp)	Cleveland, TN	12/06/2004	12/03/2004.
56,150	Dicon Fiberoptics, Inc. (Wkrs)	Richmond, CA	12/06/2004	11/23/2004.
56,151	Cinergy Solutions or Rock Hill (Comp)	Rock Hill, SC	12/06/2004	11/19/2004.
56,152	Markovitz Enterprises (Wkrs)	New Castle, PA	12/06/2004	12/02/2004.
56,153	Shawcor Ltd. (Comp)	Theodore, AL	12/06/2004	12/02/2004.
56,154	JR Green (State)	Boonton, NJ	12/06/2004	12/02/2004.
56,155	All Access Apparel (State)	Montebello, CA	12/06/2004	11/23/2004.
56,156	Spang and Co. (Wkrs)	Pittsburgh, PA	12/06/2004	12/02/2004.
56,157	Capital City Press, Inc. (Comp)	Barre, VT	12/07/2004	12/01/2004.
56,158	Square D/Schneider Electric (Comp)	Columbia, MO	12/07/2004	12/06/2004.
56,159	T and R Knitting Mills, Inc. (Comp)	Glendale, NY	12/07/2004	12/03/2004.
56,160	Kennametal, Inc. (Wkrs)	Latrobe, PA	12/07/2004	12/03/2004.
56,161	Brooks Hosiery, Inc. (Comp)	Salvania, AL	12/07/2004	12/06/2004.
56,162	Visteon Systems LLC (IUECWA)	Connersville, IN	12/07/2004	12/10/2004.
56,163	Gateway Hosiery Mills, Inc. (Comp)	Chattanooga, TN	12/07/2004	11/05/2004.
56,164	Corhart Refractories (Comp)	Louisville, KY	12/07/2004	12/06/2004.
56,165	Inland Press (Comp)	Menomonee, WI	12/07/2004	12/06/2004.
56,166	Lilli Group, Inc. (The) (State)	S. Hackensack, NJ	12/07/2004	12/06/2004.
56,167	CIGNA HealthCare (Wkrs)	Chattanooga, TN	12/07/2004	12/01/2004.
56,168	AG Communication Systems (Wkrs)	Geona, IL	12/07/2004	12/07/2004.
56,169	JDS Uniphase (Wkrs)	Ewing, NJ	12/08/2004	12/06/2004.
56,170	Broyhill Pacemaker (Wkrs)	Lenoir, NC	12/08/2004	12/01/2004.
56,171	Lear Corporation (UAW)	Hazelwood, MO	12/08/2004	12/06/2004.
56,172	Cooper Atkins (State)	Gainesville, FL	12/08/2004	12/06/2004.
56,173	Durable Ralph, Inc. (State)	Harrison, AR	12/08/2004	12/07/2004.
56,174	Maryland Specialty Wire, Inc. (State)	Cockeysville, MD	12/08/2004	12/07/2004.
56,175	New Time Garment Manufacturing (Wkrs)	San Francisco, CA	12/08/2004	12/06/2004.
56,176	Spirit Manufacturing, Inc. (State)	Jonesboro, AR	12/08/2004	12/07/2004.
56,177	Wyeth (Wkrs)	Marietta, PA	12/08/2004	11/30/2004.
56,178	Electrolux Co. (State)	St. Cloud, MN	12/08/2004	12/07/2004.
56,179	More Sewit (Comp)	Longmont, CO	12/08/2004	12/07/2004.
56,180	Bristol Meyers-Squibb (Wkrs)	Syracuse, NY	12/08/2004	12/01/2004.
56,181	Aladdin Industries, LLC Corporate HQ (Comp)	Nashville, TN	12/08/2004	12/01/2004.
56,182	Cardinal Health (Comp)	Dublin, OH	12/08/2004	12/03/2004.
56,183	Sprint Telephone and Telegraph (Wkrs)	Rocky Mount, NC	12/08/2004	12/07/2004.
56,184	Johnstown Corporation (USWA)	Johnstown, PA	12/08/2004	11/28/2004.
56,185	Adecco (Comp)	Grand Rapids, MI	12/08/2004	11/23/2004.
56,186	Worldtronics International (NPC)	Oglesby, IL	12/08/2004	12/07/2004.
56,187	AT and T (CWA)	Charleston, WV	12/08/2004	11/24/2004.
56,188	Symbol Technologies (Wkrs)	Bohemia, NY	12/09/2004	11/10/2004.
56,189	CDI-Temp Agency (State)	Corvallis, OR	12/09/2004	12/08/2004.
56,190	Knowles Electronics (Wkrs)	Itasca, IL	12/09/2004	12/06/2004.
56,191	Nilfisk Advance (State)	Plymouth, MN	12/09/2004	12/08/2004.
56,192	Douglas Battery Manufacturing Co. (Comp)	Winston-Salem, NC	12/09/2004	12/08/2004.
56,193	Midwestern Telecommunications (Wkrs)	Homewood, IL	12/10/2004	12/07/2004.
56,194	Mid-west Spring and Stamping (State)	Little Canada, MN	12/10/2004	12/09/2004.
56,195	Crotty Corp. (Comp)	Gainsboro, TN	12/10/2004	12/09/2004.
56,196	Stern Rubber Co. (State)	Staples, MN	12/10/2004	12/10/2004.
56,197	Design Group International (State)	N. Shinington, CT	12/10/2004	12/09/2004.

[FR Doc. 04-28567 Filed 12-29-04; 8:45 am]
BILLING CODE 4510-30-M

DEPARTMENT OF LABOR

Employment and Training Administration

Proposed Information Collection Request Submitted for Public Comment and Recommendations; OMB Approval for Work-Flex State Plan Submission and Reporting Requirements

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden conducts a pre-clearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA95) [44 U.S.C. 3506(c)(2)(A)]. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed.

DATES: Submit comments on or before February 28, 2005.

ADDRESSES: Send comments to Christine Kulick, Chief, Division of One-Stop Operations, U.S. Department of Labor, 200 Constitution Avenue NW., Room S-4231, Washington, DC 20210. Telephone: 202-693-3045 (this is not a toll-free number); fax: 202-693-3015; or e-mail: Kulick.christine@dol.gov.

FOR FURTHER INFORMATION CONTACT: Christine Kulick, Chief, Division of One-Stop Operations, U.S. Department of Labor, 200 Constitution Avenue NW., Room S-4231, Washington, DC 20210. Telephone: 202-693-3045 (this is not a

toll-free number); fax: 202-693-3015; or e-mail: Kulick.christine@dol.gov.

SUPPLEMENTARY INFORMATION:

I. Background

Section 192 of the Workforce Investment Act (Pub. L. 105-220, August 7, 1998) permits States to apply for a workforce flexibility (Work-Flex) waiver authority to implement reforms to their workforce investment systems in exchange for program improvements. The Act provides that the Secretary may grant Work-Flex waiver authority for a period of up to five years pursuant to a Work-Flex Plan submitted by a State.

Under Work-Flex, Governors are granted the authority to approve requests submitted by their local areas to waive certain statutory and regulatory provisions of WIA Title I programs. States may also request from the Secretary waivers of certain requirements of the Wagner-Peyser Act (Sections 8-10) and certain provisions of the Older Americans Act applicable to State agencies that administer the Senior Community Service Employment Program (SCSEP).

The intent of the Work-Flex provision is to authorize States and Local Areas the operational flexibility they need to improve employment and training productivity for adult, dislocated, and youth populations. One of the underlying principles of Work-Flex is that it will result in improved performance outcomes for persons served and that waiver authority will be granted in consideration of improved performance.

II. Desired Focus of Comments

Currently, the Department is soliciting comments concerning the proposed extension of the collection which:

- 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 agency's 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 submissions of responses.

A copy of the proposed ICR can be obtained by contacting the office listed above in the addressee section of this notice.

III. Current Actions

Type of Review: Extension.

Agency: Employment and Training Administration.

Title: Work-Flex State Plan Submission and Reporting Requirements.

OMB Number: 1205-0432.

Record Keeping: Consistent with 29 CFR 97.42, records and supporting documentation should be retained for three years on a Federal fiscal year basis. The retention period for quarterly reports associated with a fiscal year status on the date the State submits its last quarterly report for that fiscal year. The retention period for the State Work-Flex Plan starts on the last day of the fiscal year for which it was initially approved or subsequently modified, whichever is later.

Affected Public: State and local governments.

Cite/Reference/Form/etc: Workforce Investment Act (WIA) of 1998 (Pub. L. 105-220, § 192); 20 CFR Part 652 et al, WIA Final Rules, (published at 64 FR 49294 (Aug. 11, 2000)); Training and Employment Guidance Letter (TEGL) No. 6-99, dated Feb. 22, 2000.

Form/activity	Total respondents	Frequency	Total responses	Average time per response (in hours)	Burden hours
State Plan	5	Annually	5	160	800
Quarterly Report	5	Quarterly	20	8	160.
Totals .....	.....	.....	25	.....	960.

Total Burden Cost (operating/maintaining): \$24,445.

Comments submitted in response to this comment request will be summarized and/or included in the request for the Office of Management and Budget approval of the ICR; they will also become a matter of public record.

Dated this 23rd Day of December, 2004.

Dennis I. Lieberman,

Acting Administrator, Office of Workforce Investment.

Work-Flex State Plan Instructions

States requesting designation as a Work-Flex State must submit a Work-Flex Plan which includes descriptions of:

a. The process by which local areas in the State may submit and obtain approval by the State of applications for waivers of requirements applicable under Title I of WIA, including provisions for public review and comment on local area waiver applications.

b. The statutory and regulatory requirements of Title I that are likely to be waived by the State under the plan.

c. The requirements applicable under Sections 8 through 10 of the Wagner-Peyser Act that are proposed to be waived, if any.

d. The statutory and regulatory requirements of the Older Americans Act of 1965 applicable to State agencies on aging with respect to administration of the Senior Community Service Employment Program (SCSEP) that are proposed to be waived, if any.

e. The outcomes to be achieved by the waiver authority including, where appropriate, revisions to adjusted levels of performance included in the State or Local Plan under Title I of WIA.

f. Special measures (in addition to current procedures) to be taken to ensure appropriate accountability for Federal funds in connection with the waivers.

g. Prior to submitting a Work-Flex Plan to the Secretary for approval, the State must provide notice to all interested parties and to the general public adequate notice and a reasonable opportunity for comment on the waivers proposed to be implemented. The plan should describe the process used for ensuring meaningful public comment. Include a description of the Governor's and the State Workforce Investment Board's involvement in drafting, reviewing and commenting on the Plan. Describe the actions taken to collaborate in the development of the State Work-Flex Plan with local chief elected officials, local workforce investment

boards and youth councils, the business community (including small businesses), labor organizations, educators, vocational rehabilitation agencies, and other interested parties, such as service providers, welfare agencies, community and faith-based organizations, transportation providers and other stakeholders.

Work-Flex Quarterly Report Instructions

Report for each waiver granted:

1. Waiver # (assigned by State)
2. Date received
3. Date granted
4. Local Area(s) requesting waiver
5. Purpose (brief statement)
6. Regulation/statute affected.

Summary (year-to-date):

1. # of waivers granted
2. # of waivers denied
3. # of waivers pending
4. Total waivers received.

[FR Doc. 04-28574 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-30-P

DEPARTMENT OF LABOR

Employment And Training Administration

ETA-9016 Report on Alien Claimant Activity; Comment Request

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA95) [44 U.S.C. 3506(c)(2)(A)]. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Employment and Training Administration, Office of Workforce Security is soliciting comments concerning the proposed extension of the collection for the ETA 9016 Report on Alien Claimant Activity.

A copy of the proposed information collection request (ICR) can be obtained by contacting the office listed below in the **ADDRESSES** section of this notice.

DATES: Written comments must be submitted to the office listed in the

addressee's section below on or before February 28, 2005.

ADDRESSES: Diann Lowery, U.S. Department of Labor, Employment and Training Administration, Room S-4231, 200 Constitution Avenue, NW., Washington, DC 20210, Phone: 202-693-3210, Fax: 202-693-3229, e-mail: lowery.diann@dol.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The ETA-9016 Report is used by the Department of Labor to assess whether (and the extent to which) the requirements of the Immigration and Naturalization Service (INS), Systematic Alien Verification for Entitlement (SAVE) system are cost-effective and otherwise appropriate for the Unemployment Insurance (UI) program. In addition, data from the Alien Claims Activity report is being used to assist the Secretary of Labor in determining whether a State Workforce Agency's administrative costs associated with the verification program are reasonable and reimbursable. There is no other report or system available for collecting this required information. The report allows the Department of Labor to determine the number of aliens filing for UI, the number of benefit issues detected, the denials of benefits to aliens, the extent to which State Agencies use the system, and the overall effectiveness and cost efficiency of the verification system. If SWAs are not required to submit the information on the Alien Claims Activity Report, the Department of Labor would not be able to fulfill its responsibilities to assess the SAVE system.

II. Review Focus

The Department of Labor is particularly interested in comments which:

- 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 agency's 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 submissions of responses.

III. Current Actions:

Type of Review: Extension without change.

Title: ETA 9016, Report on Alien Claimant Activity.

OMB Number: 1205-0268.

Agency Number: ETA 9016.

Recordkeeping: Respondent is expected to maintain data which support the reported data for three years.

Affected Public: 53 State Agencies.

Estimated Total Burden Hours: 53 States x 4 report x 1 hours = 212 hours. Total Burden Cost (operating/maintaining): \$0.

Comments submitted in response to this comment request will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

Dated: December 22, 2004.

Cheryl Atkinson,

Administrator, Office of Workforce Security.
[FR Doc. E4-3900 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-30-P

DEPARTMENT OF LABOR

Employment and Training Administration

ETA-9000 Report on Internal Fraud Activities; Comment Request

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA95) [44 U.S.C. 3506(c)(2)(A)]. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Employment and Training Administration, Office of Workforce Security is soliciting comments concerning the proposed extension of the collection for the ETA 9000 Report on Internal Fraud Activities.

A copy of the proposed information collection request (ICR) can be obtained by contacting the office listed below in the **ADDRESSES** section of this notice.

DATES: Written comments must be submitted to the office listed in the addressee's section below on or before February 28, 2005.

ADDRESSES: Diann Lowery, U.S. Department of Labor, Employment and Training Administration, Room S-4231, 200 Constitution Avenue, NW., Washington, DC 20210, Phone: 202-693-3210, Fax: 202-693-3229, e-mail: lowery.diann@dol.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The ETA 9000 is the only data source available on instances of internal fraud activities within the Unemployment Insurance (UI) program and on the results of safeguards that have been implemented to deter and detect instances of internal fraud. The report categorizes the major areas susceptible to internal (employee) fraud and provides actual and "estimated" (predictability or cost avoidance measures) workload. The information from this report has been used and will be used to review Internal Security (IS) operations and obtain information on composite shifting patterns of nationwide activity and effectiveness in the area of internal fraud identification and prevention. The Employment and Training Administration has used this report to assess the overall adequacy of IS procedures in State Workforce Agencies (SWA) UI program administration.

II. Review Focus

The Department of Labor is particularly interested in comments which:

- 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 agency's 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 submissions of responses.

III. Current Actions

Continued collection of the ETA-9000 data will provide for a comprehensive evaluation of the UI IS program. The data are collected annually, and an analysis of the data received is formulated into a report summarizing the internal fraud cases uncovered by the 53 SWAs.

Type of Review: Extension without change.

Title: ETA 9000, Report on Internal Fraud Activities.

OMB Number: 1205-0187.

Agency Number: ETA 9000.

Recordkeeping: Respondent is expected to maintain data which support the reported data for three years.

Affected Public: 53 State governments.

Estimated Total Burden Hours: 53 States x 1 report x 3 hours = 159 hours.

Total Burden Cost (operating/maintaining): \$0.

Comments submitted in response to this comment request will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

Dated: December 22, 2004.

Cheryl Atkinson,

Administrator, Office of Workforce Security.
[FR Doc. E4-3901 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-30-P

DEPARTMENT OF LABOR

Employment Standards Administration

Proposed Collection; Comment Request

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA95) [44 U.S.C. 3506(c)(2)(A)]. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be

properly assessed. Currently, the Employment Standards Administration is soliciting comments concerning the proposed collection: Rehabilitation Plan and Award (OWCP-16). A copy of the proposed information collection request can be obtained by contacting the office listed below in the **ADDRESSES** section of this Notice.

DATES: Written comments must be submitted to the office listed in the **ADDRESSES** section below on or before February 28, 2005.

ADDRESSES: Ms. Hazel M. Bell, U.S. Department of Labor, 200 Constitution Ave., NW., Room S-3201, Washington, DC 20210, telephone (202) 693-0418, fax (202) 693-1451, E-mail bell.hazel@dol.gov. Please use only one method of transmission for comments (mail, fax, or E-mail).

SUPPLEMENTARY INFORMATION

I. Background

The Office of Workers' Compensation Programs (OWCP) is the agency responsible for administration of the Longshore and Harbor Workers' Compensation Act (LHWCA); 33 U.S.C. 901 *et seq.*, and the Federal Employees' Compensation Act (FECA), 5 U.S.C. 8101 *et seq.* Both of these Acts authorize OWCP to pay for approved vocational rehabilitation services to eligible workers with work-related disabilities. OWCP must receive the signatures of the worker and the rehabilitation counselor to show that the worker agrees to follow the proposed plan, and that the proposed plan is appropriate. The OWCP-16 is the standard format for the collection of information needed to approve proposed vocational rehabilitation services. Form OWCP-16 serves to document the agreed upon plan for rehabilitation services submitted by the injured worker and vocational rehabilitation counselor, the costs involved, and OWCP's award of payment from funds provided for rehabilitation. Form OWCP-16 summarizes the costs of the rehabilitation plan to enable OWCP to make a prompt decision on funding. This information collection is currently approved for use through June 30, 2005.

II. Review Focus

The Department of Labor is particularly interested in comments which:

- 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 agency's 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 submissions of responses.

III. Current Actions

The Department of Labor seeks the approval of the extension of this information collection in order to carry out its responsibility to provide vocational rehabilitation services to eligible workers currently unemployed because of disability.

Type of Review: Extension.

Agency: Employment Standards Administration.

Titles: Rehabilitation Plan and Award.

OMB Number: 1215-0067.

Agency Numbers: OWCP-16.

Affected Public: Business or other for-profit; Individuals or households.

Total Respondents: 7,000.

Total Annual responses: 7,000.

Estimated Total Burden Hours: 3,500.

Estimated Time Per Response: 30 minutes.

Frequency: On Occasion.

Total Burden Cost (capital/startup): \$0.

Total Burden Cost (operating/maintenance): \$0.

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

Dated: December 22, 2004.

Sue R. Blumenthal,

Acting Chief, Branch of Management Review and Internal Control, Division of Financial Management, Office of Management, Administration and Planning, Employment Standards Administration.

[FR Doc. 04-28575 Filed 12-29-04; 8:45 am]

BILLING CODE 4510-CH-P

LIBRARY OF CONGRESS

Copyright Office

[Docket No. 2004-9 CARP SRA]

Rate Adjustment for the Satellite Carrier Compulsory License

AGENCY: Copyright Office, Library of Congress.

ACTION: Notice of voluntary negotiation period.

SUMMARY: The Copyright Office of the Library of Congress is announcing the voluntary negotiation period for the purpose of determining the royalty fees for analog signals to be paid by satellite carriers under the satellite carrier compulsory license.

DATES: The voluntary negotiation period commences on December 30, 2004 and concludes on January 10, 2005.

ADDRESSES: If hand delivered by a private party, an original and five copies of voluntary agreements should be brought to Room LM-401 of the James Madison Memorial Building and the envelope should be addressed as follows: Office of the General Counsel/CARP, U.S. Copyright Office, James Madison Memorial Building, Room LM-401, 101 Independence Avenue, SE., Washington, DC 20559-6000 between 8:30 a.m. and 5 p.m. If delivered by a commercial courier, an original and five copies of voluntary agreements must be delivered to the Congressional Courier Acceptance Site located at 2nd and D Streets, NE. between 8:30 a.m. and 4 p.m. The envelope should be addressed as follows: Office of the General Counsel/CARP, Room LM-403, James Madison Memorial Building, 101 Independence Avenue, SE., Washington, DC. If sent by mail (including overnight delivery using U.S. Postal Service Express Mail), an original and five copies of voluntary agreements should be addressed to: Copyright Arbitration Royalty Panel (CARP), P.O. Box 70977, Southwest Station, Washington, DC. 20024. Voluntary agreements may not be delivered by means of overnight delivery services such as Federal Express, United Parcel Service, etc., due to delays in processing receipt of such deliveries.

FOR FURTHER INFORMATION CONTACT:

David O. Carson, General Counsel, or Gina Giuffreda, Attorney Advisor, Copyright Arbitration Royalty Panel (CARP), P.O. Box 70977, Southwest Station, Washington, DC. 20024. Telephone: (202) 707-8380. Telefax: (202) 252-3423.

SUPPLEMENTARY INFORMATION:

Background

The satellite carrier compulsory license establishes a statutory copyright licensing scheme for satellite carriers that retransmit television broadcast signals to satellite dish owners for their private home viewing. 17 U.S.C. 119. Congress created the license in 1988 with the passage of the Satellite Home Viewer Act of 1988. Congress reauthorized the satellite license for additional five-year periods in 1994 and 1999, and the license was slated to expire on December 31, 2004. However, Congress again reauthorized the satellite license for another five years with the passage of the Satellite Home Viewer Extension and Reauthorization Act of 2004 ("the 2004 Act") (as part of the Consolidated Appropriations Act, 2005), Pub. L. 108-447, which was signed into law by the President on December 8, 2004.

Satellite carriers pay royalties based on a flat, per-subscriber, per-month fee. These rates were initially set by Congress in the Satellite Home Viewer Act of 1988 and then later adjusted by a three-person arbitration panel convened by the former Copyright Royalty Tribunal. 57 FR 19052 (May 1, 1992). When the license was reauthorized in 1994, Congress directed that the rates be adjusted by the Librarian of Congress using the system that replaced the Copyright Royalty Tribunal, namely, *ad hoc* Copyright Arbitration Royalty Panels ("CARPs") administered by the Librarian of Congress and the Copyright Office. Accordingly, the Librarian adjusted the rates in 1997. 62 FR 55742 (October 28, 1997). In the Satellite Home Viewer Improvement Act of 1999, which reauthorized the license for an additional five years, Congress reduced the rates set by the Librarian.

The 2004 Act adopts the rates as reduced by Congress in 1999 but calls for the amendment of those rates to be paid by satellite carriers for the secondary transmission of the primary analog transmission of network stations and superstations. This notice begins the process mandated by the statute.

Voluntary Negotiation Period

Sections 119(c)(1)(B) of the Copyright Act, 17 U.S.C., provides that "[o]n or before January 2, 2005, the Librarian of Congress shall cause to be published in the **Federal Register** [notice] of the initiation of voluntary negotiation proceedings for the purpose of determining the royalty fee to be paid by satellite carriers * * * under subsection (b)(1)(B)." This notice initiates the voluntary negotiation period.

The statute provides that "[w]ithin 10 days after publication in the **Federal Register** of a notice of the initiation of voluntary negotiation proceedings, parties who have reached a voluntary agreement may request that the royalty fees in that agreement be applied to all satellite carriers, distributors, and copyright owners without convening an arbitration proceeding." 17 U.S.C. 119(c)(1)(D)(ii)(I). In accordance with this provision, the voluntary negotiation period commences today, December 30, 2004, and concludes January 10, 2005.

If a voluntary agreement is reached by the end of the negotiation period, the parties can request that the Librarian publish the agreement for notice and comment in accordance with section 119(c)(1)(D)(ii)(II) and adopt the rates in the voluntary agreement if no objections are received from a party with a significant interest and an intention to participate in an arbitration proceeding. 17 U.S.C. 119(c)(1)(D)(ii)(III). If an objection to the voluntary agreement is received or if parties are unable to reach a voluntary agreement, the statute dictates that the rates be determined under the current CARP system.¹ Therefore, if a CARP proceeding becomes necessary, the Library must apply the rules and regulations of 37 CFR part 251. Consequently, should the parties be unable to reach a voluntary agreement by the end of the voluntary negotiation period or should a party with a significant interest and an intention to participate in an arbitration proceeding file an objection to the agreement, the Library will publish a subsequent notice calling for the filing of Notices of Intent to Participate.

Dated: December 27, 2004.

David O. Carson,

General Counsel.

[FR Doc. 04-28605 Filed 12-29-04; 8:45 am]

BILLING CODE 1410-33-P

¹ On November 30, 2004, the President signed into law the Copyright Royalty and Distribution Act of 2004, Pub. L. 108-419, which eliminates the CARP system and replaces it with three permanent Copyright Royalty Judges. However, the 2004 Act calls for satellite royalty rates to be determined "under chapter 8 as in effect on the day before the date of enactment of the Copyright Royalty and Distribution Act of 2004." 17 U.S.C. 119(c)(1)(F).

INTERNATIONAL BOUNDARY AND WATER COMMISSION, UNITED STATES AND MEXICO

United States Section; Notice of Availability (NOA) of the Draft Supplemental Environmental Impact Statement (DSEIS) for Clean Water Act (CWA) Compliance at the South Bay International Wastewater Treatment Plant (SBIWTP), San Diego, California

AGENCY: United States Section, International Boundary and Water Commission (USIBWC).

ACTION: Notice of Availability.

SUMMARY: This announces the availability of the DSEIS that assesses the potential environmental impacts of the construction and operation of a range of treatment and disposal alternatives for the SBIWTP to achieve compliance with the CWA. Situated in the United States at the United States/Mexico border, the SBIWTP treats sewage flows originating from the City of Tijuana, Mexico and the surrounding region and discharges into the Pacific Ocean through an ocean outfall. The DSEIS considers existing and new alternatives that would enable the USIBWC to bring the SBIWTP into compliance with the CWA and the requirements contained in its National Pollutant Discharge Elimination System (NPDES) permit and to evaluate new information on the current discharges of advanced primary effluent from the SBIWTP through the South Bay Ocean Outfall (SBOO), as well as interim actions that would continue operations of the SBIWTP until the SBIWTP achieves CWA compliance. The United States Environmental Protection Agency (USEPA), Region 9, San Francisco, California, is a Cooperating Agency for this action.

DATES: Written comments are requested by February 28, 2005. The public comment period of the DSEIS will end 60 days after publication of the NOA in the **Federal Register**.

Public Hearing: A public hearing regarding the findings of the DSEIS and to take comments on the DSEIS will be held at 6:30 pm on Wednesday, February 2, 2005 at the San Ysidro Middle School (Auditorium), 4345 Otay Mesa Road, San Diego.

ADDRESSES: Written comments (no e-mails or faxes) must be addressed to: Mr. Daniel Borunda, Environmental Protection Specialist, Compliance Section, USIBWC, 4171 North Mesa Street, C-100, El Paso, Texas 79902. A copy of the DSEIS is available at <http://www.ibwc.state.gov> and in local public libraries in the San Diego area. A

limited number of copies will be available, if you wish to obtain a copy contact Mr. Daniel Borunda at the address above.

FOR FURTHER INFORMATION CONTACT: Mr. Daniel Borunda, Environmental Protection Specialist, USIBWC, at (915) 832-4701, by fax at (915) 832-4167, or by mail at the above listed address.

SUPPLEMENTARY INFORMATION: Pursuant to Section 102(2)(c) of the National Environmental Policy Act of 1969, as amended, the USIBWC has analyzed the impacts of alternatives for SBIWTP to achieve compliance with the CWA and its NPDES permit. This action is needed because the SBIWTP currently operates and discharges only at the advanced primary level and cannot meet all the requirements of the CWA and its NPDES permit, including secondary treatment requirements.

This DSEIS also evaluates new information on the current discharges of advanced primary effluent from the SBIWTP through the SBOO, as well as treatment and disposal options in Mexico to achieve CWA compliance.

The No Action Alternative and six action alternatives are evaluated in the DSEIS. The alternatives were developed in a manner that would enable wastewater flows to be treated in compliance with the CWA and the SBIWTP NPDES permit. Alternatives formulation was the result of a public consultation process that included the public, regulatory agencies and environmental organizations.

This DSEIS evaluates the following seven alternatives:

1. *Alternative 1:* No Action (Continue operation of SBIWTP as Advanced Primary Facility).

- Option A: With No Future Improvements to Mexico's Existing Conveyance Facilities

- Option B: With Future Improvements to Mexico's Existing Conveyance Facilities

2. *Alternative 2:* Operate SBIWTP as Advanced Primary Facility With Treated Flows Conveyed to Mexico for Discharge.

3. *Alternative 3:* Operate SBIWTP With City of San Diego Connections (Interim Alternative Only).

4. *Alternative 4:* Implementation of Public Law 106B457, Secondary Treatment Facility in Mexico.

- Treatment Option A: Operation of SBIWTP as Advanced Primary Facility, Secondary Treatment in Mexico

- Treatment Option B: Cease Operation of SBIWTP, Secondary Treatment in Mexico

- Treatment Option C: Bajagua LLC, Proposal—Operation of SBIWTP as

Advanced Primary Facility, Secondary Treatment in Mexico

- Discharge Option I: Treated Effluent Discharged in United States via SBOO

- Discharge Option II: Treated Effluent Discharged in Mexico at Punta Bandera

5. *Alternative 5:* Secondary Treatment in the United States at SBIWTP.

- Treatment Option A: Completely Mixed Aeration (CMA) Ponds at SBIWTP

- Treatment Options B-1 and B-2: Activated Sludge Secondary Treatment at SBIWTP

6. *Alternative 6:* Secondary Treatment in the U.S. and in Mexico.

7. *Alternative 7:* SBIWTP Closure/Shutdown.

The USIBWC has identified Alternative 4, Treatment Option C as the preferred alternative in the DSEIS. The USIBWC will consider comments on the DSEIS to make a final selection of the preferred alternative.

Background

The original Draft EIS for the SBIWTP project (1991) proposed the construction of a secondary treatment facility in San Diego to achieve secondary treatment using an activated sludge technology. Based on a 1994 Final EIS and Record of Decision (ROD), the USIBWC and the USEPA approved the construction of the SBIWTP and the connecting SBOO. The SBIWTP is on a 75-acre site in south San Diego County, California, just west of San Ysidro near the intersection of Dairy Mart and Monument roads. Treated effluent is discharged to the Pacific Ocean through the SBOO, a 4.5-mile long piping system completed in January 1999. This outfall extends about 3.5 miles offshore.

Pursuant to the completion of an Interim Operations Supplemental EIS in 1996, the USIBWC and USEPA decided to operate the SBIWTP as an advanced primary treatment facility before completion of the necessary secondary facilities. This decision would expedite the treatment of up to 25 mgd of untreated sewage from Tijuana that would otherwise have continued to pollute the Tijuana River and Estuary, as well as coastal waters in the United States.

Before the SBOO was completed in January 1999, advanced primary treated effluent was discharged through an emergency connection to the City of San Diego Point Loma Wastewater Treatment Plant. The emergency connection was used daily in the late 1980s and 1990s, but it has not been used in this manner since the SBIWTP started discharging to the completed SBOO in January 1999.

After the release of the May 1994 Final EIS and ROD and the 1996 decision regarding interim operation, significant additional information became available and changed circumstances warranted reconsidering the best means to complete the SBIWTP secondary treatment facilities. The USIBWC and USEPA decided to prepare a Supplemental EIS to examine new information as a settlement to a lawsuit that challenged the 1994 Final EIS.

In January 1998, the USIBWC and the USEPA issued the Draft Long Term Treatment Options Supplemental EIS to re-evaluate the SBIWTP secondary treatment options. In October 1998, the agencies issued a supplement to the 1996 Interim Operation Supplemental EIS that addressed impacts of the advanced primary treatment. This supplement disclosed new information about the presence of dioxins and acute toxicity in the advanced primary discharge. This new information was incorporated into the Final Long Term Treatment Options Supplemental EIS released in March 1999.

In the 1999 ROD for the Long Term Treatment Options Supplemental EIS, the USEPA and the USIBWC selected the CMA pond system at the Hofer property as the long-term option for secondary treating 25 mgd of wastewater at the SBIWTP. However, Congress did not fund the construction of these secondary treatment facilities and the plant has continued to provide advanced primary treatment only.

The specific purpose of the current analysis is to determine the environmental impacts of the alternatives that could accomplish compliance with the CWA and the SBIWTP NPDES permit. A decision on which of the alternatives will be implemented in order to achieve compliance with the CWA will be made by the USIBWC through a process that will consider a wide range of factors. The factors include, but are not limited to, environmental considerations, laws and regulations, implications for compliance with the CWA, the SBIWTP NPDES permit, budget considerations, schedule and public concerns.

A copy of the DSEIS has been filed with the USEPA in accordance with 40 CFR parts 1500-1508 and USIBWC procedures. Written comments concerning the DSEIS will be accepted at the address above until February 28, 2005.

Dated: December 21, 2004.

Susan E. Daniel,
General Counsel.

[FR Doc. 04-28378 Filed 12-29-04; 8:45 am]

BILLING CODE 4710-03-P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice 04-159]

NASA Robotic and Human Lunar Exploration Strategic Roadmap Committee; Meeting**AGENCY:** National Aeronautics and Space Administration (NASA).**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 forthcoming meeting of the NASA Robotic and Human Lunar Exploration Strategic Roadmap Committee.**DATES:** Monday, January 24, 2005, 8:30 a.m. to 4:30 p.m.; and Tuesday, January 25, 2005, 8:30 a.m. to 4:30 p.m.**ADDRESSES:** Space Center Houston, 1601 NASA Road 1, Houston, TX 77058-3145.**FOR FURTHER INFORMATION CONTACT:** Mr. Frank Bauer, Advanced Planning and Integration Office, National Aeronautics and Space Administration, Washington, DC 20546, (301) 286-3102.**SUPPLEMENTARY INFORMATION:** The meeting will be open to the public up to the capacity of the room. Visitors to the meeting will be requested to sign a visitor's register.

The agenda for the meeting includes the following topics: Goals and Objectives of the Committee, Background Briefings, Special Topics on Lunar Exploration, Roadmap Concepts, Roundtable Discussions.

It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants.

Dated: December 23, 2004.

P. Diane Rausch,*Advisory Committee Management Officer, National Aeronautics and Space Administration.*

[FR Doc. 04-28624 Filed 12-29-04; 8:45 am]

BILLING CODE 7510-13-P**NATIONAL AERONAUTICS AND SPACE ADMINISTRATION**

[Notice 04-158]

NASA Universe Exploration Strategic Roadmap Committee; Meeting**AGENCY:** National Aeronautics and Space Administration (NASA).**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 forthcoming meeting of the NASA Universe Exploration Strategic Roadmap Committee.

DATES: Tuesday, January 25, 2005, 8 a.m. to 5 p.m.; and Wednesday, January 26, 2005, 8 a.m. to 5 p.m.**ADDRESSES:** Grand Hyatt Hotel, 1000 H Street, NW., Washington, DC 20001.**FOR FURTHER INFORMATION CONTACT:** Dr. Michael Salamon, Science Mission Directorate, National Aeronautics and Space Administration, Washington, DC 20546, (202) 358-0441.**SUPPLEMENTARY INFORMATION:** The meeting will be open to the public up to the capacity of the room. Visitors to the meeting will be requested to sign a visitor's register.

The agenda for the meeting includes the following topics: Overview of Strategic Roadmap Process and Products; Relationship to Capabilities Roadmaps; Legacy Roadmap; Key Universe Science Questions and Future Missions; Roadmap Plan, Next Steps, and Assignments.

It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants.

P. Diane Rausch,*Advisory Committee Management Officer, National Aeronautics and Space Administration.*

[FR Doc. 04-28623 Filed 12-29-04; 8:45 am]

BILLING CODE 7510-13-P**NATIONAL CREDIT UNION ADMINISTRATION****Community Development Revolving Loan Fund for Credit Unions****AGENCY:** National Credit Union Administration.**ACTION:** Notice of application period.**SUMMARY:** The National Credit Union Administration (NCUA) will accept applications for participation in the Community Development Revolving Loan Fund's Loan Program throughout calendar year 2005, subject to availability of funds. Application procedures for qualified low-income credit unions are in NCUA Rules and Regulations.**ADDRESSES:** Applications for participation may be obtained from and should be submitted to: NCUA, Office of Small Credit Union Initiatives, 1775 Duke Street, Alexandria, VA 22314-3428.**DATES:** Applications may be submitted throughout calendar year 2005.**FOR FURTHER INFORMATION CONTACT:**

Tawana James, Director, Office of Small Credit Union Initiatives at the above address or telephone (703) 518-6610.

SUPPLEMENTARY INFORMATION: Part 705 of the NCUA Rules and Regulations implements the Community Development Revolving Loan Fund (Fund) for Credit Unions. The purpose of the Fund is to assist officially designated "low-income" credit unions in providing basic financial services to residents in their communities that result in increased income, ownership and employment. The Fund makes available low interest loans in amounts up to \$300,000 in the aggregate to qualified participating "low-income" designated credit unions. Interest rates are currently set at one percent. Specific details regarding availability and requirements for technical assistance grants from the Fund will be published in a Letter to Credit Unions. Fund participation is limited to existing credit unions with an official "low-income" designation.This notice is published pursuant to § 705.9 of the NCUA Rules and Regulations that states NCUA will provide notice in the **Federal Register** when funds in the program are available.

By the National Credit Union Administration Board on December 23, 2004.

Mary F. Rupp,*Secretary, NCUA Board.*

[FR Doc. 04-28583 Filed 12-29-04; 8:45 am]

BILLING CODE 7535-01-P**NATIONAL LABOR RELATIONS BOARD****Appointments of Individuals To Serve as Members of Performance Review Boards**5 U.S.C. 4314(c)(4) requires that the appointments of individuals to serve as members of performance review boards be published in the **Federal Register**. Therefore, in compliance with this requirement, notice is hereby given that the individuals whose names and position titles appear below have been appointed to serve as members of performance review boards in the National Labor Relations Board for the rating year beginning October 1, 2003 and ending September 30, 2004.**Name and Title**

Richard L. Ahearn—Regional Director, Region 19.

Frank V. Battle—Deputy Director of Administration.

Henry Breiteneicher—Solicitor.

John F. Colwell—Chief Counsel to Board Member.
 Harold J. Datz—Chief Counsel to the Chairman.
 John H. Ferguson—Associate General Counsel, Enforcement Litigation.
 Terence Flynn—Chief Counsel to Board Member.
 Robert A. Giannasi—Chief Administrative Law Judge.
 Lester A. Heltzer—Executive Secretary.
 John E. Higgins—Deputy General Counsel.
 Peter B. Hoffman—Regional Director, Region 34.
 Gloria Joseph—Director of Administration.
 Barry J. Kearney—Associate General Counsel, Advice.
 David B. Parker—Deputy Executive Secretary.
 Gary W. Shinnars—Chief Counsel to Board Member.
 Richard A. Siegel—Associate General Counsel, Operations-Management.
 Lafe E. Solomon—Director, Office of Representation Appeals.
 Peter D. Winkler—Chief Counsel to Board Member.

Dated: December 6, 2004 in Washington, DC, by direction of the Board.

Lester A. Heltzer,
Executive Secretary.

[FR Doc. 04-28599 Filed 12-29-04; 8:45 am]

BILLING CODE 7545-01-M

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Pub. L. 94-409, that the Securities and Exchange Commission will hold the following meeting during the week of January 3, 2005:

A closed meeting will be held on Thursday, January 6, 2005, at 10 a.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the Closed Meeting. Certain staff members who have an interest in the matters may also be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, one or more of the exemptions set forth in 5 U.S.C. 552(b)(3), (5), (7), (9)(B), and (10) and 17 CFR 200.402(a)(3), (5), (7), 9(ii) and (10), permit consideration of the scheduled matters at the Closed Meeting.

Commissioner Glassman, as duty officer, voted to consider the items listed for the closed meeting in closed session.

The subject matter of the Closed Meeting scheduled for Thursday, January 6, 2005, will be:

Formal orders of investigations; Institution and settlement of injunctive actions; and Institution and settlement of administrative proceedings of an enforcement nature.

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) 942-7070.

Dated: December 28, 2004.

Jill M. Peterson,
Assistant Secretary.

[FR Doc. 04-28699 Filed 12-28-04; 11:37 am]

BILLING CODE 8010-01-M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-50927; File No. SR-Amex-2004-50]

Self-Regulatory Organizations; Order Approving Proposed Rule Change and Amendment Nos. 1, 2, and 3 Thereto and Notice of Filing and Order Granting Accelerated Approval to Amendment Nos. 4 and 6 to the Proposed Rule Change by the American Stock Exchange LLC Relating to the National Association of Securities Dealers, Inc.'s Sale of Its Interest in the American Stock Exchange LLC to The Amex Membership Corporation

December 23, 2004.

I. Introduction

On June 30, 2004, the American Stock Exchange LLC ("Amex" or "Exchange") filed with the Securities and Exchange Commission ("Commission"), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934,¹ as amended (the "Act"), and Rule 19b-4 thereunder,² a proposed rule change to amend its Constitution and certain other organizational documents. On July 15, 2004, the Exchange filed Amendment No. 1 to the proposal.³ On July 21, 2004, the Exchange filed Amendment No. 2 to

the proposal.⁴ The proposed rule change was published for comment in the **Federal Register** on July 28, 2004.⁵ The Commission received no comment letters regarding the proposed rule change. On August 16, 2004, Amex filed Amendment No. 3 to the proposal.⁶ On September 1, 2004, the Exchange filed Amendment No. 4 to the proposed rule change.⁷ On December 17, 2004, the Exchange filed Amendment No. 5 to the proposed rule change.⁸ The Exchange withdrew Amendment No. 5 on December 21, 2004. On December 22, 2004, the Exchange filed Amendment No. 6 to the proposed rule change.⁹ This

⁴ See letter from Michael J. Ryan, Jr., Executive Vice President and General Counsel, Amex, to Nancy Sanow, Assistant Director, Division, Commission, dated July 20, 2004 ("Amendment No. 2"). Amendment No. 2 corrected formatting errors in the Amex Constitution, the Amended and Restated Exchange Limited Liability Company Agreement, the Second Restated Certificate of Incorporation of The Amex Membership Corporation, and the Amended and Restated By-Laws of The Amex Membership Corporation that were filed with Amendment No. 1; no substantive changes to these documents were made in Amendment No. 2.

⁵ See Securities Exchange Act Release No. 50057 (July 22, 2004), 69 FR 45091 (the "Amex Notice").

⁶ See letter from Michael J. Ryan, Jr., Executive Vice President and General Counsel, Amex, to Nancy Sanow, Assistant Director, Division, Commission, dated August 13, 2004 ("Amendment No. 3"). In Amendment No. 3, Amex revised Section 2 of its Form 19b-4 (Procedures of the Self-Regulatory Organization) to reflect the Exchange Board of Governors' action approving the final forms of the governance documents submitted as part of the proposal. Amendment No. 3 is a technical amendment, and, therefore, not subject to notice and comment.

⁷ See letter from Bruce Ferguson, Associate General Counsel, Amex, to Nancy Sanow, Assistant Director, Division, Commission, dated August 30, 2004 ("Amendment No. 4"). In Amendment No. 4, Amex amended Section 3 of Article II of the Amex Constitution to clarify that Exchange Board members, among other things, would be required to take into consideration the self-regulatory function of the Exchange and the Exchange's obligations (and their obligations) under the Act. Exhibit A to Amendment No. 4, which sets forth these changes, is available on the Commission's Web site (<http://www.sec.gov/rules/sro.shtml>). The changes proposed in Amendment No. 4 have been incorporated into this order.

⁸ See letter from Michael J. Ryan, Jr., Executive Vice President and General Counsel, Amex, to Nancy Sanow, Assistant Director, Division, Commission, dated December 17, 2004 ("Amendment No. 5").

⁹ See Amendment No. 6, dated December 22, 2004 ("Amendment No. 6"). Amendment No. 6 amends Sections 4(a) and 4(d) of Article II of the Amex Constitution, and related portions of Form 19b-4, to provide that the Chief Regulatory Officer will report only to the Regulatory Oversight Committee. Amendment No. 6 also sets forth certain Undertakings applicable to Amex. Exhibit 5 to Amendment No. 6, which sets forth these changes to Sections 4(a) and 4(d) of Article II of the Amex Constitution and the Undertakings, is available on the Commission's Web site (<http://www.sec.gov/rules/sro.shtml>). These changes and the Undertakings have been incorporated into this order. (The Commission further notes that the Undertakings are Exhibit E to the Form 19b-4.)

¹ 15 U.S.C. 78s(b)(1).

² 17 CFR 240.19b-4.

³ See letter from Michael J. Ryan, Jr., Executive Vice President and General Counsel, Amex, to Nancy Sanow, Assistant Director, Division of Market Regulation ("Division"), Commission, dated July 13, 2004 ("Amendment No. 1"). Amendment No. 1 replaced Amex's original filing in its entirety.

order approves the proposed rule change, as amended, grants accelerated approval to Amendment Nos. 4 and 6 to the proposed rule change, and solicits comments from interested persons on Amendment Nos. 4 and 6.

II. Description of Proposed Rule Change

Ownership interests in the American Stock Exchange LLC currently consist of a Class A Participation Interest held by The Amex Membership Corporation ("MC") and a Class B Participation Interest held by New NASD Holdings, Inc. ("NAHO"), a wholly owned subsidiary of the National Association of Securities Dealers, Inc. ("NASD"). Pursuant to a proposed transaction between the parties ("Transaction"), MC will become the sole owner of the Exchange through the acquisition of 100% of the Class B Participation Interest in the Exchange from NAHO. To implement the terms of the Transaction and institute new governance structures for the Exchange and MC, the Exchange has filed amendments to its Constitution, the Second Restated Certificate of Incorporation of MC ("MC Certificate of Incorporation"), the Restated By-Laws of MC ("MC Bylaws"), and the Amended & Restated Exchange Limited Liability Company Agreement ("LLC Agreement"). Each of these documents will become effective upon the closing of the Transaction.

A. The Transaction

Through MC Acquisition Sub, a corporate subsidiary, MC will acquire 100% of the Class B Participation Interest in the Exchange from NAHO.¹⁰ Thus, upon consummation of the Transaction, MC will beneficially own 100% of the equity of the Exchange. Following the consummation of the Transaction, the Class B Participation Interest will represent a non-voting interest in the Exchange; the Class A Participation Interest, which will continue to be held directly by MC, will represent the sole voting interest in the Exchange. In addition, all rights to trade through the facilities of the Exchange will continue to be owned by MC.

At the closing of the Transaction, NASD and the Exchange will restructure an existing \$50 million loan owed by the Exchange to NASD. Under the terms of the arrangement, among other things, the Exchange will have the ability to satisfy all obligations under this loan in full for \$25 million plus accrued interest

if it is repaid within the first year following the closing of the Transaction. At the closing of the Transaction, NASD and the Exchange will enter into a Revolving Credit Facility, pursuant to which the Exchange will have the ability to borrow from NASD up to a maximum, at any one time, of \$25 million.

Subject to the terms of the Transaction, the agreements relating to the 1998 transaction whereby NASD acquired the Class B Participation Interest in the Exchange (the "1998 Transaction"), including the 1998 Transaction Agreement and the 1998 Technology Transfer Agreement, will be terminated and the 1998 Limited Liability Company Agreement of the Exchange will be amended.¹¹ As the Transaction will effectively result in an unwinding of the 1998 Transaction, NASD, the Exchange, and MC will enter into certain mutual releases of obligations, including those arising under the 1998 Agreements and otherwise related to the 1998 Transaction.

NAHO will pay in full the remaining commitment under the 1998 Seat Fund Program to the owners of regular and options principal memberships of the Exchange, which is an aggregate of approximately \$17.144 million (including accrued interest) as of January 31, 2004. Such amount will be distributed *pro rata* to the owners of the Exchange's regular and options principal memberships, with each regular and options principal membership receiving an equal amount of approximately \$20,483, plus additional accrued interest on such amount at an annual rate of 5% from January 31, 2004 through the closing of the Transaction.

The existing rights and obligations of the members regarding trading through the Exchange will not be affected by the Transaction. Trading rights will continue to be owned by MC and represent the right to trade through the facilities of the Exchange. In connection with the termination of the 1998 Transaction Agreement, the regular and options principal members will no longer have the special rights to approve material market changes to the Exchange's equity and options businesses that were put in place at the time NASD took control of the Exchange. However, under the proposed changes, no amendment to the Exchange Constitution that would result in a material change in the market structure

or operations of the Exchange shall be made without first obtaining the consent from the Board of Directors of MC. In addition, as discussed below, Amex regular and options principal members will have the ability to elect the members of the Exchange Board of Governors and the MC Board of Directors.

B. LLC Agreement

The LLC Agreement will, among other things, establish the rights and obligations of MC and MC Acquisition Sub as equity owners of Amex and vest the Exchange Board with its management powers. The LLC Agreement also provides for the indemnification of any person involved in an action, suit or proceeding related to such person's affiliation with the Exchange if such person acted in good faith and in a manner he or she reasonably believed to be in or not opposed to the best interests of Amex and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful.¹²

C. Corporate Structure and Governance of the Exchange

The new governance structure for the Exchange will provide for a Board of Governors selected by the Exchange's regular and options principal members, who also will have the opportunity to vote on a "pass-through" basis on certain significant matters involving the Exchange, including the sale, issuance, transfer or other disposition of any equity security of the Exchange, or the issuance of any new trading rights by the Exchange. The new governance provisions also will provide that the Exchange Board of Governors will be largely independent and will have board committees composed primarily of Independent Governors, as defined below, with substantial authority over compensation, audit, regulatory and corporate governance matters, as well as the nomination of Governors to serve on the Exchange Board of Governors.

1. Board of Governors

The size of the Exchange's Board of Governors will be reduced from eighteen to fifteen Governors. Nine of the Governors will be "Independent Governors" and six of the Governors will be "Industry Governors." An Independent Governor will be any person that is: (1) Not an officer or employee of, and has no material business relationship with, the Exchange and the holders of the Class

¹⁰ According to the Exchange, MC Acquisition Sub will be formed for the sole purpose of acquiring and holding the Class B Participation Interest; it is being used to avoid a technical liquidation of the Exchange as a result of the closing of the Transaction.

¹¹ See Exchange Act Release No. 40622 (October 30, 1998), 63 FR 59819 (November 5, 1998) (order approving the 1998 Transaction).

¹² See Section 6.3 of the LLC Agreement.

A and Class B Participation Interests; (2) not a director of the holders of the Class A or Class B Participation Interest; and (3) not (i) a member, lessor or lessee of a membership, (ii) employed by, or affiliated or associated with, an entity that (x) is a member, (y) otherwise has trading rights or privileges on the Exchange or (z) is a broker or dealer, or (iii) a director, officer or employee of an issuer of securities that are listed on the Exchange.¹³ In addition, the Independent Governors will meet such additional criteria for independence or otherwise that are not inconsistent with the criteria above as may be established by the Amex Nominating and Corporate Governance Committee from time to time.¹⁴

Of the six Industry Governors of the Exchange, (1) two will be persons who spend a substantial portion of their time on the floor of the Exchange (the "Floor Governors"); (2) one will be the owner of a regular or options principal membership (the "Membership Governor"); (3) one will be affiliated with a regular or associate member organization that engages in a business having substantial direct contact with public securities customers (the "Upstairs Governor"); (4) one will be a director, officer, employee or representative of an issuer of securities that are listed on the Exchange (the "Listed Company Governor"); and (5) one will be the Exchange's Chief Executive Officer (the "Management Governor").¹⁵

The Chairman of the Exchange Board of Governors may be the Management Governor or any Independent Governor. If the Management Governor is designated as the Chairman of the Exchange Board of Governors, the Board will also designate an Independent Governor as the "Lead Governor" to preside over executive sessions of the Exchange Board of Governors (*i.e.*, meetings of the Exchange Board of Governors without management or staff of the Exchange). The Management Governor will not participate in executive sessions. The Exchange will publicly disclose the Lead Governor's name and a means by which interested parties may communicate with the Lead Governor. If a Lead Governor has been designated by the Exchange Board of Governors, the Lead Governor will exercise the powers and discharge the duties of the Chairman in calling and presiding at meetings of the Exchange

Board of Governors in the case of the absence or inability to act of the Chairman.¹⁶

All Governors elected at the annual meeting for the election of Governors will serve two-year terms and will hold office until their successors are elected. No Governor (other than the Management Governor) who has served four consecutive terms as a Governor will be eligible for election as a Governor except after an interval of two years; *provided, however*, that service on the Exchange Board of Governors prior to January 1, 1999 will not be taken into account for these purposes.¹⁷

All nominees for election as Governor (as well as for members of the Amex Adjudicatory Council ("Council Members"),¹⁸ and Trustees of the Gratuity Fund ("Trustees"))¹⁹ will be selected by (i) the Amex Nominating and Corporate Governance Committee or (ii) by petition of the members to the Amex Nominating and Corporate Governance Committee.²⁰ The nominees for election as Governors will reflect the applicable terms of office and the classifications of Governors as set forth above.²¹ The nomination process will be as follows:

The members may propose nominees for Governors, Council Members, and Trustees to the Amex Nominating and Corporate Governance Committee for consideration by written submission filed with the Secretary of the Exchange for delivery to the Amex Nominating and Corporate Governance Committee not less than 12 weeks prior to the date of the annual meeting of the members. In the event that any question is raised as to whether any candidate meets the criteria for the appropriate classification, such matter shall be determined by the Amex Nominating and Corporate Governance Committee, subject to the right of appeal to the full Board of Governors.²²

The Amex Nominating and Corporate Governance Committee will then report to MC at least eight weeks prior to the date of the annual meeting of the members, the names of candidates nominated by it as Governors, Council Members, and Trustees. The report of

the Amex Nominating and Corporate Governance Committee will be promptly disseminated or made available to the MC members by posting or other appropriate means and will be promptly forwarded to the Secretary of MC for mailing to the members in accordance with the MC Bylaws.²³

Members may also nominate candidates for Governors, Council Members, and Trustees by written petition filed with the Amex Nominating and Corporate Governance Committee within three weeks after the dissemination of the report of the Amex Nominating and Corporate Governance Committee.²⁴ In the event that any question is raised as to the validity of the signatures set forth on a petition or whether any candidate meets the criteria for the appropriate classification, such matter shall be determined by the Amex Nominating and Corporate Governance Committee, subject to the right of appeal to the full Exchange Board of Governors.²⁵ The persons nominated by valid petition shall be deemed nominees for the offices and positions set forth in such petition and shall be included on the ballot sent to MC by the Amex Nominating and Corporate Governance Committee. A statement of the candidates nominated by petition will be promptly disseminated or made available to the members by posting or other appropriate means and will be promptly forwarded to the Secretary of MC for mailing to the members in accordance with the MC Bylaws.²⁶

Such nominees will be voted on by the regular and options principal members, and will be elected by a plurality of votes cast by these members.²⁷ Thereafter, MC will vote its

²³ See Article III, Section 2 of the Exchange Constitution.

²⁴ See Article III, Section 4 of the Exchange Constitution.

²⁵ See *id.*

²⁶ See *id.* The time periods set forth above may be equitably adjusted by the Amex Nominating and Corporate Governance Committee with respect to the first election of Governors occurring following April 1, 2004, to facilitate a prompt initial election; provided, however, in no event shall the petition period described in the proceeding paragraph be less than 10 business days. See Article III, Section 5 of the Exchange Constitution.

²⁷ See Article III, Section 1 of the Exchange Constitution and Section 1.11 of the MC Bylaws. See also Section 8 of the MC Certificate of Incorporation. Specifically, at each meeting of the members for the election of directors of MC, Governors of the Exchange, Trustees, and Council Members, such persons shall be elected by a plurality of votes cast, in person or by proxy, at such meeting by the regular and options principal members voting together as a single class and MC, as the holder of the Class A Interest of the Exchange, shall vote such Class A Interest so as to cause the election of such persons who have been

¹³ See Article II, Section 1(a)(1) of the Exchange Constitution.

¹⁴ See *id.*

¹⁵ See Article II, Section 1(a) of the Exchange Constitution.

¹⁶ See Article II, Section 3 of the Exchange Constitution.

¹⁷ See Article II, Section 1(d) of the Exchange Constitution.

¹⁸ See Article II, Section 7 of the Exchange Constitution for a description of the Amex Adjudicatory Council.

¹⁹ See Article IX of the Exchange Constitution for a description of the Gratuity Fund.

²⁰ See Article III, Sections 1 and 4 of the Exchange Constitution.

²¹ See Section 1.14 of the MC Bylaws.

²² See Article III, Section 3 of the Exchange Constitution.

Class A Participation Interest in the Exchange to elect those Governors, Council Members, and Trustees selected by the regular and options principal members.²⁸

The Exchange contemplates a six-month transition period that will facilitate a phase-in of the new governance structure of the Exchange. Accordingly, immediately following the closing of the Transaction, the Board of Governors of the Exchange will form the initial Amex Nominating and Corporate Governance Committee, which will select nominees for Governor for the first election during the six-month transition period. By the end of the six-month transition period, the regular and options principal members of the Exchange will have elected a new Board of Governors from and among these nominees or any other candidates nominated by the members through petition. At the first election of the Exchange Board of Governors during the six-month transition period, eight of the fifteen Governors will be elected to an initial two-year term and the remaining seven Governors will be elected to an initial one-year term.²⁹ Thereafter, there will be an annual meeting for the election of Governors to succeed those Governors whose terms have expired.

The Constitution will require that each Governor, in exercising his or her powers and performing his or her duties, comply with the federal securities laws and the rules and regulations thereunder, cooperate with the Commission pursuant to its regulatory authority, and take into consideration the self-regulatory function of the Exchange, and the obligations of the Exchange (and his or her obligations) under the Act and the rules thereunder, including, without limitation, Section 6(b)³⁰ of the Act.³¹

2. Standing Committees of the Exchange

The Exchange Constitution will explicitly provide for a number of Standing Committees of the Exchange composed primarily or entirely of Independent Governors. Specifically,

the Exchange Constitution will provide for: (i) A Nominating and Corporate Governance Committee; (ii) an Executive Committee; (iii) an Audit Committee; (iv) a Regulatory Oversight Committee; and (v) a Compensation Committee.³² Any power that has been delegated to any such Standing Committee may not be delegated to any other committee formed by the Exchange Board of Governors.³³

(i) Amex Nominating and Corporate Governance Committee

The Amex Nominating and Corporate Governance Committee will be appointed by the Exchange Board of Governors and will consist of three Governors, two of whom shall be Independent Governors and one of whom shall be the Membership Governor, as established by resolution adopted by a majority of the Board of Governors then in office.³⁴ Any vacancy in the Amex Nominating and Corporate Governance Committee will be filled by the Committee's remaining members, who will elect a Governor qualified to fill the vacancy.

The Amex Nominating and Corporate Governance Committee will, among other things: (i) Establish criteria and procedures for the nomination of Governors, Council Members, and Trustees; (ii) review the qualifications of and, when necessary and appropriate, interview candidates who may be proposed for nomination as, Governors, Council Members, and Trustees; (iii) submit to MC, in its capacity as the Class A Interests holder, a slate of nominees for the election of Governors, Council Members, and Trustees; (iv) monitor and consider the Exchange's corporate governance practices; (v) consider and make recommendations concerning the composition, organization, and functions of the Exchange Board of Governors; (vi) review periodically the performance of the Exchange Board of Governors; (vii) review periodically the Exchange Constitution; (viii) make periodic reports to the entire Exchange Board of

Governors on such matters within its powers and responsibilities as the Exchange Board of Governors may specify; and (ix) perform such other duties in connection with the selection or election of the Governors, Council Members, and Trustees or other corporate governance matters as the Exchange Board of Governors may request.

(ii) Executive Committee

The Executive Committee will be appointed by the Exchange Board of Governors, upon the recommendation of the Amex Nominating and Corporate Governance Committee, and will consist of three to five Governors, at least a majority of whom will be Independent Governors and at least one of whom shall be an Industry Governor. The Executive Committee will have reasonable access during normal working hours to all information (including all books and records) respecting the Exchange and its assets. The Executive Committee, to the extent permitted by law, will have and may exercise, when the Exchange Board of Governors is not in session, all powers of the Exchange Board of Governors regarding the supervision of the management of the business and affairs of the Exchange.

(iii) Audit Committee

The Audit Committee will be appointed by the Exchange Board of Governors, upon the recommendation of the Amex Nominating and Corporate Governance Committee, and will consist of three to five Independent Governors. The Audit Committee will: (i) Have the authority to consider the qualification of the Exchange's independent public accountants, make recommendations to the Exchange Board of Governors as to their selection and retention, and review and resolve disputes between such independent public accountants and management relating to the preparation of the annual financial statements; (ii) confer with the Exchange's independent public accountants to determine the scope of the audit that such accountants will perform; (iii) receive reports from the independent public accountants and transmit such reports to the Exchange Board of Governors, and after the close of the fiscal year, transmit to the Exchange Board of Governors the financial statements certified by such accountants; (iv) inquire into, examine and make comments on the accounting procedures of the Exchange and the reports of the independent public accountants; (v) consider and make recommendations to the Exchange Board of Governors upon matters

so elected by the regular and options principal members.

²⁸ See Section 8 of the MC Certificate of Incorporation and Section 1.11 of the MC Bylaws.

²⁹ The slate of initial eight Governors serving two-year terms and the initial Governors serving one-year terms shall consist of Independent Governors and Industry Governors in approximately equal proportions. The first year of each term will be extended or shortened depending upon whether the first election is held before or after July 1, 2004. See Article II, Section 1(d) of the Exchange Constitution.

³⁰ 15 U.S.C. 78f(b).

³¹ See Article II, Section 3 of the Exchange Constitution and Amendment No. 4.

³² See Article II, Section 6 of the Exchange Constitution.

³³ To establish the Standing Committees as described herein and facilitate the transition, Industry Governors may serve as members of the Standing Committees until the earlier of (i) the six-month anniversary of the closing of the acquisition by MC (or MC Acquisition Sub) of the Class Participation B Interest (the "Class B Interest Acquisition Closing Date") or (ii) the date of the election of the Board of Governors first succeeding the Class B Interest Acquisition Closing Date. See Article II, Section 1(f) of the Exchange Constitution.

³⁴ See Article II, Section 6(a) of the Exchange Constitution. The NASD Nominating Committee will cease to exist upon the closing of the Transaction.

presented to it by the officers of the Exchange pertaining to the audit practices and procedures adhered to by the Exchange; (vi) appoint the internal auditors of the Exchange; and (vii) make periodic reports to the entire Exchange Board of Governors on such matters within its powers and responsibilities as the Exchange Board of Governors may specify.

The internal auditors of the Exchange will report directly to the Audit Committee, and to the extent that such internal auditors are officers or employees of the Exchange, also to the Chief Executive Officer (or the Chief Executive Officer's Designee).³⁵ The internal auditors shall not be terminated without the advice and consent of the Audit Committee.

(iv) Regulatory Oversight Committee

The Regulatory Oversight Committee will be appointed by the Exchange Board of Governors, upon the recommendation of the Amex Nominating and Corporate Governance Committee, and will consist of three to five Independent Governors and one Industry Governor. The Independent Governors serving as members of the Regulatory Oversight Committee will be the only voting members of the committee. The Industry Governor serving as a member of the Regulatory Oversight Committee will be a non-voting member.

The Regulatory Oversight Committee will: (i) Have authority to determine the Exchange's regulatory scheme, programs, budget and staffing proposals annually; (ii) appoint and direct the Chief Regulatory Officer; (iii) advise the Compensation Committee with respect to and approve the compensation (or any change thereto) of the Chief Regulatory Officer; (iv) be responsible for assessing regulatory performance on a regular basis; (v) have the authority to recommend the adoption of rules to the Exchange Board of Governors concerning such matters as may be specified in the Regulatory Oversight Committee's charter; and (vi) make periodic reports to the entire Exchange Board of Governors on such matters within its powers and responsibilities as the Exchange Board of Governors may specify.

Upon consummation of the Transaction, the Chief Regulatory Officer will report directly to the

Regulatory Oversight Committee.³⁶ The Exchange Board of Governors will have the power to remove the Chief Regulatory Officer only with the advice and consent of the Regulatory Oversight Committee.

(v) Compensation Committee

The Compensation Committee will be appointed by the Exchange Board of Governors, upon the recommendation of the Amex Nominating and Corporate Governance Committee, and will consist of three to five Independent Governors. The Compensation Committee will have and may exercise all of the authority of the Exchange Board of Governors in administering the Exchange's management compensation plans, and will be responsible for, among other things: (i) Reviewing and approving performance goals relevant to the compensation of the Chief Executive Officer and evaluating the Chief Executive Officer's performance in achieving such goals, and recommending the compensation of the Chief Executive Officer to the Exchange Board of Governors; (ii) recommending to the Exchange Board of Governors the compensation of executive officers of the Exchange; (iii) causing to be publicly disclosed on an annual basis the compensation (and methodology behind such compensation) of the Governors and the five most highly compensated officers of the Exchange; and (iv) making periodic reports to the entire Exchange Board of Governors on such matters within its powers and responsibilities as the Exchange Board of Governors may specify.

3. Other Committees

In addition to the Standing Committees, the Exchange Board of Governors by the affirmative vote of a majority of the entire Exchange Board of Governors may delegate such of its powers as it may from time to time determine, subject to the provisions of the Constitution and applicable law, to such committee or committees as the Exchange Board of Governors may from time to time authorize; provided, however, no such delegation may be made of any power described in the Exchange Constitution provisions concerning the responsibilities of the Amex Nominating and Corporate Governance Committee, the Executive Committee, the Audit Committee, the Regulatory Oversight Committee, and

the Compensation Committee.³⁷ Consistent with the foregoing, the Exchange Board of Governors may assign such authority and duties to the Chief Executive Officer and to other officers and employees of the Exchange in addition to those specified in the Constitution, as the Exchange Board of Governors may from time to time determine, subject to applicable law and the provisions of the Exchange Constitution.³⁸

Under the Exchange Constitution, the Exchange Board of Governors will create and consult with the Seat Owners Advisory Committee ("SOAC"), consisting of representatives of various constituencies of the Exchange as SOAC shall deem appropriate.³⁹

4. Management

The officers of the Exchange shall include a Chief Executive Officer, Treasurer, Secretary, and Chief Regulatory Officer, and such other officers as the Chief Executive Officer, subject to the approval of the Exchange Board of Governors, may appoint.⁴⁰

(i) Chief Executive Officer

The Chief Executive Officer will be selected by a majority of the Governors then in office. During his incumbency, the Chief Executive Officer shall have no affiliation with any member organization, or any other business interest proscribed by the Code of Conduct of the Exchange. The Chief Executive Officer shall be responsible to the Board of Governors of the Exchange for the management and administration of the affairs of the Exchange,⁴¹ and will be a member of the Board of Governors. The Chief Executive Officer shall have such other powers and duties in the management of the Exchange as may be determined from time to time by the Exchange Board of Governors.

All salaried officers and employees of the Exchange shall be under the

³⁷ See Article II, Section 3 of the Exchange Constitution.

³⁸ See *id.*

³⁹ See *id.*

⁴⁰ See Article II, Section 4 of the Exchange Constitution.

⁴¹ The Chief Executive Officer, or such other officer as he may designate, shall prepare and present to the Board of Governors periodic reports concerning the finances, income and expenses of the Exchange, and prior to the beginning of each fiscal year of the Exchange shall present to the Board of Governors an estimate of the income of the Exchange and recommendations as to appropriations for expenses for such fiscal year. The Chief Executive Officer may at any time recommend additional appropriations or the increase or decrease of any appropriations made by the Board of Governors and shall make reports and recommendations to the Board of Governors as to the financial policy of the Exchange. See Article II, Section 4(a) of the Exchange Constitution.

³⁵ According to the Exchange, it is expected that, after the closing of the Transaction, the NASD will continue to provide the internal audit function services pursuant to a transition services agreement with the Exchange. Consequently, the internal auditors will not initially be the officers or employees of the Exchange.

³⁶ In Amendment No. 6, Amex revised Section 4(a) and Section 4(d) of Article II of the Amex Constitution to provide that the Chief Regulatory Officer would only report to the Regulatory Oversight Committee, and not to the Chief Executive Officer (or his designee).

direction of and responsible to the Chief Executive Officer or the Chief Executive Officer's designee; provided, however, that the Chief Regulatory Officer shall report only to the Regulatory Oversight Committee and the internal auditors also shall report directly to the Audit Committee.⁴²

In the case of the absence or inability to act of the Chief Executive Officer, such other person as the Board of Governors may designate shall assume all the functions and discharge all the duties of the Chief Executive Officer. In the absence of such designation by the Board of Governors, the most senior ranking officer available shall assume all such functions and discharge all such duties of the Chief Executive Officer. In case a vacancy shall occur in the office of Chief Executive Officer, the Board of Governors, by the affirmative vote of a majority of the Governors then in office, shall fill such vacancy.

(ii) Chief Regulatory Officer

The Chief Regulatory Officer will be responsible for the management and administration of the regulatory functions of the Exchange and will be appointed by the Regulatory Oversight Committee.⁴³ The Chief Regulatory Officer will report directly to the Regulatory Oversight Committee. The Exchange Board of Governors will have the power to remove the Chief Regulatory Officer only with the advice and consent of the Regulatory Oversight Committee.

(iii) Other Officers

Subject to approval by the affirmative vote of a majority of the entire Board of Governors, the Chief Executive Officer may appoint such other officers of the Exchange, including, but not limited to, a President, Executive Vice President, Senior Vice President, and Vice President, as he may from time to time determine are required for the efficient management and operation of the Exchange, and subject to approval of a majority of the Board of Governors he shall appoint the Treasurer and the Secretary. The Chief Executive Officer shall fix the duties, responsibilities, terms and conditions of employment of officers and employees of the Exchange, other than those appointments or terms and conditions of employment that are within the power and responsibility of the Compensation Committee, the Regulatory Oversight Committee or the Audit Committee.

⁴² See Article II, Section 4(d) and Article II, Section 6(c) of the Exchange Constitution.

⁴³ See *supra* discussion under Section II.C.2(iv) "Regulatory Oversight Committee."

*D. Matters Requiring Consent of MC or the Exchange Members*⁴⁴

The Exchange Constitution will prohibit the Exchange, without MC's consent, from (i) selling, issuing, transferring or otherwise disposing of any limited liability company interest or other equity security of the Exchange or any notes or debt securities of the Exchange containing equity features, (ii) issuing any new trading privileges or material new rights to holders of existing privileges, or (iii) issuing additional memberships.⁴⁵ Any consent of MC requested by the Exchange to take such actions will only be granted by MC upon the affirmative vote of a majority of the regular memberships and the options principal memberships (voted as a single class) at a meeting duly called and convened and at which a quorum is present.⁴⁶ In addition, without the affirmative vote of a majority of regular and options principal members, neither MC nor any affiliate of MC, including MC Acquisition Sub, may sell, issue, transfer or otherwise dispose of any equity security of the Exchange or any notes or debt securities of the Exchange containing equity features.⁴⁷

The Exchange Constitution will also provide that certain of its provisions may not be amended without the consent of the Board of Directors of MC. The provisions requiring consent from the board of MC to amend are:

- Article II, Section 1 (Classification of the Exchange Board of Governors);
- Article II, Section 6 (Standing Committees);
- Article III (Nomination and Election Procedures);

⁴⁴ See Article II, Section 8, Article IV, Section 1(j), and Article XIII, Section 1 of the Exchange Constitution and Sections 7, 8 and 9 of the MC Certificate of Incorporation.

⁴⁵ See Article II, Section 8 and Article IV, Section 1(j) of the Exchange Constitution.

⁴⁶ See Sections 7(a) and 9 of the MC Certificate of Incorporation. Upon receiving a written request from the Exchange for an amendment to the MC Certificate of Incorporation to authorize the issuance of additional memberships of any class, the Secretary of MC shall call a meeting of the holders of memberships entitled to vote thereat to vote on such request in accordance with the MC Bylaws. Such an amendment may be authorized, and such additional memberships may be issued, only upon the affirmative vote of a majority of the regular memberships and the options principal memberships voted (as a single class) at a duly convened meeting.

⁴⁷ See Section 7(b) of the MC Certificate of Incorporation. Under the proposal, unless otherwise required by statute, by the MC Certificate of Incorporation, or by the MC Bylaws, all matters submitted to a vote of the MC members shall be decided by the vote of a majority of the Members entitled to vote and present in person or by proxy at the meeting. See Sections 1.10 and 1.11 of the MC Bylaws.

• Article XIII, Sections 1 and 3 (Procedure, Adoption of Amendments Requiring the Consent of MC); and

• Any amendment to the Constitution that would result in a material change in the market structure or operations of the Exchange.

Other than the provisions above, the provisions of the Exchange Constitution may be amended or repealed, and new provisions may be adopted, only if approved by a majority of Governors then in office in accordance with the procedure as specified in Article XIII of the Exchange Constitution.

E. Amex Adjudicatory Council

The Amex Adjudicatory Council has the authority to act for the Board of Governors with respect to any appeal or review of a disciplinary hearing, a statutory disqualification proceeding, or a membership proceeding; any review of a written stipulation of facts and consent to penalty; the exercise of any exemptive authority; and such other proceedings or actions authorized by the rules of the Exchange.⁴⁸ The Amex Adjudicatory Council shall consist of six individuals, three of whom shall be Industry Governors ("Industry Council Members"), and three of whom shall be Independent Governors ("Independent Council Members").⁴⁹ All Council Members shall be nominated and elected in accordance with the procedures as described in Section II.C.1 ("Board of Governors") above.

In the event that a Council Member is precluded from participating in the Council's consideration of a particular matter due to a conflict of interest, the Board of Governors shall appoint a Governor within the same classification for the position to serve as a substitute for such Council Member with respect to the particular matter. In the event that a Governor fitting the relevant classification is not available to serve as a substitute, the Board of Governors may appoint a person who would be qualified to serve as a Governor within such classification (Industry Governor or Independent Governor). If a position on the Amex Adjudicatory Council becomes vacant, whether because of

⁴⁸ See Article II, Section 7(a) of the Exchange Constitution. The Amex Board of Governors has a discretionary right of review over matters within the purview of the Amex Adjudicatory Council.

⁴⁹ See Article II, Section 7(b) of the Exchange Constitution. Under the current Exchange Constitution, the Amex Adjudicatory Council consists of three floor governors (who spend a substantial part of their time on the floor of the Exchange) and three public governors (who are the representatives of the public (i) none of whom is, or is affiliated with, a broker or dealer in securities and (ii) all of them are nominated by the NASD Nominating Committee).

death, disability, disqualification, removal or resignation, the Board of Governors shall appoint a Governor within the same classification (Industry or Independent Council Member) to fill the vacancy until the next annual election of such Council members.⁵⁰

F. Amendments to the Exchange Constitution and the Exchange LLC Agreement

The Amex Board would continue to be permitted to amend provisions of the Exchange Constitution by the affirmative vote of a majority of the entire Board, although, as noted above, the consent of MC's Board of Directors is needed to amend certain specified provisions of the Exchange Constitution.⁵¹

Any amendment to or repeal of any provision of the LLC Agreement shall not be effective until the same is filed with or filed with and approved by the Commission, under Section 19 of the Act⁵² and the rules promulgated thereunder, as the case may be.⁵³

G. Amex Ownership and Control

Any sale, issuance, transfer or other disposition in any single transaction or series of transactions of (A) any limited liability company interests or other equity security of the Exchange or any securities convertible into or exchangeable for, or options rights or warrants to acquire, any such equity securities or (B) any notes or debt securities containing equity features (including, without limitation, any notes or debt securities convertible into or exchangeable for any equity securities or containing profit participation features) shall: (i) Be made only in compliance with Sections 7(a) and 7(b) of the MC Certificate of Incorporation;⁵⁴ and (ii) be subject to

prior approval by the Commission pursuant to the rule filing procedure under Section 19 of the Act,⁵⁵ and the rules promulgated thereunder.⁵⁶ Any attempt to issue or transfer any such equity interests or any rights thereunder in violation of these provisions shall be null and void *ab initio*.⁵⁷

In addition, any sale, issuance, transfer or other disposition in any single transaction or series of transactions of (A) any equity securities of MC or MC Acquisition Sub, or any securities convertible into or exchangeable for, or options rights or warrants to acquire, any such equity securities, or (B) any notes or debt securities containing equity features (including, without limitation, any notes or debt securities convertible into or exchangeable for any equity securities or containing profit participation features) shall be subject to prior approval by the Commission pursuant to the rule filing procedure under Section 19 of the Act⁵⁸ and the rules promulgated thereunder; provided that the foregoing shall not apply to any sale, transfer or other disposition of seats or membership interests of the MC.⁵⁹ Any attempt to issue or transfer such equity interest or any rights thereunder in violation of these requirements shall be null and void *ab initio*.⁶⁰

H. Corporate Governance and Structure of MC

As detailed above, after the closing of the Transaction, MC will own 100% of the equity interests in the Exchange, and MC will continue to be a membership organization of which the members are the regular and options principal members of Amex. The MC Board of Directors will be elected by the members of MC and will consist of five persons who do not necessarily serve on the Exchange Board of Governors.⁶¹

with respect thereto, the request for such matter shall not be submitted again to the membership for a period of ninety days. See Sections 7(a) and 7(b) of the MC Certificate of Incorporation.

⁵⁵ 15 U.S.C. 78s.

⁵⁶ See Section 9.3 of the LLC Agreement.

⁵⁷ *Id.*

⁵⁸ 15 U.S.C. 78s.

⁵⁹ See Section 7(c) of the MC Certificate of Incorporation.

⁶⁰ *Id.*

⁶¹ Under the MC Certificate of Incorporation, the purposes of MC continue to be: (i) Directly or indirectly holding, acquiring, exchanging, or disposing of equity or other interests in the Exchange and exercising the rights incident to its ownership; and (ii) to conduct and carry on only activities incidental to and in furtherance of the foregoing which may lawfully be conducted and carried on by a corporation of its type formed under the New York Not-for-Profit Corporation Law. See Section 3 of the MC Certificate of Incorporation.

1. Board of Directors

The MC Board of Directors will consist of five directors elected by the members of MC in accordance with the MC Bylaws. The MC Board of Directors will be elected for one-year terms and will hold office until their successors are elected. No director of MC who has served eight consecutive elected terms as a director will be eligible for election as a director of MC except after an interval of two years; *provided, however*, that service on the Board of Directors prior to January 1, 1999 will not be taken into account for these purposes.⁶² Unless otherwise required, each matter shall be decided by a vote of a majority of the directors present at the time of the vote, provided a quorum is present.⁶³ Vacancies on the MC Board of Directors may be filled for the remaining term of such vacant position by a majority vote of all remaining MC directors.⁶⁴ The MC Bylaws will also provide limitation of liability and indemnification for MC directors and officers.⁶⁵

Under the MC Bylaws, all nominees for election as directors⁶⁶ will be selected by either (i) the MC Nominating Committee or (ii) by petition of the members of MC to the MC Nominating Committee.⁶⁷ The process is as follows:

The members of MC may propose nominees for directors of MC for consideration by the MC Nominating Committee by written submission filed with the Secretary of MC for delivery to the MC Nominating Committee not less than 12 weeks prior to the annual meeting of the members of MC. The eligibility of any candidate proposed in any such submission will be determined by the MC Nominating Committee in its sole discretion and without the right of appeal.

The MC Nominating Committee then will report to MC at least eight weeks prior to the date of the annual meeting of the members the names of candidates nominated by it as directors. Such report will be promptly disseminated or made available to members of MC by posting or other appropriate means and will be promptly forwarded to the

⁶² See Section 2.03 of the MC Bylaws.

⁶³ See Section 2.13 of the MC Bylaws.

⁶⁴ See Section 2.06 of the MC Bylaws.

⁶⁵ See Article VIII of the MC Bylaws.

⁶⁶ The MC Bylaws also includes the nomination procedures for Exchange Governors, Council Members, and Trustees of the Exchange, as described above in Section II.C.1 ("Board of Governors").

⁶⁷ See Sections 1.13 of the MC Bylaws. Any person nominated by the MC Nominating Committee or by petition, whether or not such person is a Member, may be eligible to be elected to the MC Board of Directors.

⁵⁰ Under the current Exchange Constitution, the Board of Directors of MC was authorized to fill such vacancies.

⁵¹ See Exchange Constitution Article XIII, Section 1.

⁵² 15 U.S.C. 78s.

⁵³ See Section 11.3 of the LLC Agreement.

⁵⁴ Section 7(a) of the MC Certificate of Incorporation requires that the Exchange obtain the consent of MC in order to effect such sale, issuance, transfer or other disposition. MC, in turn, must obtain the approval of the regular and options principal members to grant such consent. Specifically, a majority of the regular and options principal members must approve any such sale, issuance, transfer or other disposition (voting as a single class). Section 7(b) of the MC Certificate of Incorporation provides that MC will be required to obtain the consent of the majority of the memberships entitled to vote in order for MC or an affiliate to transfer, sell or otherwise dispose of its or the affiliate's interest in the Exchange. If a proposed sale, issuance, transfer or other disposition of interest in the Exchange is not approved at the duly convened meeting convened

Secretary of MC for mailing to the members in accordance with the MC Bylaws.

The members of MC also may nominate candidates for directors of MC by written petition filed with the Secretary of MC for delivery to the MC Nominating Committee within three weeks after the dissemination of the report of the MC Nominating Committee. The eligibility of any candidate nominated in any such petition will be determined by the MC Nominating Committee. A statement of the candidates nominated by petition will be promptly disseminated or made available to members of MC by posting or other appropriate means and will be promptly forwarded to the Secretary of MC for mailing to the members within three days after the dissemination in accordance with the MC Bylaws.⁶⁸

2. MC Nominating Committee

Under the MC Bylaws, the MC Nominating Committee will be appointed by the MC Board of Directors and will consist of two or three directors.⁶⁹ Any vacancy in the MC Nominating Committee will be filled by the Committee's remaining members, who will elect a person qualified to fill the vacancy.⁷⁰

The MC Nominating Committee will: (i) Establish criteria and procedures for the nomination of MC directors; (ii) search for qualified nominees for submission to the members of MC for election; (iii) review the qualifications of and, when necessary and appropriate, interview candidates who may be proposed, or who are nominated by petition, as MC directors; (iv) submit to the members of MC a slate of nominees for the election of MC directors; (v) perform any and all other duties in connection with the selection, election, or termination of the MC directors as the MC Board of Directors may request; and (vi) make periodic reports to the entire Board of Directors on such matters within the Committee's powers and responsibilities as the Board of Directors may specify.⁷¹

⁶⁸ The time periods set forth above may be equitably adjusted by the MC Nominating Committee with respect to the first election of directors occurring following April 1, 2004, to facilitate a prompt initial election; provided, however, in no event shall the petition period described in the proceeding paragraph be less than 10 business days. See Section 1.13(g) of the MC Bylaws.

⁶⁹ See Section 3.03(a) of the MC Bylaws.

⁷⁰ See Section 3.03(b) of the MC Bylaws.

⁷¹ See Section 3.03(a) of the MC Bylaws.

I. Confidential Information and Books and Records

All books and records of the Exchange shall be kept in the United States.⁷² All confidential information of the Exchange pertaining to the self-regulatory function of the Exchange, including all books and records of the Exchange reflecting such confidential information (including but not limited to regulatory investigations, examinations, disciplinary matters, and to the extent designated by the Exchange as confidential, trading data and trading practices) will be retained in confidence by each Governor, the Exchange and its personnel, and will not be used by each Governor, the Exchange and its personnel for any non-regulatory purposes and shall not be made available to any person (including, without limitation, any members of the Exchange) except that such confidential information may be disclosed: (i) To those personnel of the Exchange and to members of the Board of Governors of the Exchange to the extent necessary or appropriate to properly discharge the self-regulatory responsibilities of the Exchange; (ii) to the extent required by applicable statute, rule or regulation or any court of competent jurisdiction; and (iii) to the extent that such confidential information has become generally available publicly through no fault of the Exchange or its Governors, officers, employees or advisors.⁷³

Also, all confidential information of Amex pertaining to the self-regulatory function of Amex, including books, minutes and records of Amex reflecting such confidential information (including but not limited to regulatory investigations, examinations, disciplinary matters, and to the extent designated by Amex as confidential, trading data and practices) which shall come into the possession of MC, the officers, directors, employees or agents of MC, shall be retained in confidence by MC and the officers, directors, employees and agents of MC and shall

⁷² See Section 2.1 of the LLC Agreement. Likewise, all books and records of MC must be maintained in the United States. See Section 6.02 of the MC Bylaws.

⁷³ See Article II, Section 3 of the Exchange Constitution. In addition, this provision of the Constitution provides that confidential information of the Exchange shall be subject at all times to inspection and copying by the Commission, and that nothing in the Constitution should be interpreted as to limit or impede the rights of the Commission to access and examine such confidential information of the Exchange pursuant to the U.S. federal securities laws and the rules thereunder, or to limit or impede the ability of a Governor, the Exchange and its personnel to disclose such confidential information to the Commission.

not be used for any non-regulatory purposes.⁷⁴ MC shall take reasonable steps to ensure that its agents will comply with this provision.⁷⁵

MC shall keep at the office of MC or such other locations within the United States as may from time to time be designated by its Board of Directors correct and complete books and records of account and minutes of the proceedings of its members, Board of Directors and committees, if any, and a list of the names, addresses, and classes of membership of the members.⁷⁶ To the extent that the foregoing books, minutes and records are related to the activities of the Exchange, such books, minutes and records shall be deemed to be the books, minutes and records of the Exchange for the purposes of Section 17(b) of the Act,⁷⁷ and shall be subject at all times to inspection and copying by the Commission and the Exchange.⁷⁸

J. Commission and Amex Jurisdiction

For so long as MC shall control, directly or indirectly, the Exchange, MC shall, and its officers, directors and employees by virtue of their acceptance of such position shall be deemed to, irrevocably submit to the exclusive jurisdiction of the United States federal courts, the Commission, and the Exchange, for the purposes of any suit, action or proceeding pursuant to the United States federal securities laws, and the rules or regulations thereunder, arising out of, or relating to the activities of the Exchange, and MC shall, and by virtue of their acceptance of any such position, the officers, directors and employees of MC shall be deemed to, waive and agree not to assert by way of motion, as a defense or otherwise in any such suit, action or proceeding, any claims that it or they are not personally subject to the jurisdiction of the Commission as to such matters, that the suit, action or proceeding is an inconvenient forum or that the venue of the suit, action or proceeding is improper, or that the subject matter

⁷⁴ See Section 16 of the MC Certificate of Incorporation and Section 7.08 of the MC Bylaws. Nothing in the MC Certificate of Incorporation or MC Bylaws shall be interpreted as to limit or impede the rights of the Commission or Exchange to access and examine such confidential information of the Exchange pursuant to the U.S. federal securities laws and the rules thereunder, or to limit or impede the ability of a Governor, the Exchange and its personnel to disclose such confidential information to the Commission.

⁷⁵ See *id.*

⁷⁶ See Section 12 of the MC Certificate of Incorporation and Section 6.02 of the MC Bylaws.

⁷⁷ 15 U.S.C. 78q(b).

⁷⁸ See Section 12 of the MC Certificate of Incorporation and Section 6.02 of the MC Bylaws.

thereof may not be enforced in or by such courts or agency.⁷⁹

With respect to conduct by the officers and directors of MC that relates to the activities of the Exchange, such officers and directors shall be deemed to be the officers and directors of the Exchange solely for the purposes of the removal and censure authority of the Commission pursuant to Section 19(h)(4) of the Act.⁸⁰

K. Cooperation With the Commission

For so long as MC shall control, directly or indirectly, the Exchange, MC shall, and the officers, directors and employees of MC by virtue of their acceptance of such position shall be deemed to, agree to cooperate with the Commission and the Exchange, in respect of the Commission's oversight responsibilities regarding the Exchange and the self-regulatory functions and responsibilities of the Exchange.⁸¹ MC shall take reasonable steps to ensure that its agents similarly cooperate with the Commission.⁸²

L. Additional Responsibilities of MC Officers and Directors

For so long as MC shall control, directly or indirectly, the Exchange, each officer, director and employee of MC shall give due regard to the preservation of the independence of the self-regulatory function of the Exchange and to the Exchange's obligations under the Act, and the rules thereunder, including, without limitation, Section 6(b) of the Act,⁸³ and shall not take any actions which he or she knows or reasonably should have known would interfere with the effectuation of any decisions by the Exchange Board of Governors relating to its regulatory functions (including disciplinary matters) or which would adversely affect the ability of the Exchange to carry out its responsibilities under the Act.⁸⁴

M. Further Compliance

MC shall take reasonable steps to ensure that its officers, directors, and employees comply with Sections 12 (Books and Records), 13 (Officers and Directors), 14 (Consent to Jurisdiction), 15 (Cooperation with the Commission) and 16 (Confidential Information) of the

MC Certificate of Incorporation, and Sections 6.02 (Books and Records), 7.05 (Officers and Directors), 7.06 (Consent to Jurisdiction), 7.07 (Cooperation with the Commission) and 7.08 (Confidential Information) of the MC Bylaws, which shall include obtaining a written agreement from such individuals, as a condition to their initial or continued employment or service as a director, that they will comply with or consent to, as the case may be, such provisions.⁸⁵

N. Amendments to the MC Certificate of Incorporation and MC Bylaws

Under the MC Certificate of Incorporation and the MC Bylaws, for so long as MC controls, directly or indirectly, the Exchange, before any change or addition to the MC Certificate of Incorporation or MC Bylaws shall be effective, the same shall be submitted to the Exchange Board of Governors, and if the Board shall determine that the same constitutes a "rule of an exchange" as such term is defined in the Act and the rules promulgated thereunder,⁸⁶ and must be filed with or filed with and approved by the Commission before the same may be effective, under Section 19 of the Act,⁸⁷ and the rules promulgated thereunder, then the same shall not be effective until filed with or filed with and approved by the Commission, as the case may be.⁸⁸

O. Limitation on Distributions

The LLC Agreement will provide that no distribution to MC and MC Acquisition Sub, as participants of the Exchange, shall include revenues received by the Exchange from regulatory fines, fees or penalties.⁸⁹ Amex states that the purpose of this provision is to ensure that the regulatory authority of the Exchange is not used improperly to benefit the holders of the Exchange's LLC interests.

P. Transparency

In connection with the Transaction, both the Exchange and MC will adopt resolutions providing for greater transparency of their respective operations. Prior to each annual meeting at which Governors or directors, as the case may be, are elected, the Exchange and MC will distribute a proxy statement disclosing certain matters regarding each of their respective board's activities for the preceding year,

pertinent information about the independence of Governors and directors and compensation data for the Governors and five most highly compensated officers of the Exchange.

Q. Undertakings

In Amendment No. 6, Amex included certain Undertakings that are applicable to Amex. These Undertakings commit Amex to (1) not terminate Amex's current regulatory services agreement with NASD unless Amex has entered into an alternative arrangement for the provision of regulatory services that has been approved by the Commission, and to use its best efforts to comply with Amex's obligations under the current regulatory services agreement, (2) confer periodically with Commission staff regarding the status of Amex's regulatory program, and (3) submit certain financial information to the Commission.⁹⁰ The purpose of the Undertakings is to further ensure that the Exchange will be able to perform its regulatory responsibilities and that the Commission will have sufficient information to perform its regulatory function.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning Amendment Nos. 4 and 6, including whether these submissions are consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (<http://www.sec.gov/rules/sro.shtml>); or Send an e-mail to rule-comments@sec.gov. Please include File Number SR-Amex-2004-50 on the subject line.

Paper Comments

- Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549-0609.

All submissions should refer to File Number SR-Amex-2004-50. This file number should be included on the subject line if e-mail 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

⁷⁹ See Section 14 of the MC Certificate of Incorporation and Section 7.06 of the MC Bylaws.

⁸⁰ 15 U.S.C. 78s(h)(4). See Section 13 of the MC Certificate of Incorporation and Section 7.05 of the MC Bylaws.

⁸¹ See Section 15 of the MC Certificate of Incorporation and Section 7.07 of the MC Bylaws.

⁸² See *id.*

⁸³ 15 U.S.C. 78f(b).

⁸⁴ See Section 13 of the MC Certificate of Incorporation and Section 7.05 of the MC Bylaws.

⁸⁵ See Section 17 of the MC Certificate of Incorporation and Section 7.09 of the MC Bylaws.

⁸⁶ See *infra* note 140.

⁸⁷ 15 U.S.C. 78s.

⁸⁸ See Section 18 of the MC Certificate of Incorporation and Section 9.01 of the MC Bylaws.

⁸⁹ See Section 4.6(c) of the LLC Agreement.

⁹⁰ See *supra* note 9.

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 inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at the principal office of the Amex. 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, as appropriate, to Amendment No. 4 and/or Amendment No. 6 of File Number SR-Amex-2004-50 and should be submitted on or before January 20, 2005.

IV. Discussion

The Commission has considered the Exchange's proposed rule change, as amended, and finds that, in the context in which it was submitted, the proposal is consistent with the Act and the rules and regulations thereunder applicable to a national securities exchange.⁹¹ In particular, the Commission finds that the proposal is consistent with Section 6(b)(1) of the Act,⁹² which requires a national securities exchange to be so organized and have the capacity to be able to carry out the purposes of the Act and to enforce compliance by its members and persons associated with its members with the provisions of the Act, the rules or regulations thereunder, and the rules of the Exchange. The Commission also finds that the proposal is consistent with Section 6(b)(3) of the Act,⁹³ in that the proposed amendments to the Exchange Constitution and other organizational documents are designed to assure a fair representation of its members in the selection of its directors and administration of its affairs and provide that one or more directors shall be representative of issuers and investors and not be associated with a member of the Exchange, broker, or dealer. In addition, the Commission finds that the proposed rule change is consistent with Section 6(b)(5) of the Act,⁹⁴ which requires, among other

things, that the rules of an exchange be designed to promote just and equitable principles of trade; to facilitate transactions in securities; to remove impediments to and perfect the mechanisms of a free and open market and a national market system; and, in general, to protect investors and the public interest.

The Commission discusses below significant aspects of the proposed rule change.

A. Exchange Governance Structure

As outlined below, the Commission generally believes that Amex's proposed changes should serve to strengthen and improve the Exchange's governance structure and are consistent with the Act. The Commission notes, however, that it is in the process of reviewing a range of governance issues relating to self-regulatory organizations ("SROs"), including possible steps to strengthen the framework for the governance of SROs and ways to improve the transparency of the governance procedures of all SROs and has proposed rules in furtherance of these goals.⁹⁵ Depending upon the results of the proposed rules, the Commission may determine that further measures are necessary to strengthen the governance of SROs. The Commission also believes that the Amex Board should continue to monitor and evaluate the Exchange's governance structure and processes on an ongoing basis, and propose further changes as appropriate.

1. Board of Governors

The Exchange Constitution provides that within six months after the closing of the Transaction, the Exchange will transition to a fifteen member board consisting of nine Independent Governors and six Industry Governors.⁹⁶ The Commission believes that the proposal to implement a majority independent board should increase the Amex Board's ability to make judgments

in the best interests of the Exchange and investors.

The amended Constitution will prohibit an Independent Governor from: (i) Having a material business relationship with the Exchange, seat holders, or MC; (ii) being a director of a seat holder or AMC; or (iii) being employed, affiliated, or associated with members or lessors of memberships, and issuers listed on the Exchange.⁹⁷ The Commission believes that, with respect to governors, this definition of "independent" is an improvement on the Exchange's current definition of "public." In addition, the proposal requires the Board to designate an Independent Governor as the "Lead Governor" to preside over executive sessions of the Exchange Board of Governors if the Management Governor is designated as the Chairman of the Board of Governors.⁹⁸ The Exchange also will publicly disclose the Lead Governor's name and a means by which interested parties may communicate with the Lead Governor.⁹⁹ Also, the Commission notes that any quorum of Governors required to conduct the business of the Exchange shall include a number of Independent Governors at least equal to the number of Governors participating in any such meeting who are not Independent Governors.¹⁰⁰

The Commission believes that these requirements, including the majority "independence" standard for the Board and the requirement that a Lead Governor be appointed if the Chairman and Chief Executive Officer are the same person, should benefit the Exchange by assuring that persons responsible for key decisions of the Exchange are free from material relationships with—and thus from the potential for improper influence by—the Exchange or the entities that the Exchange regulates.

Further, the Commission notes that the amended Constitution expressly requires that each Governor will, in exercising his or her powers and performing his or her duties, take into consideration the self-regulatory function of the Exchange, and the obligations of the Exchange (and his or

⁹⁵ See Securities Exchange Act Release No. 50699 (November 18, 2004), 69 FR 71126 (December 8, 2004).

⁹⁶ See Article II, Section 1 of the Exchange Constitution. At the first election of the Exchange Board of Governors during the six-month transition period, eight of the fifteen Governors will be elected to an initial two-year term and the remaining seven Governors will be elected to an initial one-year term. The slate of initial eight Governors serving two-year terms and the initial Governors serving one-year terms shall consist of Independent Governors and Industry Governors in approximately equal proportions. Thereafter, there will be an annual meeting for the election of Governors to succeed those Governors whose terms have expired. All Governors elected at the annual meeting for the election of Governors will serve two-year terms and will hold office until their successors are elected.

⁹⁷ See Article II, Section 1(a)(1) of the Exchange Constitution and *supra* Section II.C.1 "Board of Governors."

⁹⁸ The Chairman of the Exchange Board of Governors may be the Management Governor or any Independent Governor. See Article II, Section 3 of the Exchange Constitution.

⁹⁹ If a Lead Governor has been designated by the Exchange Board of Governors, the Lead Governor will exercise the powers and discharge the duties of the Chairman in calling and presiding at meetings of the Exchange Board of Governors in the case of the absence or inability to act of the Chairman. See *id.*

¹⁰⁰ See *id.*, and Amendment No. 4.

⁹¹ In approving the proposed rule change, the Commission has considered its impact on efficiency, competition, and capital formation. See 15 U.S.C. 78c(f).

⁹² 15 U.S.C. 78f(b)(1).

⁹³ 15 U.S.C. 78f(b)(3).

⁹⁴ 15 U.S.C. 78f(b)(5).

her obligations) under the Act and the rules thereunder, including, without limitation, Section 6(b)¹⁰¹ of the Act.¹⁰² The Commission believes that this requirement should serve to remind Governors that they must consider the interests of all Exchange constituents and the requirements of the Act when taking actions on behalf of the Exchange.

2. Fair Representation

Section 6(b)(3) of the Act imposes specific obligations on the Amex as a registered national securities exchange to ensure that its members are fairly represented in the selection of its Governors and the administration of its affairs, and provide that one or more Governors shall be representative of issuers and investors and not be associated with a member of the Exchange, broker or dealer.¹⁰³ The Commission believes that the Amex's proposal is consistent with this requirement.

Under the proposal, one of the three members of the Amex Nominating and Corporate Governance Committee will be the Membership Governor. Amex members will vote for Board Governors and members of the Amex Adjudicatory Council¹⁰⁴ from those nominees selected by this Committee and any nominees selected by petition of the members.¹⁰⁵ The Executive Committee also will have at least 20 percent Industry Governor representation.¹⁰⁶

The Commission thus believes that the Exchange's proposed corporate governance structure is consistent with Section 6(b)(3) of the Act.¹⁰⁷ The Commission also finds that the requirements that the Exchange Board of Governors have nine Independent Governors and also include a Governor representing listed companies are consistent with Section 6(b)(3) of the Act, which requires that one or more Governors be representatives of issuers and investors.¹⁰⁸

3. Independence of the Regulatory Function and Key Committees

The Act requires registered exchanges to be so organized as to have the capacity to be able to carry out the purposes of the Act and to comply, and, subject to any applicable rule or order of the Commission, enforce compliance by its members and persons associated with its members, with the provisions of the Act, the rules and regulations thereunder, and the rules of the Exchange.¹⁰⁹ An exchange's governance structure should be designed to assure that its regulatory function is strong, vigorous, and sufficiently independent and insulated from improper influence from management or any regulated entity. In the Commission's view, the proposed amendments to the Amex's governance and management structure are designed to advance this goal.

The Exchange Constitution provides for a Regulatory Oversight Committee, which will be composed of three to five Independent Governors and a non-voting Industry Governor. The Regulatory Oversight Committee will be responsible for, among other things, determining the Exchange's regulatory plan, assessing regulatory performance on a regular basis, recommending the adoption of rules to the Exchange Board concerning regulatory matters, and making periodic reports to the Exchange Board. The Amex also has proposed to create a Chief Regulatory Officer position. The Chief Regulatory Officer will be appointed by the Regulatory Oversight Committee and will report directly to that Committee.¹¹⁰ The Exchange Board may remove the Chief Regulatory Officer only with the Regulatory Oversight Committee's advice and consent.

The Commission believes that these proposed amendments to Amex's governance structure, and in particular the creation of a Chief Regulatory Officer position reporting directly to an independent Regulatory Oversight Committee, add a significant degree of independence that should serve to insulate the Exchange's regulatory activity from economic pressures and potential conflicts of interest. The Commission believes that, in this context, the Exchange's proposal is consistent with the statutory requirements.

4. Committees

In addition, the proposed amendments to the Exchange Constitution provide for several key Board committees—called Standing

Committees—that have been delegated responsibility over critical Exchange operations, thus helping to ensure the transparency of those committees to the benefit of the Exchange and the investing public. The Commission notes that information about the functions of key Amex committees was previously not widely available or specified in the Exchange Constitution. The proposed amendments to the Constitution increase transparency with respect to several key committees and, thus, their accountability to the benefit of the Exchange and the investing public.

The Commission believes that the composition, duties, responsibilities, and guidelines assigned to each of these Standing Committees should help foster stronger and more independent governance of the Amex.¹¹¹ For example, the Amex Nominating and Corporate Governance Committee, which will be composed of three Governors, one of whom will be the Membership Governor and the rest of whom will be Independent Governors, will be responsible for establishing criteria and procedures for the nomination of Governors, Council Members, and Trustees, and interviewing and reviewing candidates for such positions. This Committee also will have the obligation to monitor the Exchange's corporate governance practices, consider and make recommendations concerning the composition, organization and functions of the Exchange Board, review the Exchange Constitution, and review periodically the performance of the Exchange Board. In the Commission's view, having a Committee with a majority of Independent Governors reviewing the Exchange's corporate governance practices and the performance of the Board should help improve the Exchange's governance process.

The Compensation Committee, which will be composed of three to five Independent Governors, will be responsible for reviewing and approving performance goals relevant to the compensation of the Chief Executive Officer, and for evaluating the Chief Executive Officer's performance in light of these goals, as well as recommending to the Board the compensation of the Chief Executive Officer and other executive officers. In addition, the requirement that the Committee make public annually the compensation of the Governors of the Exchange and the five

¹⁰¹ 15 U.S.C. 78f(b).

¹⁰² See Article II, Section 3 of the Exchange Constitution and Amendment No. 4.

¹⁰³ 15 U.S.C. 78f(b)(3).

¹⁰⁴ The Commission notes that the same process applies to the election of Trustees of the Exchange. Compare Article II, Section 7 with Article IX, Section 10 of the Exchange Constitution.

¹⁰⁵ See Article III, Section 4 of the Exchange Constitution.

¹⁰⁶ The Executive Committee will be comprised of three to five members, a majority of whom will be Independent Governors and at least one of whom will be an Industry Governor. See Article II, Section 6(b) of the Exchange Constitution.

¹⁰⁷ 15 U.S.C. 78f(b)(3).

¹⁰⁸ *Id.*

¹⁰⁹ 15 U.S.C. 78f(b)(1).

¹¹⁰ See Amendment No. 6, *supra* note 9.

¹¹¹ The Commission also notes that the Amex Board will not be able to re-delegate to any other committee any power granted to a Standing Committee. See Article II, Section 6 of the Exchange Constitution.

most highly compensated officers of the Exchange should increase the transparency of this Committee's actions and improve accountability of the Exchange's most senior officers.

The Exchange also will have a fully independent Audit Committee that will have the authority to make recommendations to the Board as to the selection and retention of the Exchange's independent public accountants, and will appoint the internal auditors. The internal auditors will report directly to the Audit Committee and, to the extent they are officers or employees of the Exchange, to the Chief Executive Officer (or the Chief Executive Officer's designee), but cannot be terminated without the advice and consent of the Audit Committee. The Commission believes that the responsibilities assigned to the Amex's Audit Committee are appropriate, particularly with respect to the Audit's Committee's direct responsibility for assuring that the Amex retain suitable public accountants and appointing the Exchange's internal auditors.

5. Improved Transparency

Finally, the Commission believes that the commitments by the Exchange and MC to adopt resolutions providing for greater transparency of their respective operations are important steps. Together with the revised governance structure and implementation of key Amex committees, such increased disclosure of the decision-making processes and the basis for Exchange and MC actions should benefit the Exchange, its constituencies, and investors.

B. Self-Regulatory Function of the Exchange

Upon the close of the Transaction, Amex will continue to be responsible for discharging its regulatory obligations under the Act, in particular Sections 6(b) and 19(g) of the Act.¹¹² Amex, however, will be wholly owned by MC, which will have a separate Board of Directors whose consent will be

required for Amex to take certain actions.¹¹³ Certain provisions of the Amex Constitution, LLC Agreement, MC Certificate of Incorporation, and MC Bylaws are designed to facilitate the ability of Amex and the Commission to fulfill their regulatory obligations under the Act with respect to Amex.¹¹⁴

In particular, all confidential information of the Exchange pertaining to the self-regulatory function of the Exchange, including all books and records of the Exchange reflecting such confidential information will be retained in confidence by each Governor, the Exchange and its personnel. In addition, such confidential information will not be used by any Governor, the Exchange or its personnel for any non-regulatory purposes, and shall not be made available to any persons (including, without limitation, any members of the Exchange). Such confidential information may only be disclosed: (i) To those personnel of the Exchange and to members of the Board of Governors of the Exchange to the extent necessary or appropriate to properly discharge the self-regulatory responsibilities of the Exchange; (ii) to the extent required by applicable statute, rule or regulation or any court of competent jurisdiction; and (iii) to the extent that such confidential information has become generally available publicly through no fault of the Exchange or its Governors, officers, employees or advisors.¹¹⁵

All confidential information of Amex pertaining to the self-regulatory function of Amex, including books, minutes and records of Amex reflecting such confidential information (including but not limited to regulatory investigations, examinations, disciplinary matters, and to the extent designated by Amex as confidential, trading data and practices) which shall come into the possession of MC, the officers, directors, employees or agents of MC, shall be retained in confidence by MC and the officers, directors, employees and agents of MC and shall not be used for any non-regulatory purposes.¹¹⁶

Also, for so long as MC shall control, directly or indirectly, the Exchange, each officer, director and employee of MC shall give due regard to the preservation of the independence of the self-regulatory function of the Exchange and to the Exchange's obligations under the Act and the rules thereunder, including, without limitation, Section 6(b) of such Act,¹¹⁷ and shall not take any actions which he or she knows or reasonably should have known would interfere with the effectuation of any decisions by the Board of Governors of the Exchange relating to its regulatory functions (including disciplinary matters) or which would adversely affect the ability of the Exchange to carry out its responsibilities under the Act.¹¹⁸

The Commission believes that these provisions, which are designed to help maintain the independence of Amex's self-regulatory function and protect from improper use confidential information pertaining to the self-regulatory function of the Exchange, are consistent with the Act.

The Commission also notes that no distribution made by the Exchange shall include revenues received by the Exchange from regulatory fines, fees or penalties.¹¹⁹ The Commission finds that this prohibition is consistent with Section 6(b)(3) of the Act¹²⁰ because it will help to ensure that the regulatory authority of the Exchange is not used improperly to benefit the Exchange's owner(s).

C. Changes in Ownership and Control of Amex

Certain provisions of the proposed rule change require that any direct and indirect changes in ownership of the Exchange be subject to prior Commission review. The Commission believes that these restrictions, which are designed to prevent any owner from exercising undue control over the operation of Amex, are consistent with the Act.

In particular, any sale, issuance, transfer or other disposition of any equity security in Amex—including any LLC interest—is subject to prior approval by the Commission pursuant to the rule filing procedure under Section 19 of the Act,¹²¹ and the rules promulgated thereunder.¹²² Any

¹¹² 15 U.S.C. 78f(b) and 15 U.S.C. 78s(g). To assist the Exchange in fulfilling its regulatory responsibilities, Amex has entered into a regulatory services contract ("RSA") with NASD. The Commission notes that, under the terms of the RSA and consistent with the Amex's Constitution, any action taken by NASD, or its employees or authorized agents, acting on behalf of Amex pursuant to the RSA will be deemed to be an action taken by the Exchange. Importantly, however, Amex will retain ultimate legal responsibility for, and control of, its self-regulatory responsibilities. See Exchange Act Release No. 50122 (July 29, 2004), 69 FR 47962 (August 6, 2004) (approving an amendment to Article III, Section 2 of the Exchange Constitution permitting the Amex to enter into a regulatory services agreement with another self-regulatory organization).

¹¹³ See *supra* discussion under Section II.D "Matters Requiring Consent of MC or the Exchange Members."

¹¹⁴ The Commission notes that it is in the process of reviewing issues relating to new ownership structures of SROs, and has proposed rules relating to the ownership of SROs, including imposing limitations on member ownership of an SRO or facility of an SRO. See Securities Exchange Act Release No. 50699, *supra* note 95.

¹¹⁵ See Article II, Section 3 of the Exchange Constitution. Also, the Exchange and MC will be required to keep all books and records in the United States. See Section 2.1 of the LLC Agreement and Section 6.02 of the MC Bylaws.

¹¹⁶ See Section 16 of the MC Certificate of Incorporation and Section 7.08 of the MC Bylaws.

¹¹⁷ 15 U.S.C. 78f(b).

¹¹⁸ See Section 13 of the MC Certificate of Incorporation and Section 7.05 of the MC Bylaws.

¹¹⁹ See Section 4.6(c) of the LLC Agreement.

¹²⁰ 15 U.S.C. 78f(b)(3).

¹²¹ 15 U.S.C. 78s.

¹²² See Section 9.3 of the LLC Agreement. Specifically, Section 9.3 provides that any sale,

attempt to issue or transfer any such equity interests or any rights thereunder in violation of these requirements shall be null and void ab initio. In addition, any sale, issuance, transfer or other disposition of any equity interest in MC or MC Subsidiary, other than the sale or transfer of seats or membership interests in MC, also shall be subject to prior approval by the Commission pursuant to the rule filing procedure under Section 19 of the Act,¹²³ and the rules promulgated thereunder, and any attempt to issue or transfer any such equity interests or any rights thereunder in violation of these requirements shall be null and void ab initio.¹²⁴

Among other things, these provisions are designed to provide the Commission with the opportunity to determine what, if any, additional measures might be necessary to provide appropriate oversight of a proposed controlling person of Amex.

D. Regulatory Jurisdiction Over MC

Certain of the terms of the MC governing documents are designed to help enable the Commission to carry out its oversight responsibilities under the Act. Specifically, the MC Certificate of Incorporation and the MC Bylaws provide that, for so long as MC shall control, directly or indirectly, the Exchange, the books, minutes, and records of MC shall be deemed to be those of Amex for the purposes of Section 17(b) of the Act¹²⁵ to the extent that such books, minutes, and records are related to the activities of the Exchange.¹²⁶ Furthermore, MC's books and records will be subject to inspection and copying by the Commission and the Exchange.¹²⁷ Likewise, for purposes of the removal and censure authority of the Commission pursuant to Section 19(h)(4) of the Act,¹²⁸ the officers and

issuance, transfer or other disposition in any single transaction or series of transactions of (A) any limited liability company interests or other equity security of the Exchange or any securities convertible into or exchangeable for, or options rights or warrants to acquire, any such equity securities or (B) any notes or debt securities containing equity features (including, without limitation, any notes or debt securities convertible into or exchangeable for any equity securities or containing profit participation features) shall (i) be made only in compliance with the member vote procedures set forth in Section 7(a) of the MC Certificate; and (ii) be subject to prior approval by the Commission pursuant to the rule filing procedure under Section 19 of the Act, and the rules promulgated thereunder.

¹²³ 15 U.S.C. 78s.

¹²⁴ See Section 7(c) of the MC Certificate of Incorporation.

¹²⁵ 15 U.S.C. 78q(b).

¹²⁶ See Section 12 of the MC Certificate of Incorporation and Section 6.02 of the MC Bylaws.

¹²⁷ See *id.*

¹²⁸ 15 U.S.C. 78s(h)(4).

directors of MC shall be deemed to be officers and directors of Amex.¹²⁹

Further, for so long as MC shall control, directly or indirectly, the Exchange, MC shall, and the officers, directors and employees of MC by virtue of their acceptance of such position shall be deemed to agree to cooperate with the Commission and the Exchange in respect of said Commission's oversight responsibilities regarding the Exchange and the self-regulatory functions and responsibilities of the Exchange.¹³⁰ MC shall take reasonable steps to ensure that its agents similarly cooperate with the Commission.¹³¹

The MC Certificate of Incorporation and the MC Bylaws also provide that, for so long as MC shall control, directly or indirectly, the Exchange, MC shall, and its officers, directors and employees by virtue of their acceptance of such position shall be deemed to, irrevocably submit to the exclusive jurisdiction of the United States Federal courts, the Commission, and the Exchange, for the purposes of any suit, action or proceeding pursuant to the United States Federal securities laws, and the rules or regulations thereunder, arising out of, or relating to the activities of the Exchange. In addition, MC shall, and by virtue of their acceptance of any such position, the officers, directors and employees of MC shall be deemed to, waive and agree not to assert by way of motion, as a defense or otherwise in any such suit, action or proceeding, any claims that it or they are not personally subject to the jurisdiction of the Commission as to such matters, that the suit, action or proceeding is an inconvenient forum or that the venue of the suit, action or proceeding is improper, or that the subject matter thereof may not be enforced in or by such courts or agency.¹³²

Pursuant to the MC Certificate of Incorporation and MC Bylaws, MC will take reasonable steps to ensure that its officers, directors and employees comply with various provisions of the MC Certificate of Incorporation, including the books and records, jurisdiction, confidential information, and cooperation provisions.¹³³ Such steps shall include obtaining from MC officers, directors and employees, as a condition to their initial or continued employment or service as a director, a

written commitment that they will comply with or consent to, as the case may be, such provisions.¹³⁴

The Commission also notes that, even in the absence of these provisions of the MC Certificate of Incorporation and MC Bylaws, Section 20(a) of the Act¹³⁵ provides that any person with a controlling interest in the Exchange would be jointly and severally liable with and to the same extent that the Exchange is liable under any provision of the Act, unless the controlling person acted in good faith and did not directly or indirectly induce the act or acts constituting the violation or cause of action. In addition, Section 20(e) of the Act¹³⁶ creates aiding and abetting liability for any person who knowingly provides substantial assistance to another person in violation of any provision of the Act or rule thereunder, and Section 21C of the Act¹³⁷ authorizes the Commission to enter a cease-and-desist order against any person who has been "a cause of" a violation of any provision of the Act through an act or omission that the person knew or should have known would contribute to the violation.

The Commission believes that, taken together, these provisions, which are designed to facilitate the ability of the Commission to exercise appropriate oversight over the Exchange and MC, are consistent with the Act.

E. Amendments to the Certificate of Incorporation and Bylaws of The Amex Membership Corporation

Section 19(b) of the Act¹³⁸ and Rule 19b-4 thereunder¹³⁹ require an SRO to file proposed rule changes with the Commission. Although MC is not an SRO, certain provisions of its Certificate of Incorporation and Bylaws may be rules of an exchange¹⁴⁰ if they are the stated policies, practices, and interpretations, as defined in Rule 19b-4 of the Act, of the Amex. Any proposed rule or any proposed change in, addition to, or deletion from the rules of an exchange must be filed pursuant to Section 19(b) of the Act and Rule 19b-

¹³⁴ See *id.*

¹³⁵ 15 U.S.C. 78t(a).

¹³⁶ 15 U.S.C. 78t(e).

¹³⁷ 15 U.S.C. 78u-3.

¹³⁸ 15 U.S.C. 78s(b).

¹³⁹ 17 CFR 240.19b-4.

¹⁴⁰ Section 3(a)(27) of the Act, 15 U.S.C.

78c(a)(27), defines the rules of an exchange to be the constitution, articles of incorporation, bylaws, and rules, or instruments corresponding to the foregoing, of an exchange, and such stated policies, practices, or interpretations of such exchange as the Commission, by rule, may determine to be necessary or appropriate in the public interest or for the protection of investors to be deemed to be rules of such exchange.

¹²⁹ See Section 13 of the MC Certificate of Incorporation and Section 7.05 of the MC Bylaws.

¹³⁰ See Section 15 of the MC Certificate of Incorporation and Section 7.07 of the MC Bylaws.

¹³¹ See *id.*

¹³² See Section 14 of the MC Certificate of Incorporation and Section 7.06 of the MC Bylaws.

¹³³ See Section 17 of the MC Certificate of Incorporation and Section 7.09 of the MC Bylaws.

4 thereunder.¹⁴¹ Accordingly, Amex has filed the MC Certificate of Incorporation and MC Bylaws with the Commission.

V. Accelerated Approval of Amendment Nos. 4 and 6

Pursuant to Section 19(b)(2) of the Act,¹⁴² the Commission may not approve any proposed rule change, or amendment thereto, prior to the thirtieth day after the date of publication of the notice of filing thereof, unless the Commission finds good cause for so finding. The Commission hereby finds good cause for approving Amendment Nos. 4 and 6 to the proposed rule change prior to the thirtieth day after publishing notice of the same in the **Federal Register** pursuant to Section 19(b)(2) of the Act.¹⁴³

Amendment No. 4 revises the first paragraph of Section 3 of Article II of the Exchange Constitution (Powers and Duties).¹⁴⁴ Specifically, Amendment No. 4 clarifies that Exchange Board members, among other things, would be required to take into consideration the self-regulatory function of the Exchange and the Exchange's obligations (and their obligations) under the Act. Because Amendment No. 4 simply clarifies the intent of the proposed rule, which has been noticed for public comment, the Commission believes that accelerating the effectiveness of Amendment No. 4 is consistent with the public interest and the protection of investors, and will not impose any significant burden on competition.

Amendment No. 6 revises Section 4(a) and Section 4(d) of Article II of the Exchange Constitution (Powers and Duties) relating to the Chief Regulatory Officer and set out certain undertakings applicable to Amex.¹⁴⁵ By amending the proposed rule to provide that the Chief Regulatory Officer will report only to the Regulatory Oversight Committee, and not, in addition, to the Exchange Chief Executive Officer (or Chief

Executive Officer's designee), Amendment No. 6 would effectively further increase the independence of the Chief Regulatory Officer. Amendment No. 6 also contains Undertakings pursuant to which Amex agrees to (1) not terminate Amex's current regulatory services agreement with NASD unless Amex has entered into an alternative arrangement for the provision of regulatory services that has been approved by the Commission, and to use its best efforts to comply with Amex's obligations under the current regulatory services agreement, (2) confer periodically with Commission staff regarding the status of Amex's regulatory program, and (3) submit certain financial information to the Commission. These proposals, which are designed to further ensure that the Exchange will be able to perform its regulatory responsibilities and to provide the Commission sufficient information to aid it in performing its regulatory oversight responsibilities, are consistent with the public interest and the protection of investors, and will not impose any significant burden on competition. Therefore, the Commission finds that good cause exists to accelerate approval of Amendment Nos. 4 and 6 to the proposed rule change, pursuant to Section 19(b)(2) of the Act.¹⁴⁶

VI. Conclusion

For the foregoing reasons, the Commission finds that the proposed rule change, as amended, is consistent with the Act and rules and regulations thereunder applicable to a national securities exchange.

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,¹⁴⁷ that the proposed rule change, including Amendment Nos. 1, 2 and 3 thereto (SR-Amex-2004-50) be, and hereby is, approved, and that Amendment Nos. 4 and 6 thereto are approved on an accelerated basis. The proposed rule change shall be effective upon the closing of the Transaction described herein.

By the Commission.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 04-28600 Filed 12-29-04; 8:45 am]

BILLING CODE 8010-01-P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-50919; File No. SR-MSRB-2004-09]

Self-Regulatory Organizations; Notice of Filing of Proposed Rule Change by the Municipal Securities Rulemaking Board Relating to Advertisements of Municipal Fund Securities Under MSRB Rule G-21

December 22, 2004.

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 December 16, 2004, the Municipal Securities Rulemaking Board ("MSRB" or "Board") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the MSRB. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The MSRB has filed with the SEC a proposed rule change amending Rule G-21, on advertising, to establish specific requirements with respect to advertisements by brokers, dealers and municipal securities dealers ("dealers") relating to municipal fund securities. The MSRB proposes an effective date for the proposed rule change of the first calendar day of the month beginning 90 or more calendar days after SEC approval.

Below is the text of the proposed rule change. Proposed new language is in *italic*; proposed deletions are in brackets.

* * * * *

Rule G-21. Advertising.

(a)-(c) No change.

(d) New Issue Advertisements. In addition to the requirements of section (c), all advertisements for new issue municipal securities (*other than municipal fund securities*) shall [also] be subject to the following requirements:

(i)-(ii) No change.

(e) *Municipal Fund Security Advertisements. In addition to the requirements of section (c), all advertisements for municipal fund securities shall be subject to the following requirements:*

¹⁴¹ For so long as MC shall control, directly or indirectly, Amex, before any change or addition to the MC Certificate of Incorporation or MC Bylaws shall be effective, the same shall be submitted to the Board of Governors of the Exchange and if said Board shall determine that the same constitutes a "rule of an exchange" as such term is defined in the Act and the rules promulgated thereunder and must be filed with or filed with and approved by the Commission before the same may be effective, under Section 19 of the Act and the rules promulgated thereunder, then the same shall not be effective until filed with or filed with and approved by said Commission, as the case may be. See Section 18 of the MC Certificate of Incorporation and Section 9.01 of the MC Bylaws.

¹⁴² 15 U.S.C. 78s(b)(2).

¹⁴³ *Id.*

¹⁴⁴ See *supra* note 7.

¹⁴⁵ See *supra* note 9 and Section II.Q.

¹⁴⁶ 15 U.S.C. 78s(b)(2).

¹⁴⁷ *Id.*

¹ 15 U.S.C. 78s(b)(1).

² 17 CFR 240.19b-4.

(i) *Required disclosures.* Each advertisement for municipal fund securities:

(A) must include a statement that:

(1) advises an investor to consider the investment objectives, risks, and charges and expenses associated with municipal fund securities before investing;

(2) explains that more information about municipal fund securities is available in the issuer's official statement;

(3) if the advertisement identifies a source from which an investor may obtain an official statement and the broker, dealer or municipal securities dealer that publishes the advertisement is the underwriter for one or more of the issues of municipal fund securities for which any such official statement may be supplied, states that such broker, dealer or municipal securities dealer is the underwriter for one or more issues (as appropriate) of such municipal fund securities; and

(4) states that the official statement should be read carefully before investing.

(B) that refers by name (including marketing name) to any municipal fund security, issuer of municipal fund securities, state or other governmental entity that sponsors the issuance of municipal fund securities, or to any securities held as assets of municipal fund securities or to any issuer thereof, must include the following disclosures, as applicable:

(1) unless the offer of such municipal fund securities is exempt from Exchange Act Rule 15c2-12 and the issuer thereof has not produced an official statement, a source from which an investor may obtain an official statement;

(2) if the advertisement relates to municipal fund securities issued by a qualified tuition program under Internal Revenue Code Section 529, a statement that advises an investor to consider, before investing, whether the investor's or designated beneficiary's home state offers any state tax or other benefits that are only available for investments in such state's qualified tuition program; and

(3) if the advertisement is for a municipal fund security that the issuer holds out as having the characteristics of a money market fund, statements to the effect that an investment in the security is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency (unless such guarantee is provided by or on behalf of such issuer) and, if the security is held out as maintaining a stable net asset value, that although the issuer seeks to preserve the value of the investment at

\$1.00 per share or such other applicable fixed share price, it is possible to lose money by investing in the security.

(C) that includes performance data must include:

(1) a legend disclosing that the performance data included in the advertisement represents past performance; that past performance does not guarantee future results; that the investment return and the value of the investment will fluctuate so that an investor's shares, when redeemed, may be worth more or less than their original cost (provided that the disclosure with respect to investment value fluctuation is not required for municipal fund securities that the issuer holds out as having the characteristics of a money market fund and as maintaining a stable net asset value); and that current performance may be lower or higher than the performance data included in the advertisement; and

(2) if a sales load or any other nonrecurring fee is charged, the maximum amount of the load or fee and, if the sales load or fee is not reflected in the performance data included in the advertisement, a statement that the performance data does not reflect the deduction of the sales load or fee and that the performance data would be lower if such load or fee were included.

(D) must present the statements required by clauses (A), (B) and (C) of this paragraph, when in a print advertisement, in a type size at least as large as and of a style different from, but at least as prominent as, that used in the major portion of the advertisement, provided that when performance data is presented in a type size smaller than that of the major portion of the advertisement, the statements required by clause (C) of this paragraph may appear in a type size no smaller than that of the performance data. If an advertisement is delivered through an electronic medium, the legibility requirements for the statements required by clauses (A), (B) and (C) of this paragraph relating to type size and style may be satisfied by presenting the statements in any manner reasonably calculated to draw investor attention to them. In a radio or television advertisement, the statements required by clauses (A), (B) and (C) of this paragraph must be given emphasis equal to that used in the major portion of the advertisement. The statements required by clause (C) of this paragraph must be presented in close proximity to the performance data and, in a print advertisement, must be presented in the body of the advertisement and not in a

footnote unless the performance data appears only in such footnote.

(ii) *Performance data.* Each advertisement that includes performance data relating to municipal fund securities must present performance data in the format, and calculated pursuant to the methods, prescribed in paragraph (d) of Securities Act Rule 482 (or, in the case of a municipal fund security that the issuer holds out as having the characteristics of a money market fund, paragraph (e) of Securities Act Rule 482), provided that:

(A) to the extent that information necessary to calculate performance data is not available from an applicable balance sheet included in a registration statement, or from a prospectus, the broker, dealer or municipal securities dealer shall use information derived from the issuer's official statement, otherwise made available by the issuer or its agents, or (when unavailable from the official statement, the issuer or the issuer's agents) derived from such other sources which the broker, dealer or municipal securities dealer reasonably believes are reliable;

(B) if the issuer first began issuing the municipal fund securities fewer than one, five, or ten years prior to the date of the submission of the advertisement for publication, such shorter period shall be substituted for any otherwise prescribed longer period in connection with the calculation of average annual total return or any similar returns;

(C) performance data shall be calculated as of the most recent calendar quarter ended prior to the submission of the advertisement for publication for which such performance data, or all information required for the calculation of such performance data, is available to the broker, dealer or municipal securities dealer as described in clause (A) of this paragraph;

(D) where such calculation is required to include expenses accrued under a plan adopted under Investment Company Act Rule 12b-1, the broker, dealer or municipal securities dealer shall include all such expenses as well as any expenses having the same characteristics as expenses under such a plan where such a plan is not required to be adopted under said Rule 12b-1 as a result of Section 2(b) of the Investment Company Act of 1940;

(E) in calculating tax-equivalent yields or after-tax returns, the broker, dealer or municipal securities dealer shall assume that any unreinvested distributions are used in the manner intended with respect to such municipal fund securities in order to qualify for any federal tax-exemption or other

federally tax-advantaged treatment with respect to such distributions, provided that:

(1) the advertisement must also provide a general description of how federal law intends that such distributions be used and disclose that such yield or return would be lower if distributions are not used in this manner; and

(2) if the then-effective federal income tax treatment upon which such yield or return was based is subject to lapse or other adverse change without extension or change of federal law, the advertisement must disclose this fact and that such yield or return would be lower if the then-effective federal income tax treatment is not extended or otherwise changed.

(F) notwithstanding any of the foregoing, this paragraph shall apply solely to the calculation of performance relating to municipal fund securities and does not apply to, or limit the applicability of any rule of the Commission, NASD or any other regulatory body relating to, the calculation of performance for any security held as an underlying asset of the municipal fund securities.

(iii) Nature of issuer and security. An advertisement for a specific municipal fund security must provide sufficient information to identify such specific security in a manner that is not false or misleading. An advertisement that identifies a specific municipal fund security must include the name of the issuer (or the issuer's marketing name for its issuance of municipal fund securities, together with the state of the issuer), presented in a manner no less prominent than any other entity identified in the advertisement, and must not imply that a different entity is the issuer of the municipal fund security. An advertisement must not raise an inference that, because municipal fund securities are issued under a government-sponsored plan, investors are guaranteed against investment losses if no such guarantee exists. If an advertisement concerns a specific class or category of an issuer's municipal fund securities (e.g., A shares versus B shares; direct sale shares versus advisor shares; in-state shares versus national shares; etc.), this must clearly be disclosed in a manner no less prominent than the information provided with respect to such class or category.

(iv) Capacity of dealer and other parties. An advertisement that relates to or describes services provided with respect to municipal fund securities must clearly indicate the entity providing those services. If any person

or entity other than the broker, dealer or municipal securities dealer is named in the advertisement, the advertisement must reflect any relationship between the broker, dealer or municipal securities dealer and such other person or entity. An advertisement soliciting purchases of municipal fund securities that would be effected by a broker, dealer or municipal securities dealer or any other entity other than the broker, dealer or municipal securities dealer that publishes the advertisement must identify which entity would effect the transaction, provided that the advertisement may identify one or more such entities in general descriptive terms but must specifically name any such other entity if it is the issuer, an affiliate of the issuer, or an affiliate of the broker, dealer or municipal securities dealer that publishes the advertisement.

(v) Tax consequences and other features. Any discussion of tax implications or other benefits or features of investments in municipal fund securities included in an advertisement must not be false or misleading. In the case of an advertisement that includes statements regarding tax or other benefits offered in connection with such municipal fund securities or otherwise offered under state or federal law, the advertisement also must state that the availability of such tax or other benefits may be conditioned on meeting certain requirements. If the advertisement describes the nature of specific benefits, such advertisement must also briefly name the factors that may materially limit the availability of such benefits (such as residency, purpose for or timing of distributions, or other factors, as applicable). Such statements of conditions or limitations must be presented in close proximity to, and in a manner no less prominent than, the description of such benefits.

(vi) Underlying registered securities. If an advertisement for a municipal fund security provides specific details of a security held as an underlying asset of the municipal fund security, the details included in the advertisement relating to such underlying security must be presented in a manner that would be in compliance with any Commission or NASD advertising rules that would be applicable if the advertisement related solely to such underlying security; provided that details of the underlying security must be accompanied by any further statements relating to such details as are necessary to ensure that the inclusion of such details does not cause the advertisement to be false or misleading with respect to the municipal fund securities advertised.

This paragraph does not limit the applicability of any rule of the Commission, NASD or any other regulatory body relating to advertisements of securities other than municipal fund securities, including advertisements that contain information about such other securities together with information about municipal securities.

(f) [(e)] No change.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the MSRB included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The MSRB has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Rule G-21, on advertising, establishes standards for dealer advertisements relating to municipal securities. The MSRB has previously provided interpretive guidance to dealers regarding the application of these standards to advertisements of municipal fund securities.³ The proposed rule change amends Rule G-21 to establish specific standards applicable solely to dealer advertisements of municipal fund securities. In particular, the proposed rule change incorporates the advertising standards enunciated in the 2002 Notice

³ See Rule G-21 Interpretation—Application of Fair Practice and Advertising Rules to Municipal Fund Securities, May 14, 2002, *reprinted in* MSRB Rule Book (the "2002 Notice"). The 2002 Notice also confirmed previous guidance on advertisements of municipal fund securities published in 2001. See Rule G-30 Interpretation—Interpretive Notice on Commissions and Other Charges, Advertisements and Official Statements Relating to Municipal Fund Securities, December 19, 2001, *reprinted in* MSRB Rule Book. Municipal fund securities are municipal securities issued by an issuer that, but for the application of Section 2(b) of the Investment Company Act of 1940, as amended (the "Investment Company Act"), would constitute an investment company within the meaning of the Investment Company Act. The most common forms of municipal fund securities sold by dealers consist of interests in trusts established by states as qualified tuition programs under Section 529 of the Internal Revenue Code of 1986, as amended ("529 college savings plans"), and interests in local government investment pools ("LGIPs").

into Rule G-21, with certain modifications. In addition, the proposed rule change includes specific requirements regarding the calculation and display of performance data for municipal fund securities in a manner consistent with Rule 482 adopted by the SEC under the Securities Act of 1933, as amended (the "Securities Act"),⁴ in connection with the advertisement of mutual fund performance. The proposed rule change also includes general disclosure requirements regarding municipal fund securities that are similar in most respects to generalized disclosures currently required for mutual fund advertisements under SEC rules.

General Disclosures

The proposed rule change includes in clauses (A) and (B) of Rule G-21(e)(i) disclosure provisions modeled after SEC general disclosure requirements for mutual fund advertisements, with certain modifications. The modifications recognize the difference between the prospectus required for mutual funds and the official statement indirectly required for municipal fund securities under Rule 15c2-12 adopted by the SEC under the Act,⁵ as well as other differences in characteristics between municipal fund securities and mutual funds.

New section (e)(i)(A) of Rule G-21 requires that all dealer advertisements relating to municipal fund securities include generalized disclosure that: (1) Advises investors to consider the investment objectives, risks, and charges and expenses associated with municipal fund securities before investing; (2) explains that more information about municipal fund securities is available in the issuer's official statement; (3) if the advertisement identifies a source from which an investor may obtain an official

statement and the dealer that publishes the advertisement is the underwriter for the municipal fund securities for which such official statement may be supplied, states that such dealer is the underwriter for such municipal fund securities; and (4) states that the official statement should be read carefully before investing. The disclosures required in clauses (1), (2), and (4) of Rule G-21(e)(i)(A) are substantially similar to the analogous disclosures required under section (b)(1)(i) of SEC Rule 482 in connection with a mutual fund advertisement that would be considered a prospectus under the Securities Act. The disclosure required in clause (3) of Rule G-21(e)(i)(A) is substantially similar to the analogous disclosure required under section (b) of Rule 135a adopted by the SEC under the Securities Act in connection with generic mutual fund advertisements.

New section (e)(i)(B) of Rule G-21 requires that all dealer advertisements that refer by name (including marketing name) to any municipal fund security, issuer of municipal fund securities, governmental entity that sponsors the issuance of municipal fund securities, or to any securities held as assets of municipal fund securities or to any issuer of such securities held as assets, must include additional disclosure that: (1) Identifies a source from which an investor may obtain an official statement; (2) if the advertisement relates to municipal fund securities issued through a 529 college savings plan, advises an investor to consider, before investing, whether the investor's or designated beneficiary's home state offers any state tax or other benefits that are only available for investments in such state's 529 college savings plan; and (3) if the advertisement is for a municipal fund security that the issuer holds out as having the characteristics of a money market fund, states that an investment in the security is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency (unless such guarantee is provided by or on behalf of such issuer) and that, if the security is held out as maintaining a stable net asset value, although the issuer seeks to preserve the value of the investment at a fixed share price, it is possible to lose money by investing in the security. The disclosure required in clause (1) of Rule G-21(e)(i)(B) is substantially similar to the analogous disclosure required under section (b)(1)(i) of SEC Rule 482. The disclosure required in clause (3) of Rule G-21(e)(i)(B) is substantially similar to the analogous disclosure required under section (b)(4) of SEC Rule 482. The

disclosure required in clause (2) of Rule G-21(e)(i)(B) is not derived from SEC mutual fund advertising rules but is analogous to the point-of-sale disclosure obligation under Rule G-17 described in the 2002 Notice.⁶

New section (e)(i)(D) of Rule G-21 requires that these general disclosures be presented in the same format required under SEC Rule 482.

Historical Performance Data

The proposed rule change establishes in new section (e)(ii) of Rule G-21 specific requirements with respect to the inclusion of performance data in municipal fund security advertisements.

Calculation and Display of Performance Data. Under the proposed rule change, such advertisements must comply with the method of computing and displaying performance data for mutual funds as prescribed in section (d) or (e) of SEC Rule 482, with certain modifications described below. In effect, for municipal fund securities other than those that are held out by the issuer as having the characteristics of a money market fund, quotations of performance in an advertisement are limited to the average annual total return, current yield (but only if accompanied by average annual total return), tax-equivalent yield (but only if accompanied by average annual total return and current yield), after-tax return (but only if accompanied by average annual total return), or other non-prescribed performance measures (but only if accompanied by average annual total return and, if adjusted to reflect the effects of taxes, after-tax return), as provided in SEC Rule 482(d). In the case of municipal fund securities that are held out by the issuer as having the characteristics of a money market fund, quotations of performance in an advertisement are limited to the current yield, effective yield (but only if accompanied by current yield), tax-equivalent yield or tax-equivalent effective yield (but only if accompanied by current yield), or total return (but only if accompanied by current yield), as provided in SEC Rule 482(e).⁷

⁶ The specific disclosure required in the proposed rule change is somewhat broader than that currently required under the point-of-sale disclosure obligation described in the 2002 Notice. The MSRB expects to file with the SEC in the near future a proposed rule change that expands this point-of-sale disclosure requirement under Rule G-17 to also reference the possible existence of other non-tax state benefits. See MSRB Notice 2004-16 (June 10, 2004).

⁷ SEC Rule 482 incorporates the calculation methods set forth in Forms N-1, N-3, and N-4 for purposes of calculating the various types of quotations described in the rule. These methods are also incorporated into Rule G-21(e)(ii).

⁴ 15 U.S.C. 77a *et seq.*

⁵ SEC Rule 15c2-12 provides, among other things, that the underwriter for most primary offerings of municipal securities must obtain and review the issuer's near-final official statement before purchasing or offering the securities, contract with the issuer to receive copies of the final official statement within specified time frames after the final agreement to purchase or offer the securities, and distribute copies of the official statement to potential customers upon request. For purposes of the rule, a final official statement must set forth information concerning the terms of the issue; information, including financial or operating data, concerning the issuer and other entities, enterprises, funds, accounts and other persons material to an evaluation of the offering; and a description of undertakings regarding the provision of secondary market information, as well as disclosure of any failures to provide such information during the past five years. A final official statement need not contain each item of information required to be included in a prospectus under the Securities Act.

Clauses (A) through (E) of Rule G–21(e)(ii) modify the basic performance data calculation methods established for mutual funds to reflect the fact that certain items of information that exist in the mutual fund industry—such as the registration statement and the specific items of information required to be disclosed in the prospectus and statement of additional information—do not exist for municipal fund securities, as well as to reflect other differences in characteristics between municipal fund securities and mutual funds. Thus, Rule G–21(e)(ii) provides that: (A) A dealer can use information provided in the issuer's official statement, otherwise made available by the issuer, or otherwise obtained from other reliable sources to calculate performance to the extent such information is not available from a balance sheet in a registration statement or from a prospectus; (B) the life of a municipal fund securities issue should be measured from when the issuer first issues the securities; (C) performance data in advertisements must be calculated as of the most recent calendar quarter ended prior to the submission of the advertisement for publication for which such performance data, or all information required for the calculation of such performance data, is available to the dealer;⁸ (D) expenses having the same characteristics as those permitted to be paid under Rule 12b–1 adopted by the SEC under the Investment Company Act but not technically accrued under a 12b–1 plan must be treated as 12b–1 expenses for purposes of calculating performance;⁹ and (E) in calculating tax-equivalent yields or after-tax returns, the dealer shall assume that any unreinvested distributions are used in a manner that qualifies for any federal tax-exemption or other federally tax-advantaged treatment with respect to such distributions, provided that: (1) The advertisement also provides a general description of how federal law intends such distributions be used and discloses that such yield or return would be lower if distributions are not used in this

manner; and (2) if the federal income tax treatment upon which such yield or return is based is subject to lapse or other adverse change without extension or change of federal law, the advertisement must disclose this fact and that such yield or return would be lower if the Federal income tax treatment is not extended or otherwise changed.

Performance data included in municipal fund security advertisements are required to be displayed in the manner provided in section (d) or (e) of SEC Rule 482, as appropriate, with respect to prominence and positioning of information.

Disclosures Accompanying Performance Data. New Section (e)(i)(C) of Rule G–21 requires that advertisements that include performance data for municipal fund securities also include certain related legends and disclosures modeled after those required under SEC Rule 482 for mutual funds advertisements that display performance information. These disclosures emphasize that the performance data is historical and does not guarantee future results, that the value of holdings is subject to fluctuation (except where the municipal fund security is held out as having the characteristics of a money market fund and as maintaining a stable net asset value), and that current performance may be different from the performance data included in the advertisement.¹⁰ Advertisements containing performance data also are required to include the maximum amount of any sales load or other nonrecurring fee and, if such load or fee is not reflected in the performance data, to disclose that the load or fee is not so reflected and that performance would be lower if it had been reflected. These nonrecurring fees that are subject to disclosure include such fees imposed not only by the dealer but also by the issuer or any other party to the issuance of the municipal fund securities or the maintenance of investments therein.

New Section (e)(i)(D) requires that these legends and disclosures be presented in the same format required under SEC Rule 482.

Additional Requirements

The proposed rule change includes in new paragraphs (iii) through (vi) of Rule G–21(e) additional requirements with respect to municipal fund security advertisements, based largely on interpretive guidance provided in the 2002 Notice.

¹⁰ As noted in footnote 17 and accompanying text, *infra*, the MSRB is publishing for comment concurrent with this filing a draft amendment that would modify this provision.

Nature of Issuer and Security. New paragraph (iii) requires that an advertisement: (1) for a specific municipal fund security provide sufficient information to identify the security in a manner that is not false or misleading; (2) that identifies a specific municipal fund security include the name of the issuer (or its marketing name, including state), presented in a manner no less prominent than any other entity identified in the advertisement, and not imply that a different entity is the issuer; (3) not raise an inference that, because municipal fund securities are issued under a government-sponsored plan, investors are guaranteed against investment losses if no such guarantee exists; and (4) that concerns a specific class or category of municipal fund securities (*e.g.*, A shares versus B shares; direct sale shares versus advisor shares; in-state shares versus national shares; etc.) clearly disclose this fact in a manner no less prominent than the information provided with respect to such class or category.

Capacity of Dealer and Other Parties. New paragraph (iv) requires an advertisement about services provided with respect to municipal fund securities to clearly indicate the entity providing such services. If any person or entity other than the dealer is named in the advertisement, it must reflect any relationship between the dealer and such other person or entity. An advertisement soliciting purchases that would be effected by any party other than the dealer that publishes the advertisement (*i.e.*, the issuer or another dealer) must identify which entity would effect the transaction, provided that it may identify one or more such entities in general descriptive terms but must specifically name any such other entity if it is the issuer, an affiliate of the issuer, or an affiliate of the dealer that publishes the advertisement.

Tax Consequences and Other Features. New paragraph (v) requires that any discussion of tax implications or other benefits or features of investments in municipal fund securities included in an advertisement not be false or misleading. If an advertisement includes statements regarding tax or other benefits offered in connection with such municipal fund securities or otherwise offered under state or federal law, it must also state that the availability of such tax or other benefits may be conditioned on meeting certain requirements. If the advertisement describes the nature of specific benefits, such advertisement must also briefly name the factors that may materially limit the availability of

⁸ As noted in footnote 17 and accompanying text, *infra*, the MSRB is publishing for comment concurrent with this filing a draft amendment that would modify this clause (C).

⁹ Thus, asset-based charges paid to the program manager or investment advisor, to the issuer or its agents, or to any other party generally are to be treated as 12b–1 expenses for purposes of calculating performance even if any such charges may not technically be paid under a formal 12b–1 plan. In addition, any 12b–1 expenses incurred in connection with underlying assets of the municipal fund securities also must be treated as 12b–1 expenses of the municipal fund securities to the extent that such expenses are not waived or not included within the asset-based charges described in the preceding sentence.

such benefits (such as residency, purpose for or timing of distributions, or other factors, as applicable).¹¹ Such statements of conditions or limitations must be presented in close proximity to, and in a manner no less prominent than, the description of such benefits.

Underlying Registered Securities. New paragraph (vi) requires that, if an advertisement for a municipal fund security provides specific details of a security held as an underlying asset of the municipal fund security, the details included in the advertisement relating to such underlying security be presented in a manner that would be in compliance with any SEC or NASD advertising rules that would be applicable if the advertisement related solely to such underlying security. Details of the underlying security included in the advertisement must be accompanied by any further statements necessary to ensure that the inclusion of such details does not cause the advertisement to be false or misleading with respect to the municipal fund securities advertised. This provision does not limit the applicability of any rule of the SEC, NASD or any other regulatory body relating to advertisements of securities other than municipal fund securities, including advertisements that contain information about such other securities together with information about municipal fund securities.

Exemption From New Issue Price/Yield Requirement

The proposed rule change exempts municipal fund security advertisements from the provision of Rule G-21(d) relating to advertisements of initial reoffering prices or yields of new issue municipal securities. This provision is designed for advertisements by underwriting syndicates for municipal debt offerings and does not deal with matters relevant to municipal fund securities.

2. Statutory Basis

The MSRB believes that the proposed rule change is consistent with section 15B(b)(2)(C) of the Act,¹² which requires that the rules of the MSRB shall "be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and

coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in municipal securities, to remove impediments to and perfect the mechanism of a free and open market in municipal securities, and, in general, to protect investors and the public interest" * * *.¹³

The MSRB believes that the proposed rule change is consistent with the Act because it will further investor protection by raising the standards for advertisements of municipal fund securities and by making information provided in such advertisements comparable for different municipal fund securities investments and between municipal fund securities and registered mutual funds.

B. Self-Regulatory Organization's Statement on Burden on Competition

The MSRB 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 since it would apply equally to all dealers.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

On June 10, 2004, the MSRB published for comment draft rule changes to Rule G-21 with respect to advertisements of municipal fund securities.¹⁴ The MSRB received eight comment letters.¹⁵ After reviewing these

¹³ *Id.*

¹⁴ See MSRB Notice 2004-16 (June 10, 2004).

¹⁵ Letter from Kenneth B. Roberts, Hawkins Delafield & Wood LLP ("Hawkins"), to Ernesto A. Lanza, Senior Associate General Counsel, MSRB, dated August 20, 2004; letter from Mary L. Schapiro, Vice Chairman, NASD, and President, Regulatory Policy and Oversight, to Ernesto A. Lanza, dated September 9, 2004; letter from Tamara K. Salmon, Senior Associate Counsel, Investment Company Institute ("ICI"), to Ernesto A. Lanza, dated September 10, 2004; letter from David J. Pearlman, College Savings Foundation ("CSF"), to Ernesto A. Lanza, dated September 13, 2004; letter from Elizabeth L. Bordowitz, General Counsel, Finance Authority of Maine ("FAME"), to Ernesto A. Lanza, dated September 13, 2004; letter from Diana F. Cantor, Chair, College Savings Plan Network ("CSPN"), and Executive Director, Virginia College Savings Plan, to Ernesto A. Lanza, dated September 15, 2004; letter from Elizabeth Varley and Michael D. Udoff, Co-Staff Advisers, Securities Industry Association ("SIA") Ad Hoc 529 Plans Committee, to Ernesto A. Lanza, dated September 15, 2004; and letter from Raquel Alexander, PhD, Assistant Professor, and LeAnn Luna, PhD, Assistant Professor, University of North Carolina at Wilmington, to Ernesto A. Lanza, dated September 15, 2004. Most commentators also provided comments on the proposed modification to the MSRB's existing point-of-sale disclosure obligation relating to sales of out-of-state 529 college savings plans, as described in the June notice. The MSRB expects to file with the SEC in the near future a

comments, the MSRB approved the draft amendments, with certain modifications, for filing with the SEC. The comments and modifications to the draft amendments are discussed below.

General Disclosures

Summary of Draft Amendment. Draft Rule G-21(e)(i)(A) would require dealer advertisements of municipal fund securities to include generalized disclosure to the effect that investors should consider the securities' investment objectives, risks and charges before investing; that more information about the securities is available in the issuer's official statement; identifies where an official statement can be obtained; and states that the official statement should be read carefully before investing. Advertisements of 529 college savings plans also must advise investors to consider whether their home states offer state tax or other benefits only available for investments in the in-state plans. Further, advertisements for municipal fund securities that are marketed as money market securities would be required to disclose that investments are not insured and, if marketed as maintaining a stable net asset value, it is still possible to lose money. These disclosures would be required to be given emphasis equal to that used in the major portion of the advertisement. In addition, the MSRB sought comment on whether the rule should require that dealers that advertise 529 college savings plans include in their generalized disclosure language the URL of an MSRB-maintained Web site where investors can obtain general information about the 529 college savings plan market.

Discussion of Comments.

Commentators generally supported the proposed general disclosures, with several providing suggested changes.

- **State tax and other benefits**—Three commentators representative of, or generally acting on behalf of, state issuers suggested modifications to the language relating to the potential benefits of investing in an in-state plan. CSPN and FAME stated that the proposed language should reflect that some benefits may be dependent on the designated beneficiary's home state (rather than or in addition to the home state of the investor). Hawkins suggested that if a state's 529 college savings plan is offered solely within that state and an advertisement of such plan is

proposed rule change that expands this point-of-sale disclosure requirement under Rule G-17 to also reference the possible existence of other non-tax state benefits. The MSRB will address comments on this subject at that time.

¹¹ For example, if an advertisement notes that investors in a particular 529 college savings plan may qualify for scholarships or matching grants, it may also need to state that such scholarships or matching grants are available only for attendance at in-state colleges or to in-state investors, if that is in fact the case.

¹² 15 U.S.C. 78o-4(b)(2)(C).

distributed solely within such state, the advertisement should be exempted from the proposed disclosure regarding potential benefits of investing in an in-state plan.

The MSRB agrees that the general disclosure language in Rule G-21(e)(i)(B)(2) should be modified to include reference to the designated beneficiary when discussing the benefits of in-state investments. However, the MSRB does not believe that the additional changes suggested by the commentators should be made. The MSRB believes that disclosure of potential in-state benefits should apply to all 529 college savings plan advertisements, even if the advertisement for a 529 college savings plan offered solely within a particular state is distributed solely within that state, as this would ensure uniform practices and avoid sometimes difficult factual determinations.

- *Advertisements with limited information*—Several commentators (CSF, CSPN, FAME and SIA) suggested that the proposed amendments permit an abbreviated form of the general disclosures for purposes of radio and television advertisements in view of the limited amount of time available in such advertisements to provide all required information. SIA argued that the requirement that equal prominence be given to the general disclosures would result in the advertisement's intended message being lost. CSF stated that the practical consequence of this requirement would quite possibly be that there would be no more radio or television advertisements of 529 college savings plans by dealers. CSF and SIA suggested that a broadcast advertisement that merely presents the dealer's name and address, the name of the 529 college savings plan and the name of the sponsoring state be permitted to substitute an abbreviated reference to the official statement for further information. SIA further suggested that such a broadcast advertisement urge the investor to read the official statement carefully before investing and state how an investor may obtain the official statement.

The MSRB notes that SEC Rule 135a effectively permits the use of certain types of mutual fund advertisements containing very limited information without including the disclosures required under SEC Rule 482. SEC Rule 135a covers advertisements that include no more than explanatory information relating to mutual funds generally and/or to specific categories of mutual funds, as well as an invitation to inquire for further information. Such advertisements must contain the name

and address of the dealer sponsoring the advertisement and whether the dealer is the principal underwriter of any mutual fund with respect to which information will be sent to any investor who asks for more information. However, such advertisements must not specifically refer by name to any mutual fund or fund family.

The suggestion of CSF and SIA would provide for including the name of the 529 college savings plan and its sponsoring state, unlike under SEC Rule 135a. However, their proposal would provide for retaining certain of the general disclosures of the proposal that are not otherwise required under SEC Rule 135a. The MSRB believes that the general disclosure provision should be modified to permit more abbreviated general disclosures, set forth in Rule G-21(e)(i)(A), where an advertisement does not refer by name (including marketing name) to any specific municipal fund security, issuer of municipal fund securities or state or other governmental entity that sponsors the issuance of municipal fund securities, or to any securities held as assets of municipal fund securities or to any issuer of such securities held as assets. Such disclosures would be limited to statements advising investors to consider the investment objectives, risks and charges of municipal fund securities before investing; that more information about municipal fund securities is available in the issuer's official statement; and that the official statement should be read carefully before investing. Because these disclosures would be considerably shorter than otherwise required, the MSRB does not believe that the equal prominence requirement for such statements should be changed. Further, the MSRB does not believe that dealers should be permitted to identify a specific product in advertisements where only these more abbreviated general disclosures are provided. Any advertisement that specifically identifies a product must also include the general disclosures set forth in Rule G-21(e)(i)(B), as applicable.

- *Reference to MSRB Web site*—Most commentators stated that the MSRB should not require that 529 college savings plan advertisements include reference to an MSRB-maintained Web site on 529 college savings plans, and no commentator supported such a requirement. The MSRB will take no further action with respect to such proposal at this time. However, the MSRB will continue to maintain and update its existing Web pages, at <http://www.msrb.org/msrb1/mfs>, that

provide generalized information about municipal fund securities.

- *Applicability to LGIPs*—Hawkins suggested that the general disclosure provisions be made inapplicable to advertisements of LGIPs, arguing that the required references to the official statement are inappropriate because official statements are not typically prepared for LGIPs. The MSRB understands that most LGIPs do in fact prepare official statements (often referred to as information statements), and dealers marketing LGIPs generally are subject to SEC Rule 15c2-12. Therefore, the MSRB has not exempted dealer advertisements of LGIPs from the rule requirements.

Performance Data

Summary of Proposal. Draft Rule G-21(e)(ii) would require advertisements that include performance data to comply with the method of computing and displaying mutual fund performance data provided under SEC Rule 482, with certain modifications. Among other things, the draft amendment would require that performance data shown in an advertisement be calculated as of the most recent calendar quarter for which such data, or all information required to calculate such performance data, is reasonably available to the dealer. SEC Rule 482 requires that such data be shown in mutual fund advertisements as of the most recent calendar quarter but does not make the determination of which calendar quarter is the most recent dependent upon the availability of such data.

In addition, draft Rule G-21(e)(i) would require certain related disclosures for municipal fund securities advertisements that contain performance data. The disclosures emphasize that the performance information is historical and does not guarantee future results, the value of holdings is subject to fluctuation, and current performance may be lower or higher than the performance quoted. Advertisements containing performance data also would be required to include basic information about sales loads and other nonrecurring fees and note the impact of such loads or fees on performance as shown. The disclosures must be given emphasis equal to that of the performance data itself. These disclosures are required under SEC Rule 482 in mutual funds advertisements that display performance information.

Discussion of Comments.

Commentators generally supported the proposed performance data calculation methods and related legends and

disclosures, with several providing suggested changes.

- *Most recent quarterly performance data*—NASD stated that the difference in the language regarding the timing of quarterly data used in Rule G–21 as compared to the language used in SEC Rule 482 “appears to give dealers latitude” that “may undermine the ability of investors to compare different municipal fund securities programs, or even the same program offered by different dealers who impose varying end dates for their performance calculation. At a minimum, the disparity between the language in Rule 482 and the MSRB’s proposal would create confusion for broker-dealers that must comply with both provisions.”

The language used in the draft amendment was not designed to give dealers latitude in deciding which timeframes to include in advertisements, nor would it normally lead to a different result under the draft rule as compared to SEC Rule 482.¹⁶ Rather, the language reflects the MSRB’s recognition that its rulemaking should not be used to indirectly regulate state issuers in structuring their programs and that a state’s structure might result in making compliance with the specific language of Rule 482 impossible without forcing a change in the structure. However, to mitigate the possibility of unintended ambiguity and possible inconsistent application of the rule between different dealers, the MSRB has modified the language of Rule G–21(e)(ii)(C) to provide that calculations must be made as of the most recent quarter for which necessary information is available, rather than when such information is *reasonably* available. Dealers wishing to advertise performance would be tasked with taking all appropriate actions necessary to obtain information that is in fact available for purposes of such calculation.

- *Most recent month-end performance data*—ICI and NASD suggested that the MSRB add a requirement that dealers include in municipal fund security advertisements that contain performance data a phone number or Web address where investors may obtain performance data current to the most recent month-end. They stated that this would make the MSRB’s advertising rule consistent with the similar requirement established under

SEC Rule 482. Rule 482 requires that mutual fund advertisements that show performance data also include a phone number or Web site address at which performance data may be obtained that is current to the most recent month, available no later than seven business days after the end of the month. This requirement was not included in draft Rule G–21(e). Concurrent with the filing of this proposed rule change, the MSRB is publishing for industry comment a draft amendment to Rule G–21 that would require inclusion in dealer advertisements that contain performance data for municipal fund securities of a phone number or Web address where investors may obtain performance data current to the most recent month-end.¹⁷

- *Affect of federal tax treatment of 529 plans*—The MSRB sought comment on whether the methods of calculating performance provided under SEC Rule 482, as modified by the draft amendments, were appropriate for municipal fund securities. ICI stated that “the proposed modifications satisfactorily address any disparities that should be taken into account in incorporating the provisions of Rule 482 into Rule G–21.” CSPN and FAME strongly supported the effort to develop a uniform method of calculating performance. They suggested that the MSRB establish basic assumptions that 529 college savings plan distributions will be used in a manner that would preserve their tax-exempt nature (with a footnote to the effect that after-tax returns would differ if current law sunsets). In addition, they suggested that after-tax returns should not be required to be shown for 529 college savings plan advertisements since such investments are intended to be tax-exempt.

The MSRB does not believe that such assumptions about the tax-exempt nature of 529 college savings plan investments should apply for all purposes of calculating performance. Thus, the baseline total return calculation would continue to ignore all tax effects. However, in calculating tax-equivalent yields or after-tax returns, the MSRB believes it is appropriate to assume that unreinvested distributions are used for purposes that would maintain any intended federal tax benefit, as set forth in Rule G–21(e)(ii)(E). Such assumption would require that the advertisement include a general description of how federal law intends that such distributions be used to maintain the favorable tax treatment

and a disclosure that the tax-equivalent yield or after-tax return would be lower if distributions are not used in such manner. In addition, if the favorable tax treatment is subject to lapse or other adverse change without extension or other change of law, the advertisement must disclose this fact and that such yield or return would be lower if the favorable tax treatment is not extended or otherwise changed.

Further, the MSRB does not believe that the provision requiring the inclusion of after tax-return should be eliminated. The only circumstance in which a dealer would be required to show after-tax return is if the advertisement also includes a performance measure that is adjusted to reflect the effect of taxes (e.g., a tax equivalent return intended to show how the tax benefits of investing in 529 college savings plans compares to other fully taxable investments). Under this circumstance, it is appropriate that the advertisement also include performance that does not include such adjustment.

Additional Requirements

Draft Rule G–21 would incorporate, with certain modifications, several existing interpretive positions from the 2002 Notice. Commentators generally supported the incorporation of these positions into the rule, with several providing suggested changes.

- *Nature of Issuer and Security*—Draft Rule 21(e)(iii) would require, among other things, that an advertisement that identifies a specific municipal fund security include the name of the issuer presented in a manner no less prominent than any other entity identified in the advertisement.

CSF argued that, in some cases, providing the name of the legal issuer in connection with 529 college savings plan securities may not help consumers understand the nature of the issuer and may result in confusion since the legal issuer may be an obscure state trust. CSF suggested that it would be more helpful to identify the 529 college savings plan by marketing name, together with the name of the state that establishes and maintains the plan. CSF also suggested that dealers be permitted to include the marketing logo, rather than a logo of the legal issuer, in advertisements, which logo should appear at least as prominently as the dealer’s logo. SIA stated that the requirement that the issuer’s name be given equal prominence to that of the dealer is unnecessary and subject to second guessing. SIA argued that the policy objective of the proposed rule, which is to prevent investor confusion

¹⁶ The MSRB notes that SEC Rule 482(g) provides a basic timeliness standard based on the “most recent practicable date considering the type of investment company and the media through which data will be conveyed” that also could be viewed as giving some latitude in deciding which timeframes to include in advertisements.

¹⁷ See MSRB Notice 2004–43 (December 16, 2004).

as to who the issuer of the security is, is satisfied by the other requirements set forth in this section that the issuer be identified and that the advertisement not imply that another entity is the issuer of the security.

The MSRB believes that it is appropriate to permit dealers to use the marketing name and state of a 529 college savings plan in substitution for the legal name of the issuer. However, the MSRB does not agree that such issuer information should be permitted to be presented in a manner that is less prominent than any other entity identified in the advertisement. This provision would also permit the use of the 529 college savings plans logo, so long as such logo is presented in a manner no less prominent than any other entity's logo included in the advertisement.

- *Capacity of Dealer and Other Parties*—Draft Rule 21(e)(iv) would require an advertisement that relates to or describes services provided with respect to municipal fund securities to clearly indicate the entity providing such services. In addition, an advertisement soliciting purchases of municipal fund securities that would be effected by any party other than the dealer that publishes the advertisement (*i.e.*, the issuer or another dealer) must clearly state which entity would effect the transaction.

CSF and SIA argued that many 529 college savings plans are marketed through hundreds of dealers and it would be extremely difficult if not impossible for a primary distributor to list in its advertisement all such dealers. CSF suggested that only dealers that are affiliates of the dealer publishing the advertisement and, if applicable, the issuer itself be required to be identified by name in such advertisements. NASD stated that this provision resembles, but is not identical to, NASD Rule 2210(d)(2)(C), which generally requires that all sales material prominently disclose the name of the member and, if it includes other names, reflect which products or services are being offered by the member.

It was not the intent of the original proposal to require that a primary distributor list its many hundreds of selling dealers used in the 529 college savings plan's distribution channels. The MSRB has modified this provision so that the only parties effecting transactions in municipal fund securities that must be specifically named in an advertisement are the dealer publishing the advertisement, any other dealer affiliated with such dealer and the issuer, as applicable. In addition, the rule language has been

revised to more closely track the NASD requirement that, if any parties other than the dealer is named in a municipal fund securities advertisement, the products or services offered by such parties in connection with such municipal fund securities must be stated.

- *Tax Consequences and Other Features*—Draft Rule 21(e)(v) would require, among other things, that an advertisement that includes statements regarding tax or other benefits offered under state or federal law must make clear the nature of such benefits and that the availability of such benefits may be materially limited based upon residency, purpose for or timing of share redemptions, or other factors, as applicable. These limitations would be required to be described in the advertisement in close proximity to, and in a manner no less prominent than, the description of such benefits.

CSF argued that state tax treatment of 529 college savings plans is extremely complex and that not all variations in state treatment will be a benefit to in-state investors. It suggested that the reference in the rule language to "state tax or other benefits" should be changed to "different state tax or other consequences." CSF also expressed concern over the proposal's requirement that an advertisement that includes information about tax or other state benefits must "make clear the nature of such benefits." CSF stated:

If all that would be required is a general statement that tax and other benefits may be available only through the home-state program, the guidance should so state. . . . If a laundry list of all potential aspects of differing treatment is required, we are concerned that such a list could not practically be updated to account for all new state laws, and that even if it could, space limitations would make it impractical or impossible to achieve compliance.

CSPN and Hawkins stated that only general statements of limitation are appropriate where an advertisement contains only general statements of benefits, so long as the investor is directed to the official statement for additional information. Hawkins suggested that the proposed rule language appears to require dealer advertisements that refer in any manner to tax or other benefits to include a detailed description of the nature of, and of limitations applicable to receipt of, such benefits. Hawkins argued that it may be impractical to include such a detailed description within most advertisements without resulting in potentially misleading or incomplete statements.

FAME suggested certain changes to terminology in this provision, stating that references to "shares" are not appropriate for many 529 college savings plans. In addition, CSPN and FAME stated that some state benefits may not be specifically provided for under state law but are created by state entities under general grants of authority.

The MSRB has modified the rule language to more narrowly focus the types of disclosures that would be required to be made in an advertisement that includes descriptions of tax or other beneficial features offered under state or federal law in connection with an investment in municipal fund securities. Thus, the modified language would make clear that general statements regarding the existence of beneficial features would not require an extensive listing of all such features but would require general disclosure that such features may be subject to limitations. However, as the information about tax matters becomes more detailed, the rule would require comparably detailed discussion of potential limitations. However, the reference to "benefits" has not been eliminated from the rule. The rule already addresses the broader concept of "tax implications" but is also specifically aimed at ensuring that the "hying" of beneficial treatment is tempered by an equally prominent discussion of potential limitations. Further, certain limited modifications have been made to the rule language to address the concerns regarding use of the term "shares" and reference to benefits provided under state law.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The MSRB proposes an effective date for the proposed rule change of the first calendar day of the month beginning 90 or more calendar days after SEC approval. Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

A. By order approve such proposed rule change, or

B. Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (<http://www.sec.gov/rules/sro.shtml>); or
- Send an e-mail to rule-comments@sec.gov. Please include File Number SR-MSRB-2004-09 on the subject line.

Paper Comments

- Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549-0609.

All submissions should refer to File Number SR-MSRB-2004-09. This file number should be included on the subject line if e-mail 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 inspection and copying in the Commission's Public Reference Room. Copies of such filing also will be available for inspection and copying at the MSRB's principal office. 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-MSRB-2004-09 and should be submitted on or before January 20, 2005.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.¹⁸

Margaret H. McFarland,

Deputy Secretary.

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-50916; File No. SR-NASD-2004-188]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval of Proposed Rule Change by National Association of Securities Dealers, Inc. Relating to the Listing and Trading of Performance Leveraged Upside Securities Based on the Value of the Index

December 22, 2004.

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 December 21, 2004, the National Association of Securities Dealers, Inc. ("NASD"), through its subsidiary, The Nasdaq Stock Market, Inc. ("Nasdaq"), filed with the Securities and Exchange Commission ("Commission" or "SEC") the proposed rule change as described in Items I and II below, which Items have been prepared by Nasdaq. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons and is approving the proposal on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of the Substance of the Proposed Rule Change

The Nasdaq proposed to list notes, know as Performance Leveraged Upside SecuritiesSM ("Notes") issued by Morgan Stanley ("Morgan Stanley"), the performance of which is linked to the Nasdaq-100 ("Nasdaq-100" or "Index").

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 Nasdaq 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 III below. The Nasdaq has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Nasdaq proposes to list and trade Performance Leveraged Upside Securities ("PLUS"), the return on which is based upon the Nasdaq-100 Index (the "Index").³

Under NASD Rule 4420(f), Nasdaq may approve for listing and trading innovative securities which cannot be readily categorized under traditional listing guidelines.⁴ Nasdaq proposes to

³ The Index is a modified capitalization-weighted index of 100 of the largest non-financial companies listed on The Nasdaq National Market tier of The Nasdaq Stock Market. The Index constitutes a broadly diversified segment of the largest securities listed on The Nasdaq Stock Market and includes companies across a variety of major industry groups. The securities in the Index must, among other things, have an average daily trading volume on Nasdaq of at least 200,000 shares.

In order to ensure that there is no domination of the Index by a few large stocks, the Index is calculated under a "modified capitalization-weighted" methodology, which is a hybrid between equal weighting and conventional capitalization weighting. Under the methodology employed, on a quarterly basis coinciding with Nasdaq's quarterly scheduled weight adjustment procedures, the Index Securities are categorized as either "Large Stocks" or "Small Stocks" depending on whether their current percentage weights (after taking into account such scheduled weight adjustments due to stock repurchases, secondary offerings, or other corporate actions) are greater than, or less than or equal to, the average percentage weight in the Index (*i.e.*, as a 100-stock index, the average percentage weight in the Index is 1.0%). Such quarterly examination will result in an Index rebalancing if either one or both of the following two weight distribution requirements are not met: (1) The current weight of the single largest market capitalization Index component security must be less than or equal to 24.0%, and (2) the "collective weight" of those Index component securities whose individual current weights are in excess of 4.5%, when added together, must be less than or equal to 48.0%.

Index securities are ranked by market value and are evaluated annually to determine which securities will be included in the Index. Moreover, if at any time during the year an Index security is no longer trading on the Nasdaq Stock Market, or is otherwise determined by Nasdaq to become ineligible for continued inclusion in the Index, the security will be replaced with the largest market capitalization security not currently in the Index that meets the Index eligibility criteria.

For a detailed description of the Index, *see* the prospectus supplement that will be filed by Morgan Stanley with the Commission prior to the issuance of the Notes. The Index is widely disseminated at Bloomberg, Reuters and Thomson Financial, where its value is updated every 15 seconds during normal trading hours. In the event that the calculation and this type of dissemination of the Index is discontinued, Nasdaq will delist the notes.

⁴ *See* Securities Exchange Act Release No. 32988 (September 29, 1993), 58 FR 52124 (October 6, 1993).

¹⁸ 17 CFR 200.30-3(a)(12).

¹ 15 U.S.C. 78s(b)(1).

² 17 CFR 240.19b-4.

list for trading notes based on the Index under NASD Rule 4420(f).

The Notes, which will be registered under Section 12 of the Act, will initially be subject to Nasdaq's listing criteria for other securities under NASD Rule 4420(f). Specifically, under NASD Rule 4420(f)(1):

(A) The issuer shall have assets in excess of \$100 million and stockholders' equity of at least \$10 million.⁵ In the case of an issuer which is unable to satisfy the income criteria set forth in paragraph (a)(1), Nasdaq generally will require the issuer to have the following: (i) Assets in excess of \$200 million and stockholders' equity of at least \$10 million; or (ii) assets in excess of \$100 million and stockholders' equity of at least \$20 million;

(B) There must be a minimum of 400 holders of the security, provided, however, that if the instrument is traded in \$1,000 denominations, there must be a minimum of 100 holders;

(C) For equity securities designated pursuant to this paragraph, there must be a minimum public distribution of 1,000,000 trading units;

(D) The aggregate market value/principal amount of the security will be at least \$4 million.

In addition, Morgan Stanley satisfies the listed marketplace requirement set forth in NASD Rule 4420(f)(2).⁶ Lastly, pursuant to NASD Rule 4420(f)(3), prior to the commencement of trading of the Notes, Nasdaq will distribute a circular to members providing guidance regarding compliance responsibilities and requirements, including suitability recommendations, and highlighting the special risks and characteristics of the Notes. In particular, Nasdaq will advise members recommending a transaction in the Notes to: (1) determine that such transaction is suitable for the customer; and (2) have a reasonable basis for believing that the customer can evaluate the special characteristics of, and is able to bear the financial risks of, such transaction.

The Notes will be subject to Nasdaq's continued listing criterion for other securities pursuant to NASD Rule 4450(c). Under this criterion, the aggregate market value or principal amount of publicly-held units must be at least \$1 million. The Notes also must

have at least two registered and active market makers as required by NASD Rule 4310(c)(1). The Notes will be subject to the NASD's existing trading halt rules. Nasdaq will also consider prohibiting the continued listing of the Notes if Morgan Stanley is not able to meet its obligations on the Notes.

The Notes are a series of medium-term, senior non-convertible debt securities that will be issued by Morgan Stanley. The original public offering price of the Notes will be \$10 per PLUS. The Notes will not pay interest and are not subject to redemption by Morgan Stanley or at the option of any beneficial owner before maturity on March 30, 2006.

At maturity, if the value of the Index has increased, a beneficial owner will be entitled to receive a payment on the Notes based on 200% the amount of that percentage increase, subject to a maximum total payment at maturity that is expected to be between \$11.50 and \$11.70 (the "Maximum Payment at Maturity").⁷ Thus, the Notes provide investors the opportunity to obtain leveraged returns based on the Index subject to a cap that is expected to represent an appreciation of 15% to 17% over the original issue price of the Notes. Unlike ordinary debt securities, the Notes do not guarantee any return of principal at maturity. Therefore, if the value of the Index has declined at maturity, a beneficial owner will receive less, and possibly significantly less, than the original issue price of \$10 per PLUS.

The payment that a beneficial owner will be entitled to receive at maturity depends entirely on the relation of the value of the Index on March 30, 2006 (the "Final Index Value") and the value of the Index on the day the PLUS is offered for initial sale to the public (the "Initial Index Value"). If the Final Index Value is greater than the Initial Index Value, the payment at maturity per PLUS will equal the lesser of (a) \$10 plus the Leveraged Upside Payment⁸ and (b) the Maximum Payment at Maturity. If the Final Index Value is less than or equal to the Initial Index Value, the payment at maturity per PLUS will equal \$10 times the Index Performance Factor.⁹

⁷ The actual Maximum Payment at Maturity will be determined at the time of issuance of the Notes.

⁸ The Leveraged Upside Payment is the product of (i) \$10 and (ii) 200% and (iii) the Index Percent Increase (a fraction, the numerator of which is the Final Index Value minus the Initial Index Value and the denominator of which is the Initial Index Value).

⁹ The Index Performance Factor is a fraction, the numerator of which is the Final Index Value and the denominator of which is the Initial Index Value.

The Notes are cash-settled in U.S. dollars and do not give the holder any right to receive a portfolio security, dividend payments or any other ownership right or interest in the portfolio or index of securities comprising the Index. The Commission has previously approved the listing of options on, and other securities the performance of which have been linked to or based on, the Index.¹⁰

As of the close of business on December 17, 2004, the adjusted market capitalization of the securities included in the Index ranged from a high of \$188.2 billion to a low of \$3.7 billion. As of the same date, the average daily trading volume for these same securities since the beginning of 2004 ranged from a high of 67.1 million shares to a low of 416,600 shares.

Since the Notes will be deemed equity securities for the purpose of NASD Rule 4420(f), the NASD and Nasdaq's existing equity trading rules will apply to the Notes. First, pursuant to NASD Rule 2310 and IM-2310-2, members must have reasonable grounds for believing that a recommendation to a customer regarding the purchase, sale or exchange of any security is suitable for such customer upon the basis of the facts, if any, disclosed by such customer as to his other security holdings and as to his financial situation and needs.¹¹ In addition, as previously described, Nasdaq will distribute a circular to members providing guidance regarding compliance responsibilities and requirements, including suitability recommendations, and highlighting the special risks and characteristics of the

¹⁰ See Securities Exchange Act Release Nos. 48065 (June 19, 2003), 68 FR 38414 (June 27, 2003) (approving the listing and trading of Performance Leveraged Upside Securities based on the Value of the Nasdaq-100 Index); 45429 (February 11, 2002), 67 FR 7438 (February 19, 2002) (approving the listing and trading of Enhanced Return Notes Linked to the Nasdaq-100 Index); 45024 (November 5, 2001), 66 FR 56872 (November 13, 2001) (approving the listing and trading of Enhanced Return Notes Linked to the Nasdaq-100 Index); 44913 (October 9, 2001), 66 FR 52469 (October 15, 2001) (approving the listing and trading of Performance Leveraged Upside Securities based upon the performance of the Nasdaq-100 Index); 43000 (June 30, 2000), 65 FR 42409 (July 10, 2000) (approving the listing and trading of options based upon one-tenth of the value of the Nasdaq-100 Index); 41119 (February 26, 1999), 64 FR 11510 (March 9, 1999) (approving the listing and trading of Portfolio Depositary Receipts based on the Nasdaq-100 Index); and 33428 (January 5, 1994), 59 FR 1576 (January 11, 1994) (approving the listing and trading of options on the Nasdaq-100 Index).

¹¹ NASD Rule 2310(b) requires members to make reasonable efforts to obtain information concerning a customer's financial status, a customer's tax status, the customer's investment objectives, and such other information used or considered to be reasonable by such member or registered representative in making recommendations to the customer.

⁵ Morgan Stanley satisfies this listing criterion.

⁶ NASD Rule 4420(f)(2) requires issuers of securities designated pursuant to this paragraph to be listed on The Nasdaq National Market or the New York Stock Exchange ("NYSE") or be an affiliate of a company listed on The Nasdaq National Market or the NYSE; provided, however, that the provisions of NASD Rule 4450 will be applied to sovereign issuers of "other" securities on a case-by-case basis.

Notes. Furthermore, the Notes will be subject to the equity margin rules. Lastly, the regular equity trading hours of 9:30 a.m. to 4:00 p.m. will apply to transactions in the Notes.

Nasdaq represents that NASD's surveillance procedures are adequate to properly monitor the trading of the Notes. Specifically, NASD will rely on its current surveillance procedures governing equity securities, and will include additional monitoring on key pricing dates.

Pursuant to Rule 10A-3 of the Act and Section 3 of the Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, 116 Stat. 745 (2002), Nasdaq will prohibit the initial or continued listing of any security of an issuer that is not in compliance with the requirements set forth therein.

Morgan Stanley will deliver a prospectus in connection with the initial purchase of the Notes. The procedure for the delivery of a prospectus will be the same as Morgan Stanley's current procedure involving primary offerings.

2. Statutory Basis

Nasdaq believes that the proposed rule change is consistent with the provisions of Section 15A of the Act,¹² in general, and with Section 15A(b)(6) of the Act,¹³ in particular, in that the proposal 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, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

Nasdaq does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act, as amended.

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. 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 e-mail to rule-comments@sec.gov. Please include File Number SR-NASD-2004-188 on the subject line.

Paper Comments

- Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549-0609.

All submissions should refer to File Number SR-NASD-2004-188. This file number should be included on the subject line if e-mail 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 inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at the principal office of the NASD. 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-NASD-2004-188 and should be submitted on or before January 20, 2005.

IV. Commission's Findings and Order Granting Approval of Proposed Rule Change

After careful consideration, the Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder, applicable to a national securities association, and, in particular, with the requirements of Section 15A(b)(6) of the Act.¹⁴ The Commission has previously approved the listing of options on, and securities the performance of which have been

linked to or based on the Index.¹⁵ Accordingly, the Commission finds that listing and trading of the Notes is consistent with the Act and will promote just and equitable principles of trade, foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, in general, to protect investors and the public interest.¹⁶ The requirements of NASD Rule 4420(f) were designed to address the concerns attendant to the trading of hybrid securities like the Notes. NASD Rule 4420(f)(2) provides that only issuers satisfying substantial asset and equity requirements may issue securities such as the Notes. In addition, Nasdaq's continued listing criterion for other securities further require that the Notes have a market value of at least \$4 million.¹⁷ The Commission also notes that the 100 component stocks that comprises the Index are reporting companies under the Act, and the Notes will be registered under Section 12 of the Act. Thus, by imposing the hybrid listing standards, suitability, disclosure, and compliance requirements noted above, the Commission believes the Nasdaq has addressed adequately the potential problems that could arise from the hybrid nature of the Notes.

In approving the product, the Commission recognizes that the Index is a modified capitalization-weighted index¹⁸ of 100 of the largest and most active non-financial domestic and international companies listed on Nasdaq. Given the large trading volume and capitalization of the compositions of the stocks underlying the Index, the Commission believes that the listing and trading of the Notes that are linked to the Index should not unduly impact the market for the underlying securities compromising the Index or raise manipulative concerns.¹⁹ Moreover, the issuers of the underlying securities comprising the Index are subject to reporting requirements under the Act, and all of the component stocks are

¹⁵ *Supra* note 10.

¹⁶ In approving the proposed rule, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

¹⁷ See NASD Rule 4450(c).

¹⁸ See *supra* Note 3.

¹⁹ The issuer Morgan Stanley disclosed in the prospectus that the original issue price of the Notes includes commissions (and the secondary market prices are likely to exclude commissions) and Morgan Stanley's costs of hedging its obligations under the Notes. These costs could increase the initial value of the Notes, thus affecting the payment investors receive at maturity. Such hedging activity must, of course, be conducted in accordance with applicable regulatory requirements.

¹² 15 U.S.C. 78o-3.

¹³ 15 U.S.C. 78o-3(b)(6).

¹⁴ 15 U.S.C. 78o-3(b)(6).

either listed or traded on, or traded through the facilities of, U.S. securities markets.

The Commission also believes that any concerns that a broker-dealer, such as Morgan Stanley or a subsidiary providing a hedge for the issuer, will incur undue position exposure are minimized by the size of the Notes issuance in relation to the net worth of Morgan Stanley.²⁰

Finally, the Commission notes that the value of the Index will be widely disseminated at least once fifteen seconds throughout the trading day. Nasdaq represents that the Nasdaq-100 will be determined, calculated and maintained solely by Nasdaq.

The Commission finds good cause for approving the proposed rule change prior to the 30th day after the date of publication of the notice of filing thereof in the **Federal Register**. Nasdaq has requested accelerated approval because this product is similar to several other instruments currently listed and traded on the Nasdaq.²¹ The Commission believes that the Notes will provide investors with an additional investment choice and that accelerated approval of the proposal will allow investors to begin trading the Notes promptly. Additionally, the Notes will be listed pursuant to Nasdaq's existing hybrid security listing standards as described above. Therefore, the Commission finds good cause, consistent with Section 19(b)(2) of the Act,²² to approve the proposal on an accelerated basis.

Accordingly, the Commission believes there is good cause, consistent with Sections 15A(b)(6) and 19(b)(2) of the Act,²³ to approve the proposal, on an accelerated basis.

²⁰ See Securities Exchange Act Release Nos. 44913 (October 9, 2001), 66 FR 52469 (October 15, 2001) (order approving the listing and trading of notes whose return is based on the performance of the Nasdaq-100 Index) (File No. SR-NASD-2001-73); 44483 (June 27, 2001), 66 FR 35677 (July 6, 2001) (order approving the listing and trading of notes whose return is based on a portfolio of 20 securities selected from the Amex Institutional Index) (File No. SR-Amex-2001-40); and 37744 (September 27, 1996), 61 FR 52480 (October 7, 1996) (order approving the listing and trading of notes whose return is based on a weighted portfolio of healthcare/biotechnology industry securities) (File No. SR-Amex-96-27).

²¹ See Securities Exchange Act Release Nos. 45966 (May 20, 2002), 67 FR 36942 (May 28, 2002) (approval to list and trade notes linked to the performance of the Nasdaq-100); 47911 (May 22, 2003), 68 FR 32558 (May 30, 2003) (approving the listing and trading of notes (Wachovia TEES) linked to the S&P 500); 47983 (June 4, 2003), 68 FR 35032 (June 11, 2003) (approving the listing and trading of a CSFB Accelerated Return Notes linked to S&P 500); and 50019 (July 14, 2004), 69 FR 43635 (July 21, 2004) (approving the listing and trading of Morgan Stanley PLUS Notes).

²² 15 U.S.C. 78f(b)(5) and 78s(b)(2).

²³ 15 U.S.C. 78o3(b)(6) and 78s(b)(2).

V. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,²⁴ that the proposed rule change (SR-NASD-2004-188) is hereby approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.²⁵

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 04-28582 Filed 12-29-04; 8:45 am]

BILLING CODE 8010-01-P

DEPARTMENT OF SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-50929; File No. SR-NYSE-2004-68]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule and Amendment No. 1 Thereto by the New York Stock Exchange, Inc. To Amend Exchange Rules 440B ("Short Sales") and 440C ("Deliveries Against Short Sales")

December 23, 2004.

Pursuant to Section 19(b)(1) ¹ of the Securities Exchange Act of 1934 ("SEA" or the "Exchange Act"),² and Rule 19b-4 thereunder,³ notice is hereby given that on December 1, 2004, the New York Stock Exchange, Inc. ("NYSE" or the "Exchange") filed with the Securities and Exchange Commission (the "Commission" or "SEC") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. On December 23, 2004, NYSE filed Amendment No. 1 to the proposed rule change.⁴ The proposed rule change, as amended, was filed by NYSE as a non-controversial filing, under Rule 19b-4(f)(6) of the Act.⁵ The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

²⁴ 15 U.S.C. 78s(b)(2).

²⁵ 17 CFR 200.30-3(a)(12).

¹ 15 U.S.C. 78s(b)(1).

² 15 U.S.C. 78a *et seq.*

³ 17 CFR 240.19b-4.

⁴ See letter from Mary Yeager, Assistant Corporate Secretary, NYSE, to Nancy Sanow, Assistant Director, Division of Market Regulation, Commission, dated December 23, 2004 ("Amendment No. 1").

⁵ 17 CFR 240.19b-4(f)(6). For purposes of determining the effective date and calculating the sixty-day period within which the Commission may summarily abrogate the proposed rule change under Section 19(b)(3)(C) of the Act, the Commission considers that period to commence on December 22, 2004, the date NYSE filed Amendment No. 1. See 15 U.S.C. 78s(b)(3)(C).

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The New York Stock Exchange, Inc. ("NYSE" or the "Exchange") is filing with the Securities and Exchange Commission ("SEC" or "Commission") proposed amendments to Rule 440B ("Short Sales") and 440C ("Delivery Against Short Sales"), including Supplementary Material to conform Exchange rules to the requirements of recent Commission rule amendments regarding short sales, and adoption of Regulation SHO—Regulation of Short Sales ("Regulation SHO").⁶ The text of the proposed amendments is available from the NYSE and the Commission.⁷ New language is *italicized*; deletions are in brackets.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Changes

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.

(1) Purpose

Background. On June 23, 2004, the SEC adopted new Regulation SHO, under the Exchange Act.⁸ Regulation SHO, which together with other concurrent Commission actions, provide for significant changes to SEC short sale⁹ rules that are referenced in, and apply to members and member organizations through, Exchange Rules 440B ("Short Sales") and 440C

⁶ See Securities Exchange Act Release No. 50103 (July 28, 2004), 69 FR 48008 (August 6, 2004) ("Adopting Release"), available at <http://www.sec.gov/rules/final/34-50103.htm>.

⁷ Both Exhibits A and B are available at <http://www.nyse.com/regulation/> and <http://www.sec.gov/rules/sro.shtml>.

⁸ U.S.C. 78a *et seq.*

⁹ A short sale is the sale of a security that the seller does not own or any sale that is consummated by the delivery of a security borrowed by, or for the account of, the seller. In order to deliver the security to the purchaser, the short seller will borrow the security, typically from a broker-dealer or an institutional investor. The short seller later closes out the position by purchasing equivalent securities on the open market, or by using an equivalent security it already owned, and returning the security to the lender. In general, short selling is used to profit from an expected downward price movement, to provide liquidity in response to unanticipated demand, or to hedge the risk of a long position in the same, or related, security.

("Deliveries Against Short Sales").¹⁰ These SEC amendments rescind Rules 3b-3 ("Definition of Short Sale")¹¹ and 10a-2 ("Requirements for Covering Purchases"),¹² under the Exchange Act, and replace them with new Rules 200 ("Definition of Short Sale and Marking Requirements")¹³ and 203 ("Borrowing and Delivery Requirements"),¹⁴ to Regulation SHO. In addition, the Commission has amended Rule 10a-1¹⁵ ("Short Sales") to conform to Regulation SHO.

New SEA Rule 202T. Regulation SHO includes new Rule 202T,¹⁶ which provides procedures for the SEC to temporarily suspend the application of the tick test and any short sale price test of any exchange or national securities association for designated securities.¹⁷ Concurrently with the adoption of Regulation SHO, the SEC issued a Pilot Order¹⁸ suspending the provisions of the tick test and any self-regulatory organization ("SRO") price test for short sales in: (1) Certain "designated securities" (identified in Appendix A of the Pilot Order); (2) any security included in the Russell 1000 index effected between 4:15 p.m. EST and the open of the consolidated tape on the following day; and (3) any other security effected between the close of the consolidated tape (*i.e.*, 8 p.m. EST) and the open of the tape on the following day. During the Pilot, all other provisions of Rule 10a-1 and Regulation SHO—including the marking, locate and delivery requirements—remain in effect.

The Exchange proposes to amend Rule 440B by adding new paragraph (c),

which suspends the requirements of the price test for the period that the Pilot remains in effect.

New SEA Rule 200. Rule 200¹⁹ to Regulation SHO replaces Rule 3b-3,²⁰ which had defined ownership of securities for purposes of short sales. Rule 200 incorporates the substance of Rule 3b-3, with some modifications, and provides guidance to broker-dealers to calculate net positions within defined aggregation units rather than on a firm-wide basis. Rule 200 also requires broker-dealers to mark sales in all equity securities "long," "short," or "short exempt." In this regard, an order can be marked "long" only when the seller owns the security being sold and the security is in the physical possession or control of the broker-dealer, or it is reasonably expected that the security will be in the physical possession or control of the broker-dealer prior to settlement. An order can be marked "short exempt" if the seller is entitled to rely on any exception from the tick test, under Rule 10a-1, or any SRO rule (*e.g.*, Rule 440B). As a general matter, orders marked "short exempt" still need to comply with the locate requirement. Short sales of securities in the Pilot should be marked "short exempt."

The Exchange is proposing to amend the Supplementary Material to Exchange Rule 440B to incorporate the marking requirements and ownership aspects of Regulation SHO, Rule 200, to paragraphs 440B.13 ("Marking of Orders"), 440B.14 ("Ownership of Securities") and 440B.20 ("Short Exempt Sell Orders").

New SEA Rule 203. Rule 203²¹ provides various safeguards against "naked" short selling by consolidating and expanding stock "locate requirements," and imposing new delivery requirements for securities in which a substantial number of fails have occurred ("threshold securities"²²). In this regard, Rule 203 requires broker-dealers, prior to effecting short sales in all equity securities, to locate securities available for borrowing. Specifically, Rule 203(b)²³ prohibits a broker-dealer

from accepting a short sale in any equity security from another person, or effecting a short sale for the broker-dealer's own account, unless the broker-dealer has: (1) Borrowed the security, or entered into an arrangement to borrow the security; or (2) has "reasonable grounds" to believe that the security can be borrowed so that it can be delivered on the delivery date; and (3) has documented compliance with the rule.

The Commission has set forth two ways to show a broker-dealer has "reasonable grounds" to believe the security can be borrowed: (1) Reliance on an "easy to borrow" list, provided the information used to generate the list is less than 24 hours old, and securities on the list are so readily available that fails to deliver are unlikely (reliance on the fact that a security is not on a "hard to borrow" list is not sufficient);²⁴ and (2) reliance on a customer's assurance that a "locate" was received from another source (*e.g.*, a prime broker), provided the broker-dealer documents the customer's source, and prior assurances from such customer resulted in timely deliveries in settlement of the customer's transactions.

The SEC also identified a number of exceptions to this locate requirement, including exceptions for transactions in security futures, and for broker-dealers that have accepted a short sale order from another registered broker-dealer required to comply with Rule 203(b), unless the broker-dealer contractually undertook responsibility for compliance. Rule 203(a)²⁵ replaces current Rule 10a-2²⁶ and incorporates its substantive requirements and extends them to all equity securities, as opposed to only exchange-listed securities. With certain exceptions, Rule 203(a) prohibits a broker-dealer from failing to deliver, or lending securities to prevent a fail to deliver, on a sale that it knows, or has reasonable grounds to believe, is marked "long."

To conform with Regulation SHO, the Exchange is proposing to change the title of Rule 440C to "Short Sale Borrowing and Delivery Requirements," delete paragraph .10 ("Failure to Deliver"), and incorporate by reference Rule 10a-1 and Regulation SHO, as if they were fully set forth therein. The

¹⁰ The "tick test" of Rule 440B, which limits short sales only to an advancing market, and delivery requirements of Rule 440C, which requires short sellers to "locate" the stock to deliver prior to making a trade, are designed to prevent abusive short selling activities, including "short squeezes" and "naked" short selling. Regulation SHO also seeks to reduce the number of "fails to deliver" in the Continuous Net Settlement ("CNS") system.

¹¹ 17 CFR 240.3b-3.

¹² 17 CFR 240.10a-2.

¹³ 17 CFR 242.200.

¹⁴ 17 CFR 242.203.

¹⁵ 17 CFR 240.10a-1.

¹⁶ 17 CFR 242.202T.

¹⁷ The SEC deferred consideration of their proposal to replace the current "tick test" with a new uniform bid test restricting short sales to a price above the consolidated best bid, and also deferred consideration of the proposed exceptions to the uniform bid test. The SEC will reconsider any further action on these proposals after the completion of the Pilot.

¹⁸ See Securities Exchange Act Release No. 50104 (July 28, 2004), 69 FR 48032 (August 6, 2004) ("Pilot Order"), available at <http://www.sec.gov/rules/other/34-50104.htm>. See also Securities Exchange Act Release No. 50747 (November 29, 2004)(Order Delaying Pilot Period for Suspension of the Operation of the Operation of Short Sale Price Provisions) ("Second Pilot Order"), available at <http://www.sec.gov/rules/other/34-50747.htm>.

¹⁹ 17 CFR 242.200.

²⁰ 17 CFR 240.3b-3.

²¹ 17 CFR 242.203.

²² Regulation SHO defines "threshold securities" as equity securities of reporting issuers, where: for five consecutive days the security has aggregate fails to deliver at a registered clearing agency of 10,000 shares or more; this figure is equal to at least 0.5% of the issue's total shares outstanding; and a list of such threshold securities is calculated and disseminated daily by the SRO on which the security is listed or for which the SRO bears primary surveillance responsibility. The SEC has estimated that approximately 4% of all equity securities would meet this threshold.

²³ 17 CFR 242.203(b).

²⁴ In the Adopting Release, the SEC noted that "threshold securities" generally should not be included on "easy to borrow" lists. While the Commission has stated that easy to borrow lists could satisfy the "reasonable grounds" determination in Rule 203, it has also clearly stated that reliance on the fact that a security is not on a "hard to borrow" list cannot satisfy the "reasonable grounds" test.

²⁵ 17 CFR 242.203(a).

²⁶ 17 CFR 240.10a-2.

Exchange expects additional interpretations to be added to the rule at a later date, after experience with the operation of Regulation SHO.

New SEA Rule 203(b). Rule 203(b) of Regulation SHO requires clearing brokers to close-out any fail to deliver position in a threshold security that has remained open for 13 consecutive settlement days, by purchasing securities of like kind and quantity. A list of threshold securities will be disseminated daily by the Exchange prior to the opening bell.²⁷ In addition, certain restrictions are triggered if the clearing broker does not take action to close-out the open fail to deliver position.

The Exchange is proposing to amend paragraph .17 ("Covering Transactions") to Rule 440B to delete aspects of the rule that do not conform with Regulation SHO, and to reference Rule 203(b)(3) to determine how to handle covering transactions.

Proposed Amendments to Exchange Rules. Currently, Exchange Rule 440B includes the complete text of Rule 10a-1, under the Exchange Act, and Rules 440B and 440C set forth many sections of repealed Rules 3b-3 and 10a-2, under the Exchange Act, respectively. The proposed amendments to Rules 440B and 440C, including Supplementary Material, conform to the changes in Rule 10a-1 and recently adopted Regulation SHO, under the Exchange Act. The changes remove the text of SEA Rule 10a-1 from Exchange Rule 440B, and instead incorporate both SEA Rule 10a-1 and Regulation SHO by reference, as though they were fully set forth therein.

The amendments to Exchange Rule 440B conform to Regulation SHO and also include a revised Explanatory Note, which generally describes the recent changes to short sale regulation and implementation dates. The Exchange proposes to amend the Supplementary Material to Rule 440B to delete references to repealed rules and incorporate amendments to conform to and reference amended Rule 10a-1 and Regulation SHO. In addition, the Exchange proposes to amend .10 ("General Rule"), .12 ("Place of Transaction") and .15 ("Price At Which Short Sales May Be Made") to make clear, consistent with the Adopting Release of Regulation SHO, that the Exchange short sale regulations apply to all trades in listed securities: (a) whenever they occur, including the

after-hours market, and (b) which have been agreed to in the US, regardless of where the transaction is executed or "booked."

(2) Statutory Basis

The statutory basis for the proposed rule change is Sections 6(b)(5) and 17A of the Exchange Act²⁸ which require, among other things, that the rules of the Exchange are designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to perfect the mechanism of a free and open market and national market system, and in general to protect investors and the public interest; and the prompt and accurate clearance and settlement of securities transactions.

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 Exchange Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

The Exchange has neither solicited nor received written comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The proposed rule change is filed pursuant to paragraph (A) of Section 19(b)(3)²⁹ and Rule 19b-4(f)(6).³⁰ Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A) of the Exchange Act and Rule 19b-4(f)(6) thereunder.

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate 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 Exchange Act.³¹

The Exchange requests the Commission waive the five-day notification period and the 30-day pre-operative delay specified in Rule 19b-4(f)(6)(iii).³² Waiver of these periods will allow the Exchange to have the proposed rule change in place at the same time as the Commission's compliance date for Regulation SHO. The Exchange expects to make the proposed rule change operative on January 3, 2005.

The Commission believes that waiving both the 5-day notification period and the 30-day pre-operative delay requirements is consistent with the protection of investors and the public interest. The Commission believes that waiving these requirements does not raise any new regulatory issues, significantly affect the protection of investors or the public interest, or impose any significant burden on competition. Additionally, The Commission notes that the operative date of this proposed rule change, January 3, 2004, is the same date as the compliance date of Regulation SHO.

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 Exchange Act.

Electronic Comments

- Use the Commission's Internet comment form (<http://www.sec.gov/rules/sro.shtml>); or
- Send e-mail to rule-comments@sec.gov. Please include File Number SR-NYSE-2004-68 on the subject line.

Paper Comments

- Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549-0609.

All submissions should refer to File Number SR-NYSE-2004-68. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your

²⁷ As the exact means of conveying the list of threshold securities has not yet been determined, members and member organizations will be informed by a later Information Memo of the exact time, location and form of dissemination of the list prior to the launch of the Pilot.

²⁸ 15 U.S.C. 78f(b)(5) and 15 U.S.C. 78q-1, respectively.

²⁹ 15 U.S.C. 78s(b)(3)(A).

³⁰ 17 CFR 240.19b-4(f)(6).

³¹ For purposes of determining the effective date and calculating the sixty-day period within which the Commission may summarily abrogate the proposed rule change under Section 19(b)(3)(C) of the Exchange Act, the Commission considers that period to commence on December 23, 2004, the date NYSE filed Amendment No. 1. See 15 U.S.C. 78s(b)(3)(C).

³² 17 CFR 240.19b-4(f)(6)(iii).

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 inspection and copying in the Commission's Public Reference Room. Copies of such filing also will be available for inspection and copying at the principal office of the NYSE. 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-NYSE-2004-68 and should be submitted on or before January 20, 2005.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.³³

Margaret H. McFarland,
Deputy Secretary.

[FR Doc. E4-3899 Filed 12-29-04; 8:45 am]

BILLING CODE 8010-01-P

SOCIAL SECURITY ADMINISTRATION

Agency Information Collection Activities: Proposed Request and Comment Request

The Social Security Administration (SSA) publishes a list of information collection packages that will require clearance by the Office of Management and Budget (OMB) in compliance with Public Law 104-13 effective October 1, 1995, The Paperwork Reduction Act of 1995. The information collection packages that may be included in this notice are for new information collections and revisions to OMB-approved information collections.

SSA is soliciting comments on the accuracy of the agency's burden estimate; the need for the information; its practical utility; ways to enhance its quality, utility and clarity; and on ways to minimize burden on respondents, including the use of automated collection techniques or other forms of information technology. Written

comments and recommendations regarding the information collection(s) should be submitted to the OMB Desk Officer and the SSA Reports Clearance Officer (contact information is listed below).

(OMB) Office of Management and Budget, Attn: Desk Officer for SSA, Fax: 202-395-6974.

(SSA) Social Security Administration, DCFAM, Attn: Reports Clearance Officer, 1338 Annex Bldg., 6401 Security Blvd., Baltimore, MD 21235, Fax: 410-965-6400.

I. The information collection listed below has been submitted to OMB for clearance. Your comments on the information collection would be most useful if received by OMB and SSA within 60 days from the date of this publication. You can obtain a copy of the OMB clearance package by calling the SSA Reports Clearance Officer at 410-965-0454, or by writing to the address listed above.

1. Homeless Outreach Project and Evaluation (HOPE)

Background

Congress passed the McKinney Act of 1987 in recognition of and in an effort to address situations and conditions facing people without permanent shelter. The Act funded 15 emergency services and nine individual titles to authorize the provision of specific programs by Federal agencies. The Act also established the Interagency Council on Homelessness (ICH) composed of leaders from 15 Federal agencies who are in charge of coordinating efforts to assist people who are homeless. During the past decade, SSA and other ICH agencies have compiled important data about people who are homeless and have carried out evaluations of services which have generated evidence about "best" or "promising practices" well suited to combating homelessness.

In fiscal year 2003, President George W. Bush announced an initiative to end chronic homelessness in 10 years. As a result, SSA developed Project HOPE and in May 2004 awarded 34 Cooperative Agreements to organizations which provide outreach, support services and benefit application assistance to the chronically homeless and other underserved populations. An additional 7 cooperative agreements were awarded in November 2004 for a total of 41. The goal of Project HOPE is to improve both the quantity and quality of applications for disability benefits. Project HOPE gives focused support to Cooperative (co-op) awardees via a training program and ongoing technical assistance.

Evaluation of Project HOPE

SSA is undertaking the project HOPE evaluation to determine the effectiveness and the efficiency of the program. To obtain the information needed for the evaluation, SSA is developing an interactive Web site that will be used by co-op awardees to input client and program data, and by SSA to communicate project-wide announcements to the awardees. The respondents are HOPE grantees/non-profit social services organizations serving people who are homeless & disabled.

Type of Request: New information collection.

Number of Respondents: 41.

Frequency of Response: 12.

Average Burden Per Response: 65 minutes.

Estimated Annual Burden: 533 hours.

II. The information collection listed below has been submitted to OMB for clearance. Your comments on the information collection would be most useful if received by OMB and SSA within 30 days from the date of this publication. You can obtain a copy of the OMB clearance package by calling the SSA Reports Clearance Officer at 410-965-0454, or by writing to the address listed above.

1. Social Security Disability Report—20 CFR 404.1512 & 416.912—0960-0579

SSA requires applicants for disability payments to furnish medical, work history, and other evidence or information indicating they have an impairment which is disabling. The information is used by State DDSs to make disability determinations for SSA. The respondents are applicants for Title II and Title XVI disability benefits. These applicants may provide the information using any of the following modalities: (1) The traditional paper form SSA-3368; (2) an interview with an SSA field office representative, using the Electronic Disability Collection System (EDCS); (3) the Internet (i3368); and (4) a new modality, the i3368-PRO, an Internet form designed to be completed by representatives of applicants for disability payments. The latter three versions of the form collect the same information as the paper form, but may be formatted differently and include certain enhancements (ex: self-help screens) to guide the claimant or interviewer through the application process.

Type of Request: Revision of an OMB-approved information collection.

Note: In the 60-day **Federal Register** notice, published on November 1, 2004 at 69 FR 63429, the number of respondents for the

³³ 17 CFR 200.30-3(a)(12).

paper version was given as 10,000 and the number of respondents using the EDCS modality was listed as 1,956,667. Since

publishing the Notice, the Agency has realized those numbers should actually be

reversed, and they are published correctly in the chart below.

Collection format	Number of respondents	Frequency of response	Average burden per response (hours)	Estimated annual burden (hours)
SSA-3368 (Paper version)	10,000	1	1	10,000
Field office/Electronic Disability Collection System (EDCS)	1,956,667	1	1	1,956,667
i3368 (Internet version; Hour burden varies from 1½–3 hours, depending on information required)	66,000	1	2½	165,000
i3368-PRO	84,000	1	1½	126,000
Totals	2,116,667	.....	.....	2,257,667

Dated: December 22, 2004.

Elizabeth A. Davidson,

Reports Clearance Officer, Social Security Administration.

[FR Doc. 04-28562 Filed 12-29-04; 8:45 am]

BILLING CODE 4191-02-P

DEPARTMENT OF STATE

[Public Notice 4945]

Deployment of the Biometric Visa Program for the Collection of Biometric Identifiers of Nonimmigrant and Immigrant Visa Applicants

This public notice announces the Biometric Visa Program, which has been operating in a pilot mode since September 22, 2003, which became a permanent program effective October 26, 2004.

Section 303 of the "Enhanced Border Security and Visa Entry Reform Act" (The Border Security Act) (Pub. L. 107-173, 116 Stat. 543), requires that "not later than October 26, 2004, the Attorney General [now the Secretary of Homeland Security] and the Secretary of State shall issue to aliens only machine-readable, tamper-resistant visas and travel and entry documents that use biometric identifiers." In order to fulfill the requirement for biometric identifiers, we established the Biometric Visa Program, by which immigrant and nonimmigrant visa applicants enroll fingerscans of their two index fingers and submit photographs with visa applications.

In establishing the Biometric Visa Program, we coordinated closely with the Department of Homeland Security (DHS). The Biometric Visa Program is a partner program to the DHS US-VISIT Program that is in effect at U.S. ports of entry and that uses the same biometric identifiers, two index fingerscans and a photograph. By coordinating these two programs, the two departments have ensured the integrity of the U.S. visa. This is accomplished by sending the fingerscans and photos of visa

applicants to DHS databases. When a person to whom a visa has been issued arrives at a port of entry, his or her photo is retrieved from a database and projected on the computer screen of the Customs and Border Protection officer. The person's fingerscans are compared to the fingerscans in the database to ensure that the person presenting the visa is the same as the person to whom the visa was issued.

Certain exemptions to the fingerscans under the Biometric Visa Program were also coordinated with the Department of Homeland Security to coincide with the exemptions to fingerscans under the US-VISIT Program. Under the Biometric Visa Program, applicants for diplomatic or official visas, for visas to represent their governments at recognized international organizations such as the United Nations or for visas to serve as employees of such organizations, for NATO visas, or for government officials on official transit through the U.S. are exempt from the fingerscans. The aforementioned are represented by visa categories: A-1, A-2, G-1, G-2, G-3, G-4, NATO-1, NATO-2, NATO-3, NATO-4, NATO-5, NATO-6 and C-3 (except for attendants, servants, or personal employees of accredited officials). In addition, persons under age 14 and persons age 80 or above are exempt from the fingerscans, unless the person is applying for a nonimmigrant visa at a consular post in Mexico. In Mexico, we have been requiring fingerscans for applicants age 7 and above under the program for issuance of biometric Border Crossing Cards (commonly known as "laser visas"), which began in 1998. We will continue to require fingerscans for any nonimmigrant visa applicant age 7 and above at our posts in Mexico. These age exemptions are being put into effect for operational efficiencies; however, the Secretary of State retains the authority to require fingerscans of children under age 14 or adults age 80 or above. All visa applicants are required to submit a photograph with the visa application,

except at consular posts in Mexico where most nonimmigrant visa applicants have a live-capture photo taken at post.

By checking fingerscans against a biometric watchlist, the Biometric Visa Program enables consular officers to deny visas to persons on the watchlist who are ineligible for visas. For the great majority of travelers, the Biometric Visa Program performs a travel facilitation function by allowing for biometric identity verification at ports of entry, which serves to facilitate admission to the United States.

Dated: December 17, 2004.

Maura Harty,

Assistant Secretary for Consular Affairs, Department of State.

[FR Doc. 04-28566 Filed 12-29-04; 8:45 am]

BILLING CODE 4710-06-P

DEPARTMENT OF STATE

[Public Notice 4927]

Notice of Meeting; United States International Telecommunication Advisory Committee Meeting on Preparations for the ITU Telecommunication Standardization Study Group 2 Meeting and Preparations for the CITEL Permanent Consultative Committee II Meeting in Guatemala

The Department of State announces the following meetings of the International Telecommunication Advisory Committee (ITAC) to prepare for the ITU-T Study Group 2 (Service Definitions, Numbering, Routing, and Global Mobility) meeting. This Study Group 2 meeting will be held February 16-24, 2005, in Geneva, Switzerland. In addition, five preparatory meetings of the ITAC will be held to prepare for the OAS Inter-American Telecommunication Commission (CITEL) Permanent Consultative Committee II meeting in Guatemala from April 26-19, 2005.

The ITAC will meet as follows with an agenda for preparations for the ITU-T Study Group 2 meeting on January 14 and February 2, 2005 from 9:30–12 p.m.; these meetings will be held in the Washington, DC area. People desiring to attend may find the actual location and the call-in numbers for a teleconference bridge by e-mailing the secretariat at minardje@state.gov.

The ITAC will meet as follows with an agenda for preparations for the CITEI Permanent Consultative Committee II meeting in Guatemala. These meetings will be held from 10 a.m. to 12 p.m. on January 25, February 22, March 8, March 22 and April 5, 2005 at a location to be determined in the Washington, DC area. For information on the location of these meetings, please contact Cecily Holiday at holidaycc@state.gov or Anne Jillson at jillsonad@state.gov.

Dated: December 22, 2004.

Anne Jillson,

Foreign Affairs Officer, International Communications and Information Policy, Department of State.

[FR Doc. 04–28564 Filed 12–29–04; 8:45 am]

BILLING CODE 4710–07–P

DEPARTMENT OF STATE

[Public Notice 4944]

Notice of Receipt of Application for Presidential Permit To Expand the Mariposa Port of Entry at Nogales, Arizona

Notice is hereby given that the Department of State has received an application for a permit authorizing the construction, operation and maintenance of two additional commercial cargo lanes at the Mariposa Port of Entry at Nogales, Arizona. The application has been filed by the Border Trade Association Foundation of Phoenix, Arizona. The expansion project to be carried out in conjunction with the Department of Homeland Security and the Arizona Department of Transportation will enable reconfiguration of the Mariposa Port of Entry and the construction of two Free and Secure Trade (FAST) lanes. FAST lanes are dedicated commercial traffic lanes capable of rapidly screening and clearing trucks operated by certified low-risk shippers.

The Department's jurisdiction with respect to this application is based upon Executive Order 11423, dated August 16, 1968, as amended.

As required by E.O. 11423, the Department is circulating this application to concerned agencies for comment.

Interested persons may submit their views regarding this application in writing by January 30, 2005 to Mr. John A. Ritchie, Coordinator, U.S.-Mexico Border Affairs, Room 4258, Department of State, 2201 C St. NW., Washington, DC 20520.

The application and related documents made part of the record to be considered by the Department of State in connection with this application are available for review in the Office of Mexican Affairs during normal business hours throughout the comment period.

Any questions related to this notice may be addressed to Mr. Ritchie at the above address or by fax at (202) 647–5752.

Dated: July 15, 2003.

John A. Ritchie,

Coordinator US-Mexico Border Affairs.

Roberta S. Jacobson,

Director, Office of Mexican Affairs, Department of State.

Editorial Note: This document was received in the Office of the Federal Register on December 23, 2004.

[FR Doc. 04–28565 Filed 12–29–04; 8:45 am]

BILLING CODE 4710–29–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Petitions Under Section 302 on the Valuation of Chinese Currency; Decisions Not to Initiate Investigations

AGENCY: Office of the United States Trade Representative.

ACTION: Decisions not to initiate investigations.

SUMMARY: The United States Trade Representative (USTR) has determined not to initiate investigations under section 302 of the Trade Act of 1974 with respect to petitions addressed to the valuation of Chinese currency because initiation of investigations would not be effective in addressing the issues raised in the petitions.

EFFECTIVE DATES: With respect to the petition filed by the China Currency Coalition: September 9, 2004. With respect to the petition filed by the Congressional China Currency Action Coalition: November 12, 2004.

FOR FURTHER INFORMATION CONTACT: Terrence McCartin, Senior Director of Monitoring and Enforcement for China, (202) 395–3900; or William Busis, Associate General Counsel, (202) 395–3150.

SUPPLEMENTARY INFORMATION: On September 9, 2004, the China Currency Coalition filed a petition pursuant to

section 302(a)(1) of the Trade Act of 1974, as amended (the Trade Act), alleging that certain acts, policies and practices of the Government of China with respect to the valuation of Chinese currency deny and violate international legal rights of the United States, are unjustifiable, and burden or restrict U.S. commerce. In particular, the petition alleged that China's acts, policies and practices that maintain a fixed exchange rate vis a vis the U.S. dollar have resulted in a significant undervaluation of Chinese currency. The petition alleged that these acts, policies and practices: amount to a prohibited export subsidy under the Agreement on Subsidies and Countervailing Measures and articles VI and XVI of the General Agreement on Tariffs and Trade 1994 (GATT 1994); amount—under article XV of the GATT 1994—to exchange action that frustrates the intent of articles I, II, III, and XI of the GATT 1994; and amount to subsidies that are inconsistent with China's obligations under articles 3, 9, and 10 of the Agreement on Agriculture. The petition also alleged that these acts, policies and practices of China violate international legal rights of the United States under articles IV and VIII of the Articles of Agreement of the International Monetary Fund, and that they burden or restrict U.S. commerce by, among other things, suppressing U.S. manufacturing for domestic consumption and the growth in U.S. exports.

Upon receipt of the petition, the USTR determined not to initiate an investigation under section 302 of the Trade Act because an investigation would not be effective in addressing the acts, policies, and practices covered in the petition. The Administration is currently involved in efforts to address with the Government of China the currency valuation issues raised in the petition. The USTR believes that initiation of an investigation under section 302 would hamper, rather than advance, Administration efforts to address Chinese currency valuation policies.

Subsequent to the USTR's decision not to initiate an investigation in response to the petition filed by the China Currency Coalition, a different petitioner—the Congressional China Currency Action Coalition—filed a petition on September 30, 2004 with respect to Chinese currency valuation. As compared to the earlier petition, the second petition addressed the same acts, policies and practices of China, and contained substantially the same allegations that those acts, policies, and practices deny and violate international legal rights of the United States, are

unjustifiable, and burden or restrict U.S. commerce. The USTR's determination with respect to the second petition was the same as his determination with respect to the earlier petition: namely, the USTR decided not to initiate an investigation in response to the second petition because an investigation would not be effective in addressing the acts, policies, and practices covered in the petition.

William Busis,

Chairman, Section 301 Committee.

[FR Doc. 04-28625 Filed 12-29-04; 8:45 am]

BILLING CODE 3190-W5-P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

WTO Dispute Settlement Proceeding Regarding Countervailing Duty Measures Concerning Certain Products from the European Communities

AGENCY: Office of the United States Trade Representative.

ACTION: Notice; request for comments.

SUMMARY: The Office of the United States Trade Representative ("USTR") is providing notice that the European Communities ("EC") has requested the establishment of a dispute settlement panel under the *Marrakesh Agreement Establishing the World Trade Organization* ("WTO Agreement"). That request may be found at <http://www.wto.org> contained in a document designated as WT/DS212/15. As a result of that request, a dispute settlement panel has been established to examine certain sunset review determinations by the United States Department of Commerce ("Commerce"). USTR invites written comments from the public concerning the issues raised in this dispute.

DATES: Although USTR will accept any comments received during the course of the dispute settlement proceedings, comments should be submitted on or before January 31, 2005, to be assured of timely consideration by USTR.

ADDRESSES: Comments should be submitted (i) electronically, to FR0504@ustr.eop.gov, Attn: "Change in Ownership Methodology Dispute" in the subject line, or (ii) by fax, to Sandy McKinzy at 202-395-3640, with a confirmation copy sent electronically to the e-mail address above.

FOR FURTHER INFORMATION CONTACT: Elizabeth V. Baltzan, Associate General Counsel, Office of the United States Trade Representative, 600 17th Street,

NW., Washington, DC 20508, (202) 395-3582.

SUPPLEMENTARY INFORMATION: Section 127(b) of the Uruguay Round Agreements Act ("URAA") (19 U.S.C. 3537(b)(1)) requires that notice and opportunity for comment be provided after the United States submits or receives a request for the establishment of a WTO dispute settlement panel. The dispute settlement panel, which will hold its meetings in Geneva, Switzerland, is expected to issue a report on its findings and recommendations by May, 2005.

Major Issues Raised by the EC

On January 8, 2003, the WTO Dispute Settlement Body ("DSB") adopted the Appellate Body report and the panel report, as modified by the Appellate Body, in the case WT/DS212 (*United States—Countervailing Measures concerning Certain Products from the European Communities*). These reports involved the "change-in-ownership" methodology applied by Commerce in proceedings under the U.S. countervailing duty law. The DSB recommended that the United States bring its administrative practice and the twelve individual determinations found to be inconsistent with the *Agreement on Subsidies and Countervailing Measures* ("SCM Agreement") into conformity with its WTO obligations.

On January 27, 2003, the United States informed the DSB that it intended to implement the recommendations and rulings of the DSB in a manner consistent with its WTO obligations. After publishing a modification of its change-in-ownership methodology, Commerce applied that new methodology to the twelve individual determinations that had been found by the DSB to be inconsistent with U.S. WTO obligations. Commerce issued final revised determinations November 7, 2003. Also on November 7, 2003, the United States informed the DSB that it had fully complied with the DSB's recommendations and rulings.

On March 17, 2004, the EC initiated proceedings under Article 21.5 of the DSU by requesting consultations with the United States. In its consultation request, the EC alleged that the United States had not fully complied with the DSB's recommendations and rulings. Because consultations did not resolve the matter, the EC requested the establishment of a panel pursuant to Articles 6 and 21.5 of the DSU, Article 30 of the SCM Agreement, and Article XXIII of the *General Agreement on Tariffs and Trade 1994* ("GATT 1994"). The DSB established the panel and

referred the matter to the original panelists.

In its panel request, the EC identifies the following measures and claims:

- With respect to the revised determination in the sunset review on *Certain Corrosion-Resistant Carbon Steel Flat Products from France* (C-427-810), the EC claims that Commerce failed to properly examine the existence, continuation or likelihood of recurrence of subsidization. In particular, with regard to the privatization concerned, the EC alleges that Commerce improperly analysed the consequences of the price charged to employees and retirees for shares in the privatized company. The EC claims that this is inconsistent with Articles 10, 14, 19.4, 21.1 and 21.3 of the SCM Agreement and Article VI: 3 of GATT 1994.

- With respect to the revised determinations in the sunset reviews on *Cut-to-Length Carbon Steel Plate from United Kingdom* (C-412-815), and *Cut-to-Length Carbon Steel Plate from Spain* (C-469-804) (Case No. 11), the EC claims that Commerce failed to properly determine whether there was continuation or recurrence of subsidization and injury, because Commerce did not examine the nature of the privatizations in question and their impact on the continuation of the alleged subsidization. According to the EC, this is inconsistent with Articles 10, 14, 19.4, 21.1 and 21.3 of the SCM Agreement and Article VI:3 of GATT 1994.

Public Comment: Requirements for Submissions.

Interested persons are invited to submit written comments concerning the issues raised in this dispute. Persons submitting comments may either send one copy by fax to Sandy McKinzy at (202) 395-3640, or transmit a copy electronically to FR0504@ustr.eop.gov, with "Change in Ownership Methodology Dispute (DS212)" in the subject line. For documents sent by fax, USTR requests that the submitter provide a confirmation copy to the electronic mail address listed above.

USTR encourages the submission of documents in Adobe PDF format, as attachments to an electronic mail. Interested persons who make submissions by electronic mail should not provide separate cover letters; information that might appear in a cover letter should be included in the submission itself. Similarly, to the extent possible, any attachments to the submission should be included in the same file as the submission itself, and not as separate files.

A person requesting that information contained in a comment submitted by that person be treated as confidential business information must certify that such information is business confidential and would not customarily be released to the public by the submitter. Confidential business information must be clearly designated as such and the submission must be marked "BUSINESS CONFIDENTIAL" at the top and bottom of the cover page and each succeeding page of the submission.

Information or advice contained in a comment submitted, other than business confidential information, may be determined by USTR to be confidential in accordance with section 135(g)(2) of the Trade Act of 1974 (19 U.S.C. 2155(g)(2)). If the submitting person believes that information or advice may qualify as such, the submitting person—

(1) Must clearly so designate the information or advice;

(2) Must clearly mark the material as "SUBMITTED IN CONFIDENCE" at the top and bottom of each page of the cover page and each succeeding page; and

(3) Is encouraged to provide a non-confidential summary of the information or advice.

Pursuant to section 127(e) of the URAA (19 U.S.C. 3537(e)), USTR will maintain a file on this dispute settlement proceeding, accessible to the public, in the USTR Reading Room, which is located at 1724 F Street, NW., Washington, DC 20508. The public file will include non-confidential comments received by USTR from the public with respect to the dispute; if a dispute settlement panel is convened, the U.S. submissions to that panel, the submissions, or non-confidential summaries of submissions, to the panel received from other participants in the dispute, as well as the report of the panel; and, if applicable, the report of the Appellate Body. An appointment to review the public file (Docket No. WT/DS-212, Change in Ownership Methodology Dispute) may be made by calling the USTR Reading Room at (202) 395-6186. The USTR Reading Room is open to the public from 9:30 a.m. to noon and 1 p.m. to 4 p.m., Monday through Friday.

Daniel E. Brinza,

Assistant United States Trade Representative for Monitoring and Enforcement.

[FR Doc. 04-28626 Filed 12-29-04; 8:45 am]

BILLING CODE 3190-W5-P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

[Docket No. WTO/DS324]

WTO Dispute Settlement Proceeding Regarding United States—Provisional Antidumping Measures on Shrimp From Thailand

AGENCY: Office of the United States Trade Representative.

ACTION: Notice; request for comments.

SUMMARY: The Office of the United States Trade Representative ("USTR") is providing notice that on December 9, 2004, Thailand requested consultations with the United States under the Marrakesh Agreement Establishing the World Trade Organization ("WTO Agreement") concerning the imposition of provisional antidumping measures on shrimp from Thailand. That request may be found at <http://www.wto.org> contained in a document designated as WT/DS324/1. USTR invites written comments from the public concerning the issues raised in this dispute.

DATES: Although USTR will accept any comments received during the course of the dispute settlement proceedings, comments should be submitted on or before January 15, 2005 to be assured of timely consideration by USTR.

ADDRESSES: Comments should be submitted (i) electronically, to FR0501@ustr.eop.gov, Attn: "Thailand Shrimp Provisional AD Dispute (DS324)" in the subject line, or (ii) by fax, to Sandy McKinzy at (202) 395-3640. For documents sent by fax, USTR requests that the submitter provide a confirmation copy to the electronic mail address listed above.

FOR FURTHER INFORMATION CONTACT: Jeff Weiss, Assistant General Counsel, Office of the United States Trade Representative, 600 17th Street, NW., Washington, DC 20508, (202) 395-4498.

SUPPLEMENTARY INFORMATION: Section 127(b) of the Uruguay Round Agreements Act ("URAA") (19 U.S.C. 3537(b)(1)) requires that notice and opportunity for comment be provided after the United States submits or receives a request for the establishment of a WTO dispute settlement panel. Consistent with this obligation, but in an effort to provide additional opportunity for comment, USTR is providing notice that consultations have been requested pursuant to the WTO *Understanding on Rules and Procedures Governing the Settlement of Disputes* ("DSU"). If such consultations should fail to resolve the matter and a dispute settlement panel is established pursuant to the DSU, such panel, which would

hold its meetings in Geneva, Switzerland, would be expected to issue a report on its findings and recommendations within six to nine months after it is established.

Major Issues Raised by Thailand

On August 4, 2004, the Department of Commerce published in the **Federal Register** notice of its affirmative preliminary less-than-fair-value ("LTFV") determination in an investigation concerning certain frozen and canned warm water shrimp from Thailand (69 Fed. Reg. 47,100). That notice contains the estimated margins of LTFV sales, as provided in section 733 of the Tariff Act of 1930, as amended.

In its request for consultations, Thailand alleges that the United States "through its use of 'zeroing' * * * failed to make a fair comparison between the export price and the normal value and calculated distorted margins of dumping," and therefore violated Articles 2.4 and 2.4.2 of the AD Agreement; that its use of "adverse facts available" to determine normal values for one Thai exporter was inconsistent with Articles 6.8 and 6.13 and paragraphs 3, 5, 6, and 7 of Annex II of the AD Agreement; and that the U.S. "failure to make due allowances * * * for differences that affected price comparability between export prices and normal values for the Thai exporters, including differences relating to levels of trade and duty drawback payments" also was inconsistent with Article 2.4 of the AD Agreement.

Further, Thailand's consultation request states that, as a result of "the foregoing methodologies, calculations, comparisons, and determinations," the United States has acted inconsistently with Articles 1 and 7.1 of the AD Agreement and Article VI of the GATT 1994.

Public Comment: Requirements for Submissions

Interested persons are invited to submit written comments concerning the issues raised in this dispute. Persons may submit their comments either (i) electronically, to FR0501@ustr.eop.gov, Attn: "Thailand Shrimp Provisional AD Dispute (DS324)" in the subject line, or (ii) by fax to Sandy McKinzy at (202) 395-3640. For documents sent by fax, USTR requests that the submitter provide a confirmation copy to the electronic mail address listed above.

USTR encourages the submission of documents in Adobe PDF format, as attachments to an electronic mail. Interested persons who make submissions by electronic mail should not provide separate cover letters;

information that might appear in a cover letter should be included in the submission itself. Similarly, to the extent possible, any attachments to the submission should be included in the same file as the submission itself, and not as separate files.

A person requesting that information contained in a comment submitted by that person be treated as confidential business information must certify that such information is business confidential and would not customarily be released to the public by the submitter. Confidential business information must be clearly designated as such and the submission must be marked "BUSINESS CONFIDENTIAL" at the top and bottom of the cover page and each succeeding page.

Information or advice contained in a comment submitted, other than business confidential information, may be determined by USTR to be confidential in accordance with section 135(g)(2) of the Trade Act of 1974 (19 U.S.C. 2155(g)(2)). If the submitter believes that information or advice may qualify as such, the submitter—

(1) Must clearly so designate the information or advice;

(2) Must clearly mark the material as "SUBMITTED IN CONFIDENCE" at the top and bottom of the cover page and each succeeding page; and

(3) Is encouraged to provide a non-confidential summary of the information or advice.

Pursuant to section 127(e) of the URAA (19 U.S.C. 3537(e)), USTR will maintain a file on this dispute settlement proceeding, accessible to the public, in the USTR Reading Room, which is located at 1724 F Street, NW., Washington, DC 20508. The public file will include non-confidential comments received by USTR from the public with respect to the dispute; if a dispute settlement panel is convened, the U.S. submissions to that panel, the submissions, or non-confidential summaries of submissions, to the panel received from other participants in the dispute, as well as the report of the panel; and, if applicable, the report of the Appellate Body. An appointment to review the public file (Docket No. WT/DS-324, Thailand Shrimp Provisional AD Dispute) may be made by calling the USTR Reading Room at (202) 395-6186. The USTR Reading Room is open to the

public from 9:30 a.m. to noon and 1 p.m. to 4 p.m., Monday through Friday.

Bruce R. Hirsh,

Acting Assistant United States Trade Representative for Monitoring and Enforcement.

[FR Doc. 04-28627 Filed 12-29-04; 8:45 am]

BILLING CODE 3190-W5-P

DEPARTMENT OF TRANSPORTATION

[Docket No. OST-2004-19172]

Office of Small & Disadvantaged Business Utilization and Minority Resource Center; Notice of Request for New Data Collection;

AGENCY: Office of the Secretary, DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), OSDBU invites public comment on a public information collection, which will be submitted to OMB for approval. Copies of the public information collection may be obtained by contacting Nancy Strine, Manager, Short-term Lending Program, Office of Small and Disadvantaged Business Utilization, U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590, (202) 366-5344.

DATES: Comments must be received on or before January 14, 2005.

ADDRESSES: You may submit comments identified by DOT DMS Docket Number OST-2004-19172 by any of the following methods:

- Web Site: <http://dms.dot.gov>. Follow the instructions for submitting comments on the DOT electronic docket site.
- Fax: 1-202-493-2251.
- Mail: Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL-401, Washington, DC 20590-0001.
- Hand Delivery: Room PL-401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington DC, between 9 a.m. and 5 p.m., Monday through Friday, except on Federal holidays.
- Federal eRulemaking Portal: Go to <http://www.regulations.gov>. Follow the online instructions for submitting comments.

Instructions: All submissions must include the agency name and docket number or Regulatory Identification Number (RIN) for this rulemaking. For detailed instructions submitting comments and additional information on the rulemaking process, see the

Public Participation heading of the **SUPPLEMENTARY INFORMATION** section of this document. Note that all comments received will be posted without change to <http://dms.dot.gov> including any personal information provided. Please see the Privacy Act heading under Regulatory Notes.

Docket: For access to the docket to read background documents or comments received, go to <http://dms.dot.gov> at any time or to Room PL-401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.

FOR FURTHER INFORMATION CONTACT:

Nancy Strine, Manager, Short-term Lending Program, Office of Small and Disadvantaged Business Utilization, U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590, (202) 366-5344.

SUPPLEMENTARY INFORMATION:

Title: Short-term Loan Program Online Application.

OMB Control Number: N/A.

Type of Request: New request for data collection.

Abstract: In accordance with 49 U.S.C. 332(b)(2), (5), the Office of Small and Disadvantaged Business Utilization and Minority Resource Center is authorized to facilitate, encourage, promote, and assist minority entrepreneurs and businesses in getting transportation-related contracts, subcontracts, and projects related to those business opportunities. In response to developmental need, the U.S. Department of Transportation (DOT) Short Term Lending Program (STLP) was developed by the Office of Small and Disadvantaged Business Utilization and Minority Resource Center to offer certified Disadvantaged Business Enterprises (DBEs) the opportunity to obtain short-term working capital at prime interest rates for transportation related contracts. DBE firms participating in the STLP program will submit loan applications on-line to participating DOT Preferred Bank Lenders (PBL). The cumulative data collected will be analyzed by the Office of Small and Disadvantaged Business Utilization and Minority Resource Center and PBLs to determine the eligibility of DBEs for revolving lines of credit to finance accounts receivable arising from transportation-related contracts. The information will also be used to increase uniformity among participating PBLs.

Respondents: Disadvantaged Business Enterprises (DBEs).

Estimated Number of Respondents: 50.

Estimated Total Burden on Respondents: 50.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; (b) the accuracy of the Department's estimate of the burden of the proposed information collection; (c) ways to enhance the quality, utility and clarity of the information collection; and (d) ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology. All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Issued in Washington, DC, on December 21, 2004.

Sean M. Moss,

Director, Office of Small and Disadvantaged Business Utilization.

[FR Doc. 04-28546 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-62-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Agency Information Collection Activity Under OMB Review

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget (OMB) for extension of the currently approved collection. The ICR describes the nature of the information collection and the expected burden. The Federal Register Notice with a 60-day comment period soliciting comments on the following collection of information was published on September 10, 2004 page 54840.

DATES: Comments must be submitted on or before January 31, 2005. A comment to OMB is most effective if OMB receives it within 30 days of publication.

FOR FURTHER INFORMATION CONTACT: Judy Street on (202) 267-9895.

SUPPLEMENTARY INFORMATION:

Federal Aviation Administration (FAA)

Title: Certification of Airports, 14 CFR part 139.

Type of Request: Extension of a currently approved collection.

OMB Control Number: 2120-0675.

Form(s): FAA Form 5280-1.

Affected Public: A total of 600 airport operators.

Abstract: This rule revised the airport certification regulations and establishes certification requirements for airports serving scheduled air carrier operations in aircraft with 10-30 seats. The changes to 14 CFR Part 139 result in additional information collections from respondents.

Estimated Annual Burden Hours: An estimated 52,993 hours annually.

ADDRESSES: Send comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725 17th Street, NW., Washington, DC 20503, Attention FAA Desk Officer.

Comments are invited on: Whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimates of the burden of the proposed information collection; ways to enhance the quality, utility and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Issued in Washington, DC, on December 22, 2004.

Judith D. Street,

FAA Information Collection Clearance Officer, Standards and Information Division, APF-100.

[FR Doc. 04-28558 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent To Request Renewal From the Office of Management and Budget (OMB) of Four Current Public Collections of Information

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), the FAA invites public comment on four currently approved public information collections which will be submitted to OMB for renewal.

DATES: Comments must be received on or before February 28, 2005.

ADDRESSES: Comments may be mailed or delivered to the FAA at the following address: Ms. Judy Street, Room 613, Federal Aviation Administration, Standards and Information Division, APF-100, 800 Independence Ave., SW., Washington, DC 20591.

FOR FURTHER INFORMATION CONTACT: Ms. Judy Street at the above address or on (202) 267-9895.

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995, 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. Therefore, the FAA solicits comments on the following current collections of information in order to evaluate the necessity of the collection, the accuracy of the agency's estimate of the burden, the quality, utility, and clarity of the information to be collected, and possible ways to minimize the burden of the collection in preparation for submission to renew the clearances of the following information collections.

1. 2120-0024, Dealer's Aircraft Registration Certificate Application. AC Form 8050-5 is an application for a dealer's Aircraft Registration Certificate which, under 49 U.S.C., 1404, may be issued to a person engaged in manufacturing, distributing, or selling aircraft. Information received enables the Civil Aviation registry to determine eligibility of an applicant to receive a Dealer's Certificate and issue the same to the correct name and address. The current estimated annual reporting burden is 1,557 hours.

2. 2120-0595, FAA Acquisition Management System (FAAAMS). Pursuant to Section 348 of Public Law 104-50, the FAA implements an acquisition management system that addresses the unique needs of the agency. This document established the policies, guiding principles, and internal procedures for the FAA's acquisition system. The current estimated annual reporting burden is 170,109 hours.

3. 2120-0643, Commercial Space Transportation Reusable Launch Vehicle and Reentry Licensing Regulation. The required information will be used to determine whether applicants satisfy requirements for obtaining a launch license to protect the public from risks associated with reentry operations from a site not operated by or situated on a Federal launch range. The respondents are those applying for a launch site license. The current estimated annual reporting burden is 4,384 hours.

4. 2120-0674, Special Federal Regulation (SFAR)92, Flightcrew Compartment Access and Door Signs. SFAR 92 (to part 119) temporarily authorizes variances for certain air carrier from existing design standards for the flightcrew compartment doors and allows for return to service of modified airplanes without prior approved data. This allows certain air carriers to modify their flightcrew compartment door to delay or deter unauthorized entry to the flightcrew compartment. The modifications are conditional on submitting a detailed description of the changes within 90 days and within 180 days providing a schedule for accomplishing changes necessary to comply with all applicable airworthiness requirements. The current estimated annual reporting burden is 2,352 hours.

Issued in Washington, DC, on December 21, 2004.

Judith D. Street,

FAA Information Collection Clearance Officer, APF-100.

[FR Doc. 04-28559 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Docket No. FRA-2000-7257; Notice No. 35]

Railroad Safety Advisory Committee; Notice of Meeting

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Notice of the Railroad Safety Advisory Committee (RSAC) meeting.

SUMMARY: FRA announces the next meeting of the RSAC, a Federal Advisory Committee that develops railroad safety regulations through a consensus process. The RSAC meeting topics will include remote control locomotives, the Foster-Miller, Inc., study on medical standards for safety-critical railroad employees, the Burlington Northern Santa Fe Railway's positive train control project (Electronic Train Management System), the status of the proposed rule on Performance Standards for Processor-Based Signal and Train Control Systems, issues concerning the maintenance of the highway-rail grade crossing inventory, the report on review of the Railroad Safety Board process, and a railroad security update. Status reports will be given on the Event Recorder Working Group, and other active working groups. The Committee will be asked to vote on the Passenger Safety Working Group's

mechanical recommendations for amendments to existing regulations, and the Committee may be asked to accept a new task relating to review of the Roadway Worker Protection regulations.

DATES: The meeting of the RSAC is scheduled to commence at 9:30 a.m., and conclude at 4 p.m., on Wednesday, January 26, 2005.

ADDRESSES: The meeting of the RSAC will be held at the Washington Plaza, 10 Thomas Circle, NW., Washington, DC 20005, (202) 842-1300. The meeting is open to the public on a first-come, first-serve basis and is accessible to individuals with disabilities. Sign and oral interpretation can be made available if requested 10 calendar days before the meeting.

FOR FURTHER INFORMATION CONTACT: Trish Butera, RSAC Coordinator, FRA, 1120 Vermont Avenue, NW., Stop 25, Washington, DC 20590, (202) 493-6212 or Grady Cothen, Acting Associate Administrator for Safety, FRA, 1120 Vermont Avenue, NW., Mailstop 25, Washington, DC 20590, (202) 493-6302.

SUPPLEMENTARY INFORMATION:

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), FRA is giving notice of a meeting of the RSAC. The meeting is scheduled to begin at 9:30 a.m., and conclude at 4 p.m., on Wednesday, January 26, 2005. The meeting of the RSAC will be held at the Washington Plaza, 10 Thomas Circle, NW., Washington, DC, 20005, (202) 842-1300. All times noted are Eastern Standard Time.

RSAC was established to provide advice and recommendations to the FRA on railroad safety matters. The Committee consists of 48 individual voting representatives and five associate representatives drawn from among 30 organizations representing various rail industry perspectives, two associate representatives from the agencies with railroad safety regulatory responsibility in Canada and Mexico and other diverse groups. Staffs of the National Transportation Safety Board and Federal Transit Administration also participate in an advisory capacity.

See the RSAC Web site for details on pending tasks at:

<http://rsac.fra.dot.gov/>. Please refer to the notice published in the **Federal Register** on March 11, 1996, (61 FR 9740) for more information about the RSAC.

Issued in Washington, DC, on December 23, 2004.

Grady C. Cothen, Jr.,

Acting Associate Administrator for Safety.

[FR Doc. 04-28560 Filed 12-29-04; 8:45 am]

BILLING CODE 4910-06-P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 34563]

Buffalo & Pittsburgh Railroad, Inc.— Lease and Operation Exemption— South Buffalo Railway Company

AGENCY: Surface Transportation Board, DOT.

ACTION: Notice of exemption.

SUMMARY: Under 49 U.S.C. 10502, the Board is granting a petition for exemption from the prior approval requirements of 49 U.S.C. 10902 for Buffalo & Pittsburgh Railroad, Inc., a Class II rail carrier, to lease and operate an approximately 2-mile segment of rail line between approximately milepost 0.0 and approximately milepost 2.0 in Buffalo, Erie County, NY, owned by its Class III rail carrier affiliate, South Buffalo Railway Company.

DATES: The exemption will be effective on December 30, 2004. Petitions to stay must be filed by January 3, 2005. Petitions to reopen must be filed by January 12, 2005.

ADDRESSES: Send an original and 10 copies of all pleadings referring to STB Finance Docket No. 34563, to: Surface Transportation Board, 1925 K Street, NW., Washington, DC 20423-0001. In addition, send one copy of pleadings to Jo A. DeRoche, Weiner Brodsky Sidman Kider PC, 1300 19th Street, NW., Fifth Floor, Washington, DC 20036-1609.

FOR FURTHER INFORMATION CONTACT: Eric S. Davis, (202) 565-1608. [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. To purchase a copy of the full decision, write to, e-mail or call: ASAP Document Solutions, 9332 Annapolis Rd., Suite 103, Lanham, MD 20706; e-mail asapdc@verizon.net; telephone (202) 306-4004. [Assistance for the hearing impaired is available through FIRS at 1-800-877-8339.]

Board decisions and notices are available on our Web site at <http://www.stb.dot.gov>.

Decided: December 22, 2004.

By the Board, Chairman Nober, Vice Chairman Mulvey, and Commissioner Buttrey.

Vernon A. Williams,
Secretary.

[FR Doc. 04-28486 Filed 12-29-04; 8:45 am]

BILLING CODE 4915-01-P

DEPARTMENT OF THE TREASURY**Office of the Comptroller of the Currency****Agency Information Collection Activities: Submission for OMB Review; Comment Request**

AGENCY: Office of the Comptroller of the Currency (OCC), Treasury.

ACTION: Notice and request for comment.

SUMMARY: The OCC, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on a continuing information collection, as required by the Paperwork Reduction Act of 1995. The OCC is soliciting comment concerning its information collection titled, "(MA)—Management Official Interlocks—12 CFR 26." The OCC also gives notice that it has sent the information collection to OMB for review and approval.

DATES: You should submit your comments to the OCC and the OMB Desk Officer by January 31, 2005.

ADDRESSES: You should direct your comments to:

Communications Division, Office of the Comptroller of the Currency, Public Information Room, Mailstop 1-5, Attention: 1557-0196, 250 E Street, SW., Washington, DC 20219. In addition, comments may be sent by fax to (202) 874-4448, or by electronic mail to regs.comments@occ.treas.gov. You can inspect and photocopy the comments at the OCC's Public Information Room, 250 E Street, SW., Washington, DC 20219. You can make an appointment to inspect the comments by calling (202) 874-5043.

Mark Menchik, OMB Desk Officer, Office of Management and Budget, New Executive Office Building, Room 3208, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: You can request additional information or a copy of the collection from Mary Gottlieb, OCC Clearance Officer, or Camille Dixon, (202) 874-5090, Legislative and Regulatory Activities Division, Office of the Comptroller of the Currency, 250 E Street, SW., Washington, DC 20219.

SUPPLEMENTARY INFORMATION: The OCC is requesting OMB approval on a proposed revision to the following information collection:

Title: (MA)—Management Official Interlocks—12 CFR 26.

OMB Number: 1557-0196.

Description: The OCC is requesting comment on its proposed revision of the information collection titled, "(MA)—

Management Official Interlocks—12 CFR 26."

Under the Interlocks Act, two competing depository institutions generally may not share management officials. However, the OCC has legal authority to implement exemptions to this general prohibition. This information collection is needed to prevent any management official interlock that would result in a monopoly or substantial lessening of competition, and to foster competition between unaffiliated institutions. The OCC uses the information to ensure that a proposed management interlock is permitted under statute, is eligible for an exemption, and does not have an anticompetitive effect. The OCC also uses the information to determine whether it can share a management official with a competing depository institution.

Type of Review: Revision of a currently approved collection.

Affected Public: Businesses or other for-profit (national banks).

Estimated Number of Respondents: 2.

Estimated Total Annual Responses: 2.

Frequency of Response: On occasion.

Estimated Time per Respondent: 2 hours.

Estimated Total Annual Burden: 4 hours.

An agency may not conduct or sponsor, and a respondent is not required to respond to, an information collection unless the information collection displays a currently valid OMB control number.

Comments submitted in response to this notice will be summarized and included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on:

(a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information has practical utility;

(b) The accuracy of the agency's estimate of the burden of the collection of information;

(c) Ways to enhance the quality, utility, and clarity of the information to be collected;

(d) Ways to minimize the burden of the collection on respondents, including through the use of automated collection techniques or other forms of information technology; and

(e) Estimates of capital or startup costs and costs of operation, maintenance,

and purchase of services to provide information.

Stuart Feldstein,

Assistant Director, Legislative and Regulatory Activities Division.

[FR Doc. 04-28633 Filed 12-29-04; 8:45 am]

BILLING CODE 4810-33-P

DEPARTMENT OF THE TREASURY**Fiscal Service****Renegotiation Board Interest Rate; Prompt Payment Interest Rate; Contract Disputes Act**

AGENCY: Bureau of the Public Debt, Fiscal Service, Treasury.

ACTION: Notice.

SUMMARY: For the period beginning January 1, 2005 and ending on June 30, 2005, the prompt payment interest rate is 4.250 per centum per annum.

ADDRESSES: Comments or inquiries may be mailed to Trina Cook, Team Leader, Borrowings Accounting Team, Division of Accounting Operations, Office of Public Debt Accounting, Bureau of the Public Debt, Parkersburg, West Virginia, 26106-1328. A copy of this Notice will be available to download from <http://www.publicdebt.treas.gov>.

DATES: This notice announces the applicable interest rate for the January 1, 2005 to June 30, 2005 period.

FOR FURTHER INFORMATION CONTACT: Stephanie Brown, Director, Division of Accounting Operations, Office of Public Debt Accounting, Bureau of the Public Debt, Parkersburg, West Virginia, 26106-1328, (304) 480-5181; Trina Cook, Team Leader, Borrowings Accounting Team, Division of Accounting Operations, Office of Public Debt Accounting, Bureau of the Public Debt, Parkersburg, West Virginia, 26106-1328, (304) 480-5166; Edward C. Gronseth, Deputy Chief Counsel, Office of the Chief Counsel, Bureau of the Public Debt, (304) 480-8692; or Latisha R. Brown, Attorney-Adviser, Office of the Chief Counsel, Bureau of the Public Debt, (202) 504-3710.

SUPPLEMENTARY INFORMATION: Although the Renegotiation Board is no longer in existence, other Federal Agencies are required to use interest rates computed under the criteria established by the Renegotiation Act of 1971 Sec. 2, Pub. L. 92-41, 85 Stat. 97. For example, the Contract Disputes Act of 1978 Sec. 12, Pub. L. 95-563, 92 Stat. 2389 and, indirectly, the Prompt Payment Act of 1982, 31 U.S.C. 3902(a), provide for the calculation of interest due on claims at a rate established by the Secretary of the

Treasury for the Renegotiation Board under Pub. L. 92–41.

Therefore, notice is given that the Secretary of the Treasury has determined that the rate of interest applicable, for the period beginning January 1, 2005 and ending on June 30, 2005, is 4.250 per centum per annum. This rate is determined pursuant to the above-mentioned sections for the purpose of said sections.

Dated: December 20, 2004.

Donald V. Hammond,

Fiscal Assistant Secretary.

[FR Doc. 04–28219 Filed 12–29–04; 8:45 am]

BILLING CODE 4810–39–M

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0253]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits 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 Benefits Administration (VBA), 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 January 31, 2005.

FOR FURTHER INFORMATION CONTACT:

Denise McLamb, Records Management Service (005E3), Department of Veterans Affairs, 810 Vermont Avenue, NW., or e-mail denise.mclamb@mail.va.gov.

Please refer to “OMB Control No. 2900–0253.” Send comments and recommendations concerning any aspect of the information collection 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. 2900–0253” in any correspondence.

SUPPLEMENTARY INFORMATION:

Title: Non-supervised Lender’s Nomination and Recommendation of Credit Underwriter, VA Form 26–8736a.
OMB Control Number: 2900–0253.

Type of Review: Extension of a currently approved collection.

Abstract: VA Form 26–8736a is completed by nonsupervised lender’s and the lender’s nominee for credit underwriting with the Department of Veterans Affairs. Lenders are authorized by VA to make automatic guaranteed loans if approved for such purposes. The lender is required to have a qualified underwriter to review loans to be closed on automatic basis and determine that the loan meets VA’s credit underwriting standards. VA uses the data collected on the form to evaluate the nominee’s credit underwriting experience.

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 September 15, 2004, at pages 55664.

Affected Public: Business or other for-profit.

Estimated Annual Burden: 1,000 hours.

Estimated Average Burden Per Respondent: 20 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 3,000.

Dated: December 15, 2004.

By direction of the Secretary.

Loise Russell,

Director, Records Management Service.

[FR Doc. 04–28591 Filed 12–29–04; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0474]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits 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 Benefits Administration (VBA), 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 January 31, 2005.

FOR FURTHER INFORMATION CONTACT:

Denise McLamb, Records Management Service (005E3), Department of Veterans Affairs, 810 Vermont Avenue, NW., or e-mail denise.mclamb@mail.va.gov.

Please refer to “OMB Control No. 2900–0474.” Send comments and recommendations concerning any aspect of the information collection 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. 2900–0474” in any correspondence.

SUPPLEMENTARY INFORMATION:

Title: Create Payment Request for the VA Funding Fee Pay System (VA FFPS); A Computer Generated Funding Fee Receipt, VA Form 26–8986.

OMB Control Number: 2900–0474.

Type of Review: Extension of a currently approved collection.

Abstract: Veterans obtaining a VA-guaranteed home loan must pay a funding fee to VA before the loan can be guaranteed. The only exceptions are loans made to veterans receiving VA compensation for service-connected disabilities, (or veterans whom, but for receipt of retirement pay, would be entitled to receive compensation) and unmarried surviving spouses of veterans who died in active military service or from service-connected disability regardless of whether the spouse has his or her own eligibility.

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 September 15, 2004, at pages 55663–55664.

Affected Public: Business or other for profit and individuals or households.

Estimated Annual Burden: 14,167 hours.

Estimated Average Burden Per Respondent: 2 minutes.

Frequency of Response: One-time.

Estimated Number of Respondents: 425,000.

Dated: December 15, 2004.

By direction of the Secretary.

Loise Russell,

Director, Records Management Service.

[FR Doc. 04–28592 Filed 12–29–04; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900-0011]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501-3521), this notice announces that the Veterans Benefits Administration (VBA), 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; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before January 31, 2005.

FOR FURTHER INFORMATION CONTACT:

Denise McLamb, Records Management Service (005E3), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273-8030, FAX (202) 273-5981 or e-mail denise.mclamb@mail.va.gov. Please refer to "OMB Control No. 2900-0011." Send comments and recommendations concerning any aspect of the information collection to VA's 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. 2900-0011" in any correspondence.

SUPPLEMENTARY INFORMATION: *Title:* Application for Reinstatement, VA Form 29-352 (Insurance Lapsed for more than 6 months) and VA Form 29-353 (Non-medical Comparative Health Statement).

OMB Control Number: 2900-0011.

Type of Review: Extension of a currently approved collection.

Abstract: VA Forms 29-352 and 29-353 are used to apply for reinstatement of insurance and/or Total Disability Income Provision that has lapsed for more than six months. VA uses the information collected to establish the applicant's eligibility for reinstatement.

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 September 15, 2004, at pages 55664-55665.

Affected Public: Individuals or households.

Estimated Annual Burden: a. VA Form 29-352—500 hours. b. VA Form 29-353—375 hours.

Estimated Average Burden Per Respondent: a. VA Form 29-352—20 minutes. b. VA Form 29-353—15 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: a. VA Form 29-352—1,500. b. VA Form 29-353—1,500.

Dated: December 15, 2004.

By direction of the Secretary.

Loise Russell,

Director, Records Management Service.

[FR Doc. 04-28595 Filed 12-29-04; 8:45 am]

BILLING CODE 8320-01-P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900-0045]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits 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 Benefits Administration (VBA), 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 January 31, 2005.

FOR FURTHER INFORMATION CONTACT:

Denise McLamb, Records Management Service (005E3), Department of Veterans Affairs, 810 Vermont Avenue, NW., or e-mail denise.mclamb@mail.va.gov. Please refer to "OMB Control No. 2900-0045." Send comments and

recommendations concerning any aspect of the information collection 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. 2900-0045" in any correspondence.

SUPPLEMENTARY INFORMATION: *Title and Form Number:* VA Request for Determination of Reasonable Value (Real Estate), VA Form 26-1805.

OMB Control Number: 2900-0045.

Type of Review: Extension of a currently approved collection.

Abstract: VA Form 26-1805 is used to collect data necessary to identify and locate properties to be appraised and to make assignments to appraisers. No loan may be guaranteed or made unless the nature and conditions of the property is suitable for dwelling purposes is determined; the loan amount to be paid by the veteran for such property for the cost of construction, repairs, or alterations does not exceed the reasonable value; or if the loan is for repair, alteration, or improvements of property, the work substantially protects or improves the basic livability of the property. VA or the lender's participating in the lender appraisal processing program issues a notice of values to notify the veteran and requester of the determination of reasonable value and any conditional requirements.

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 September 15, 2004, at page 55663.

Affected Public: Individuals or households.

Estimated Annual Burden: 60,000 hours.

Estimated Average Burden Per Respondent: 12 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 300,000.

Dated: December 15, 2004.

By direction of the Secretary.

Loise Russell,

Director, Records Management Service.

[FR Doc. 04-28596 Filed 12-29-04; 8:45 am]

BILLING CODE 8320-01-P



Federal Register

**Thursday,
December 30, 2004**

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

**42 CFR Parts 403, 412, 413, et al.
Medicare Program; Changes to the
Hospital Inpatient Prospective Payment
Systems and Fiscal Year 2005 Rates;
Correcting Amendment; Final Rule**

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Parts 403, 412, 413, 418, 460, 480, 482, 483, 485, and 489****[CMS-1428-F2]****RIN 0938-AM80****Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Correcting Amendment****AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Final rule; correcting amendment.

SUMMARY: In the October 7, 2004 *Federal Register* (69 FR 60242), we published a correction to the final rule that appeared in the August 11, 2004 *Federal Register* entitled “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates.” This amendment corrects errors in that final rule and the correction of the final rule.

EFFECTIVE DATE: January 1, 2005.**FOR FURTHER INFORMATION CONTACT:** Marc Hartstein, (410) 786-4548.**SUPPLEMENTARY INFORMATION:****I. Background and Summary of Errors**

In FR Doc. 04-17943 (69 FR 48916, August 11, 2004) the final rule entitled “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates” (hereinafter referred to as the FY 2005 final rule) there were a number of errors. Some of these errors were identified and corrected in the correction of the final rule that was published in the October 7, 2004 *Federal Register*.

We note that sections II.A., II.B., II.C. items 1 through 11 and 13, and II.D. of this correcting amendment apply to IPPS payments effective October 1, 2004, as if they had been included correctly in the FY 2005 final rule. Items 12 and 14 through 29 of section II.C. apply to discharges occurring on or after January 1, 2005.

A. Summary of Preamble Errors

In the FY 2005 final rule, we identified codes for spinal fusion procedures that were to be used in various combinations to identify cases that are eligible to receive new technology add-on payments for bone morphogenetic proteins (BMPs) for spinal fusion (69 FR 49009). We made an error in listing the spinal fusion

codes for the Stryker Biotech OP-1 Putty product. FDA approved the use of OP-1 Putty for refusion of the spine with a posterior approach (codes 81.35 and 81.38) but not for initial spinal fusions (codes 81.05 and 81.08). It is our policy to restrict the payment of new technology add-on payments only to cases in which FDA-approved indications are present. Therefore, we should not have included codes 81.05 and 81.08 in the final rule as procedure codes that could be used with OP-1 Putty in order to receive new technology add-on payments. As a result, the correct codes for receiving the OP-1 Putty BMP new technology payments are 84.52 (for the BMP) and either 81.35 or 81.38 (for the refusion of the spine with a posterior approach) and without code 84.51 for the LT Cage.

This correction, which removes codes 81.05 and 81.08 from the new technology logic for Stryker Biotech OP-1 Putty, reflects our policy of not making new technology add-on payments for off-label uses. Currently there is no plan to release a January Pricer update; therefore, the next the update of the Pricer would probably be effective April 1, 2005. However, we do not believe that payment will be made for many cases as a result of this error. The FDA approved OP-1 Putty under a humanitarian device exemption (HDE). As a result, the FDA has imposed a strict limitation on the number of cases in which the product can be used. In addition, an independent review board reviews each case in which OP-1 Putty will be used to ensure that the use of the product is in the best interest of the patient. Therefore, we expect off-label use of the product will be minimal and we will not try to recover monies paid on claims reporting codes 81.05 and 81.08 in conjunction with the code for OP-1 Putty (84.52) that receive add-on payments during the 6-month period from October 1, 2004 through March 31, 2005.

Finally, we are not modifying the new technology payments for the InFUSE™ product because the code logic adopted in the FY 2005 final rule reflects FDA-approval criteria. However, we are making some revisions to our discussion of the code logic for InFUSE™ in order to clarify our policy of making add-on payments only for FDA-approved uses of this technology. (See II.A. of this correcting amendment for these revisions.)

B. Summary of Regulations Text Errors

In the FY 2005 final rule, we made an error in adding new § 412.230(d). Subparagraph (C) was inadvertently added to a nonexistent paragraph

(d)(3)(iii) instead of (d)(1)(iii) (69 FR 49249). In the October 7, 2004 correction of the final rule, we also erred by adding a new subparagraph (B) to § 412.230(d)(3)(ii). In section II of this correcting amendment, we are amending § 412.230(d)(1)(iii) to add the subparagraph (C) that was inadvertently placed in paragraph (d)(3)(iii); revising paragraph (d)(1)(iii)(B) to reflect the language that was inadvertently placed in (d)(3)(ii)(B); making editorial changes to paragraphs (d)(3)(i) and (ii); and revising paragraph (d)(3) to reflect the correct text. (See section II.B. item 1 of this correcting amendment.)

The FY 2005 final rule (69 FR 49251) included § 412.534 regarding special payment provisions for long-term care hospitals-within-hospitals (HwHs) and satellites of long-term care hospitals (LTCHs). The LTCH prospective payment system (PPS) is a per discharge system and therefore the specific payment adjustment implemented in this regulation will be made for each Medicare patient who is discharged from the LTCH HwH or satellite of a LTCH during a cost reporting period if that patient was admitted to the LTCH or satellite of a LTCH from the host hospital and if the number of such patients exceeds specific thresholds (detailed in other sections of the regulation). We believe that adding the term “discharged” before the phrase “Medicare inpatient population” and changing the term “referred” to “admitted” (with regard to the source of patients) in the following subsections of the regulatory text will increase the clarity of our policy at § 412.534(c)(1), (c)(2), (d)(1), and (e)(1). Our policy goal in establishing § 412.534 is to distinguish between those LTCH HwHs and satellites that are functioning as totally separate providers from their host hospital and those that are behaving as units of the host, a configuration that is statutorily precluded and to provide a payment adjustment under the LTCH PPS when the LTCH HwH or satellite behaves like a unit. We have determined that this distinction can best be reflected by focusing on the percentage of total discharges from a LTCH HwH or satellite for a particular cost reporting period that were admitted from the host. (This policy rationale was first articulated in the September 1, 1994 IPPS final rule (59 FR 45389)). This policy is articulated on numerous pages in the preamble of the IPPS final rule (69 FR 48916, 49196, 49198, 49201, 49206, and 49213). The use of the term “referred” is imprecise with regards to this policy and we are correcting the

regulation text to more precisely mirror the final policy as established in the preamble (see 69 FR 49196). Further clarifying the same policy, we are revising the phrase “threshold for discharges of patients from the co-located hospital” in § 412.534(c)(2), (d)(1), and (e)(1), respectively, to conform the regulation text to the preamble language on pages 49196, 49198, 49201, 49206, and 49213 where we state that we examine the percentage of a LTCH’s or satellite’s discharges that were admitted from the host. The present regulation text omits the phrase “who have been admitted;” and therefore, does not make as clear as it could that we examine the percentage of LTCH’s or satellite’s discharges from its host.

The revised regulation text will refer to the “threshold for discharges of patients who have been admitted from the co-located hospital.” The policy, as articulated above, is focused on identifying the percentage of patients discharged from the HwH or satellite that were admitted from the host hospital in order to apply a payment adjustment when specific thresholds (detailed elsewhere in the regulation text) are exceeded.

In the preamble to the FY 2005 final rule on pages 49196, 49206, and 49213, we established an adjustment for discharges from LTCHs or satellites if the LTCH or satellite is located in a rural area and is co-located with a host hospital or if it is co-located with the only urban hospital in the MSA or a MSA-dominant host hospital. On page 49206 of the preamble, we state that these particular adjustments are in effect “* * * following the phase-in period * * *” However, we inadvertently excluded this statement from the regulation text at § 412.534(d) and (e) which detail this adjustment. In the regulation text that specifies the phase-in period at § 412.534(f)(4), we establish a threshold of “* * * 25 percent or the applicable percentage determined under paragraph (d) or (e) of this section” which clearly indicates that we intended that the particular payment adjustments for rural, single urban, or MSA dominant hosts would go into effect only after the transition period set forth in paragraph (f). We are concerned that the regulation text in § 412.534(d) and (e) does not state this policy clearly and unambiguously. Therefore, we are adding the phrase “[S]ubject to paragraph (f) of this section” in both § 412.534(d)(1) and in (e)(1) to clarify that the specific payment adjustment established in § 412.534(d) for rural hospitals and in § 412.534(e) for single urban or MSA dominant hospitals

begins after the phase-in described in § 412.534(f). Similarly, we are adding the phrase, “[E]xcept as provided in paragraph (f) of this section” at the beginning of § 412.534(c)(1), which indicates that the 25 percent threshold for the payment adjustment specified in the following paragraphs begins only after the transition set forth in paragraph (f). In the preamble to the FY 2005 final rule on pages 49196 and 49213, we established a “hold harmless” for cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005 for “grandfathered” LTCHs HwHs and satellites. We stated that “* * * even for grandfathered facilities, in the first cost reporting period, the percentage of discharges admitted from the host hospital may not exceed the percentage of discharges admitted from the host hospital in its FY 2004 cost reporting period.” However, referring to HwHs and satellites that are governed by this policy (“grandfathered”), we state at § 412.534(f)(1) that “For each discharge during the first cost reporting period beginning on or after October 1, 2004 and before October 1, 2005 the amount paid is the amount payable under this subpart with no adjustment under this § 412.534.” We inadvertently omitted from this regulation text that these facilities are required to not exceed the percentage of discharges admitted from the host hospital in its FY 2004 cost reporting period as was indicated in the preamble of the FY 2005 final rule on pages 49213 and 49196. We are revising the wording in paragraph (f)(1) to include this requirement and thus precisely reflect the policy stated in the preamble by adding “but the hospital may not exceed the percentage of patients admitted from the host during its FY 2004 cost reporting period” to the end of that paragraph.

In the regulation text at § 412.534(f)(2), we specify that cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006, the percentage of patients discharged from the HwH or satellite that may be admitted from the host hospital with no payment adjustment may not exceed the lesser of the “percentage of patients admitted from the host during fiscal year 2004 or 75 percent” and at paragraph (f)(3), we specify that cost reporting periods beginning on or after October 1, 2006 and before October 1, 2007, the percentage of patients discharged from the HwH or satellite that may be admitted from the host hospital with no payment adjustment may not exceed the lesser of the “percentage of patients

admitted from the host during fiscal year 2004 or 50 percent.” The policy to which we are referring is on pages 49196 and 49213 of the preamble, but in the preamble we use the much clearer phrase “* * * FY 2004 cost reporting period.” in describing the specific period used for the comparison, rather than the “fiscal year 2004” in paragraphs (f)(2) and (f)(3). We are revising the regulation text in paragraphs (f)(2) and (3) replacing “fiscal year 2004” with “its FY 2004 cost reporting period” to conform to the above cited preamble pages.

Accordingly, we have revised § 412.534 to incorporate these corrections. (See section II.B. item 2 of this correcting amendment.)

In the October 7, 2004 correction of the final rule, we corrected § 413.79(a)(10) (69 FR 60252). In this correction, we inadvertently omitted the term “portions” from the beginning of the sentence. Therefore, we are correcting this error in section II.B., item 3 of this correcting amendment.

The October 7, 2004 correction of the final rule also included a correction to § 485.610 (69 FR 60252). This correction stated that paragraph (b)(3) is deleted. Since there were two paragraphs (b)(3) in the FY 2005 final rule, we want to clarify that only the first of these paragraphs was deleted. In section II.B. item 4 of this correcting amendment, we have republished § 485.610(b)(3) to clarify this correction.

C. Summary of Addendum Errors

In the October 7, 2004 correction of the final rule (69 FR 60242), we noted the correction of errors in the tables and addendum language of the FY 2005 final rule related to the wage indexes, geographic reclassifications, and IPPS payments rates. In addition, we posted corrected wage tables and geographic reclassification tables on the CMS Website at: <http://www.cms.hhs.gov/providers/hipps/ippswage.asp>. We also noted that we would publish the corrected tables in a subsequent **Federal Register** document.

In section II.C. items 1 through 8 and 10 of this correcting amendment, we are publishing revised operating standardized amounts and capital Federal payment rates, including Tables 1A, 1B, 1C, and 1D as posted on the CMS Website as of September 29, 2004. Thus, these corrections simply make the standardized amounts and rates consistent with the hospitals’ actual payment designations, which have been in effect since October 1, 2004. Items 9, 11, and 13 merely correct typographical errors in and the placement of the headings of the wage index tables.

Accordingly, we believe it is appropriate to make the corrections in items 1 through 11 and 13 of section II.C. of this correcting amendment applicable October 1, 2004.

The FY 2005 final rule and the correction to the final rule were effective October 1, 2004. Since that date, we have identified additional errors in the wage index, geographic reclassification, and out-migration adjustment tables that were posted on the CMS Website. As discussed in this section, we are correcting the errors in the wage index, out-migration adjustment, and geographic reclassification tables in items 12 and 14 through 29 of section II.C. of this correcting amendment.

We granted several hospitals' wage data revision requests, but inadvertently failed to include the revised data in the wage index tables in the FY 2005 final rule. These errors affected the wage index value for several CBSAs. We are correcting these errors in the revised wage index tables in this correcting amendment.

In addition, we also have received information that several hospitals were assigned to incorrect labor market areas. We discovered that our data files incorrectly listed these hospitals in counties other than the counties in which these hospitals are actually located. These incorrect geographic designations affected the wage index computations for labor market areas in several States. We have revised the wage index computations for hospitals in the affected labor market areas to reflect the correct geographic designations of these hospitals.

Additionally, we discovered that we had incomplete and outdated information regarding hospitals located in urban areas that have been reclassified as rural under § 412.103 of the regulations. Accordingly, we have updated and corrected this information and revised the wage index computations for hospitals in the affected labor market areas. We also discovered, subsequent to the publication of the FY 2005 final rule, that we had inadvertently neglected to provide the hold-harmless wage index for providers in several counties that were previously designated as urban. In the final rule, we had provided that hospitals in areas that are classified as rural under the new MSA definitions, but had been designated as urban under the MSA definitions in effect through FY 2004, could retain their assignment to the wage index of the area in which they had previously been located. Accordingly, we have revised the wage index assignments for these hospitals.

Moreover, changes to county-level wage data due to the revisions described above, have also resulted in changes to the list of counties eligible for the out-migration wage index adjustment under section 505 of Pub. L. 108–173. In some cases, the wage data revisions have also resulted in changes to the amount of the adjustment. We have revised and corrected the list of eligible counties and the computation of the adjustment amounts. Thus, we are publishing revised versions of the tables displaying average hourly wages, wage index values, and capital geographic adjustment factors, specifically Tables 2, 3A₁, 3A₂, 3B₁, 3B₂, 4A₁, 4A₂, 4B₁, 4B₂, 4C₁, 4C₂, 4G, and 4H. We are also publishing a revised version of Table 4J, which displays the list of counties qualifying for the out-migration adjustment and adjustment amounts. In addition, we note that in Tables 4A₂ and 4G of the FY 2005 final rule, we inadvertently included 2 rural geographic areas in our list of urban areas. The two rural geographic areas were Enid, OK and Jamestown, NY. In accordance with the 3-year hold-harmless provision, all hospitals in these areas will maintain their current geographic area assignment for the 3-year period beginning FY 2005 and ending in FY 2007. Accordingly, we have removed these two geographic areas from Tables 4A₂ and 4G.

There were errors in several of the entries in Tables 9A¹ and 9A² of the FY 2005 final rule. Therefore, we are correcting these errors by republishing these tables in their entirety. These errors were brought to our attention after the publication of the FY 2005 final rule.

Lastly when identifying and correcting errors to the wage index, we believe it is appropriate to apply the changes to the wage index prospectively. As we stated in the January 3, 1984 final rule (49 FR 258), "Application of a retroactive adjustment to the rates [for corrections in the wage index] would erode the basis of the prospective payment system that payment will be made at a predetermined, specified rate." Therefore, we will apply the corrections to the wage index, geographic reclassification, and out-migration adjustment tables to discharges occurring on or after January 1, 2005.

D. Summary of Appendix A (Regulatory Impact Analysis) Errors

Section IV of the correction of the final rule that appeared in the October 7, 2004 **Federal Register** stated that we would include a revised impact analysis in a forthcoming correction notice.

Accordingly, we have included corrections to the regulatory impact analysis (Appendix A) based on the corrections summarized in section I.C. of this correcting amendment. In addition, we also note that we are deleting duplicative impact analysis language. (See section II.D. of this correcting amendment.)

II. Correction of Errors

Given the errors summarized in section I of this correcting amendment, we are making the following corrections to FR Doc. 04–17943 (69 FR 48916) and FR Doc. 04–22389 (69 FR 60242):

A. Correction of Preamble Errors

1. On page 49009, lines 9 through 51, the paragraph that begins with the phrase "Cases using InFUSE™ should be" and ending with the phrase "\$1,995 for FY 2005" is corrected to read as follows:

"FDA has not approved coverage for InFUSE™ when it is applied through a posterior approach. It is our policy to restrict the payment of new technology add-on payments only to cases in which FDA approved indications are present. Therefore, we are excluding add-on payments for those cases that contain procedure codes that indicate off-label uses of InFUSE(tm).

The posterior approach is captured through one of the following codes:

- 81.05 Dorsal and dorsolumbar fusion, posterior technique.
- 81.08 Lumbar and lumbosacral fusion, posterior technique.
- 81.35 Refusion of dorsal and dorsolumbar fusion, posterior technique.
- 81.38 Refusion of lumbar and lumbosacral fusion, posterior technique.

Cases using InFUSE™ should be identified by the combination of procedure codes 84.51 and 84.52, as described above and as required in the previous year of new technology add-on payments for this technology. Therefore, we are adopting the following code logic for new technology add-on payments for this product: cases in DRGs 497 and 498 with codes 84.52 and 84.51, but without any of the following codes: 81.05, 81.08, 81.35, or 81.38.

"For cases using the OP–1 Putty, the procedure code 84.52 (Insertion of recombinant bone morphogenetic protein) must be coded in combination with procedure codes identifying posterolateral spinal fusions, as is consistent with the FDA approval of this device. However, unlike InFUSE™, the OP–1 Putty is not used with a LT Cage (code 84.51). Therefore, we will provide new technology add-on payments for the OP–1 Putty through the following

payment logic: Cases in DRGs 497 and 498 with code 84.52 and one of the following codes: 81.35 or 81.38 and without code 84.51.

“Both of these devices have FDA approval that is consistent with cases that would be assigned to DRGs 497 to 498. Because Stryker Biotech did not submit an application for new technology add-on payments, we were unable to do a complete analysis of the cost of the device. However, we have been able to determine that the costs associated with the OP-1 Putty are similar to those associated with InFUSE™. Therefore, we believe that the same payment amount for new technology add-on payments is appropriate for both devices. Accordingly, cases containing one of the above combinations of procedure codes and that fall into DRGs 497 or 498 will be eligible to receive the add-on payment, with a maximum of \$1,955 for FY 2005.”

B. Correction of Regulation Text Errors

■ Given the errors summarized in section I.B. of this correcting amendment, we are making the following correcting amendments to 42 CFR Parts 412, 413, and 485:

PART 412—[CORRECTED]

§ 412.230 [Corrected]

- 1. Section 412.230 is amended by—
- A. Revising paragraphs (d)(1)(iii)(A) and (B).
- B. Adding a new paragraph (d)(1)(iii)(C).
- C. Revising paragraph (d)(3).

The revisions and additions read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

* * * * *

(d) *Use of urban or other rural area's wage index.*

- (1) * * *
- (iii) * * *

(A) With respect to redesignations for Federal fiscal years 1994 through 2001, the hospital's average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located;

(B) With respect to redesignations for Federal fiscal years 2002 through 2005, the hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent and in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; or

(C) With respect to redesignations for Federal fiscal year 2006 and subsequent

years, the hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent and in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of all other hospitals in the area in which the hospital is located;

* * * * *

(3) *Rural referral center exceptions.*

(i) If a hospital was ever a rural referral center, it does not have to demonstrate that it meets the average hourly wage criterion set forth in paragraph (d)(1)(iii) of this section.

(ii) If a hospital was ever a rural referral center, it is required to meet only the criterion that applies to rural hospitals under paragraph (d)(1)(iv) of this section, regardless of its actual location in an urban or rural area.

* * * * *

§ 412.534 [Corrected]

■ 2. Section 412.534 is amended by—

- A. Republishing the introductory text of paragraph (c).
- B. Revising paragraph (c)(1).
- C. Revising the first sentence and republishing the last sentence of paragraph (c)(2).
- D. Republishing the introductory text of paragraph (d).
- E. Revising the first sentence and republishing the last sentence of paragraph (d)(1).
- F. Republish the introductory text of paragraph (e).
- G. Revising the first sentence and republishing the second sentence of paragraph (e)(1).
- H. Republish the introductory text of paragraph (f).
- I. Revising paragraphs (f)(1), (f)(2), and (f)(3).

§ 412.534 Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals.

(c) *Patients admitted from the hospital located in the same building or on the same campus as the long-term care hospital or satellite facility.*

Payments to the long-term care hospital for patients admitted to it or to its satellite facility from the co-located hospital will be made under either paragraph (c)(1) or paragraph (c)(2) of this section.

(1) Except as provided in paragraph (f) of this section, for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or its satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the hospital or its satellite facility from the co-located hospital, payments are made under the

rules at § 412.500 through § 412.541 in this subpart with no adjustment under this section.

(2) Except as provided in paragraph (d), (e), or (f) of this section, for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent to the amount that would be determined under the rules at Subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

* * * * *

(d) *Special treatment of rural hospitals.* (1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or satellite facility that is located in a rural area as defined in § 412.62(f) and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent to the amount that would be otherwise payable under Subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

* * * * *

(e) *Special treatment of urban single or MSA dominant hospitals.* (1) Subject to paragraph (f) of this section, In the case of a long-term care hospital or

satellite facility that is co-located with the only other hospital in the MSA or with a MSA dominant hospital as defined in paragraph (e)(4) of this section, for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (e)(2) of this section were admitted to the hospital from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital to exceed the applicable threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent to the amount that otherwise would be determined under Subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart with no adjustment under this section.

* * * * *

(f) *Transition period for long-term care hospitals and satellite facilities paid under this subpart.* In the case of a long-term care hospital or a satellite facility that is paid under the provisions of this Subpart O of Part 412 on October 1, 2004 or of a hospital that is paid under the provisions of this Subpart O on October 1, 2005 and whose qualifying period under § 412.23(e) began on or before October 1, 2004, the amount paid is calculated as specified below:

(1) For each discharge during the first cost reporting period beginning on or

after October 1, 2004, and before October 1, 2005, the amount paid is the amount payable under this subpart with no adjustment under this section but the hospital may not exceed the percentage of patients admitted from the host during its FY 2004 cost reporting period.

(2) For each discharge during the cost reporting period beginning on or after October 1, 2005, and before October 1, 2006, the percentage that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host during its FY 2004 cost reporting period or 75 percent.

(3) For each discharge during the cost reporting period beginning on or after October 1, 2006, and before October 1, 2007, the percentage that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host during its FY 2004 cost reporting period or 50 percent.

* * * * *

PART 413—[CORRECTED]

§ 413.79 [Corrected]

■ 3. Section 413.79 is amended by revising paragraph (a)(10) to read as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(a) * * *

(10) Effective for portions of cost reporting periods beginning on or after October 1, 2004, if a hospital can document that a resident

simultaneously matched for 1 year of training in a particular specialty program, and for a subsequent year(s) of training in a different specialty program, the resident's initial residency period will be determined based on the period on board eligibility associated with the program for which the resident matched for the subsequent year(s) of training.

* * * * *

PART 485—[CORRECTED]

§ 485.610 [Corrected]

■ 4. Section 485.610(b)(3) is republished to read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(b) * * *

(3) Effective only for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

* * * * *

C. Correction of Errors in the Addendum

1. On page 49275, third column, line 15, the figure "0.993833" is corrected to read "0.993659".

2. On page 49278, top half of the page, the table is corrected to read as follows:

	Operating standardized amounts	Capital federal rate
National	0.948978	0.950591
Puerto Rico	0.973183	0.973749

3. On page 49280, top of the page, the table entitled Comparison of FY 2004 Standardized Amounts to FY 2005

Single Standardized Amount with Full Update and Reduced Update is corrected by changing the figures in

second and third columns for the listed entries to read as follows:

	Full update (3.3 percent)	Reduced update (2.9 percent)
FY 2005 Reclassification Budget Neutrality Factor	0.993659	0.993659
Adjusted for Blend of FY 2004 DRG Recalibration and Wage Index Budget Neutrality Factors*	Labor: \$3,418.96 Nonlabor: \$1,389.70 0.948978	Labor: \$3,405.72 Nonlabor: \$1,384.32 0.948978
FY 2005 Outlier Factor		
Rate for FY 2005 (after multiplying FY 2004 base rate by above factors) where the wage index is less than or equal to 1.0000	Labor: \$2,823.64 Nonlabor: \$1,730.62	Labor: \$2,812.70 Nonlabor: \$1,723.91
Rate for FY 2005 (after multiplying FY 2004 base rate by above factors) where the wage index is greater than 1.0000	Labor: \$3,238.07	Labor: \$3,225.53

	Full update (3.3 percent)	Reduced update (2.9 percent)
	Nonlabor: \$1,316.18	Nonlabor: \$1,311.08

4. On page 49283,
a. Second column, line 63, the figure “\$416.63” is corrected to read “\$416.53”; and
b. Third column, line 1, the figure “0.68” is corrected to read “0.65”.

5. On page 49286, third column,
a. Line 31, the figure “0.9997” is corrected to read “0.9995”; and
b. Line 35, the figure “0.9905” is corrected to read “0.9903”.

6. On page 49287, the table Budget Neutrality Adjustment for DRG Reclassifications and Recalibration and the Geographic Adjustment Factors” the following entries are corrected to read as follows:

Fiscal year	National Incremental Adjustment				Puerto Rico Incremental Adjustment			
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	Cumulative	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	Cumulative
2005	010.99946 ¹¹	1.00094	1.00140 ¹¹	0.991317	0.99115 ¹¹	1.00094	0.99208 ¹¹	0.98946

7. On page 49288,
a. First column,
(1) Line 48, the figure “1.0006” is corrected to read “1.0004”;
(2) Line 61, the figure “1.0006” is corrected to read “1.0004”;
(3) Line 64, the figure “0.9914” is corrected to read “0.9912”; and
(4) Line 67, the phrase “FY 002” is corrected to read “FY 2002”.
b. Second column,

(1) Line 3, the figure “1.0006” is corrected to read “1.0004”; and
(2) Line 4, the figure “0.9914” is corrected to read “0.9912”.
8. On page 49289,
a. Top of the page,
(1) Second column,
(a) Line 9, the figure “\$416.63” is corrected to read “\$416.53”; and
(b) Line 18, the figure “1.0006” is corrected to read “1.0004”.

(2) Third column
(a) Line 16, the figure “0.06” is corrected to read “0.04”
(b) Line 28, the figure “0.68” is corrected to read “0.65”
b. Middle of the page, the table entitled, Comparison of Factors and Adjustments: FY 2004 Capital Federal Rate ¹ and FY 2005 Capital Federal Rate two entries and a footnote are corrected to read as follows:

	FY 2004 ¹	FY 2005	Change	Percent change
GAF/DRG Adjustment factor ²	1.0025	1.0004	1.004	0.04
Capital federal rate	\$413.83	\$416.53	1.0065	0.65

² The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2004 to FY 2005 resulting from the application of the 1.0004 GAF/DRG budget neutrality factor for FY 2005 is 1.004.

c. Lower third of the page, the table, Comparison of Factors and

Adjustments: FY 2005 Proposed Capital Federal Rate ¹ and FY 2005 Final Capital

Federal Rate, two entries are corrected to read as follows:

	Proposed FY 2005	Final FY 2005	Change	Percent change
GAF/DRG adjustment factor ²	1.0015	1.0004	0.9989	-0.11
Capital federal rate	\$416.59	\$416.53	0.9999	-0.01

9. On page 49292, second column, seventh paragraph, the paragraph “Table 2—Hospital Case-Mix Indexes For Discharges Occurring in Federal Fiscal Year 2003; Hospital Average Hourly Wage For Federal Fiscal Years 2003 (1999 Wage Data), 2004 (2000 Wage Data), and 2005 (2001 Wage Data) Wage Indexes and 3-YEAR Average of

Hospital Average Hourly Wages” is corrected to read “Table 2.—Hospital Case-Mix Indexes For Discharges Occurring in Federal Fiscal Year 2003; Hospital Wage Indexes For Federal Fiscal Year 2005; Hospital Average Hourly Wages For Federal Fiscal Years 2003 (1999 Wage Data), 2004 (2000 Wage Data), and 2005 (2001 Wage Data);

and 3-Year Average of Hospital Average Hourly Wages”.

10. On page 49294,
a. Table 1A.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor is corrected to read as follows:

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR
[71.1 Percent Labor Share/28.9 Percent Nonlabor Share If Wage Index Greater Than 1]

Full update (3.3 Percent)		Reduced update (2.9 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
\$3,238.07	\$1,316.18	\$3,225.53	\$1,311.08

b. Table 1B.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor is corrected to read as follows:

TABLE 1B.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR
[62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Less Than or Equal to 1]

Full update (3.3 Percent)		Reduced update (2.9 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
\$2,823.64	\$1,730.62	\$2,812.70	\$1,723.91

c. Table 1C.—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor is corrected to read as follows:

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if Wage Index Greater Than 1		Rates if Wage Index Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	\$3,238.07	\$1,316.18	\$2,823.64	\$1,730.62
Puerto Rico	1,554.79	625.84	1,351.99	828.64

d. Table 1D.—Capital Standard Federal Payment Rate is corrected to read as follows:

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	\$416.53
Puerto Rico	199.01

11. On page 49295, at the top of the page, the heading “TABLE 2.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL

FISCAL YEAR 2003; HOSPITAL FISCAL YEAR 2005 WAGE INDEX; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES” is corrected to read “TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS

2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES”.

12. On pages 49295 through 49424, in Table 2—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 2003; Hospital Fiscal Year 2005 Wage Index; Hospital Average Hourly Wage for Federal Fiscal Years 2003 (1999 Wage Data), 2004 (2000 Wage Data), and 2005 (2001 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages, the table is corrected to read as follows:

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
010001	1.4628	0.7651	17.9841	19.4061	20.6563	19.3592
010004	***	*	20.1613	22.2674	22.7585	21.6609
010005	1.1670	0.9178	19.9733	19.6063	20.4937	20.0290
010006	1.3945	0.7906	18.3931	19.0976	21.0241	19.4984
010007	1.1115	0.7651	16.0781	17.5462	16.8811	16.8364
010008	1.0017	0.8311	19.0182	19.6573	23.8333	20.8947
010009	1.0250	0.8893	19.7273	20.4309	21.6422	20.5897
010010 ^h	1.0203	0.9097	17.7348	19.2644	22.3021	19.7359

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
010011	1.6232	0.9178	24.8922	25.8231	24.8166	25.1564
010012	1.2209	0.7856	20.3375	20.0896	21.7622	20.7424
010015	0.9482	0.7651	19.8205	18.8890	20.4732	19.7680
010016	1.2926	0.9178	20.3175	21.7918	23.0414	21.7886
010018	1.3080	0.9178	19.5519	19.2071	20.5888	19.7714
010019	1.2206	0.7906	17.6414	18.9177	20.1336	18.8827
010021 ^h	1.1834	0.7651	25.3335	17.7596	20.7108	20.6787
010022	0.9284	0.8909	22.1250	22.2267	25.8797	23.4461
010023	1.7445	0.8311	18.4567	20.4901	23.7791	20.7075
010024	1.6395	0.8311	17.3746	18.5942	20.0067	18.6270
010025	1.2124	0.7651	17.4702	19.3649	19.8561	18.8705
010027	0.7657	0.7651	16.5157	14.0975	14.9585	15.1595
010029	1.5338	0.8357	19.3393	20.9868	21.6724	20.7210
010031	***	*	19.2612	21.0176	20.9463	20.4044
010032	0.8718	0.7651	16.3968	16.4713	18.5073	17.1611
010033	2.0723	0.9178	21.9828	24.5088	25.5165	23.9915
010034	0.9857	0.8311	14.9379	14.9333	17.1625	15.6290
010035	1.1993	0.9178	20.7808	21.6182	23.1319	21.8768
010036	1.0902	0.7651	18.7157	19.2501	20.5125	19.4735
010038	1.1714	0.8011	19.6887	18.6578	20.3935	19.6125
010039	1.6404	0.8838	21.3550	23.0339	23.4151	22.6371
010040	1.4871	0.8077	20.4486	20.7779	21.6708	20.9799
010043	0.9615	0.9178	17.3567	19.9012	19.5422	18.9651
010044	1.0238	0.7651	23.4576	25.8560	23.0220	24.0513
010045	1.1016	0.8390	18.7569	22.7713	20.5658	20.5841
010046	1.6184	0.8077	18.8741	19.6754	20.8935	19.9036
010047	0.9117	0.7806	13.4130	16.1695	19.5937	16.1765
010049	1.1141	0.7651	16.3349	16.2973	17.7801	16.8074
010050	1.0486	0.9178	20.3028	20.7398	21.5625	20.8933
010051	0.8803	0.8339	12.3280	14.3006	14.7053	13.7722
010052	0.8896	0.7651	19.8289	11.9019	21.3673	16.4899
010053	1.0729	0.7651	15.4156	17.3238	17.4160	16.7020
010054	1.0491	0.8893	20.9656	20.6382	23.1894	21.5890
010055	1.4918	0.7651	19.5667	18.9664	19.1847	19.2296
010056	1.4717	0.9178	20.5645	21.1104	22.7183	21.5191
010058	0.8823	0.9157	16.1265	17.7800	20.3182	17.9980
010059	1.0548	0.8893	19.1270	20.5534	23.6963	21.1230
010061	1.0168	0.8157	18.5320	17.0447	20.5683	18.6485
010062	1.0883	0.7651	16.9721	17.1786	18.1323	17.4330
010064	1.7161	0.9178	20.5650	22.2280	25.4345	22.4456
010065	1.3846	0.8070	17.0557	17.2698	20.0108	18.1438
010066	0.8112	0.7651	14.8904	14.8696	17.0935	15.6113
010068	1.2149	0.9178	23.4322	18.3308	17.5690	20.1824
010069	1.0378	0.7651	15.4497	17.0957	19.6317	17.4477
010072	1.1030	0.7949	16.5652	18.8807	21.5419	18.9501
010073	0.9193	0.7651	13.5594	14.9826	16.4043	14.9376
010078	1.2359	0.8011	18.5127	20.1447	21.0633	19.8889
010079	1.1543	0.8838	17.1612	20.7401	20.4254	19.3330
010083 ^h	1.2127	0.8118	18.4282	19.8524	20.2166	19.4500
010084	1.5436	0.9178	19.8773	21.6522	22.5219	21.4099
010085	1.2555	0.8893	21.5860	22.5282	23.7007	22.6206
010086	1.0352	0.7651	16.8886	18.0122	19.4332	18.0635
010087	1.8181	0.7997	18.7915	19.7620	21.6226	20.0048
010089	1.2094	0.9157	19.5241	19.5783	22.2508	20.4322
010090	1.6804	0.7997	19.5635	20.0287	21.4322	20.3544
010091	0.9701	0.7651	17.1775	17.4672	19.4222	18.0426
010092	1.4402	0.8390	18.5478	19.9351	22.0709	20.1834
010095	0.8396	0.8339	12.3064	12.5243	13.4426	12.7704
010097	0.7691	0.8311	14.2675	15.1593	17.1735	15.4853
010098	0.9776	0.7651	15.5763	15.1629	19.6717	16.5274
010099	1.0663	0.7651	15.9232	16.3307	18.1849	16.8379
010100 ^h	1.5256	0.8118	18.3755	19.8146	20.0027	19.4279
010101	1.1213	0.7949	18.9525	19.0718	21.0085	19.6864
010102	0.9256	0.7651	15.7778	16.4637	19.9196	17.3540
010103	1.7993	0.9178	22.0802	22.5709	24.2201	22.9368
010104	1.6744	0.9178	21.9457	20.9391	24.1929	22.2745
010108	1.1065	0.8311	19.1596	20.7787	23.7803	21.1826

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
010109	0.9816	0.7651	15.9627	18.2235	21.7128	18.5994
010110	0.7468	0.7651	15.5817	16.0015	19.2706	17.3294
010112	0.9609	0.7651	15.6041	17.9243	17.2963	16.8980
010113	1.6569	0.7997	18.2774	19.4106	20.4181	19.3908
010114	1.3468	0.9178	19.3772	20.1763	21.5319	20.3330
010115	0.8452	0.7744	15.3510	15.7872	17.5985	16.2135
010118	1.2575	0.8311	17.4621	19.5302	18.8560	18.5514
010119	***	*	19.5163	20.5245	21.8215	20.6281
010120	0.9950	0.7997	18.9975	19.4368	20.5855	19.6680
010121	***	*	15.2345	17.1640	17.0329	16.5712
010125	1.0374	0.7651	16.5117	16.8622	16.8419	16.7415
010126	1.0882	0.8311	19.5933	19.9647	23.1856	20.9538
010128	0.8524	0.7651	16.6898	14.7646	17.9354	16.3915
010129 ^h	1.0610	0.8118	16.7609	16.4905	18.7821	17.4262
010130	0.9761	0.9178	17.4614	18.7190	18.4944	18.2496
010131	1.2915	0.8838	19.0492	22.9969	24.2197	22.1728
010134	0.8697	*	18.5178	17.7717	*	18.1134
010137	1.2445	0.9178	21.3573	28.9402	29.7665	26.1994
010138	0.7579	0.7651	14.1368	14.2025	13.5082	13.9815
010139	1.5044	0.9178	20.5708	22.8390	24.9410	22.7783
010143	1.1936	0.9178	18.9084	20.5639	22.1312	20.5538
010144	1.5383	0.7997	18.8272	19.1497	20.6425	19.5545
010145	1.2420	0.8390	20.8157	22.1394	23.1976	22.0834
010146	1.0689	0.8011	18.3666	21.3083	19.9944	19.8782
010148	0.8709	0.7651	18.4590	17.6829	18.5309	18.2453
010149	1.2944	0.8311	19.0199	21.0086	23.1593	20.9862
010150	1.0639	0.8357	19.4819	21.2360	20.6738	20.4784
010152	1.3146	0.7997	19.8990	21.6038	22.1626	21.2042
010155	***	*	13.6137	*	*	13.6137
010157	1.1366	0.7906	17.7373	19.6977	21.3574	19.5828
010158	1.0915	0.8893	18.6052	18.5464	22.4440	19.7809
010159	***	*	19.3950	*	*	19.3950
010161	***	*	*	*	27.5119	27.5119
020001	1.7071	1.2164	28.6530	30.1452	31.6091	30.2393
020002	***	*	28.2758	*	*	28.2758
020004	1.2047	1.1733	29.2351	27.3516	29.9926	28.8392
020005	0.8979	*	35.0860	32.7936	*	33.9497
020006	1.1674	1.2164	33.0843	31.2673	33.4210	32.5617
020007	***	*	27.7271	*	*	27.7271
020008	1.2534	1.3119	31.8877	33.4543	34.5856	33.3645
020009	***	*	18.5594	*	*	18.5594
020010	0.9035	*	23.7276	20.7929	*	22.1109
020011	***	*	27.5062	*	*	27.5062
020012	1.3522	1.1733	26.7586	27.9955	29.3419	28.1074
020013	0.9687	*	29.5647	30.6423	*	30.1127
020014	1.1194	1.1733	27.7870	29.6805	32.1233	29.9193
020017	1.8770	1.2164	28.8753	30.3017	32.9281	30.7977
020024	1.0782	1.1733	25.5933	28.0930	27.9799	27.2883
020025	***	*	29.4374	*	*	29.4374
030001	1.2134	0.9985	22.8996	25.7513	27.7572	25.2939
030002	1.9953	0.9985	23.1450	25.6038	27.9628	25.6016
030003	***	*	23.9850	22.1436	*	23.0546
030004	1.0093	*	13.8452	*	*	13.8452
030006	1.6635	0.9125	20.5019	23.2881	24.0169	22.4651
030007	1.3947	1.0564	22.2473	26.1551	26.9442	25.2403
030009	1.1142	0.9125	19.1258	19.9131	21.4065	20.1252
030010	1.3878	0.9125	19.8496	20.7204	22.8647	21.1646
030011	1.4758	0.9125	19.8141	21.0028	22.8422	21.2114
030012	1.2790	0.9985	21.1099	24.2366	25.5205	23.8026
030013	1.3507	0.9125	19.9517	21.9766	23.5229	21.8802
030014	1.4627	0.9985	20.3017	23.3663	25.1189	22.9571
030016	1.3052	0.9985	22.2526	24.3380	27.1583	24.6799
030017	1.6980	0.9985	23.1702	21.8792	24.4055	23.1546
030018	1.1998	0.9985	21.8067	24.9216	24.4308	23.7395
030019	1.1887	0.9985	22.0341	23.2973	28.4917	24.3829
030022	1.6736	0.9985	22.3351	24.9941	25.1461	24.2980
030023	1.6129	1.0777	25.4626	28.6627	28.4112	27.6224

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
030024	2.1141	0.9985	23.7663	26.7641	28.3470	26.1920
030025	***	*	20.2690	*	*	20.2690
030027	0.9766	0.9125	18.5500	19.4583	21.0527	19.7088
030030	1.5804	0.9985	23.1280	25.2425	24.6005	24.2281
030033	1.2643	1.0564	20.3034	26.3814	26.6009	24.3844
030034	***	*	19.5578	*	*	19.5578
030035	***	*	20.5339	*	*	20.5339
030036	1.2000	0.9985	22.2690	24.9432	26.5708	24.6324
030037	2.1363	0.9985	23.7325	23.0542	30.3907	25.3379
030038	1.6005	0.9985	23.4477	25.2632	26.5178	25.1009
030040	0.8710	0.9125	19.3707	21.2717	22.5130	21.0352
030041	***	*	18.4749	*	*	18.4749
030043	1.2791	0.9125	20.5653	23.5172	26.0825	23.4414
030044	0.9557	0.9125	18.6781	21.9503	19.5714	19.9272
030047	***	*	22.7385	*	*	22.7385
030049	***	*	19.7315	*	*	19.7315
030054	***	*	15.7974	*	*	15.7974
030055 ^h	1.3097	1.1345	20.8373	22.8612	23.1837	22.3625
030059	***	*	27.3929	*	*	26.9545
030060	1.1863	0.9125	19.5021	21.7685	22.3551	21.2224
030061	1.6178	0.9985	21.1013	22.9706	23.4722	22.5411
030062	1.1997	0.9125	19.2670	21.1639	21.9849	20.8320
030064	1.8861	0.9125	21.6435	22.8009	24.6732	23.0238
030065	1.6009	0.9985	22.2846	24.6064	25.6738	24.2585
030067	0.9665	0.9125	17.6414	18.4003	19.1332	18.3489
030068	1.0854	0.9125	18.9718	19.7097	19.7030	19.4968
030069 ^h	1.3534	1.1345	23.4903	24.5432	25.6243	24.5990
030080	1.4335	0.9125	21.2299	22.8953	24.3573	22.8911
030083	1.3118	0.9985	23.5049	24.3273	24.9269	24.2989
030085	1.5587	0.9125	21.6542	21.8196	23.2070	22.2934
030087	1.5889	0.9985	23.1339	25.6351	26.3878	25.1083
030088	1.3864	0.9985	21.4491	23.5761	23.2478	22.8032
030089	1.5208	0.9985	22.0850	24.5055	26.2166	24.3651
030092	1.4203	0.9985	19.6625	24.0515	25.4127	23.2498
030093	1.2658	0.9985	21.7195	23.2485	23.5623	22.9162
030094	1.3193	0.9985	21.8049	24.5992	26.9985	24.3985
030095	***	*	20.5222	*	*	20.5222
030099	0.9046	0.9125	19.8092	20.3310	26.7996	22.1687
030100	1.9561	0.9125	23.5868	27.6299	*	25.8489
030101 ^h	1.3419	1.1345	21.1029	23.7661	25.0077	23.1660
030102	2.4891	0.9985	21.5405	27.9419	*	24.8036
030103	1.6329	0.9985	28.9308	29.1105	28.2832	28.7420
030104	***	*	32.8669	34.6028	*	33.8315
030105	2.6154	0.9985	*	*	27.6900	27.6900
030106	2.3713	0.9985	*	*	30.4791	30.4791
040001	1.0995	0.8670	16.3882	18.7141	23.1475	19.5432
040002	1.1706	0.7581	16.1353	18.0776	19.3429	17.8255
040003	1.0866	0.7581	15.5186	16.3918	18.5000	16.7495
040004	1.5912	0.8670	19.0105	21.2335	23.3504	21.3232
040005	***	*	16.5465	*	*	16.5465
040007	1.5795	0.8840	22.5319	23.3992	23.4565	23.1106
040008	***	*	20.2122	*	*	20.2122
040010	1.4170	0.8670	19.8251	20.7114	22.0984	20.8951
040011	0.9733	0.7581	17.1337	18.8346	19.0319	18.5339
040014	1.2952	0.8840	19.3996	22.4970	24.0846	21.9495
040015	0.9850	0.7581	17.9601	18.8513	18.0793	18.2951
040016	1.6960	0.8840	19.8087	21.2198	22.7219	21.2351
040017	1.1121	0.8267	16.5648	17.7545	19.4365	17.8909
040018	1.0668	0.8310	18.8203	22.0408	23.8515	21.6003
040019	1.1459	0.8887	21.0465	21.1711	21.5316	21.2611
040020	1.5207	0.8887	17.6056	18.6419	20.9136	19.0968
040021	1.1647	0.8840	21.3321	23.5620	24.7771	23.3281
040022	1.5752	0.8670	19.2393	21.4194	23.7462	21.2573
040024	1.0407	0.7581	17.1507	17.5750	20.1101	18.3059
040025	***	*	14.8070	*	*	14.8070
040026	1.5991	0.9268	21.0143	22.7699	24.3053	22.7334
040027	1.3854	0.8267	17.7161	19.3388	19.9348	18.9814

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
040028	***	*	15.2850	*	*	15.2850
040029	1.5039	0.8840	22.5094	22.1882	22.8770	22.5261
040030	***	*	16.5488	*	*	16.5488
040032	0.9642	*	13.8013	16.2781	18.5171	16.1503
040035	0.8922	0.7581	11.0611	11.8237	13.4265	12.0575
040036	1.5023	0.8840	21.1066	21.6742	24.2851	22.3500
040037	***	*	15.4985	*	*	15.4985
040039	1.2725	0.7581	15.2811	15.9673	17.7976	16.3796
040040	***	*	19.6705	*	*	19.6705
040041	1.1707	0.8840	17.7783	20.4646	22.0188	20.0911
040042	1.3102	0.9231	16.6875	16.2285	18.9550	17.2476
040044	***	*	17.1869	*	*	17.1869
040045	0.9625	0.7581	16.6648	19.5572	18.7952	18.2593
040047	1.0548	0.8026	18.6295	21.6323	21.5334	20.6477
040050	1.1094	0.7581	14.2087	15.1428	15.4782	14.9341
040051	1.0272	0.7581	18.2152	17.6964	18.8943	18.2885
040053	0.9972	0.7581	14.1508	19.2586	20.8153	17.5782
040054	1.0424	0.7581	16.5217	16.5573	16.7370	16.6038
040055	1.4787	0.8310	17.4236	19.7336	22.2237	19.7620
040058	***	*	19.3124	*	*	19.3124
040060	***	*	15.4220	*	*	15.4220
040062	1.5584	0.8310	19.4255	21.9336	21.6403	20.9790
040064	***	*	13.3479	*	*	13.3479
040066	1.0431	0.8840	19.5619	21.7766	23.4616	21.6179
040067	1.0538	0.7581	15.0081	16.0516	15.1441	15.3964
040069	1.1116	0.8887	18.9754	20.5968	21.7607	20.4611
040070	1.0039	*	18.6066	*	*	18.6066
040071	1.5333	0.8726	18.4956	19.4324	22.9350	20.2395
040072	1.0808	0.8840	21.3320	19.3079	20.8269	20.4867
040074	1.1335	0.8840	20.8465	22.0800	22.6147	21.8283
040075	0.9844	0.8670	14.6681	15.7875	16.2583	15.5643
040076	1.0126	0.8656	21.8010	23.5947	21.0442	22.0817
040077	0.9878	0.7581	14.7230	16.7832	18.3261	16.5572
040078	1.5293	0.9268	19.6363	21.4854	24.4589	21.9124
040080	0.9910	0.8229	22.8154	18.4470	21.3483	20.6735
040081	0.8328	0.7581	12.4797	13.2797	13.7148	13.1618
040082	***	*	16.4840	*	*	16.4840
040084	1.1179	0.8840	18.3410	20.1163	22.6441	20.4399
040085	0.9985	0.7581	14.1782	15.5811	18.0756	15.8198
040088	1.3499	0.8955	18.3159	20.0032	21.2974	19.8367
040090	***	*	16.6619	*	*	16.6619
040091	1.2814	0.8440	20.2904	20.6688	23.0252	21.3255
040093	***	*	14.7132	*	*	14.7132
040100	1.3423	0.7740	17.0271	17.8889	19.3560	18.1847
040105	1.0320	0.7581	14.8936	15.4697	15.8171	15.4079
040106	***	*	19.0936	*	*	19.0936
040107	0.9113	*	20.6852	17.6695	*	19.2231
040109	1.1431	0.7581	16.2496	17.1706	18.8624	17.4430
040114	1.7775	0.8840	21.3826	21.6849	23.5628	22.2116
040118	1.4221	0.8229	19.6248	21.7913	24.2547	22.0146
040119	1.3583	0.8840	18.6028	19.9013	20.1631	19.5668
040126	0.8714	0.7581	16.3391	13.3832	12.5944	13.8589
040132	***	*	24.6947	29.2343	36.5525	30.3513
040134	2.4517	0.8840	22.1291	24.4646	*	23.3449
040136	***	*	21.4138	*	*	21.4138
040137	1.1769	0.8840	*	24.7813	23.4672	24.1071
040138	1.1841	0.8670	*	22.3523	23.3615	22.8913
040140	***	*	*	*	25.1224	25.1224
050002	1.4035	1.5338	30.2629	30.9729	31.9709	31.0784
050006	1.5602	1.0450	22.4890	25.4604	27.6176	25.4669
050007	1.4877	1.4694	31.6270	34.1406	37.5804	34.4787
050008	1.3667	1.4694	28.2021	32.4067	36.9371	32.5714
050009	1.8839	1.4133	28.3021	30.2740	35.5384	31.4470
050013	2.0261	1.4133	27.2552	29.8401	31.7637	29.6455
050014	1.1627	1.1756	25.1664	27.7646	29.5726	27.5073
050015	1.2392	1.0450	28.2204	27.5652	30.1398	28.6270
050016	1.1481	1.1115	22.7014	25.5508	25.5735	24.6660

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
050017	2.0023	1.1756	25.7403	28.4911	30.5863	28.2416
050018	1.1589	1.1742	16.5909	17.9621	20.3179	18.3521
050022	1.5791	1.0979	26.2574	28.1312	28.2773	27.6284
050024	1.1174	1.1260	21.5230	25.1425	26.9378	24.7268
050025	1.7773	1.1260	26.0161	29.8262	31.7242	29.2573
050026	1.5392	1.1260	23.4651	24.2564	26.6406	24.8828
050028	1.2246	1.0450	17.9421	18.7866	21.5448	19.5088
050029	***	*	26.6783	30.2538	34.3934	29.9982
050030	1.2557	1.0546	21.8639	21.9251	22.9148	22.2387
050032	***	*	24.4176	28.8046	*	26.4686
050033	***	*	31.1768	*	*	31.1768
050036	1.6468	1.0450	24.8017	25.3885	27.4915	25.9272
050038	1.5562	1.4723	32.1757	36.1619	35.0441	34.5289
050039	1.5373	1.0546	23.8478	26.8993	29.8179	26.9395
050040	1.1781	1.1742	30.1153	30.7426	31.8983	30.9709
050042	1.2538	1.1709	25.4903	27.6765	29.8062	27.6641
050043	1.5672	1.5338	38.8988	37.3217	39.6054	38.6251
050045	1.1878	1.0450	21.0356	22.1691	22.7051	21.9490
050046	1.1542	1.1742	25.3067	25.5490	25.2786	25.3770
050047	1.6483	1.4694	31.6959	34.4427	39.3993	35.3295
050051	***	*	17.9266	*	*	17.9266
050054	1.1778	1.0979	19.2395	21.3495	27.1437	22.2812
050055	1.2232	1.4694	32.0923	36.1182	36.9386	35.0923
050056	1.4087	1.1742	24.7994	27.1458	29.4829	27.2030
050057	1.6159	1.0450	22.2584	24.2759	26.2099	24.3476
050058	1.5844	1.1742	24.8366	25.9389	27.3584	26.0730
050060	1.5647	1.0648	21.9971	22.9491	26.5515	23.9483
050061	1.5036	1.0757	23.9906	25.3042	*	24.6327
050063	1.3802	1.1742	25.5798	28.6093	32.0515	28.7954
050065	1.8252	1.1730	27.6677	28.8369	33.8223	30.2555
050066	***	*	26.3920	*	*	26.3920
050067	1.2271	1.1993	22.1250	27.8867	29.6982	25.7491
050068	***	*	19.2325	21.9031	*	19.8252
050069	1.5827	1.1730	25.8560	27.2744	28.6752	27.2574
050070	1.2693	1.4694	36.4136	39.5178	40.5645	38.9110
050071	1.2117	1.5338	36.4834	40.1344	41.1036	39.3177
050072	1.3637	1.5338	36.1146	39.2529	40.8108	38.8556
050073	1.2998	1.5338	36.1054	38.6763	41.3430	38.8513
050075	1.2462	1.5338	37.8104	40.2265	43.7101	40.7734
050076	2.0695	1.5338	37.0415	40.8075	43.0845	40.3198
050077	1.6248	1.1260	25.3481	27.1234	29.6264	27.3341
050078	1.2394	1.1742	23.0613	24.1091	25.6814	24.3042
050079	1.5268	1.5338	36.5455	38.8981	42.7385	39.7417
050082	1.7403	1.1742	23.7718	27.5022	28.9139	26.6018
050084	1.5700	1.1138	25.1155	26.0607	28.2664	26.5592
050088	0.8219	1.1115	25.2282	27.1103	26.4093	26.2305
050089	1.3284	1.1131	23.4120	24.7857	29.4884	25.8460
050090	1.2937	1.3246	25.4545	27.4193	31.1774	27.9574
050091	1.1092	1.1742	26.6463	29.2522	30.1534	28.7339
050092	***	*	17.1883	*	*	17.1883
050093	1.5357	1.0648	27.2048	29.2642	31.1083	29.2944
050095	***	*	29.2228	*	*	29.2228
050096	1.3911	1.1742	22.5034	23.0525	24.2277	23.1998
050097	***	*	24.2548	24.6726	26.6788	25.1549
050099	1.5024	1.1131	26.2363	27.1282	28.7711	27.4160
050100	1.7732	1.1260	23.9877	25.6798	28.0303	25.8976
050101	1.3660	1.4538	33.1232	32.9866	35.4655	33.8972
050102	1.2746	1.0979	22.6741	25.5763	24.9381	24.3305
050103	1.4671	1.1742	23.5946	27.8079	28.7375	26.6551
050104	1.3878	1.1742	27.3260	26.1592	29.1240	27.5138
050107	1.3797	1.0757	22.2745	22.6900	27.6002	24.3549
050108	1.9362	1.1756	25.6983	28.5244	31.4271	28.5322
050110	1.2765	1.0757	21.3399	21.9297	20.0769	21.0071
050111	1.2334	1.1742	21.0813	23.7715	26.6345	23.8200
050112	1.5086	1.1742	29.1268	31.9797	34.0258	31.8161
050113	1.3060	1.4694	32.4493	32.6932	34.2851	33.1750
050114	1.3403	1.1742	27.6486	28.1938	29.2858	28.4022

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
050115	1.5361	1.1260	24.3748	24.1481	27.5207	25.3681
050116	1.6038	1.1742	27.0331	28.2924	28.8193	28.0729
050117	1.3507	1.0989	23.0697	24.7555	28.2227	25.4459
050118	1.1585	1.1138	24.9094	28.9358	33.0650	29.1714
050121	1.3693	1.0450	18.8430	25.0858	25.5962	22.9069
050122	1.5514	1.1138	26.9048	29.1534	29.7629	28.6276
050124	1.2888	1.1742	23.9379	23.0843	26.7065	24.5798
050125	1.3386	1.4723	33.3290	35.6573	40.9218	36.7497
050126	1.3579	1.1742	26.9718	27.7126	29.6203	28.1272
050127	1.3493	1.1683	20.5928	21.8719	23.6208	21.9780
050128	1.5056	1.1260	26.2519	28.7668	28.3278	27.7857
050129	1.8088	1.1131	23.7432	25.2780	27.8488	25.6046
050131	1.2137	1.4694	33.0979	37.7845	38.6834	36.6672
050132	1.3799	1.1742	24.1582	27.8805	29.4317	27.1434
050133	1.4609	1.0620	23.9479	25.1948	27.6030	25.6990
050135	0.9452	1.1742	23.2750	*	24.9415	24.0588
050136	1.2420	1.3246	28.0754	31.6146	35.2834	31.6860
050137	1.3008	1.1742	33.7489	35.0503	36.5409	35.0951
050138	1.9011	1.1742	40.8913	43.0858	43.8671	42.6456
050139	1.2215	1.1742	35.1492	33.8749	35.1013	34.7094
050140	1.4016	1.1131	36.7096	36.1708	37.5473	36.8236
050144	1.4257	1.1742	29.8983	30.3679	32.4042	30.9480
050145	1.2869	1.3820	37.5003	37.5722	39.5676	38.2547
050148	1.0800	1.0450	21.1621	17.3908	24.7063	20.7433
050149	1.5371	1.1742	25.8880	28.0500	30.1596	27.8848
050150	1.1778	1.1756	25.9494	26.7728	31.5333	28.0206
050152	1.3802	1.4694	34.5096	34.5694	40.3464	36.6036
050153	1.5765	1.4723	33.3333	34.5870	40.4446	36.0526
050155	1.0420	1.1742	23.2119	21.2068	21.8829	22.1262
050158	1.2971	1.1742	28.9764	30.6598	33.6400	31.2133
050159	1.2630	1.1742	26.6140	27.4051	30.8069	28.2926
050167	1.3398	1.1138	21.9596	23.2022	25.9850	23.7818
050168	1.6823	1.1730	27.1971	27.5313	30.8036	28.4978
050169	1.4020	1.1742	24.7737	25.6896	26.2864	25.5983
050170	***	*	27.7692	29.4075	*	28.5112
050172	1.2746	1.0450	22.0400	24.5849	27.1497	24.5792
050173	1.1982	1.1730	*	27.7070	27.6097	27.6547
050174	1.7598	1.3655	31.6888	33.5204	36.3117	34.0156
050175	1.3022	1.1742	26.0146	26.9627	31.5615	28.1510
050177	1.2200	1.1742	22.5039	23.1575	24.7531	23.4567
050179	1.1785	1.1993	22.8941	23.0583	25.8072	23.9667
050180	1.6065	1.5338	34.0900	36.9905	40.8101	37.3796
050186	***	*	25.0791	27.6638	*	26.3758
050188	1.3376	1.4723	30.6007	34.1503	39.3507	34.8263
050189	0.9822	1.3820	28.3295	32.3513	20.0709	25.6362
050191	1.5115	1.1742	29.4162	28.1689	*	28.7551
050192	1.0034	1.0450	19.0400	19.5327	21.2448	19.9850
050193	1.1550	1.1730	25.5293	24.6307	30.7341	26.9959
050194	1.2811	1.4759	28.5389	28.1413	38.6750	31.6195
050195	1.4801	1.5338	39.1617	42.1735	43.9696	41.8230
050196	1.1320	1.0450	19.4304	20.7257	25.2168	21.6072
050197	1.9489	1.4694	34.6878	*	40.8832	37.6336
050204	1.4387	1.1742	23.0192	24.9458	25.2512	24.4720
050205	1.2592	1.1742	24.1275	25.2841	28.0504	25.8192
050207	1.3222	1.0450	23.7774	25.1863	27.0216	25.3211
050211	1.2909	1.5338	33.2481	34.3396	38.3319	35.2596
050214	1.4703	1.1742	21.1480	22.4773	24.4785	22.6170
050215	1.6874	1.4723	31.6895	36.6063	41.6886	36.6088
050217	1.2167	1.0450	21.3026	22.2055	23.6286	22.3914
050219	1.0843	1.1742	21.7637	21.8649	22.9226	22.2450
050222	1.6931	1.1260	23.0670	25.2922	26.3882	24.9615
050224	1.7014	1.1730	24.8431	26.2108	26.7916	26.0048
050225	1.4137	1.0546	22.0981	25.0219	29.5184	25.5541
050226	1.5534	1.1730	26.1959	26.0826	29.2259	27.1921
050228	1.3658	1.5338	36.0632	38.6751	40.1362	38.2963
050230	1.3563	1.1730	26.7963	30.0380	34.1417	30.4321
050231	1.6282	1.1742	27.4697	27.8896	30.1298	28.5338

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
050232	1.4661	1.1115	25.8640	25.3439	24.4383	25.1909
050234	1.1504	1.1260	25.0104	24.0754	29.2421	25.9702
050235	1.5715	1.1742	26.0323	27.2838	27.8965	27.0815
050236	1.3305	1.1742	27.7406	27.0687	28.1969	27.6512
050238	1.4768	1.1742	25.1796	26.0312	29.1481	26.8188
050239	1.6086	1.1742	24.9469	27.0866	28.2327	26.8433
050240	1.6546	1.1742	28.8910	32.8542	35.2284	32.6305
050242	1.3998	1.4759	33.5646	34.4412	39.7629	35.9654
050243	1.5892	1.0979	26.0256	28.5626	31.8153	28.8813
050245	1.3235	1.1131	24.6092	25.7585	27.0949	25.8577
050248	1.0760	1.3820	28.4413	29.1192	31.6240	29.7919
050251	0.9414	1.0450	27.9530	24.4552	26.5021	26.1432
050253	0.8940	1.1730	21.0399	23.9246	22.2450	22.4112
050254	1.1655	1.1756	22.3414	23.3358	24.1512	23.3225
050256	1.7636	1.1742	25.1104	26.8618	28.4728	26.8599
050257	0.9838	1.0450	15.6379	17.4909	20.8367	18.0051
050260	***	*	30.1623	*	*	30.1623
050261	1.2647	1.0450	19.4649	21.4693	25.3005	22.0287
050262	1.9550	1.1742	30.8866	33.0425	36.1162	33.3924
050264	1.3440	1.5338	33.2270	37.4742	41.3478	37.1652
050267	***	*	27.8394	26.6558	26.7060	27.0912
050270	1.2834	1.1260	26.4092	27.9871	30.0540	28.2704
050272	1.4246	1.1131	23.3443	24.0921	25.9103	24.4736
050276	1.2460	1.5338	34.0633	34.7422	41.2251	36.8082
050277	1.2564	1.1742	23.6065	35.6323	35.8246	32.0771
050278	1.5387	1.1742	24.9699	26.0331	28.0351	26.3900
050279	1.2703	1.1131	22.2776	23.5145	25.5299	23.7872
050280	1.6777	1.1830	26.3392	28.5504	30.6723	28.5663
050281	1.4351	1.1742	25.2698	25.7832	26.2623	25.8272
050282	***	*	26.4698	*	*	26.4698
050283	1.5681	1.5338	32.3270	35.1831	38.5600	35.4742
050286	***	*	20.6190	19.7352	19.4973	19.9061
050289	1.5984	1.4694	32.2125	34.9645	38.6875	35.2956
050290	1.6311	1.1742	31.5000	31.9510	32.6388	32.0351
050291	1.7489	1.3246	30.9334	28.3451	29.6162	29.5747
050292	1.0285	1.0979	21.4357	27.6114	27.0775	25.2754
050293	***	*	17.1935	*	*	17.1935
050295	1.5630	1.0450	25.4405	25.4332	31.5960	27.0241
050296	1.1549	1.4723	30.0984	33.5948	34.9952	32.9186
050298	1.1253	1.1131	22.4000	26.1707	25.8232	24.7510
050299	1.3307	1.1742	24.6751	26.9870	27.7535	26.5352
050300	1.6002	1.1131	26.0298	26.3182	28.3862	26.9438
050301	1.2424	1.0450	24.7987	25.7167	28.5769	26.4086
050305	1.4704	1.5338	36.6981	38.7597	40.9978	38.8596
050308	1.4367	1.4723	30.3887	31.6790	38.0564	33.4068
050309	1.3856	1.1756	25.5221	25.5367	28.9181	26.7014
050312	1.6034	1.1830	26.0172	28.2557	32.6846	29.2299
050313	1.1710	1.1138	28.9125	25.3372	27.5321	27.1784
050315	1.4110	1.0450	22.5906	23.6638	26.1224	24.1843
050320	1.2867	1.5338	31.6571	31.4570	36.3252	33.3109
050324	1.9545	1.1260	26.8313	28.4931	30.9958	28.8746
050325	1.2761	1.1993	22.6352	26.6325	30.2280	26.1975
050327	1.6411	1.1131	31.1527	33.0549	29.8327	31.2216
050329	1.3055	1.0979	24.2134	26.6341	26.8021	25.9438
050331	1.2629	1.3246	25.2110	21.5193	20.9847	22.6062
050333	1.1237	1.0450	14.1808	15.6929	15.3119	15.0561
050334	1.7059	1.3820	34.3956	37.2336	38.7635	36.8622
050335	1.4820	1.0626	22.9335	24.9274	27.4046	25.1372
050336	1.2582	1.1138	22.0202	23.2687	25.3062	23.5022
050342	1.1848	1.0450	22.4510	23.0282	24.7654	23.4399
050348	1.6467	1.1730	29.3364	28.9864	33.2676	30.6134
050349	0.9532	1.0450	15.4536	15.6043	16.9251	15.9684
050350	1.3278	1.1742	27.2368	27.2573	29.4262	27.9426
050351	1.4875	1.1742	25.2436	27.4042	29.3082	27.4273
050352	1.2212	1.1756	27.7489	32.6572	24.2931	27.8949
050353	1.5494	1.1742	24.1009	25.4309	26.6332	25.4247
050355	0.8275	1.0450	41.4707	*	11.2498	20.5891

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
050357	1.3323	1.0757	24.3540	25.2126	26.7265	25.4355
050359	1.1560	1.0450	19.7653	22.9175	23.6030	22.1297
050360	1.4100	1.4694	33.3592	35.9032	38.8658	36.1674
050366	1.1521	1.0450	22.0442	23.4696	25.7692	23.8612
050367	1.3959	1.4538	31.7487	32.6760	34.4959	33.0088
050369	1.2685	1.1742	26.6627	28.0909	27.1327	27.3063
050373	1.4011	1.1742	29.9749	30.7301	32.2315	30.9778
050376	1.4140	1.1742	28.4026	30.3530	30.7562	29.8294
050377	***	*	11.6463	14.3892	20.2484	13.8073
050378	1.0552	1.1742	27.8389	30.4937	33.9087	30.7032
050379	0.9219	1.0450	24.2409	27.5151	31.7645	27.7551
050380	1.6068	1.4723	31.5962	35.8014	39.1098	35.4231
050382	1.3413	1.1742	26.3968	26.8950	26.0927	26.4631
050385	1.3045	1.3246	27.1692	*	25.5735	26.2354
050388	***	*	17.6762	*	*	17.6762
050390	1.1781	1.0979	25.8556	25.7881	28.7761	26.7764
050391	1.1852	1.1742	19.0832	20.2887	21.3012	20.1817
050392	1.0964	1.0450	24.9004	21.8139	22.7209	23.0523
050393	1.2970	1.1742	25.4028	26.4918	28.2369	26.7640
050394	1.4948	1.1742	23.1641	25.1869	26.0074	24.8523
050396	1.6243	1.0757	25.7580	28.4161	30.5470	28.3141
050397	0.8564	1.0648	23.3213	24.7279	27.4716	25.1220
050404	***	*	16.4845	*	*	16.4845
050406	***	*	21.5282	*	*	21.5282
050407	1.2436	1.4694	32.0753	33.2894	35.6035	33.6812
050410	***	*	17.1718	19.8436	19.4995	18.7459
050411	1.3422	1.1742	33.1718	35.5207	37.3817	35.3683
050414	1.3055	1.1756	24.5471	28.2381	28.8561	27.2835
050417	1.2227	1.0450	23.3862	24.5360	25.2930	24.3723
050419	1.4058	1.1709	25.1449	26.4357	28.4471	26.6564
050420	1.2159	1.1742	26.4201	26.7537	26.1838	26.4539
050423	0.9497	1.0979	24.8113	26.5188	28.5944	26.8040
050424	1.9099	1.1260	25.9378	27.5273	29.9133	27.7834
050425	1.3273	1.1756	33.7276	37.7347	38.5317	36.8369
050426	1.3374	1.1730	26.7941	30.9610	30.0077	29.2330
050427	***	*	31.4156	*	*	31.4156
050430	0.9069	1.0450	25.2322	31.5170	24.6684	26.2981
050432	1.4370	1.1742	26.0686	28.1105	30.3547	28.2703
050433	0.8921	1.0450	17.7979	14.3846	20.7565	17.5511
050434	1.1173	1.0450	24.0017	*	25.9506	25.0135
050435	1.1001	1.1260	22.5428	22.6618	32.2183	25.4595
050438	1.5756	1.1742	25.3763	26.5535	26.4668	26.1457
050440	***	*	25.4767	*	*	25.4767
050441	1.9952	1.4723	33.4696	36.6680	38.2823	36.1818
050443	***	*	16.8897	*	*	16.8897
050444	1.3825	1.0989	22.6469	23.5299	27.6971	24.5287
050446	***	*	20.3611	*	*	20.3611
050447	0.8760	1.1260	24.4339	25.7274	21.8552	23.7871
050448	1.1248	1.0450	22.6612	26.6967	25.0983	24.6971
050454	1.8507	1.4694	30.3063	34.4813	36.8383	33.8918
050455	1.6565	1.0450	20.5575	24.1694	24.5314	23.0077
050456	1.2345	1.1742	17.5845	23.7594	22.1675	20.7473
050457	1.6310	1.4694	34.2116	37.4570	40.2725	37.1222
050464	1.7422	1.1993	25.8092	31.4768	37.1342	31.7474
050468	1.5137	1.1742	22.9771	17.8128	29.4280	22.5159
050469	1.0786	1.0450	*	25.7995	27.3281	26.6090
050470	1.0753	1.0648	15.7765	21.6981	18.4689	18.4143
050471	1.7249	1.1742	29.4705	32.3570	34.5484	32.1366
050476	1.3097	1.0707	25.9458	26.0482	30.9974	27.6386
050477	1.4185	1.1742	30.8781	32.1676	34.6400	32.6903
050478	1.0308	1.0757	28.1830	28.3894	30.9865	29.1971
050481	1.4192	1.1742	28.5320	30.3890	31.9177	30.3563
050482	***	*	21.6091	*	*	21.6091
050485	1.6049	1.1742	25.2723	27.1437	28.8459	27.0303
050488	1.2717	1.5338	33.8291	37.2438	40.5313	37.3033
050491	0.9858	1.1730	27.7413	29.2987	30.6461	29.2417
050492	1.4734	1.0648	23.4977	23.7384	27.4933	25.0895

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
050494	1.3243	1.2938	30.2876	30.8706	35.1457	32.0953
050496	1.7293	1.5338	32.7474	35.7115	38.2871	35.5428
050497	***	*	*	14.4481	15.9501	15.1581
050498	1.3228	1.1756	27.6099	28.2196	28.2667	28.0378
050502	1.6874	1.1742	27.2724	28.0102	28.7200	28.0110
050503	1.4279	1.1260	25.7668	26.7924	29.2001	27.2829
050506	1.6048	1.1115	27.1555	30.4731	32.4509	30.0721
050510	1.1787	1.5338	36.2548	39.6005	44.3883	40.1811
050512	1.3349	1.5338	36.0785	39.0767	41.8921	39.1165
050515	1.2916	1.1260	37.3440	36.3131	37.4251	37.0308
050516	1.4978	1.1756	25.3450	30.0985	29.4936	28.0936
050517	1.1032	1.1131	23.6067	23.4131	23.6034	23.5417
050522	***	*	37.0295	38.9157	*	37.5829
050523	1.2626	1.5338	32.1272	33.8053	34.7491	33.6018
050526	1.2497	1.1730	26.8814	29.0004	29.9495	28.6527
050528	1.1580	1.0450	21.1741	23.9177	28.6273	24.7915
050531	1.1534	1.1742	*	22.7311	25.0157	23.8961
050534	1.3201	1.0979	24.4038	26.7941	29.7546	27.1168
050535	1.3024	1.1730	27.7626	29.7904	32.3646	30.2162
050537	1.3103	1.1683	26.2342	25.1291	27.4196	26.2710
050539	1.2998	1.0707	23.7778	25.3328	28.0586	25.6658
050541	1.4734	1.5338	37.0551	41.1980	43.7765	40.7592
050542	0.9456	*	21.8129	21.2846	*	21.5965
050543	0.7402	1.1730	22.4134	24.0334	25.7161	24.1159
050545	0.8151	1.1742	33.6302	33.4322	42.9451	35.7939
050546	0.6867	1.0450	39.4267	42.8052	52.7180	44.2209
050547	0.9320	1.3246	37.7632	40.6483	45.1842	40.9624
050548	0.6769	1.1730	30.3337	32.3944	37.1314	33.1735
050549	1.5501	1.2938	30.0948	31.8525	33.8288	32.0221
050550	1.3497	1.1730	26.5515	29.0938	31.1918	29.0913
050551	1.2894	1.1730	26.1042	28.6834	31.6782	28.9731
050552	1.1029	1.1742	20.6068	24.9755	26.8274	24.4067
050557	1.5691	1.1993	23.8340	25.8719	28.3111	26.1521
050559	***	*	26.3798	25.3299	26.9662	26.1992
050561	1.3689	1.1742	34.2065	35.9611	37.5863	35.9396
050566	***	*	21.7712	*	*	21.7712
050567	1.5998	1.1730	26.2588	27.8475	30.1167	28.1139
050568	1.3378	1.0542	21.9313	20.8324	22.5008	21.7453
050569	1.3067	1.2938	27.3294	27.7955	30.4874	28.5507
050570	1.5515	1.1730	26.8965	29.9470	32.6896	29.9887
050571	1.2982	1.1742	26.2226	29.1716	32.1656	29.2903
050573	1.7368	1.0979	25.9380	27.2328	30.5249	27.9600
050575	1.2352	1.1742	27.8579	23.1358	23.2447	24.4730
050577	1.3034	1.1742	25.2861	26.4806	28.7060	26.7920
050578	1.6041	1.1742	32.0554	30.4934	31.5953	31.3583
050579	1.3273	1.1742	32.0245	34.9794	40.2740	35.9794
050580	1.2832	1.1730	22.7522	27.2431	29.4337	26.2798
050581	1.4091	1.1742	26.0580	28.9696	32.0823	29.1204
050583	1.5371	1.1260	26.2664	30.0427	33.5209	30.2128
050584	1.4598	1.1131	24.5294	24.5544	24.5757	24.5530
050585	1.2331	1.1730	26.4446	26.0595	27.2982	26.6489
050586	1.1608	1.1131	*	25.7172	25.3551	25.5353
050588	1.3170	1.1742	27.0506	30.5453	32.3603	30.1319
050589	1.2121	1.1730	23.7918	27.9845	30.6273	27.4205
050590	1.3263	1.1756	25.1100	27.0620	31.5987	27.5768
050591	1.1653	1.1742	26.7662	28.6151	28.5915	28.0684
050592	1.1900	1.1730	23.8267	25.9545	32.5000	27.1441
050594	1.9084	1.1730	28.7415	30.8028	34.6747	31.6043
050597	1.2460	1.1742	23.1209	24.5542	25.4868	24.3972
050598	***	*	25.1623	24.6875	*	24.9066
050599	1.9026	1.1756	26.3782	27.7684	30.8420	28.3351
050601	1.5322	1.1742	29.7734	32.3033	35.0325	32.5236
050603	1.4308	1.1730	24.9032	25.0996	28.6982	26.3008
050604	1.2553	1.4723	36.4669	42.0018	45.4433	41.3890
050608	1.3393	1.0450	20.9171	20.7955	22.1999	21.3699
050609	1.4737	1.1742	34.8949	37.4563	38.4561	36.9281
050613	1.1061	1.4694	34.9769	*	*	34.9769

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
050615	1.3147	1.1742	25.8697	29.4323	32.8786	29.5326
050616	1.3515	1.1742	25.0016	23.1748	28.5636	25.5306
050618	0.9507	1.0450	22.3548	22.3481	25.4500	23.4384
050623	1.1279	1.1742	28.6475	29.9553	29.6550	29.3955
050624	1.2505	1.1742	22.4030	23.3492	28.1941	24.4726
050625	1.7368	1.1742	29.3665	30.8013	33.5137	31.2789
050630	***	*	25.2915	27.7051	28.0726	27.0318
050633	1.2905	1.1115	27.8165	30.2883	33.4771	30.5689
050636	1.3520	1.1260	25.0213	23.2573	27.2360	25.2117
050638	***	*	15.6375	*	*	15.6375
050641	1.1927	1.1742	17.9379	21.5030	20.4720	20.2332
050644	1.0042	1.1742	*	28.4054	25.6614	26.9492
050662	0.7397	1.4723	38.9591	40.9242	47.5065	42.0959
050663	0.9469	1.1742	22.7770	22.9161	25.1493	23.5792
050667	0.8853	1.4133	26.9236	31.4906	25.9250	28.0922
050668	1.0310	1.5338	57.8627	55.9594	*	57.1408
050670	***	*	24.1626	*	*	24.1626
050674	1.3023	1.1756	33.7845	36.8871	38.4454	36.4893
050676	***	*	16.3947	*	*	16.3947
050677	1.3818	1.1742	34.0936	36.2702	37.3389	35.9193
050678	1.2442	1.1730	25.2143	27.1337	29.1159	27.2938
050680	1.2834	1.4538	31.9166	32.7065	35.6614	33.5011
050682	0.8548	1.0648	19.8107	23.0984	21.7264	21.4166
050684	1.1621	1.0979	24.2792	23.7443	25.2575	24.4494
050685	***	*	30.4194	*	*	30.4194
050686	1.3244	1.1701	34.8278	37.3033	38.5595	36.9365
050688	1.2048	1.4723	34.9937	36.5555	41.3305	37.6150
050689	1.5932	1.5338	34.0571	37.5449	40.3815	37.6346
050690	1.2893	1.3655	36.7516	41.1385	43.9228	40.7665
050693	1.2866	1.1730	29.1213	32.6638	34.8040	32.4525
050694	1.3002	1.0979	25.1963	25.8298	26.7041	25.9441
050695	1.0712	1.1138	26.2838	27.8742	30.1226	28.1703
050696	2.1214	1.1742	29.6684	29.9410	36.9314	32.4790
050697	1.0862	1.1830	24.1116	18.6962	19.2603	20.3265
050698	***	*	24.9559	*	*	24.9559
050699	***	*	23.4611	26.0909	25.6818	24.9432
050701	1.2778	1.0979	26.4901	28.4650	29.6896	28.2745
050704	1.0017	1.1742	25.6565	24.6072	24.6609	24.9725
050707	1.2630	1.4694	28.2637	27.7366	32.4877	29.5180
050708	1.6680	1.0648	24.5607	22.1606	21.2163	22.6876
050709	1.2146	1.0979	21.8770	22.7897	21.9079	22.1851
050710	1.2949	1.0648	30.5918	33.7204	34.8311	33.2239
050713	0.9680	1.1742	18.2822	19.0071	20.7448	19.3408
050714	1.2188	1.4759	30.3290	30.3263	32.4491	31.0508
050717	1.1972	1.1742	31.5021	33.0719	34.5519	33.0437
050718	1.3623	1.0979	22.5990	21.7835	15.4037	18.3570
050719	***	*	*	22.0998	*	22.0998
050720	0.8490	1.1730	*	26.1941	24.8117	25.5276
050723	1.1997	1.1742	32.0291	33.0797	34.9814	33.5056
050724	2.0713	1.0450	*	23.7567	*	23.7567
050725	1.0337	1.1742	*	20.6592	22.0946	21.5366
050726	1.6214	1.1993	*	25.8742	27.0928	26.5383
050727	1.0537	1.1742	*	*	23.7179	23.7179
050728	1.3366	1.3246	*	*	31.4768	31.4768
060001	1.5659	1.0679	21.4562	23.1548	24.9410	23.3105
060003	1.4190	1.0679	21.9043	23.0807	24.7856	23.3626
060004	1.2166	1.0879	22.9265	25.0037	28.0656	25.4883
060006	1.3005	0.9356	21.0003	21.8609	22.7493	21.9079
060007	1.0665	0.9356	19.3071	21.4244	21.4792	20.7379
060008	1.1119	0.9356	18.7098	19.8803	21.8037	20.1619
060009	1.4716	1.0879	23.9272	24.7920	27.0511	25.2861
060010	1.7217	1.0230	24.2735	25.8475	27.2290	25.7967
060011	1.5236	1.0879	22.2058	25.8919	26.1958	24.7793
060012	1.4406	0.9356	21.2980	22.6374	24.1557	22.6840
060013	1.3645	0.9356	23.5248	23.9554	24.9708	23.8003
060014	1.8598	1.0879	25.7701	27.0326	29.6744	27.4579
060015	1.6588	1.0879	23.6015	27.6338	30.1158	27.1990

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
060016	1.1648	0.9356	20.2361	22.9300	23.9655	22.4186
060018	1.2543	0.9356	21.8479	21.0581	23.6620	22.1787
060020	1.5776	0.9356	19.7348	20.9025	22.2052	21.0033
060022	1.6078	0.9771	22.8059	24.7928	25.7832	24.5054
060023	1.6091	0.9932	22.4731	24.3749	26.7285	24.5867
060024	1.7644	1.0879	24.3658	25.2409	28.7231	26.1534
060027	1.5405	1.0679	22.1717	25.1480	26.6348	24.7867
060028	1.4570	1.0879	24.2985	27.1303	27.9686	26.4616
060029	0.9334	*	19.8498	19.7379	*	19.7932
060030	1.3459	1.0230	21.2612	22.8309	26.0011	23.5385
060031	1.5517	0.9771	23.3995	23.8781	25.6207	24.3400
060032	1.4888	1.0879	24.7678	27.1783	28.2234	26.8043
060033	0.9986	*	17.8514	16.7266	*	17.2895
060034	1.5132	1.0879	24.3652	26.1602	28.4604	26.4088
060036	1.1602	0.9356	18.6521	19.4144	20.4635	19.5159
060037	***	*	15.7495	*	*	15.7495
060038	***	*	16.6526	*	*	16.6526
060041	0.8958	0.9356	19.5871	20.8746	22.7123	21.0301
060042	1.1042	*	19.3967	*	*	19.3967
060043	0.9786	0.9356	15.4074	19.1085	20.0939	18.2959
060044	1.1219	1.0679	21.3102	25.6112	25.2471	24.5591
060046	***	*	22.6819	*	*	22.6819
060047	***	*	17.9172	*	*	17.9172
060049	1.3476	1.0230	25.9592	25.3425	26.8089	26.0783
060050	1.1924	*	*	20.4386	21.9108	21.1679
060052	***	*	16.0543	*	*	16.0543
060053	***	*	19.4746	*	*	19.4746
060054	1.4122	0.9932	19.7753	21.1281	23.5803	21.4905
060056	***	*	21.9586	*	*	21.9586
060057	1.0340	1.0679	24.6599	24.3982	26.9891	25.4467
060058	***	*	16.4504	*	*	16.4504
060060	***	*	19.4418	*	*	19.4418
060062	***	*	17.1032	*	*	17.1032
060064	1.4135	1.0879	28.8746	29.1806	30.0963	29.4469
060065	1.3033	1.0879	24.4554	29.2377	28.5282	27.4045
060066	***	*	17.5556	*	*	17.5556
060070	1.0131	*	19.2220	22.6894	*	20.9589
060071	1.2135	0.9356	17.6452	20.1385	20.2706	19.3858
060073	***	*	18.4971	*	*	18.4971
060075	1.2699	1.1677	25.0552	27.7835	30.7835	27.8798
060076	1.3164	0.9356	22.9426	23.6266	25.5406	24.1006
060085	***	*	10.9724	*	*	10.9724
060088	***	*	20.7211	*	*	20.7211
060090	1.0058	*	16.5321	*	*	16.5321
060096	1.5946	1.0679	21.9950	26.4167	27.4085	25.3345
060100	1.6440	1.0879	24.8116	28.0561	29.7690	27.6225
060103	1.2656	1.0679	24.4962	26.6863	28.8063	26.7655
060104	1.3509	1.0879	24.4248	26.7683	30.8625	27.4536
060107	1.2642	1.0879	*	*	26.8267	26.8267
060108	***	*	19.1327	19.0011	*	19.0448
060109	***	*	27.3180	*	*	27.3180
060110	***	*	*	29.8561	*	29.8561
060111	***	*	*	*	31.2571	31.2571
070001	1.6543	1.2928	27.7441	29.9592	32.2718	29.9131
070002	1.8043	1.1583	26.6881	28.1101	29.0663	27.9442
070003	1.0877	1.1583	28.1722	29.8684	31.3716	29.8404
070004	1.2288	1.1583	25.4310	25.7207	27.3004	26.1163
070005	1.4070	1.2928	27.6733	29.8173	29.3265	28.9347
070006 ²	1.3256	1.3318	33.6291	33.3814	33.9310	33.6555
070007	1.2988	1.1627	28.0875	29.0336	30.3648	29.1845
070008	1.2755	1.1583	25.1362	24.3907	24.9176	24.8223
070009	1.2819	1.1583	24.9408	25.6072	28.8649	26.4656
070010	1.8047	1.3457	28.3168	30.4192	33.1535	30.6792
070011	1.3651	1.1583	24.8206	24.9457	27.5391	25.7127
070012	1.2553	1.1583	37.5917	34.9099	40.3337	37.5692
070015	1.4868	1.3457	29.2693	30.0614	30.9728	30.0956
070016	1.4051	1.2928	28.4833	29.7505	29.6662	29.2712

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
070017	1.4019	1.2928	27.5514	29.2978	30.3951	29.0728
070018 ²	1.3714	1.3318	32.6301	33.8654	35.7189	34.1711
070019	1.2641	1.2928	26.2348	27.9838	29.6290	27.9856
070020	1.3571	1.1656	26.6203	28.4084	29.9507	28.3943
070021	1.2252	1.1583	29.4597	30.3254	31.4397	30.4614
070022	1.8110	1.2928	27.2423	29.7376	32.3625	29.7867
070024	1.4172	1.1627	26.3544	28.3460	30.8308	28.5554
070025	1.8768	1.1583	27.3592	28.3017	29.2540	28.3054
070027	1.3275	1.1583	25.9279	36.9700	27.3487	29.2726
070028	1.6206	1.3457	26.7286	28.2078	29.5653	28.1832
070029	1.3123	1.1583	23.8427	25.8107	26.3871	25.3719
070031	1.2493	1.2928	25.6347	25.5880	27.2359	26.1749
070033	1.3795	1.3457	34.1591	34.3904	35.5355	34.7141
070034 ²	1.3932	1.3318	30.0744	32.8074	35.6831	32.8177
070035	1.3209	1.1583	24.5996	26.1693	27.1816	25.9558
070036	1.6434	1.2918	31.2961	35.0701	34.0555	33.4573
070038	***	*	26.3126	*	31.1133	27.2024
070039	0.9246	1.2928	*	32.6059	35.0164	33.8498
080001	1.6719	1.1134	26.8887	28.0859	30.2463	28.4442
080002	***	*	20.9385	23.7309	26.4192	23.6246
080003	1.5422	1.1134	24.8200	24.8199	27.1131	25.5237
080004	1.3774	1.0904	21.7344	24.2251	26.0092	24.0021
080006	1.2866	0.9631	20.9399	23.6838	24.4204	23.0247
080007	1.3987	1.0316	21.5415	23.4964	24.6485	23.2356
090001	1.7555	1.1026	23.0365	29.5432	31.3552	27.7731
090002	***	*	20.6550	23.5158	29.6780	23.4282
090003	1.3656	1.1026	27.1087	22.7014	27.0514	25.4701
090004	1.8944	1.1026	25.9717	28.7417	29.9785	28.4391
090005	1.3632	1.1026	26.8690	28.6142	30.2504	28.6956
090006	1.4019	1.1026	22.9658	23.7241	25.9086	24.2077
090007	***	*	24.6668	25.8430	30.1419	26.6936
090008	1.4854	1.1026	*	19.3212	29.6744	24.0820
090010	***	*	25.9373	*	*	25.9373
090011	2.0598	1.1026	27.6038	31.7710	32.4412	30.6405
100001	1.4525	0.9565	22.0101	22.6150	25.2381	23.3871
100002	1.3597	1.0348	21.5772	22.5982	22.1269	22.1101
100004	0.9448	0.8626	16.1638	15.6306	16.2637	16.0223
100006	1.6079	0.9731	21.6922	23.3745	26.2372	23.8819
100007	1.6891	0.9731	22.5317	24.3305	25.4333	24.2013
100008	1.6486	0.9870	21.6416	22.7706	25.7377	23.4549
100009	1.4653	0.9870	22.6370	24.7811	24.4666	23.9891
100010	***	*	23.9581	25.5614	26.9486	25.4664
100012	1.6359	0.9338	22.0244	24.2602	24.5762	23.6309
100014	1.3625	0.9018	21.9875	21.7566	22.3054	22.0128
100015	1.3100	0.9074	18.9383	22.1272	22.5781	21.2637
100017	1.5402	0.9018	20.1417	21.1905	22.9545	21.5050
100018	1.6043	1.0531	22.6587	24.1885	27.8582	24.9765
100019	1.6342	0.9625	25.8297	24.2888	25.5566	25.1966
100020	1.2343	0.9870	21.7421	23.5303	23.6106	23.0052
100022	1.7003	1.0382	27.4235	27.9072	29.0519	28.1457
100023	1.3237	0.9731	20.2034	21.8111	21.4015	21.1410
100024	1.2862	0.9870	22.9872	24.4070	27.6476	25.0345
100025	1.6680	0.8626	20.1360	21.2568	21.1174	20.8749
100026	1.6324	0.8626	21.3742	20.1602	21.3533	20.9436
100027	0.9323	0.8626	20.5889	23.8982	12.0314	18.2953
100028	1.2789	0.9625	20.3751	21.8879	23.7818	22.0247
100029	1.1305	0.9870	22.2553	24.6814	26.9307	24.5586
100030	1.2695	0.9731	19.5604	21.8567	22.4887	21.4341
100032	1.8040	0.9074	20.6543	21.6415	23.0174	21.7882
100034	1.7719	0.9870	20.0099	23.1111	24.4064	22.5984
100035	1.5932	0.9610	21.3519	22.6349	25.3590	23.0863
100038	1.8341	1.0382	24.9548	25.7948	27.4422	26.1330
100039	1.4038	1.0382	23.3111	23.8060	26.6016	24.6112
100040	1.6325	0.9565	19.5154	22.4679	23.5372	21.8865
100043	1.2917	0.9074	20.7688	21.7738	22.8963	21.8399
100044	1.4111	1.0093	22.9474	23.9952	26.3208	24.4024
100045	1.3114	0.9731	22.8096	25.2285	23.0520	23.6227

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
100046	1.2293	0.9074	23.2027	24.2746	26.6169	24.8423
100047	1.6906	0.9472	21.4971	24.3522	24.4212	23.5067
100048	0.8988	0.8626	17.3663	17.5533	18.3767	17.7520
100049	1.1421	0.8943	20.9490	21.8679	22.9532	21.9412
100050	1.1905	0.9870	17.8960	20.0405	20.6893	19.5468
100051	1.3294	0.9731	19.3258	20.0231	22.3311	20.7020
100052	1.3756	0.8943	19.6620	20.5916	20.9078	20.3897
100053	1.2555	0.9870	21.6634	23.7837	27.3383	24.3051
100054	1.2260	0.8781	20.9612	22.0352	25.7279	23.0243
100055	1.3175	0.9074	19.1325	19.6350	22.1051	20.2297
100056	***	*	23.1737	25.9245	25.7945	24.9651
100057	1.3810	0.9731	22.3406	24.6417	22.6038	23.1318
100061	1.4629	0.9870	24.5277	26.1273	26.7673	25.8520
100062	1.7430	0.9234	21.9054	24.9807	24.1413	23.6307
100063	1.3178	0.9074	19.2510	21.5620	21.5566	20.8353
100067	1.4592	0.9074	19.2168	23.8892	23.9333	22.4748
100068	1.5814	0.9018	19.9648	23.7840	24.9025	24.0014
100069	1.2868	0.9074	18.5789	19.6037	22.4386	20.3465
100070	1.5621	0.9610	20.9592	23.5524	23.7746	22.8911
100071	1.2031	0.9074	20.7461	21.7675	23.4176	22.1925
100072	1.3339	0.9018	22.0317	23.5362	24.2934	23.3686
100073	1.7662	1.0382	22.2425	23.5843	25.3685	23.7848
100075	1.5240	0.9074	20.4604	22.3890	23.3503	22.0804
100076	1.2260	0.9870	18.4815	19.6444	21.0777	19.7252
100077	1.4118	0.9472	20.9482	22.3755	24.3478	22.5887
100078	***	*	16.6004	*	*	16.6004
100080	1.7036	1.0348	22.9720	22.8704	26.3596	24.1112
100081	1.1459	0.8653	16.5149	16.8087	16.9168	16.7506
100084	1.7415	0.9731	24.5682	24.1122	25.4140	24.7109
100086	1.1811	1.0382	24.3067	25.2375	26.4817	25.3800
100087	1.9320	0.9610	22.1764	26.5915	25.9909	24.9427
100088	1.7059	0.9565	20.6667	23.6270	24.8729	23.1132
100090	1.3861	0.9565	21.0431	22.5894	24.0501	22.5894
100092	1.4930	0.9625	21.4601	25.4630	26.0856	24.1570
100093	1.7034	0.8626	18.7153	20.2949	21.1547	20.0867
100098	1.0429	1.0348	21.1723	20.0639	21.2505	20.8483
100099	1.0886	0.8943	16.5271	18.5287	20.4328	18.3874
100102	1.1226	0.8626	19.0193	21.6772	22.8850	21.1693
100103	0.9371	0.9500	19.1222	20.3633	21.7494	20.3776
100105	1.4243	1.0093	22.7793	24.5464	24.9503	24.0896
100106	0.9761	0.8626	21.4342	20.3417	20.2882	20.7173
100107	1.1826	0.9338	21.7553	23.3789	24.4484	23.1833
100108	0.8248	0.8626	18.4126	14.8039	16.3757	16.3500
100109	1.2854	0.9731	20.6007	23.0779	23.8836	22.5682
100110	1.5456	0.9731	22.8127	24.4533	28.3699	25.4724
100112	***	*	16.2110	*	*	16.2110
100113	1.8723	0.9446	23.3380	24.3614	25.0067	24.2527
100114	1.3209	0.9870	22.5326	25.3699	27.7413	25.1107
100117	1.2141	0.9565	21.3085	23.9134	26.0451	23.8882
100118	1.2721	0.9121	21.7067	24.1104	23.6669	23.1050
100121	1.1757	0.8943	19.9033	23.1100	24.0937	22.4434
100122	1.1923	0.8781	24.9765	24.1820	21.2597	23.2094
100124	1.1507	0.8626	20.0867	24.3048	21.6483	21.9310
100125	1.1774	0.9870	20.3232	22.4185	25.3532	22.8150
100126	1.5110	0.9074	21.4349	21.7977	23.2996	22.1919
100127	1.6080	0.9074	20.5153	21.0153	21.3223	20.9562
100128	2.1360	0.9074	23.5835	24.4104	25.6763	24.6219
100130	1.2661	1.0348	21.0023	20.2478	22.8324	21.3596
100131	1.2815	0.9870	24.6184	25.4811	25.8316	25.3385
100132	1.2217	0.9074	19.5259	21.1538	23.0428	21.2692
100134	0.8889	0.8626	16.9302	18.3391	19.5337	18.2884
100135	1.5307	0.8689	19.7675	20.4915	22.3071	20.8396
100137	1.1480	0.8943	20.9014	20.4007	23.3692	21.6041
100138	***	*	14.9759	*	*	14.9759
100139	0.8454	0.9446	15.7378	18.2204	14.5046	16.1844
100140	1.1447	0.9565	20.2288	22.5124	24.8165	22.6153
100142	1.2107	0.8626	17.7250	20.0689	20.7219	19.4501

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
100146	***	*	20.8381	*	*	20.8381
100147	0.9367	*	17.1566	17.1045	*	17.1298
100150	1.2999	0.9870	25.4269	22.9194	25.7122	24.6389
100151	1.7682	0.9565	26.6143	26.6470	26.1848	26.4559
100154	1.4221	0.9870	21.6715	23.0820	26.3703	23.7877
100156	1.1162	0.8626	20.0348	20.6928	22.2757	21.0438
100157	1.5890	0.8943	24.2188	23.1045	25.9133	24.4033
100159	***	*	15.0634	*	*	15.0634
100160	1.2098	0.8626	22.6942	23.4877	27.2019	24.5476
100161	1.5793	0.9731	23.3612	24.6268	28.3607	25.5840
100162	***	*	24.2950	23.8001	*	24.0481
100166	1.4348	0.9610	22.2419	23.7419	24.4251	23.4473
100167	1.2463	1.0382	25.7675	26.4517	26.8584	26.3859
100168	1.3713	1.0348	23.0121	24.6276	26.0864	24.6003
100169	***	*	21.6397	23.4575	*	22.5513
100170	***	*	21.2469	*	*	21.2469
100172	1.3951	0.9870	15.7827	17.6051	18.4651	17.2801
100173	1.7317	0.9074	18.3828	19.7190	22.4866	20.1761
100175	1.0244	0.8857	21.2532	21.0474	22.0666	21.4378
100176	1.9088	1.0093	24.6595	26.8740	29.8326	27.1345
100177	1.2516	0.9625	25.1037	24.5078	25.3973	25.0090
100179	1.7478	0.9565	23.9633	24.1801	26.6537	25.0065
100180	1.3800	0.9074	22.7781	24.9433	26.3299	24.8073
100181	1.0678	0.9870	17.9048	18.1320	19.5022	18.4708
100183	1.1482	0.9870	22.2063	24.4575	26.7893	24.4872
100187	1.2744	0.9870	21.4988	23.4760	26.1394	23.7305
100189	1.3038	1.0382	27.1295	26.6846	26.5763	26.7708
100191	1.3519	0.9074	22.0526	24.1911	24.3553	23.5378
100200	1.3810	1.0382	24.8878	24.8120	28.0926	25.9374
100204	1.5168	0.9446	21.1922	22.2613	24.4697	22.7021
100206	1.2752	0.9074	20.3436	22.8782	23.0340	22.0526
100208	***	*	20.4678	24.1482	24.9854	23.3245
100209	1.4170	0.9870	22.8236	23.8502	25.0778	23.9934
100210	1.4661	1.0382	23.0431	26.0933	28.6449	25.9638
100211	1.2427	0.9074	21.6367	24.3243	*	22.9720
100212	1.4878	0.9234	21.7239	22.6584	24.2669	22.9037
100213	1.5527	0.9610	22.0176	24.4467	25.1893	23.9275
100217	1.2447	1.0093	22.7116	24.0291	25.2635	24.0217
100220	1.6455	0.9338	24.6234	24.9733	25.0154	24.8740
100221	***	*	23.2263	*	*	23.2263
100223	1.5614	0.8781	21.8962	21.2434	23.4556	22.2543
100224	1.2359	1.0382	22.3567	23.0804	23.3593	22.9486
100225	1.1840	1.0382	22.4619	23.9971	27.9473	24.8279
100226	1.2824	0.9565	22.7301	23.8701	27.8003	24.8477
100228	1.3226	1.0382	24.9691	26.2593	27.2873	26.2480
100229	***	*	19.7259	21.0038	*	20.3419
100230	1.4004	1.0382	23.4169	25.0518	26.3690	25.1751
100231	1.7520	0.8626	21.5712	23.5418	24.6994	23.2423
100232 ^h	1.2093	0.9793	20.1459	21.8105	23.9405	21.9914
100234	1.3913	1.0348	24.3355	24.9141	25.2574	24.8587
100236	1.3749	0.9472	21.7886	23.9781	25.9282	23.8851
100237	1.9685	1.0382	23.2712	26.7664	25.6112	25.1666
100238	1.5656	0.9074	23.3747	24.6513	27.1748	25.0754
100239	1.3106	0.9074	23.2242	25.0509	26.9668	25.1209
100240	0.8900	0.9870	21.3495	23.0650	23.4830	22.6468
100241	***	*	14.1059	*	*	14.1059
100242	1.3884	0.8626	19.1097	20.4681	21.5130	20.4341
100243	1.5043	0.9074	22.4496	23.2812	25.2987	23.7180
100244	1.3370	0.9338	21.4386	23.4876	24.1515	23.0877
100246	1.6072	1.0093	23.5614	26.7630	27.6382	26.0293
100248	1.4857	0.9074	22.1553	23.8742	25.9170	24.0072
100249	1.2482	0.9174	18.4932	21.3942	23.4021	21.0109
100252	1.1643	0.8859	22.0976	22.6475	24.9860	23.2783
100253	1.3562	1.0348	22.6517	23.6939	24.4051	23.6314
100254	1.5455	0.8689	20.4410	23.2794	25.0192	23.0550
100255	1.1813	0.9074	20.7228	22.9793	22.2341	21.9641
100256	2.0163	0.9074	22.4844	24.1969	26.0629	24.2500

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
100258	1.4931	1.0348	22.0790	24.5699	31.8772	25.8663
100259	1.2365	0.9074	21.4991	24.1148	24.9404	23.5859
100260	1.3787	1.0093	21.2413	23.5164	25.2630	23.4298
100262	***	*	22.7137	23.8006	26.3954	24.2596
100264	1.2387	0.9074	21.7410	22.4800	25.0250	23.1561
100265	1.2830	0.9074	20.2664	21.0688	23.4758	21.6885
100266	1.3386	0.8626	20.2821	21.5258	22.6614	21.5572
100267	1.2510	0.9610	22.8054	23.3760	26.5059	24.2860
100268	1.1393	1.0348	23.5414	26.0297	29.8289	26.5173
100269	1.3821	1.0348	26.0271	24.9002	25.3228	25.3769
100270	***	*	20.8217	*	*	20.8217
100271	2.2363	*	21.9823	*	*	21.9823
100275	1.2601	1.0348	23.2920	23.1419	24.3059	23.6174
100276	1.2113	1.0382	24.8251	25.4557	27.2589	25.8569
100277	1.1368	0.9870	14.9157	25.2985	47.3905	21.5273
100279	1.2444	0.9338	23.1776	24.8484	25.4909	24.4816
100280	***	*	19.0157	*	*	19.0157
100281	1.2595	1.0382	23.4729	25.3382	27.0864	25.4496
100282	***	*	20.9257	*	*	20.9257
100284	1.0905	0.9870	18.5716	22.3046	22.5927	21.1697
100286	1.5071	1.0531	*	*	27.1051	27.1051
100287	1.3212	1.0348	*	*	28.2229	28.2229
100288	1.4796	1.0348	*	*	37.4785	37.4785
100289	1.7901	1.0382	*	*	28.4504	28.4504
110001	1.2587	0.9851	22.4535	24.0561	25.1164	23.9048
110002	1.2917	0.9851	20.2149	20.4502	21.8616	20.8258
110003	1.2840	0.9565	18.2793	19.7061	20.0968	19.3813
110004	1.2272	0.9208	20.6096	21.8791	22.7929	21.7866
110005	1.1417	0.9960	21.8105	23.6146	22.3645	22.6386
110006	1.5047	1.0173	22.0325	23.8762	25.0719	23.6542
110007	1.6710	1.1277	25.9135	28.2025	30.7430	28.3399
110008	1.3519	0.9960	20.4972	22.6308	23.4662	22.3396
110009	***	*	16.6452	*	*	16.6452
110010	2.1559	0.9960	25.1930	27.2029	28.7690	27.0594
110011	1.1978	0.9960	20.4028	23.2149	25.4620	23.0836
110013	***	*	16.7833	*	*	16.7833
110014	0.9800	*	18.4463	*	*	18.4463
110015	1.1633	0.9960	21.2601	23.2280	25.5661	23.5181
110016	1.2299	0.8357	14.7571	18.8228	18.8376	17.3246
110017	***	*	21.2969	*	*	21.2969
110018	1.1804	0.9960	23.0577	24.7007	25.6485	24.5320
110020	1.1524	0.9960	20.9687	23.3004	24.8735	23.0386
110023	1.3743	0.9851	21.6512	23.5673	25.3746	23.6656
110024	1.4237	0.9464	21.3945	22.1471	23.8091	22.4754
110025	1.4467	1.1958	20.2493	29.0965	31.5253	25.9559
110026	1.1210	0.8006	16.9160	19.3201	20.5740	18.9282
110027	1.0784	0.8393	19.8976	19.8351	19.2323	19.6358
110028	1.7736	0.9183	28.1695	25.9474	25.1836	26.3363
110029	1.5894	0.9851	21.3694	22.7981	25.2335	23.1979
110030	1.2774	0.9960	20.4656	22.2341	25.0842	22.6223
110031	1.2379	0.9960	20.9219	22.8695	24.1711	22.7426
110032	1.1838	0.8006	19.2685	18.0744	20.7211	19.3573
110033	1.4386	0.9960	23.1939	24.1447	25.2326	24.1460
110034	1.6529	0.9183	23.0724	24.0791	24.4141	23.8156
110035	1.5054	0.9960	21.8646	24.2581	25.7562	24.0454
110036	1.8311	0.9464	22.5481	24.4788	25.4854	24.2256
110038	1.5304	0.8486	18.4508	20.1710	20.5880	19.7422
110039	1.4711	0.9183	18.9817	17.0608	19.4032	18.4981
110040	1.0602	0.9846	17.7798	17.3095	18.8744	17.9959
110041	1.1744	0.9974	20.1398	20.8080	21.5402	20.8653
110042	1.0418	0.9960	25.0535	25.5588	26.8321	25.8613
110043	1.7776	0.9464	21.2714	22.7589	25.2788	23.1437
110044	1.1799	0.8006	17.5905	19.2562	19.6940	18.8331
110045	1.1240	0.9960	22.2424	19.7746	21.3922	21.0887
110046	1.2407	0.9960	22.8820	21.6201	24.0022	22.8885
110048	***	*	18.8751	*	*	18.8751
110049	1.0170	0.8006	17.1396	18.9096	19.8706	18.6923

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
110050	1.1505	*	18.9048	*	25.6020	22.4537
110051	1.1250	0.8006	17.2050	17.6816	19.0995	18.0105
110054	1.4590	0.9851	20.7825	20.5387	22.2250	21.1685
110056	0.9430	0.8006	17.9037	21.7608	23.0080	20.9242
110059	1.1175	0.8006	17.8076	19.9802	18.7097	18.8340
110061	0.9467	*	17.4601	18.6696	*	18.1120
110062	***	*	17.9422	*	*	17.9422
110063	1.0952	0.8296	18.0256	19.4401	20.3760	19.3446
110064	1.4533	0.8691	18.8742	21.7636	23.8739	21.4770
110065	***	*	16.9829	*	*	16.9829
110066	***	*	23.4554	*	*	23.4554
110069	1.1885	0.9535	21.1513	21.0518	22.3006	21.5110
110070	***	*	19.6361	*	*	19.6361
110071	0.9988	0.8006	21.5042	15.2336	13.3731	15.9957
110072	***	*	13.6626	*	*	13.6626
110073	1.0530	0.8006	17.9372	15.2711	16.3610	16.3982
110074	1.5016	1.0173	24.4924	24.4094	27.5836	25.4906
110075	1.2692	0.9464	20.1604	20.4634	20.9973	20.5420
110076	1.4252	0.9960	23.6127	23.8211	25.2424	24.2729
110078	2.0457	0.9960	25.7416	28.2149	27.8627	27.2910
110079	1.3563	0.9960	22.3641	22.8017	24.5255	23.2240
110080	1.5253	0.9960	19.4635	24.1958	21.5482	21.5982
110082	1.9176	0.9960	22.7015	27.2931	28.9731	26.1071
110083	1.9429	0.9960	22.2609	24.6460	26.2604	24.4266
110086	1.3421	0.8006	19.0163	18.8751	20.8557	19.5405
110087	1.4195	0.9960	24.0994	25.7908	26.2872	25.4624
110089	1.1339	0.8006	19.0453	20.6757	21.2013	20.3266
110091	1.2984	0.9960	23.7110	24.3354	26.3857	24.8617
110092	1.0361	0.8006	15.9178	16.9116	18.7397	17.2529
110094	***	*	16.8890	*	*	16.8890
110095	1.4143	0.8006	18.9904	20.1024	21.8709	20.3886
110096	1.0627	0.8006	18.0418	18.5513	19.4498	18.6974
110097	***	*	17.8454	*	*	17.8454
110098	***	*	16.7800	*	*	16.7800
110100	0.9729	0.8006	18.6821	15.1316	16.5833	16.8273
110101	1.0212	0.8006	13.8787	13.3943	14.4630	13.9254
110103	***	*	21.5685	*	*	21.5685
110104	1.0566	0.8006	16.6322	17.9805	19.5575	18.0908
110105	1.2669	0.8006	18.1306	19.2156	20.6270	19.3315
110107	1.8355	0.9922	21.2267	21.8167	26.0763	23.0323
110108	***	*	20.1141	*	*	20.1141
110109	1.0382	0.8006	16.5977	18.7397	20.4726	18.5175
110111	1.1261	0.9183	18.4274	20.9535	20.5577	20.0362
110112	0.9511	0.8006	18.9574	20.4565	21.0612	20.1809
110113	1.0602	0.9156	16.0942	18.0770	16.7641	16.9657
110114	***	*	16.8297	*	*	16.8297
110115	1.7377	0.9960	26.5759	26.3274	29.8699	27.5187
110118	1.0120	*	17.5714	17.7344	*	17.6522
110120	1.0949	*	18.4738	20.3098	*	19.4033
110121	1.1030	0.8006	18.8744	19.5230	21.2534	19.8995
110122	1.4509	0.8486	20.6070	20.4184	22.0210	21.0497
110124	1.0794	0.8434	19.4093	19.7004	20.9334	20.0283
110125	1.1364	0.8006	19.5666	19.8695	22.1458	20.5878
110127	***	*	16.1108	*	*	16.1108
110128	1.2178	0.9464	20.3047	28.4943	23.2576	23.6773
110129	1.5416	0.8691	20.9442	21.8204	22.4202	21.7655
110130	0.9146	0.8006	16.6915	17.5272	17.6529	17.3161
110132	1.0949	0.8006	17.1821	17.2924	18.9927	17.8306
110134	***	*	19.0305	*	*	19.0305
110135	1.2035	0.8006	15.6668	18.5125	20.0057	17.8218
110136	1.0848	0.8267	20.7827	21.1235	22.7715	21.5466
110141	***	*	13.2711	*	*	13.2711
110142	0.9666	0.8006	14.1203	16.3359	17.3328	15.9707
110143	1.3843	0.9960	22.4254	24.3898	25.4932	24.1200
110144	***	*	17.5678	*	*	17.5678
110146	1.0684	0.8006	17.8499	17.2250	19.9221	18.2306
110149	1.2567	0.9960	25.2525	25.3619	24.7686	25.1225

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Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
110150	1.2424	0.9814	22.8322	22.7366	23.8157	23.1526
110152	***	*	16.3837	*	*	16.3837
110153	1.1180	0.9535	20.6972	21.5300	22.8660	21.6706
110154	***	*	16.5286	*	*	16.5286
110155	***	*	16.4757	16.1785	*	16.3430
110156	***	*	16.0759	*	*	16.0759
110161	1.4753	0.9960	24.5776	26.4200	27.4435	26.2006
110163	1.4631	1.1277	20.1183	21.9411	25.5461	22.4274
110164	1.5194	0.9922	22.6605	23.7801	26.4450	24.2372
110165	1.4250	0.9960	22.5604	23.4071	24.3897	23.4742
110166	2.0118	0.9922	22.3822	23.6665	25.2264	23.5687
110168	1.8754	0.9851	22.3181	23.3426	24.6321	23.4811
110169	***	*	23.3749	24.7083	*	24.1231
110171	***	*	24.5313	32.6386	*	28.8253
110172	1.3239	0.9960	24.7005	25.2396	27.0240	25.6126
110177	1.6345	0.9183	22.7831	24.0700	25.0129	24.0267
110179	***	*	24.3673	26.0365	26.1173	25.4991
110181	***	*	13.9591	*	*	13.9591
110183	1.2715	0.9960	24.2899	26.4248	27.6020	26.1456
110184	1.2285	0.9960	22.2761	24.3379	25.5420	24.0982
110185	***	*	17.3330	*	*	17.3330
110186	1.3009	0.8691	19.7172	21.1176	23.2348	21.4537
110187	1.2677	0.9851	22.8248	23.2571	22.5730	22.8794
110188	***	*	22.0258	24.4785	*	23.2998
110189	1.1401	0.9851	19.8453	21.4255	23.9404	21.7778
110190	1.0754	0.8188	20.7292	21.9008	19.1054	20.4860
110191	1.3005	0.9960	21.3404	24.0572	25.8409	23.7862
110192	1.3263	0.9960	22.9684	24.3823	25.7406	24.4508
110193	1.3262	0.9960	22.1477	25.1779	27.8223	25.0972
110194	0.9360	0.8006	15.8129	16.8075	16.3148	16.3086
110195	***	*	10.9444	*	*	10.9444
110198	1.3384	0.9960	24.8275	28.0634	30.8014	28.0274
110200	1.8886	0.8691	17.9632	20.1816	21.2177	19.8668
110201	1.4223	0.9922	21.9313	24.1171	27.0388	24.1702
110203	0.9491	0.9960	24.2061	30.2609	25.8951	26.5225
110204	***	*	35.3698	*	*	35.3698
110205	1.1013	0.9851	20.1405	23.1969	20.6150	21.2933
110207	***	*	14.6045	*	*	14.6045
110208	***	*	15.0350	*	*	15.0350
110209	0.6023	0.8006	20.0630	17.4145	19.1000	18.8543
110211	***	*	20.1023	*	*	20.1023
110212	0.9725	0.8334	15.8420	18.7651	20.9365	18.2449
110215	1.2616	0.9960	21.0263	22.5679	23.9657	22.7016
110218	***	*	*	*	26.1073	26.1073
110219	1.3949	0.9960	*	*	27.1880	27.1880
120001	1.6968	1.1033	29.4126	30.0871	31.7108	30.3779
120002	1.2465	1.0558	23.5667	24.2715	26.9900	24.9958
120003	***	*	24.6238	*	*	24.6238
120004	1.2923	1.1033	26.1398	26.8010	28.3569	27.1076
120005	1.3260	1.0558	22.3213	23.0113	26.9053	24.1323
120006	1.1925	1.1033	26.6302	28.1562	29.6751	28.1658
120007	1.7873	1.1033	22.7179	27.8497	28.7964	26.1945
120009	***	*	16.7629	*	*	16.7629
120010	1.8869	1.1033	24.9089	25.4050	27.1265	25.7490
120011	1.4126	1.1033	35.2051	30.9308	31.7447	32.4428
120012	***	*	22.0372	*	*	22.0372
120014	1.2204	1.0558	25.3557	25.3682	28.0786	26.2546
120016	***	*	43.5064	39.1173	52.1034	44.5404
120019	1.1335	1.0558	23.8536	24.4036	28.9661	25.6590
120021	***	*	36.8291	*	*	36.8291
120022	1.8197	1.1033	22.2781	22.4951	24.7875	23.2173
120024	0.8663	1.0558	21.9657	*	*	21.9657
120025	0.7128	1.1033	40.1342	40.2473	48.7148	43.1744
120026	1.3584	1.1033	25.7023	26.3653	28.5048	26.8979
120027	1.2398	1.1033	23.1434	24.9464	26.4630	24.7136
120028	1.2861	1.1033	27.5365	29.5070	31.3195	29.4817
130001	***	*	19.6328	*	*	19.6328

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
130002	1.3455	0.9032	18.5746	20.1143	21.6626	20.1741
130003	1.4035	0.9950	23.0994	23.9403	25.4904	24.2000
130005	***	*	22.6364	24.4844	25.2550	24.0521
130006	1.7403	0.9338	21.4640	22.8567	24.3982	22.9900
130007	1.7612	0.9338	22.0895	22.8475	24.8764	23.3254
130008	0.9741	*	19.3392	*	*	19.3392
130009	0.9211	*	20.8748	*	*	20.8748
130010	***	*	17.7826	*	*	17.7826
130011	1.1706	0.8891	22.1125	23.1120	22.9336	22.7137
130012	***	*	24.2451	*	*	24.2451
130013	1.3471	0.9338	22.6624	23.5316	26.3118	24.2162
130014	1.2440	0.9338	19.8240	21.6495	23.4789	21.6591
130015	***	*	16.4136	*	*	16.4136
130016	***	*	20.1221	*	*	20.1221
130017	***	*	19.9511	*	*	19.9511
130018	1.5598	0.9337	20.0563	22.2249	23.9798	22.1211
130019	***	*	19.5147	*	*	19.5147
130021	0.8818	*	14.4430	18.0006	18.9400	16.8542
130022	1.1120	*	19.7814	21.5602	*	20.7171
130024	1.1790	0.8948	19.9934	22.1610	21.7853	21.3344
130025	1.2218	0.8673	17.5989	18.7814	19.7066	18.7126
130026	1.1696	0.9337	23.2094	24.4976	25.4020	24.3594
130027	***	*	20.6641	*	*	20.6641
130028	1.3053	0.9589	21.2217	21.1492	25.2938	22.5343
130029	***	*	22.9242	*	*	22.9242
130030	***	*	18.5826	*	*	18.5826
130031	***	*	20.4144	*	*	20.4144
130034	***	*	20.5802	*	*	20.5802
130035	***	*	17.2864	*	*	17.2864
130036	***	*	15.1590	18.5921	16.7907	16.7949
130037	***	*	19.2108	*	*	19.2108
130043	***	*	17.6920	*	*	17.6920
130044	***	*	18.7068	*	*	18.7068
130045	0.9546	*	17.5152	19.0270	*	18.2842
130049	1.3517	1.0458	22.0520	23.7212	24.5841	23.4851
130054	***	*	16.4674	*	*	16.4674
130056	***	*	28.8005	*	*	28.8005
130060	***	*	23.2512	24.6773	26.7516	24.9541
130062	0.8368	0.8673	19.8264	24.0494	16.7951	20.0540
130063	1.5235	0.9338	18.4797	18.8782	20.9502	19.4897
140001	1.1657	0.8347	18.1511	20.0247	21.4779	19.9510
140002	1.3101	0.9083	20.9959	23.0207	24.4908	22.8160
140003	1.0503	*	18.0163	19.2097	22.6230	19.9654
140004	1.2045	*	18.9713	*	*	18.9713
140005	0.9238	*	12.4144	13.2365	*	12.8298
140007	1.3166	1.0864	24.9847	25.1836	26.7943	25.6480
140008	1.4523	1.0864	24.2634	26.3287	27.2211	25.9317
140010	1.4498	1.0864	28.0863	29.0224	31.5774	29.7507
140011	1.1617	0.8347	18.4052	19.0903	20.6338	19.4213
140012	1.1857	1.0709	22.5885	24.4070	24.3675	23.8348
140013	1.3487	0.8888	20.3147	19.9800	22.6022	20.9786
140014	***	*	22.2945	*	*	22.2945
140015	1.3003	0.8973	20.3540	21.4328	22.2266	21.3909
140016	1.0418	0.8347	15.4453	16.3417	17.1372	16.3009
140018	1.3576	1.0864	23.4062	24.3285	27.3334	25.0042
140019	0.9983	0.8347	16.1180	17.4206	18.4554	17.2801
140024	0.9876	0.8347	16.1032	15.6616	16.9672	16.2623
140025	***	*	21.7775	*	*	21.7775
140026	1.1694	0.8693	19.7839	20.4084	21.6847	20.6233
140027	1.1806	0.8758	20.5979	20.9855	22.6208	21.4013
140029	1.5550	1.0864	28.5670	25.0485	27.7304	27.0375
140030	1.7126	1.0864	25.3715	26.5733	28.7623	26.9353
140031	***	*	16.9650	*	*	16.9650
140032	1.1932	0.8973	19.8033	20.6273	22.8157	21.1074
140033	1.2754	1.0759	22.8705	23.4279	26.1553	24.1573
140034	1.2111	0.8973	19.7711	20.9635	22.1003	20.9052
140035	***	*	17.4515	*	*	17.4515

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
140036	1.1832	*	21.2366	*	*	21.2366
140037	0.9211	*	14.3082	15.5578	*	14.9473
140038	***	*	19.8197	*	*	19.8197
140040	1.2031	0.8862	18.0342	19.2160	20.0269	19.1108
140041	***	*	18.8043	*	*	18.8043
140042	0.9886	*	16.1157	*	*	16.1157
140043	1.2002	0.9484	21.7356	23.3751	26.0330	23.7570
140045	1.0210	0.8347	17.4262	18.9587	21.0042	19.1862
140046	1.4596	0.8973	20.0859	21.7969	22.5022	21.4825
140047	***	*	16.6672	*	*	16.6672
140048	1.3065	1.0864	23.8652	25.9122	27.0874	25.6357
140049	1.5818	1.0864	26.7160	21.9546	26.6533	25.1874
140051	1.5823	1.0864	24.7180	24.2472	27.9935	25.6434
140052	1.1905	0.9083	21.0450	21.8161	22.2588	21.6993
140053	1.8922	0.8732	20.9768	22.6099	23.5477	22.3774
140054	1.4086	1.0864	23.9459	35.5659	31.7265	30.4170
140055	***	*	15.8756	*	*	15.8756
140058	1.3696	0.8732	19.1199	20.5089	22.1269	20.5860
140059	1.1866	0.9083	18.2593	19.9777	22.7121	20.2903
140061	0.9554	0.8347	18.4264	22.7515	30.9925	22.9450
140062	1.2110	1.0864	28.6390	30.7005	31.2359	30.2222
140063	1.3734	1.0864	29.6998	30.5430	26.5584	28.8346
140064	1.1954	0.8758	19.6954	20.6505	21.7470	20.6960
140065	1.4045	1.0864	25.5939	26.3521	26.1904	26.0502
140066	1.2215	0.9083	15.4818	18.0915	20.4353	17.7146
140067	1.7807	0.8888	20.7511	21.9579	23.5906	22.1449
140068	1.1992	1.0864	22.3622	24.1316	25.8963	24.0800
140069	***	*	17.7785	*	*	17.7785
140070	***	*	25.2646	25.2960	*	25.2788
140074	***	*	22.2563	*	*	22.2563
140075	1.3230	1.0864	21.8472	26.5350	26.9257	24.7743
140077	1.0226	0.9083	17.3236	18.0487	19.0922	18.2004
140079	***	*	22.7046	25.7090	29.3040	25.9482
140080	1.4884	1.0864	22.0682	24.4056	26.0109	24.1401
140081	***	*	18.1746	*	*	18.1746
140082	1.5007	1.0864	26.5960	25.0474	26.8077	26.1158
140083	1.1851	1.0864	20.7703	23.2822	24.6491	22.8432
140084	1.2127	1.0759	23.0263	25.4818	27.6819	25.4191
140086	***	*	19.1815	*	*	19.1815
140087	***	*	21.4593	*	*	21.4593
140088	1.8662	1.0864	26.5258	28.4219	31.0364	28.5985
140089	1.2472	0.8347	19.3230	20.7632	22.1227	20.7470
140090	***	*	28.0530	35.0300	*	31.1758
140091	1.7937	0.9515	23.5559	23.7560	26.1075	24.5322
140093	1.1498	0.9301	20.7564	21.5376	22.1540	21.4704
140094	1.1421	1.0864	22.8892	24.2166	25.3678	24.1743
140095	1.2829	1.0864	25.5716	24.7706	29.9746	26.8933
140097	***	*	21.8418	*	*	21.8418
140100	1.3435	1.0759	23.8226	27.1868	32.8743	28.2968
140101	1.2007	1.0864	23.1418	24.6106	25.4784	24.4645
140102	1.0403	0.8732	18.6328	19.8678	21.2278	19.9151
140103	1.3360	1.0864	19.1834	21.2404	21.7512	20.7501
140105	1.2561	1.0864	23.8258	27.3323	26.3054	25.7682
140107	***	*	11.5827	*	*	11.5827
140108	***	*	27.9140	*	*	27.9140
140109	1.0764	0.8347	15.9178	16.4261	17.8103	16.7311
140110	1.0579	0.8888	20.9631	21.9880	25.6561	22.9121
140112	***	*	18.1119	*	*	18.1119
140113	1.5249	0.9515	26.2393	25.6621	23.5337	25.1119
140114	1.3958	1.0864	23.0383	24.1926	25.7968	24.3761
140115	1.0660	1.0864	20.4587	25.3410	26.3677	23.9652
140116	1.2917	1.0864	25.5980	26.8924	30.5166	27.7940
140117	1.5053	1.0864	22.0889	23.3531	25.6314	23.7250
140118	1.7034	1.0864	25.3249	26.7350	27.7392	26.5951
140119	1.8037	1.0864	30.6468	31.3486	33.6302	31.8532
140120	1.2165	0.8888	17.7667	20.3237	22.5795	20.1397
140121	1.2420	*	16.2607	17.6019	*	16.8820

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
140122	1.4030	1.0864	26.7882	26.8595	26.4991	26.7112
140124	1.0983	1.0864	30.6820	30.9648	35.2798	32.2749
140125	1.1833	0.9083	17.8190	19.5359	20.7189	19.3549
140127	1.6064	0.9110	20.8397	21.3102	22.8172	21.6942
140128	***	*	23.5481	*	*	23.5481
140129	1.0370	*	21.6253	21.6495	*	21.6375
140130	1.2473	1.0759	26.0464	25.7324	26.3518	26.0481
140132	***	*	23.7046	23.0595	*	23.3607
140133	1.2922	1.0864	20.1740	24.0458	26.1599	23.3563
140135	1.3866	0.8347	18.2479	19.7919	21.2104	19.8265
140137	1.0533	0.9080	20.4807	21.6017	20.5053	20.8543
140138	***	*	14.5771	*	*	14.5771
140140	1.0631	*	18.8186	19.1636	21.4710	19.8054
140141	1.0542	*	20.2605	20.3706	23.0515	21.2286
140143	1.1173	0.8888	19.9885	22.0009	23.8255	21.7978
140144	0.9556	*	24.8854	26.9258	27.8046	26.5266
140145	1.0810	0.9083	19.4509	19.6429	21.6168	20.2676
140146	***	*	19.4272	*	*	19.4272
140147	1.1707	0.8347	17.1013	18.2692	19.5896	18.3227
140148	1.7637	0.8732	19.7630	21.5777	23.0022	21.4874
140150	1.6882	1.0864	28.9853	32.9291	33.9013	31.9623
140151	0.8245	1.0864	20.8820	21.5167	22.4842	21.6382
140152	1.2362	1.0864	28.3946	28.5468	29.6882	28.9127
140155 ²	1.2660	1.0709	24.2906	25.2034	27.6610	25.6644
140158	1.3789	1.0864	23.7428	22.5638	23.8542	23.3705
140160	1.1811	0.9484	19.8825	20.9986	22.7002	21.1923
140161	1.1461	1.0709	21.2045	22.2191	24.1071	22.5592
140162	1.5965	0.9110	21.6901	22.6426	26.0312	23.5146
140164	1.7044	0.8973	19.8246	19.7774	22.0424	20.5911
140165	1.0546	0.8347	16.3700	17.0666	15.9312	16.4256
140166	1.1540	0.8347	19.3672	20.7849	21.7776	20.5857
140167	1.0595	0.8347	18.8532	19.5959	19.7610	19.4061
140168	1.1488	0.9083	18.2896	18.7504	20.0225	19.0253
140170	0.9716	0.8347	17.6901	17.0665	17.1608	17.3221
140171	0.9425	*	15.2617	17.3214	*	16.3046
140172	1.3543	1.0864	24.8587	27.3372	27.1121	26.5971
140173	0.8466	*	16.0030	*	*	16.0030
140174	1.4929	1.0864	22.0418	23.6893	24.7011	23.4906
140176	1.2285	1.0864	26.3468	25.6824	28.9378	27.1086
140177	0.9662	1.0864	20.3142	20.8526	19.3328	20.1303
140179	1.3331	1.0864	22.7345	24.1539	26.3200	24.4164
140180	1.3175	1.0864	22.7508	25.4022	27.4366	25.1661
140181	1.1869	1.0864	22.6643	23.7308	23.6034	23.3513
140182	1.4794	1.0864	25.1302	32.1969	28.0337	28.3827
140184	1.2064	0.8347	17.9169	20.6499	20.1279	19.5955
140185	1.4747	0.9083	18.8573	20.0903	22.0222	20.3386
140186 ²	1.4865	1.0709	25.6807	26.0970	28.1977	26.7088
140187	1.5935	0.9083	19.4049	20.5829	22.0674	20.6496
140189	1.1662	0.9301	21.1515	22.5875	25.6954	23.0907
140190	1.0848	0.8347	16.6674	17.9193	18.8530	17.7856
140191	1.3262	1.0864	27.4166	24.5446	25.2817	25.6418
140193	1.0287	*	18.5651	20.5958	22.9443	20.6815
140197	1.2694	1.0864	19.9407	19.2980	21.8060	20.3232
140199	1.0531	0.8347	18.5409	19.7888	21.3464	19.8905
140200	1.4422	1.0864	22.4627	24.1358	24.9217	23.8647
140202	1.5835	1.0759	25.2777	26.2460	27.4336	26.4012
140203	1.0582	1.0864	24.8870	26.5789	28.2212	26.6848
140205	2.1121	0.9770	*	25.1010	*	25.1010
140206	1.1091	1.0864	22.8223	24.7616	27.5481	24.9466
140207	1.3545	1.0864	25.4539	23.3197	25.7331	24.9515
140208	1.6850	1.0864	28.3112	27.4671	27.6586	27.7968
140209	1.5598	0.8888	20.2433	22.0813	23.3886	21.9504
140210	1.1293	0.8347	15.5345	15.5339	16.6729	15.9015
140211	1.2517	1.0864	22.8852	25.8556	29.5114	26.2011
140213	1.2057	1.0864	25.6839	27.4607	29.1649	27.5019
140215	***	*	18.5503	18.6962	22.3097	19.7686
140217	1.4108	1.0864	25.9030	24.7146	29.3711	26.6990

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
140218	***	*	17.4171	*	*	17.4171
140220	***	*	19.3915	*	*	19.3915
140223	1.4799	1.0864	26.2168	27.4355	29.2540	27.6782
140224	1.4068	1.0864	25.6766	27.1725	29.0350	27.4449
140228	1.5712	0.9607	21.8627	22.9899	25.0074	23.3128
140230	***	*	12.3494	*	*	12.3494
140231	1.4680	1.0864	26.0208	25.5536	28.3545	26.6937
140233	1.5672	0.9607	24.4419	24.7103	27.3379	25.5650
140234	1.0706	0.8888	19.7266	20.8676	23.2604	21.3613
140239	1.5363	0.9607	21.6074	23.9205	24.2112	23.2443
140240	1.3733	1.0864	25.1418	25.0325	27.2654	25.8268
140242	1.4802	1.0864	26.1850	28.8686	30.4005	28.5596
140245	0.9868	0.8347	15.1320	15.2537	16.0772	15.4874
140246	0.9890	*	15.0650	16.1305	*	15.5895
140250	1.2497	1.0864	25.3410	25.5501	27.4628	26.1221
140251	1.3775	1.0864	23.5128	24.8256	26.7266	25.0191
140252	1.4262	1.0864	26.4715	28.3479	30.2656	28.4235
140253	***	*	18.4567	*	*	18.4567
140258	1.5154	1.0864	25.0743	27.5741	27.9478	26.9112
140271	0.8694	0.8732	16.0351	17.5174	18.8535	17.5336
140275	1.2785	0.8758	22.9656	23.1871	25.2824	23.7763
140276	1.8202	1.0864	26.1713	25.3222	27.5936	26.3414
140280	1.5093	0.8758	20.0763	21.7004	21.9302	21.2393
140281	1.6375	1.0864	26.5197	27.9115	29.2602	27.9572
140285	1.2857	0.8732	15.7435	*	17.7824	16.6510
140286	1.1614	1.0864	24.0369	25.5805	28.4378	26.0735
140288	1.5412	1.0864	25.8717	26.3572	26.9581	26.4221
140289	1.3742	0.9083	17.7886	20.7506	22.3274	20.3275
140290	1.3630	1.0864	26.5055	29.9098	28.6926	28.4189
140291	1.2222	1.0759	26.8629	27.6675	28.2338	27.6174
140292	1.1261	1.0864	26.8610	26.4077	26.1781	26.4582
140294	1.1472	0.8347	19.4218	21.7473	22.6123	21.2212
140300	1.3128	1.0864	28.9830	30.5172	33.3983	30.9640
150001	1.1574	1.0104	22.6875	25.4897	27.1021	25.2130
150002	1.4200	1.0709	20.7353	22.3327	23.3804	22.1505
150003	1.6797	0.9051	21.4649	21.0944	23.3196	21.9918
150004	1.5136	1.0709	22.8061	23.6169	24.8884	23.7405
150005	1.2283	1.0104	22.8149	23.8818	25.4443	24.1126
150006	1.2533	0.9434	21.8435	23.1779	24.8976	23.3421
150007	1.3410	0.9023	21.2811	22.1098	23.5841	22.4141
150008	1.3398	1.0709	23.0208	23.8916	23.6953	23.5330
150009	1.3317	0.9146	19.5869	19.4763	20.4993	19.8592
150010	1.3622	0.9023	21.2466	22.5445	23.9740	22.6422
150011	1.1427	1.0104	19.9096	22.1559	23.2249	21.7803
150012	1.6025	0.9434	21.7903	23.1644	22.9314	22.6416
150013	0.9576	0.8699	17.5531	19.8564	19.7689	19.0865
150014	1.4141	1.0104	22.8402	24.3754	26.5785	24.5423
150015	1.3157	1.0709	24.2370	23.1616	24.3015	23.8826
150017	1.8504	0.9802	20.6758	22.7979	23.7180	22.4365
150018	1.5738	0.9257	22.8922	24.6138	24.7048	24.1143
150019	1.1574	*	19.8341	17.3170	*	18.4629
150020	1.0363	*	15.9405	18.4689	*	17.2379
150021	1.6999	0.9802	23.3800	24.3658	27.8168	25.1834
150022	1.0551	0.8948	18.7751	22.2973	22.8035	21.5527
150023	1.5373	0.8699	20.3015	20.6926	23.1253	21.3434
150024	1.4254	1.0104	19.8368	21.7593	24.7879	22.0685
150026	1.3273	0.9257	21.9448	23.2169	23.7185	22.9747
150027	1.0733	1.0104	19.4238	21.5766	21.2855	20.7979
150029	1.3561	0.9434	24.8939	25.2067	23.4103	24.3976
150030	1.1853	1.0104	20.7256	23.0196	24.4361	22.7653
150031	1.1068	*	21.3494	18.9180	*	19.9678
150033	1.7170	1.0104	23.0756	24.1701	25.8851	24.3767
150034	1.4698	1.0709	23.3718	22.8812	23.9388	23.4018
150035	1.4772	0.9405	22.3779	23.5468	26.0952	24.0002
150036	***	*	22.1464	*	*	22.1464
150037	1.2949	1.0104	22.3699	24.4997	27.7009	24.8057
150038	1.1542	1.0104	20.3454	21.6608	24.4188	22.0777

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
150039	1.1313	*	16.0227	*	*	16.0227
150042	1.3731	0.8699	18.0185	23.7838	21.9917	21.0664
150043	1.0188	*	20.6301	*	*	20.6301
150044	1.2944	0.9146	19.8951	20.5156	23.1200	21.1614
150045 ^h	1.0886	1.0218	20.6406	23.0361	24.2899	22.7402
150046	1.3804	0.8699	19.4146	20.3453	21.0417	20.2984
150047	1.6982	0.9802	21.9824	24.8786	24.5455	23.7796
150048	1.2368	0.9497	21.1441	22.5181	24.5864	22.7864
150049	1.2004	0.8699	21.6309	18.4942	20.2178	20.1025
150050	***	*	18.0411	*	*	18.0411
150051	1.5967	0.8699	20.6895	21.4009	22.6866	21.6323
150052 ^h	1.0837	0.9146	18.8345	19.1070	19.6073	19.1807
150053	***	*	18.3494	*	*	18.3494
150054	***	*	19.3424	*	*	19.3424
150056	1.8813	1.0104	23.0603	24.7841	27.6754	25.1879
150057	2.0625	1.0104	17.4043	28.0884	22.7804	22.2798
150058	1.5636	0.9434	23.0273	24.9479	26.9753	25.0080
150059	1.5623	1.0104	23.1398	25.6738	27.0792	25.3799
150060	1.1052	0.8699	19.5011	19.8990	23.2409	20.8351
150061	1.1811	0.8699	19.4014	19.2826	21.3640	20.0300
150062	1.1794	0.8852	21.2607	22.9214	23.5550	22.5696
150063	***	*	24.8588	24.4091	19.0377	22.9018
150064	1.1554	0.8699	20.6232	21.2512	21.6370	21.1751
150065	1.1210	1.0104	21.4572	23.0636	24.4451	23.0185
150066	0.8962	*	19.6845	*	*	19.6845
150067	1.0677	*	20.5000	21.4374	*	20.9866
150069	1.1934	0.9536	23.5510	23.8353	25.3445	24.1524
150070	0.9378	0.8699	18.9332	20.7413	22.6260	20.8438
150071	***	*	16.4179	*	*	16.4179
150072	1.1779	0.8699	18.5813	18.5447	20.3191	19.1866
150073	***	*	19.8034	14.8287	*	16.6860
150074	1.5196	1.0104	21.3500	22.9598	24.4374	22.9562
150075	1.1297	0.9802	17.2267	20.1119	24.2085	20.3068
150076	1.1964	0.9434	23.3724	25.4519	24.1434	24.3143
150078	0.9872	0.9306	20.2068	20.1259	21.2476	20.5686
150079	1.0889	0.9146	18.3667	19.3860	20.6486	19.4947
150082	1.7416	0.8699	19.6881	21.0651	22.2054	21.0724
150084	1.8295	1.0104	24.9529	27.8354	28.7722	27.2590
150086	1.2207	0.9536	19.7763	21.5815	22.4471	21.3241
150088	1.2980	0.9589	22.3055	22.2627	23.0998	22.5643
150089	1.5120	0.8699	21.5664	21.6806	22.6545	21.9840
150090	1.3579	1.0709	21.9803	24.9021	24.6758	23.7887
150091 ^h	1.1509	1.0375	26.5235	26.4248	27.8087	26.8601
150092	***	*	18.2592	*	*	18.2592
150094	***	*	16.8351	*	*	16.8351
150095	***	*	22.3214	*	*	22.3214
150096	0.9574	0.8699	*	19.7975	21.9091	20.8347
150097	1.0619	1.0104	21.1462	22.4564	24.4179	22.7769
150098	1.1551	*	16.4763	*	*	16.4763
150100	1.7146	0.8699	18.7289	21.2980	22.2687	20.6246
150101	1.0195	0.9802	21.2025	26.1271	27.9745	24.4114
150102	1.0993	1.0709	20.8817	21.3313	22.6870	21.6474
150103	***	*	19.3652	*	*	19.3652
150104	1.0494	1.0104	21.3141	21.0799	21.8172	21.4108
150105	***	*	21.6975	*	*	21.6975
150106 ^h	0.9550	0.9802	18.7088	19.1976	20.9955	19.6788
150109	1.4074	0.9051	21.7870	23.4642	24.3786	23.2294
150111	1.3006	*	24.1560	*	*	24.1560
150112	1.3928	1.0104	22.1939	23.5151	24.7455	23.4673
150113	1.2228	0.9589	20.5871	21.2412	23.0450	21.6918
150114	***	*	18.3097	*	*	18.3097
150115	1.2819	0.8699	18.1308	20.3863	20.5215	19.6986
150122	1.1308	0.8898	20.7540	22.2752	24.2471	22.4836
150123	0.9457	0.8699	16.2897	15.5997	15.3050	15.7485
150124	1.1116	0.8699	16.2104	17.9063	18.8218	17.6460
150125	1.4386	1.0709	22.0299	23.1464	24.3872	23.2299
150126	1.4368	1.0709	24.0000	24.1917	25.5585	24.5863

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
150127	***	*	18.0533	*	*	18.0533
150128	1.3554	1.0104	20.4742	20.9869	23.1660	21.6089
150129	1.1673	1.0104	29.9888	34.3166	35.4311	33.2370
150130	1.0455	0.8699	18.3852	18.5578	21.5678	19.4353
150132	1.3738	1.0709	21.2747	22.2707	24.2559	22.6184
150133	1.2352	0.9134	20.0320	21.8807	21.8839	21.2868
150134	1.0649	0.9146	20.2764	20.7680	22.1085	21.0778
150136	1.1430	1.0104	22.9091	25.8467	25.7004	24.8117
150146	0.9981	0.9134	*	25.1827	26.1168	25.5972
150147	0.9266	1.0709	*	*	32.3336	32.3336
150148	***	*	*	26.2188	27.2081	26.7661
150149	1.0002	0.8699	*	*	23.8554	23.8554
150150	1.2142	0.9802	*	*	26.5138	26.5138
160001	1.2068	0.9101	20.1699	22.8426	23.8657	22.2778
160002	1.1516	*	17.6600	19.9607	*	18.7916
160003	1.0324	0.8515	17.5429	17.5050	19.0037	18.0283
160005	1.1479	0.8515	19.3348	20.3313	21.1745	20.2615
160007	***	*	14.9137	*	*	14.9137
160008	1.0539	0.8515	16.7863	17.9463	19.8066	18.1465
160009	***	*	19.0664	*	*	19.0664
160012	0.9609	*	17.9236	*	*	17.9236
160013	1.1956	0.8733	20.3023	21.0541	23.0163	21.4347
160014	0.9530	0.8515	18.7253	18.3097	19.2447	18.7641
160016	1.5221	0.9101	21.6050	21.8400	21.2785	21.5641
160018	***	*	16.0794	*	*	16.0794
160020	1.0802	0.8515	15.7960	16.6092	19.0043	17.1574
160021	***	*	16.7921	*	*	16.7921
160023	***	*	15.3855	*	*	15.3855
160024	1.5603	0.9266	20.5622	22.4256	24.2385	22.3852
160026	1.0142	0.9480	20.4567	22.8967	24.2045	22.5201
160027	***	*	18.2082	*	*	18.2082
160028	1.3022	0.9740	22.9000	25.1998	26.0052	24.7057
160029	1.5649	0.9649	22.2106	23.7268	24.9493	23.6562
160030	1.2511	0.9480	21.6899	23.3687	24.9920	23.3788
160031	0.9937	0.8515	16.8957	17.8994	18.5281	17.7876
160032	1.0477	0.8787	19.2464	20.5024	22.3837	20.7033
160033	1.7622	0.8758	20.1916	22.2660	23.4148	21.9600
160034	0.9396	0.8515	17.3644	19.0684	19.4837	18.6062
160035	***	*	17.0165	*	*	17.0165
160036	***	*	20.2598	*	*	20.2598
160037	0.9941	*	19.5067	*	*	19.5067
160039	0.9716	0.8515	19.1998	19.8851	20.9623	20.0272
160040	1.2616	0.8963	19.6339	20.0567	21.8187	20.4960
160041	***	*	18.7943	*	*	18.7943
160043	0.9238	*	16.7840	15.5765	*	16.1621
160044	1.1446	0.8515	19.5552	19.0956	19.5635	19.3956
160045	1.7267	0.8963	21.4757	22.1285	24.4957	22.7180
160046	***	*	16.8665	*	*	16.8665
160047	1.3794	0.9740	20.4259	22.1550	24.5000	22.4520
160048	1.0870	0.8515	17.2709	18.1174	19.5701	18.3315
160049	0.9487	*	15.3233	*	*	15.3233
160050	1.0257	0.8515	21.1184	21.6247	23.8830	22.1800
160051	***	*	15.8213	*	*	15.8213
160052	***	*	22.1933	*	*	22.1933
160054	***	*	16.5258	*	*	16.5258
160055	***	*	17.6177	*	*	17.6177
160056	***	*	17.9534	*	*	17.9534
160057	1.3030	0.9486	19.6802	20.8345	22.0472	20.8573
160058	1.8989	0.9649	22.2812	23.5663	25.5244	23.8102
160060	***	*	17.7489	*	*	17.7489
160061	***	*	17.2064	*	*	17.2064
160062	***	*	18.8162	*	*	18.8162
160063	***	*	17.3770	*	*	17.3770
160064	1.6399	1.0481	25.2962	23.8367	27.6301	25.5547
160065	***	*	17.0609	*	*	17.0609
160066	1.1154	0.8515	19.3203	20.4609	21.4631	20.4247
160067	1.3343	0.8963	17.6602	19.9422	21.9418	19.6020

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
160068	***	*	20.5994	*	*	20.5994
160069	1.4997	0.8730	20.5989	21.7197	22.7514	21.6807
160070	***	*	17.7856	*	*	17.7856
160072	1.0176	*	15.3384	15.8236	*	15.5805
160073	***	*	15.5946	*	*	15.5946
160074	1.0071	0.8515	18.4624	22.2988	20.2418	20.2627
160075	***	*	20.7843	*	*	20.7843
160076	0.9967	0.8515	19.1590	20.1603	20.9749	20.1266
160077	***	*	15.0468	*	*	15.0468
160079	1.5216	0.8963	20.5010	21.6562	22.5299	21.5681
160080	1.1984	0.9484	19.6680	21.1713	23.5721	21.3830
160081	1.1714	0.8515	19.1442	20.4415	21.3614	20.2899
160082	1.7886	0.9266	20.7306	21.6230	23.8181	22.0419
160083	1.6282	0.9266	21.3221	23.4670	25.0617	23.2724
160085	***	*	19.1929	*	*	19.1929
160086	***	*	19.0477	*	*	19.0477
160088	***	*	23.8098	*	*	23.8098
160089	1.2688	0.9101	18.3526	19.9688	21.5693	19.9669
160090	1.0243	0.8515	18.4210	19.6767	21.2753	19.8215
160091	0.9671	0.8515	14.8904	16.1660	18.0630	16.3560
160092	1.0679	0.8515	17.9251	20.4731	22.0841	20.1247
160093	0.9714	*	19.5732	22.8553	*	20.9212
160094	***	*	18.7835	*	*	18.7835
160095	***	*	16.4927	*	*	16.4927
160097	***	*	17.7860	*	*	17.7860
160098	***	*	16.8997	*	*	16.8997
160099	***	*	16.0710	*	*	16.0710
160101	1.0847	0.9266	19.6314	22.1741	24.2309	21.9996
160102	***	*	14.4837	*	*	14.4837
160103	***	*	19.6169	*	*	19.6169
160104	1.2844	0.8758	21.0059	23.2832	24.0075	22.7783
160106	1.0578	*	19.4385	19.8905	21.4912	20.2695
160107	1.0418	0.8515	18.8937	19.5111	21.3754	19.9069
160108	***	*	17.7577	*	*	17.7577
160109	0.9390	*	18.2938	*	*	18.2938
160110	1.6822	0.8963	20.9959	21.9299	24.1762	22.4246
160111	***	*	15.1104	*	*	15.1104
160112	1.2590	0.8515	19.6950	20.4038	21.8901	20.6784
160113	0.9564	0.8515	14.9448	16.7574	18.6599	16.7958
160114	0.9716	*	18.0532	19.1743	*	18.6182
160115	1.0355	0.8515	16.9992	17.6815	19.5764	18.0168
160116	1.0368	0.8515	18.4261	19.6923	22.2019	20.1223
160117	1.2931	0.8730	20.1682	22.3228	23.4250	21.9540
160118	1.0128	0.8515	17.1480	16.9466	18.3322	17.5246
160120	***	*	15.0576	*	*	15.0576
160122	1.0449	0.8515	18.8470	21.2843	22.9565	21.0855
160124	1.1732	0.8515	19.9144	21.2279	22.7223	21.3019
160126	0.9909	0.8515	17.8643	20.0149	20.3748	19.3989
160129	***	*	18.0113	*	*	18.0113
160130	0.9344	*	16.2628	*	*	16.2628
160131	0.9568	*	16.5397	18.0486	*	17.2959
160134	***	*	14.6396	*	*	14.6396
160135	***	*	18.3973	*	*	18.3973
160138	***	*	18.3956	*	*	18.3956
160140	0.9931	0.8879	19.6154	22.1666	22.5230	21.4658
160142	***	*	17.2792	*	*	17.2792
160143	1.0650	*	18.1287	19.0623	*	18.5983
160145	***	*	17.8887	*	*	17.8887
160146	1.4019	0.9067	19.0576	20.6638	20.9583	20.2206
160147	1.2381	0.9101	21.6062	22.7993	26.6577	23.7398
160151	***	*	18.3398	*	*	18.3398
160152	***	*	17.0751	*	*	17.0751
160153	1.6556	0.9067	22.7004	23.5212	26.3671	24.2226
170001	1.1801	0.8126	18.5120	19.8149	20.9837	19.7996
170004	***	*	17.2262	*	*	17.2262
170006	1.2065	0.8573	19.1982	19.4488	20.6460	19.7801
170008	0.9258	*	17.7062	18.2352	*	17.9761

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Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
170009	1.0753	0.9623	25.0508	25.8246	29.1979	26.7866
170010	1.2057	0.8737	19.5990	20.6294	21.2131	20.4787
170012	1.6314	0.9187	20.2412	21.8587	22.6869	21.5846
170013	1.6058	0.9187	20.1852	21.4954	23.1159	21.5977
170014	1.0121	0.9623	19.6044	21.3416	22.9772	21.2385
170015	0.9529	0.8126	17.2443	18.0485	19.1902	18.1581
170016	1.6872	0.8896	22.1023	22.9479	24.2336	23.1145
170017	1.1342	0.9486	19.7908	21.6323	23.3030	21.6195
170018	0.9045	0.8126	14.8793	16.9169	17.9497	16.6476
170019	1.2158	0.8126	17.4699	18.7916	20.3243	18.8417
170020	1.5359	0.9187	19.1418	20.6658	22.2571	20.7442
170022	1.1962	0.9623	20.3269	21.1947	22.9313	21.4834
170023	1.4379	0.9187	19.6533	21.6273	23.2690	21.5239
170024	0.9817	*	15.0081	16.1196	*	15.5632
170025	1.1417	*	19.1721	19.2123	*	19.1915
170026	0.9204	*	16.9094	17.0836	*	16.9949
170027	1.3807	0.8126	18.4466	20.7776	21.4678	20.2821
170030	0.9888	*	12.9413	*	*	12.9413
170031	***	*	16.4661	*	*	16.4661
170032	***	*	15.2207	*	*	15.2207
170033	1.3966	0.9187	20.4533	20.0627	20.0801	20.2001
170034	0.8419	*	17.8240	18.1074	*	17.9629
170035	***	*	19.8334	*	*	19.8334
170038	***	*	15.2505	*	*	15.2505
170039	0.9628	0.9472	18.5780	18.4473	20.1983	19.0814
170040	1.9259	0.9623	23.1014	24.5234	27.1771	25.0772
170041	0.9614	*	9.9263	13.9709	*	11.6651
170045	0.9920	*	20.5454	*	*	20.5454
170049	1.4655	0.9623	21.2917	22.9404	24.1208	22.8637
170051	***	*	16.9003	*	*	16.9003
170052	1.1623	0.8126	16.0948	15.8809	17.3794	16.4626
170053	***	*	14.3629	*	*	14.3629
170054	1.0156	*	15.2814	18.5239	17.5500	17.1080
170055	***	*	18.1782	*	*	18.1782
170056	0.8477	*	19.7369	17.1872	*	18.6155
170058	1.0958	0.8573	20.1090	23.0648	22.0398	21.7489
170060	0.9073	*	17.5289	*	*	17.5289
170061	1.0019	*	15.6413	*	*	15.6413
170063	***	*	13.7611	*	*	13.7611
170066	***	*	16.8010	*	*	16.8010
170067	***	*	20.7945	*	*	20.7945
170068	1.1997	0.8126	19.2629	20.5512	20.8771	20.2365
170070	1.0667	0.8126	14.8349	15.0539	16.4767	15.4454
170073	***	*	17.7586	*	*	17.7586
170074	1.1339	0.8126	17.6543	18.5446	20.4936	18.9467
170075	0.8625	0.8126	14.4939	15.6809	16.2047	15.4970
170076	0.9108	*	14.9393	*	*	14.9393
170077	0.8861	*	14.1376	14.6377	*	14.3947
170079	***	*	16.7227	*	*	16.7227
170080	0.9403	*	13.6793	15.0079	*	14.3578
170081	***	*	15.0840	*	*	15.0840
170082	0.8969	*	14.8154	15.9973	*	15.4029
170084	***	*	13.6517	*	*	13.6517
170085	0.8840	0.8126	21.8907	17.2585	18.4867	19.3032
170086	1.5612	0.8896	20.7298	22.1067	22.7737	21.8864
170089	***	*	20.2263	*	*	20.2263
170090	0.9576	*	23.6839	16.3550	15.9807	17.8436
170093	0.8263	0.8126	14.7803	15.0307	16.8710	15.5787
170094	0.9972	0.8896	21.2484	20.1253	20.3678	20.6300
170095	0.9779	*	16.1078	*	*	16.1078
170097	0.9058	*	18.6023	18.9865	20.3391	19.3146
170098	1.1165	0.8126	17.3479	18.6676	20.0078	18.6191
170099	1.1247	*	16.5248	15.8117	*	16.1638
170101	0.8750	*	17.3382	17.9291	*	17.6471
170102	***	*	14.4499	*	*	14.4499
170103	1.2105	0.9486	18.6172	20.1263	21.4985	20.1233
170104	1.4993	0.9623	22.0671	23.6589	26.1866	23.9928

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
170105	1.0860	0.8126	18.2788	18.3824	19.6687	18.7982
170109	0.9735	0.9623	18.3483	20.7580	22.7166	20.6908
170110	1.0074	0.8126	21.0637	16.5883	21.8904	19.8917
170112	***	*	15.8097	*	*	15.8097
170113	1.0161	*	16.4939	19.9957	*	17.9133
170114	0.8679	0.8126	13.9726	17.4688	18.1610	16.3775
170115	***	*	13.0254	*	*	13.0254
170116	1.0235	0.8126	19.4278	20.8800	23.1127	21.1385
170117	***	*	16.8301	*	*	16.8301
170119	***	*	15.1981	*	*	15.1981
170120	1.2174	0.8573	18.2832	18.5895	19.8723	18.9135
170122	1.6151	0.9486	21.4588	22.2681	24.6532	22.7610
170123	1.6521	0.9486	25.2122	25.0073	26.4676	25.5847
170124	***	*	16.3925	*	*	16.3925
170126	***	*	14.5527	*	*	14.5527
170128	***	*	17.6258	*	*	17.6258
170133	1.0633	0.9623	19.9778	20.0593	21.7748	20.5957
170134	***	*	15.1932	*	*	15.1932
170137	1.2717	0.8126	19.3344	21.4394	22.7676	21.1717
170139	***	*	14.8156	*	*	14.8156
170142	1.3103	0.8126	19.0547	19.8269	22.4095	20.4139
170143	1.1361	0.8126	16.3258	18.0308	19.7643	18.0791
170144	***	*	20.8488	23.9180	24.4259	22.7916
170145	1.0833	0.8737	20.1494	20.5143	21.4472	20.7120
170146	1.4820	0.9623	25.2520	27.0312	28.1965	26.9350
170147	1.2527	0.9486	18.4634	18.2480	23.1610	19.8742
170148	***	*	24.4828	26.3491	*	25.3383
170150	1.1232	0.8126	14.9718	16.3724	17.4916	16.2770
170151	0.9404	*	14.5001	15.7242	*	15.1193
170152	***	*	16.0930	*	*	16.0930
170160	***	*	17.0628	*	*	17.0628
170164	***	*	17.0792	*	*	17.0792
170166	0.9239	0.8126	16.5113	17.8131	18.5978	17.6133
170171	***	*	14.7050	14.7251	*	14.7158
170175	1.3386	0.9187	20.8671	22.5605	23.6262	22.2664
170176	1.3057	0.9623	23.5743	25.5404	24.2283	24.4336
170180	***	*	*	25.0935	*	25.0935
170182	1.4803	0.9623	21.9797	23.2115	24.3820	23.2221
170183	1.9494	0.9486	16.6577	19.6919	22.8633	19.7661
170185	1.1226	0.9623	26.8136	26.8307	24.8478	26.0707
170186	2.9515	0.9486	33.2457	28.5602	30.5157	30.5405
170187	1.2282	0.8126	*	20.8289	21.0780	20.9654
170188	2.1282	0.9623	*	25.2504	27.2225	26.3122
170189	***	*	*	28.1996	*	28.1996
170190	0.9116	0.8126	*	*	22.4865	22.4865
170191	1.0067	0.8126	*	*	24.9599	24.9599
180001	1.1948	0.9536	20.8169	22.2674	24.7647	22.5886
180002	1.0229	0.7813	19.8195	20.5135	21.6843	20.6864
180004	1.1189	0.7813	18.0494	19.8552	19.0834	18.9860
180005	1.1922	0.9009	23.4941	22.6704	22.8871	23.0158
180006	0.9801	0.7813	11.2872	14.4066	15.7136	13.5723
180007	1.4053	0.9336	18.6823	21.3545	21.8724	20.6451
180009	1.5859	0.9560	21.7746	22.4450	24.0971	22.8155
180010	1.9059	0.9336	19.4210	22.6846	26.4116	22.7610
180011	1.4295	0.8931	22.6798	18.8056	22.3183	21.2452
180012	1.4965	0.9146	19.6614	20.2758	22.9096	20.9578
180013	1.4558	0.9758	20.0950	21.0512	21.4728	20.9081
180014	***	*	23.0067	*	*	23.0067
180016	1.2944	0.9146	19.7242	20.5203	22.2148	20.8553
180017	1.2860	0.7813	16.7649	18.0329	19.0694	17.9749
180018	1.3805	0.8931	18.1529	17.5670	18.3314	18.0200
180019	1.1208	0.7813	19.5953	20.8416	22.0379	20.8096
180020	1.0654	0.7813	19.4391	20.9964	22.3477	20.9038
180021	1.1248	0.7813	16.5377	17.6331	17.9346	17.3741
180023	***	*	19.0574	*	*	19.0574
180024	1.1511	0.7813	19.6313	22.3922	23.6826	22.0438
180025	1.0657	0.9126	17.1875	18.3306	17.4781	17.6757

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
180026	1.0938	0.7813	13.9960	15.5354	15.8431	15.1128
180027	1.2625	0.8109	19.6928	20.5017	22.1072	20.7790
180028	0.8925	0.9009	26.2221	20.6324	21.4766	22.4249
180029	1.2496	0.8235	20.0841	20.4262	21.2110	20.6029
180030	***	*	17.5043	*	*	17.5043
180031	***	*	17.1003	*	*	17.1003
180032	***	*	17.2362	*	*	17.2362
180033	***	*	17.0499	*	*	17.0499
180034	***	*	17.0349	*	*	17.0349
180035	1.5545	0.9536	22.4651	24.3874	26.7702	24.5908
180036	1.1980	0.9560	20.6951	22.2389	23.1636	22.0893
180037	1.2812	0.9146	21.0177	22.7893	24.4451	23.0162
180038	1.3972	0.8450	19.3837	20.6888	22.2750	20.8090
180040	2.0734	0.9146	22.2270	23.2341	24.5590	23.3814
180041	1.1072	0.7813	17.5950	19.1325	18.5483	18.3898
180042	***	*	15.5660	*	*	15.5660
180043	1.1978	0.7813	17.2414	20.6498	18.8436	18.9201
180044	1.4334	0.9009	21.1057	21.8163	21.6837	21.5313
180045	1.2190	0.9536	20.7498	22.1027	24.5856	22.4422
180046	1.0405	0.9336	21.6955	23.1139	24.7562	23.2153
180047	0.9015	0.7813	17.8625	17.8574	20.4768	18.7740
180048	1.2892	0.7813	18.3151	20.0114	22.3601	20.1998
180049 ^h	1.3587	0.9336	17.8418	18.5188	19.4488	18.5953
180050	1.1065	0.7813	19.4992	19.9082	21.7150	20.3768
180051	1.3746	0.8109	18.3028	18.8186	19.2100	18.7757
180053	1.0094	0.7813	17.3167	17.6239	18.6610	17.8760
180054	1.0219	0.7813	17.4354	19.1340	19.0657	18.6210
180055 ^h	1.1441	0.9336	16.6072	17.8704	21.1989	18.5032
180056	1.0604	0.8398	18.7038	19.4072	21.4695	19.8919
180058	***	*	14.8840	*	*	14.8840
180059	***	*	17.2541	*	*	17.2541
180063	1.1769	0.7813	14.7338	15.5078	15.9185	15.4288
180064	1.1474	0.7813	16.3894	21.1067	15.3819	17.4786
180065	***	*	11.0966	*	*	11.0966
180066	1.0624	0.9758	20.7907	21.1884	24.6359	22.2657
180067	1.9904	0.9336	20.2762	22.0056	24.0551	22.0151
180069	1.0699	0.9009	19.0836	20.3982	20.8797	20.1274
180070	1.0982	0.7813	15.4643	16.9892	17.4266	16.6474
180072	***	*	17.0576	17.5411	*	17.2676
180078	1.0991	0.9009	23.7765	23.4616	25.4196	24.2197
180079	1.1188	0.7813	18.1683	18.0472	19.5783	18.5997
180080	1.3468	0.8931	17.6735	18.9582	20.1651	18.9486
180087	1.1901	0.7813	16.2378	16.4726	17.7758	16.8511
180088	1.5808	0.9146	22.8908	23.7217	24.6053	23.9260
180092	1.1283	0.9336	18.8964	19.6790	22.4864	20.3849
180093	1.4395	0.8218	17.7592	18.8469	19.2748	18.6312
180094	0.9147	*	14.3306	15.7640	*	15.0182
180095	1.1201	0.7813	15.4477	15.9881	17.1354	16.1990
180099	0.9400	*	14.0464	14.0115	*	14.0297
180101	1.1847	0.9336	21.0704	22.4094	24.2242	22.6117
180102	1.5442	0.8109	18.8169	20.1885	19.1136	19.3390
180103	2.1712	0.9336	20.9598	21.3867	25.1577	22.5176
180104	1.6086	0.8109	20.2731	21.3866	22.8911	21.5448
180105	0.8522	0.7813	18.2975	18.3521	19.5364	18.7463
180106	0.9463	0.7813	15.5278	15.4937	15.7851	15.6114
180108	0.9046	*	14.8720	16.7327	*	15.7981
180115	0.9655	0.7813	18.0951	19.2396	19.9316	19.1066
180116	1.2010	0.8109	19.2389	20.5453	21.8698	20.5636
180117	0.9905	0.7813	20.7961	17.7885	20.5952	19.6297
180118	***	*	17.9018	*	*	17.9018
180120	0.8434	*	16.4226	20.4507	*	18.2085
180121	1.0665	*	16.9571	16.9881	*	16.9732
180122	***	*	18.7549	*	*	18.7549
180123	***	*	21.5962	*	*	21.5962
180124	1.3186	0.9758	19.7138	20.5369	21.4270	20.5273
180125	***	*	22.6610	*	*	22.6610
180126	1.1798	0.7813	14.8501	14.5644	15.1776	14.8734

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
180127	1.2280	0.9146	18.0498	20.0059	21.4633	19.8860
180128	0.9591	0.8095	18.7194	19.8502	20.5575	19.7385
180129	0.8653	*	15.6637	14.1861	*	14.9304
180130	1.6472	0.9146	21.9413	23.4982	24.8441	23.4721
180132	1.3564	0.8931	19.8393	19.9358	22.2101	20.6457
180133	***	*	23.2679	*	*	23.2679
180134	1.0677	0.7813	16.5901	*	17.3449	17.0266
180138	1.2244	0.9146	19.8524	23.0996	25.1789	22.6748
180139	1.0388	0.8931	20.3816	20.6287	21.3797	20.8113
180140	***	*	14.6466	*	*	14.6466
180141	1.9007	0.9146	20.3404	22.6722	24.3140	22.3929
180143	1.3435	0.9336	21.3196	20.1309	23.9125	21.8391
190001	1.0837	0.9100	18.8583	20.4946	19.5680	19.6565
190002	1.7356	0.8299	20.6057	20.7172	21.7000	21.0149
190003	1.4002	0.8299	19.5115	20.7505	21.8156	20.6841
190004	1.3529	0.7761	19.6755	20.5272	22.1835	20.7630
190005	1.4917	0.9100	19.0994	20.0551	20.7987	19.9608
190006	1.6017	0.8299	17.7333	18.8115	22.1499	20.7786
190007	1.1729	0.7370	16.3633	17.9392	18.7854	17.7774
190008	1.7041	0.7761	22.4797	20.3278	21.4137	21.3696
190009	1.1798	0.8178	16.0395	17.5144	18.8295	17.3661
190010	1.1100	0.7771	17.7616	18.1797	19.9788	18.6286
190011	1.0098	0.7913	15.7319	15.4699	18.1525	16.3890
190013	1.3662	0.7959	16.7770	18.7538	19.6346	18.3899
190014	1.1101	0.7370	18.6929	17.0630	17.4740	17.7511
190015	1.3321	0.9100	19.7673	20.6167	22.1046	20.8722
190017 ^h	1.3411	0.8534	19.8449	18.3528	18.6962	18.8914
190018	1.1525	*	13.1355	19.2055	*	15.6672
190019	1.6767	0.8178	18.7344	20.8193	23.0704	20.9006
190020	1.0852	0.8339	18.7252	18.5659	19.8505	19.0370
190025	1.2406	0.7370	18.1892	19.9969	20.4651	19.5545
190026	1.5025	0.8178	19.0130	19.9229	21.3386	20.1124
190027	1.5961	0.7959	18.4070	19.4057	21.2449	19.6765
190029	***	*	18.7344	*	*	18.7344
190034	1.2112	0.7370	19.2007	16.8439	17.5002	17.8306
190036	1.6228	0.9100	21.2960	23.3903	23.7356	22.8512
190037	0.9402	0.7940	14.1323	15.6062	16.7629	15.4000
190039	1.5062	0.9100	18.7625	20.4900	23.3105	20.8378
190040	1.3668	0.9100	23.1819	22.9262	23.8076	23.2916
190041	1.5226	0.9130	19.5511	21.9983	23.9082	21.6315
190043	1.0035	0.7370	15.5644	15.7333	16.8944	16.0947
190044 ^h	1.1765	0.8299	17.6788	17.7460	19.5304	18.3544
190045	1.6489	0.9100	22.0065	22.8709	24.0490	23.0241
190046	1.4113	0.9100	20.2414	21.1019	22.2884	21.1918
190048	1.0464	0.7370	16.6848	18.1698	18.6148	17.8403
190049	1.0036	0.8015	18.5902	19.3768	20.1229	19.3736
190050	1.1095	0.7370	16.9053	18.6663	18.5287	18.0350
190053	1.1184	0.7370	13.4768	13.8037	15.7258	14.3833
190054	1.2686	0.8299	17.7269	19.9370	20.3525	19.3624
190059	0.8492	0.8322	17.8651	18.3334	19.2396	18.4817
190060	1.4286	0.7959	19.9121	20.2207	22.2517	20.8132
190064	1.5662	0.8339	19.7215	21.1262	21.5514	20.8022
190065	1.4752	0.8339	18.3280	20.3583	23.0523	20.5321
190071	***	*	16.3822	*	*	16.3822
190077	0.8604	0.7908	16.8829	17.0480	18.4043	17.4434
190078 ^h	1.0714	0.8534	19.5879	19.8607	21.5782	20.3859
190079	1.0868	0.9100	18.8187	20.5000	21.8158	20.3442
190081	0.8947	0.7370	14.7919	11.4756	14.9141	13.7432
190083	0.9080	0.7370	16.2970	18.4954	19.2683	18.1242
190086	1.3158	0.8955	17.6237	18.2005	18.8306	18.2132
190088 ^h	1.1237	0.9835	20.4726	18.6738	22.5045	20.4262
190089	1.0069	0.7370	15.2055	15.5151	16.2961	15.6910
190090	1.0957	0.7370	19.8201	19.0519	20.0745	19.6592
190095	***	*	17.3637	16.9519	18.7302	17.6733
190098	1.5598	0.9130	21.4328	20.7537	23.0802	21.7299
190099	1.0728	0.8299	19.0545	23.1606	21.1657	21.1146
190102	1.6803	0.8299	21.1614	22.0190	23.4618	22.2709

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
190103	***	*	15.6415	*	*	15.6415
190106	1.1184	0.8299	19.9117	20.3114	21.5643	20.6057
190109	1.1295	0.7761	16.3641	16.6515	17.4842	16.8446
190110	0.9482	0.7370	15.2652	16.5007	19.0611	16.9388
190111	1.5904	0.9130	21.3622	24.4380	25.2370	23.7300
190112	***	*	24.2806	*	*	24.2806
190113	***	*	19.0411	*	*	19.0411
190114	1.0488	0.7370	13.5044	13.6101	14.6258	13.9058
190115	1.2378	0.9130	24.0098	25.4984	26.0272	25.1031
190116	1.3343	0.7370	18.3223	17.8297	18.6074	18.2486
190118	0.9462	0.9130	17.8543	17.5060	19.0200	18.1434
190120	***	*	17.6709	*	*	17.6709
190122	1.2677	0.8339	16.7189	17.7811	19.3131	17.8794
190124	1.6313	0.9100	22.8245	23.3859	23.4862	23.2316
190125	1.6626	0.7913	20.1401	21.5692	22.3976	21.3596
190128	1.1949	0.8339	21.5869	23.8786	24.7842	23.4711
190130	0.9497	0.7370	14.5586	15.2678	16.6910	15.5600
190131	1.1827	0.9100	19.7483	21.3154	22.5032	21.1774
190133	0.8596	0.7608	15.7835	13.4062	14.3089	14.4683
190135	1.4411	0.9100	23.0214	24.4908	26.9920	24.8491
190136	***	*	15.6286	*	*	15.6286
190140	1.0128	0.7370	14.8738	15.4030	17.0371	15.7699
190142	***	*	19.0464	*	*	19.0464
190144 ^h	1.1576	0.9835	18.3513	21.3838	21.1658	20.3047
190145	0.9295	0.7370	16.4403	17.4407	17.3361	17.0873
190146	1.5866	0.9100	20.9312	22.1502	23.7721	22.2954
190147	0.8887	*	15.2732	16.3596	*	15.8026
190148	0.9618	*	19.4518	19.3245	20.8321	19.8487
190149	0.9132	0.7370	16.5153	18.4197	17.1671	17.3348
190151	1.0023	0.7370	16.2783	17.3402	17.8741	17.1665
190152	1.3510	0.9100	22.7142	25.1136	27.4708	25.2158
190156	0.8585	0.7370	17.6573	18.0528	18.3702	18.0268
190158	1.1777	0.9100	21.6307	23.2361	26.2352	23.8697
190160	1.4913	0.7913	19.3139	19.8428	20.0025	19.7550
190161	1.0866	0.7959	15.7807	16.5322	17.8794	16.7092
190162	1.0184	0.9100	20.9645	20.7350	22.1781	21.2897
190164	1.1297	0.8178	19.0474	20.2791	21.4247	20.3677
190167	1.1932	0.7370	15.5795	17.2643	17.8604	16.8909
190170	***	*	16.2045	*	*	16.2045
190175	1.3584	0.9100	23.0144	22.7574	24.6790	23.4224
190176	1.7052	0.9100	21.7051	25.2536	25.8482	24.3236
190177	1.6497	0.9100	20.3679	22.3318	25.4769	22.7987
190182	1.2830	0.9100	23.1997	23.6016	25.0837	23.9887
190183	1.1676	0.7761	16.7402	17.1805	18.3151	17.3985
190184	0.9556	0.7370	18.6583	20.6096	21.3191	20.0986
190185	1.3053	0.9100	20.7351	29.7870	24.4176	24.5671
190186	***	*	16.7272	*	*	16.7272
190190	0.8717	0.7370	13.7951	16.2819	14.0052	14.3932
190191 ^h	1.2761	0.8534	19.7218	21.9141	22.3755	21.3660
190196	0.8709	0.8299	19.1961	20.7601	21.9355	20.7026
190197	1.3174	0.7913	20.9871	21.6908	22.9631	21.9483
190199	1.2118	0.8322	17.8288	19.7776	18.5317	18.6450
190200	1.4105	0.9100	22.3510	24.1667	26.4258	24.3389
190201	1.2789	0.7959	21.7185	21.4335	22.5588	21.9213
190202	1.4005	0.8339	22.4701	22.4062	21.8900	22.2701
190203	1.4208	0.9100	23.0636	24.9518	26.9099	25.0997
190204	1.5258	0.9100	22.9134	26.1231	28.8777	26.2119
190205	1.8060	0.8299	18.8750	20.2374	21.7696	20.3569
190206	1.6181	0.9100	21.7867	24.2892	26.9117	24.4993
190207	***	*	20.7024	21.5325	*	21.1317
190208	0.7696	0.7370	17.6834	23.0838	24.8409	20.9597
190218	1.0364	0.8955	20.7290	21.6206	23.9182	22.1717
190236	1.4445	0.9130	22.5796	24.4661	23.8233	23.6496
190240	0.9388	0.7370	16.0658	15.4026	13.9888	15.1564
190241	1.2981	0.7761	*	24.2462	28.9620	26.7568
190242	1.1891	0.8339	*	18.6672	20.5937	19.5839
190243	***	*	*	*	30.6060	30.6060

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
200001	1.3018	0.9937	19.7904	21.6050	23.2210	21.5711
200002	1.1048	0.9807	22.3145	22.0700	24.1446	22.8997
200003	1.2180	*	18.5780	*	*	18.5780
200006	***	*	18.9818	*	*	18.9818
200007	1.0715	1.0102	19.0388	21.0603	22.3920	20.8293
200008	1.2425	1.0102	23.2883	25.1115	25.1741	24.5695
200009	1.8773	1.0102	23.3090	24.9041	28.1409	25.4643
200012	1.1788	0.9027	20.5141	21.8529	24.1243	22.1883
200013	1.0985	0.9213	20.3793	22.8909	23.9048	22.4199
200016	***	*	16.2939	*	*	16.2939
200018	1.2082	0.9027	19.8848	21.1330	24.3294	21.8510
200019	1.2980	1.0102	21.1893	23.1114	24.0926	22.8178
200020	1.2594	1.0793	24.7433	27.0798	28.7351	26.9781
200021	1.1904	1.0102	22.0144	24.9925	25.1027	24.0972
200024	1.4400	0.9807	21.0633	22.9698	24.6484	22.9176
200025	1.1788	1.0102	21.4247	22.9023	24.3646	22.8925
200026	1.0236	0.9027	18.1459	19.7172	21.9997	19.9757
200027	1.3228	0.9027	20.2100	21.0156	23.2912	21.4967
200028	1.0246	0.9027	19.8886	21.2180	24.3061	21.8004
200031	1.2806	0.9027	17.7875	18.8262	20.6202	19.0739
200032	1.1911	0.9027	20.9148	23.0487	24.2221	22.7787
200033	1.9114	0.9937	23.6298	25.1723	26.8727	25.2865
200034	1.3252	0.9807	21.8266	23.5415	26.1150	23.9339
200037	1.1455	0.9027	19.5004	22.6534	23.3490	21.7266
200038	***	*	22.9220	*	*	22.9220
200039	1.2741	0.9807	21.5695	22.1333	24.0474	22.6198
200040	1.2806	1.0102	20.7744	21.8528	23.6791	22.1249
200041	1.1455	0.9027	20.2986	21.3816	23.6797	21.9048
200043	***	*	20.0281	*	*	20.0281
200050	1.2933	0.9937	23.0314	23.4391	25.5233	24.0774
200052	1.1286	0.9027	18.9290	19.0535	22.7763	20.3075
200055	***	*	19.4998	*	*	19.4998
200062	***	*	18.0949	*	*	18.0949
200063	1.2056	0.9807	22.5265	23.0135	24.7235	23.4375
200066	1.2028	0.9027	18.4281	19.5890	21.6354	19.8615
210001	1.4599	0.9992	21.5280	22.6614	26.3144	23.5483
210002	2.1065	0.9892	26.5907	25.6975	25.2859	25.8015
210003	1.6774	1.1026	22.3090	23.0790	32.3042	25.5703
210004	1.4289	1.0992	27.2278	29.4841	29.4300	28.7764
210005	1.3054	1.0952	22.5304	24.7185	27.1276	24.8458
210006	1.1033	0.9892	20.8607	24.7327	25.6396	23.6960
210007	1.9394	0.9892	23.4582	27.5104	28.4496	26.5095
210008	1.3317	0.9892	21.0767	24.6569	26.3008	24.1785
210009	1.8331	0.9892	20.8476	23.4889	24.6332	23.0529
210010	1.0816	0.9225	20.4097	23.7761	24.5071	22.9040
210011	1.4004	0.9892	20.4017	22.3262	24.8373	22.5098
210012	1.6215	0.9892	24.8430	25.2892	25.7934	25.3087
210013	1.3848	0.9892	23.1649	23.0151	23.9875	23.3984
210015	1.3236	0.9892	23.9651	23.8419	25.8532	24.5701
210016	1.8330	1.0992	24.7441	27.2632	28.6992	26.9578
210017	1.1871	0.9225	18.2963	19.0248	21.3983	19.5783
210018	1.2623	1.0992	23.6442	25.3112	27.5431	25.4917
210019	1.7254	0.9225	21.5429	23.5259	24.9252	23.3921
210022	1.4268	1.0992	25.6728	27.6680	30.1470	27.8874
210023	1.4898	1.0101	24.4815	26.7837	29.0844	26.8138
210024	1.7328	0.9892	24.7858	24.8939	27.1756	25.6947
210025	1.2065	0.9225	21.4910	22.8882	23.8943	22.7518
210026	***	*	20.7985	*	*	20.7985
210027	1.5012	0.9225	16.2219	19.3517	23.9255	19.4953
210028	1.1125	0.9225	20.4027	22.4054	24.1265	22.3643
210029	1.3027	0.9892	24.7605	26.2082	31.2888	27.3677
210030	1.2878	0.9225	21.9547	20.7802	27.5507	23.2800
210032	1.1630	1.1134	20.0825	20.3407	25.7138	22.0621
210033	1.2020	0.9892	22.8303	25.0301	26.6113	24.9179
210034	1.3018	0.9892	22.6812	22.8827	26.3896	23.9088
210035	1.3075	1.1026	21.6662	21.6973	24.5198	22.6676
210037	1.2058	0.9225	21.1659	23.5536	24.1913	22.9905

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
210038	1.3179	0.9892	25.9701	26.5696	28.3414	26.9834
210039	1.1606	1.1026	23.3583	24.0987	25.8415	24.4755
210040	1.2800	0.9892	23.7067	25.4729	28.3723	25.9321
210043	1.3245	1.0101	22.9504	22.2177	24.3070	23.2006
210044	1.3783	0.9892	22.9540	23.8101	24.8083	23.8495
210045	1.1023	0.9225	13.5654	11.8350	15.0867	13.6815
210048	1.2964	1.0179	24.9381	24.4328	25.0617	24.8082
210049	1.1961	0.9892	21.1056	24.7148	25.9342	24.1727
210051	1.3574	1.1026	24.8949	25.7103	27.3692	26.0431
210054	1.3191	1.1026	25.1694	27.3551	24.6658	25.7175
210055	1.2599	1.1026	23.8025	27.4218	28.0014	26.3750
210056	1.3916	0.9892	22.6958	23.5881	26.6884	24.4432
210057	1.4083	1.0992	25.6142	27.3520	29.2233	27.4597
210058	1.3028	0.9892	17.4250	22.0351	24.8576	21.2951
210060	1.1848	1.1026	26.4566	25.8377	28.7531	27.1384
210061	1.2420	0.9225	20.8975	22.5455	24.1369	22.7021
220001	1.2336	1.1199	23.4091	25.8030	27.3238	25.5166
220002	1.3411	1.1484	25.4158	26.3348	28.9722	26.9220
220003	1.0241	1.1199	17.6069	18.8150	20.5790	18.9368
220006	1.4081	1.1276	23.8920	27.1576	29.5946	26.9448
220008	1.2540	1.1101	24.2393	25.6647	27.1675	25.7561
220010	1.3242	1.1276	23.4009	24.5020	27.4161	25.1525
220011	1.1618	1.1484	20.6390	32.2266	32.6624	28.3003
220012	1.4279	1.2327	31.1041	32.0521	32.9791	32.1013
220015	1.2064	1.0438	24.1348	25.0272	25.5449	24.9568
220016	1.1800	1.0438	24.6149	25.7740	26.8798	25.7262
220017	1.3284	1.1766	25.9000	28.9024	28.8264	27.8471
220019	1.1767	1.1199	19.9268	21.6620	22.2294	21.2756
220020	1.1940	1.1101	22.5375	23.5737	24.2279	23.4787
220024	1.2575	1.0438	23.8620	24.1071	25.5837	24.5165
220025	1.0032	1.1199	22.0003	23.2374	24.5186	23.2414
220028	1.4375	1.1199	24.1251	31.4858	31.3592	28.7775
220029	1.1358	1.1276	25.7660	27.4792	28.1432	27.1307
220030	1.0906	1.0438	18.9012	20.0816	23.6257	20.9187
220031	1.5785	1.1766	28.3832	30.8324	32.2660	30.4929
220033	1.1663	1.1276	21.8156	25.4500	26.8049	24.7741
220035	1.2372	1.1276	25.7456	26.8486	27.5533	26.7074
220036	1.5389	1.1766	25.5771	28.2182	29.6296	27.7573
220038	1.0474	*	22.9821	*	*	22.9821
220041	***	*	28.6790	28.8184	29.7464	29.0350
220042	***	*	28.4675	*	*	28.4675
220046	1.3284	1.1574	24.1931	26.1955	27.7726	26.0634
220049	1.1826	1.1484	25.4358	26.7688	27.0464	26.4221
220050	1.0900	1.0438	23.3330	23.7326	24.9945	24.0446
220051	1.2251	1.0438	22.4827	22.2965	26.5575	23.9237
220052	1.1926	1.1766	25.4091	26.3043	28.0925	26.7839
220057	***	*	26.2944	*	*	26.2944
220058	0.9241	1.1199	21.6814	22.4885	25.0598	23.0989
220060	1.2146	1.2158	28.3950	29.6960	30.8242	29.7039
220062	0.6022	1.1199	22.5567	22.6598	21.9489	22.3621
220063	1.1816	1.1484	21.8365	23.3704	25.5840	23.5996
220064	***	*	24.0982	*	*	24.0982
220065	1.1986	1.0438	21.5657	22.4143	24.8737	22.9452
220066	1.3398	1.0438	24.5463	27.5575	26.2561	26.1630
220067	1.1990	1.1766	28.2685	22.4968	28.5220	26.1159
220070	1.1940	1.1484	23.9850	26.2697	28.9100	26.9930
220071	1.8301	1.1766	27.7679	27.7773	31.8322	29.1764
220073	1.2122	1.1101	27.4778	27.9309	29.2399	28.2247
220074	1.2989	1.1766	25.3331	25.7840	27.5763	26.2579
220075	1.3955	1.1766	24.6982	26.0527	27.9503	26.2554
220076	1.1248	1.1484	24.1224	24.8040	27.2534	25.4198
220077	1.6997	1.1070	27.1503	27.0946	28.0935	27.4578
220079	***	*	25.7305	*	*	25.7305
220080	1.2031	1.1276	22.9911	24.7399	27.1578	25.0258
220081	***	*	31.1325	*	*	31.1325
220082	1.2772	1.1484	23.2818	23.9542	24.8060	24.0108
220083	1.1633	1.1766	27.2605	28.3533	29.9001	28.5130

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
220084	1.2586	1.1484	26.0395	26.8596	29.0505	27.3737
220086	1.6871	1.1766	28.7324	29.4911	31.7482	29.9498
220088	1.8332	1.1766	25.0671	26.5849	28.5711	26.7593
220089	1.1819	1.1484	25.3521	28.9252	32.4409	29.0233
220090	1.1791	1.1199	26.0265	26.5552	29.7945	27.5298
220092	***	*	29.4173	*	*	29.4173
220095	1.1192	1.1199	22.6828	23.7629	24.9871	23.8295
220098	1.1925	1.1484	24.7180	26.2287	26.8538	25.9294
220100	1.2790	1.1766	26.8001	27.0265	28.4848	27.4932
220101	1.2720	1.1484	28.0856	26.9992	31.0834	28.6783
220105	1.2064	1.1484	25.5692	26.7570	30.0892	27.5654
220106	***	*	27.6811	*	*	27.6811
220108	1.2214	1.1766	24.5939	26.0166	29.0804	26.5232
220110	2.0833	1.1766	30.6173	33.0445	35.4242	33.0914
220111	1.2429	1.1766	26.7573	27.7395	28.9092	27.7674
220116	1.9252	1.1766	28.5716	30.9871	32.2337	30.6846
220119	1.1861	1.1766	24.6344	25.9789	27.8372	26.2021
220123	***	*	29.6084	*	*	29.6084
220126	1.1657	1.1766	23.8123	26.9853	26.7660	25.9304
220133	***	*	29.8367	33.0819	31.2981	31.4484
220135	1.3188	1.2327	29.6837	31.9159	31.3246	31.0032
220153	0.9189	1.0438	*	*	18.9267	18.9267
220154	0.9207	1.1766	23.3590	25.6069	30.9009	26.3094
220163	1.6201	1.1199	29.3552	29.9312	30.5056	30.0383
220171	1.7061	1.1484	27.3487	27.2647	28.9733	27.8501
220174	1.1783	1.1276	*	*	30.3356	30.3356
230001	1.1496	0.8783	23.3051	22.0875	24.3660	23.2388
230002	1.3060	1.0362	24.3116	23.7972	27.0305	25.0820
230003	1.2293	1.0689	21.6493	22.4322	25.2596	23.1458
230004	1.7517	1.0689	22.4538	23.0827	25.5573	23.7400
230005 ^h	1.2465	1.1037	20.5596	20.3750	22.1018	21.1201
230006	1.1082	0.9653	20.6985	22.0733	22.7656	21.8763
230013	1.3430	1.1165	20.0954	20.4633	22.7014	21.0682
230015	1.0765	0.9142	21.9499	21.7640	23.4512	22.3932
230017	1.6625	1.0689	25.7900	26.1609	27.3259	26.4713
230019	1.5589	1.1165	23.8779	24.7472	27.6563	25.4765
230020	1.7237	1.0756	28.8869	25.8267	26.8516	27.1422
230021	1.5166	0.9037	20.9145	22.0757	23.4663	22.1537
230022	1.1887	1.0756	21.8808	22.2179	22.2528	22.1184
230024	1.5986	1.0756	26.2155	24.7364	27.6555	26.1270
230027	1.0407	0.9471	22.5115	21.2223	22.5736	22.1078
230029	1.6633	1.1165	24.9754	26.7646	27.9012	26.5372
230030	1.2755	0.9418	19.2441	19.9853	20.9867	20.1046
230031	1.3863	1.0171	19.4675	22.1874	23.2910	21.7662
230032	***	*	22.8436	23.8366	*	23.3430
230034	1.1848	0.8783	17.9276	18.5768	20.9195	19.0909
230035	1.2489	0.9418	20.5906	18.0735	20.9197	19.7752
230036	1.3258	1.1165	25.1507	25.9801	26.5854	25.9210
230037	1.2629	1.0756	22.7382	24.4115	24.7875	23.9864
230038	1.7472	1.0689	20.9389	23.4685	25.2499	23.4809
230040	1.1581	0.9830	20.2451	21.8062	21.9813	21.3574
230041	1.4882	0.9751	23.2870	24.2297	25.2518	24.2327
230042	1.2368	0.9474	20.7745	21.8241	24.3640	22.3344
230046	1.8575	1.1037	26.1787	28.2320	29.2683	27.8848
230047	1.3609	1.0253	23.7178	24.3622	26.2447	24.8027
230053	1.6321	1.0756	23.5702	26.1415	28.3030	25.9637
230054	2.0168	0.9578	22.2105	23.0818	24.0137	23.1226
230055	1.1673	0.8783	20.8930	20.9350	23.7671	21.9275
230056	***	*	17.3516	*	*	17.3516
230058	1.1761	0.8783	21.6619	22.4516	21.9308	22.0224
230059	1.4748	1.0689	20.6540	21.2743	23.1451	21.6942
230060	1.4037	0.8783	20.5120	22.3512	24.5073	22.5104
230062	***	*	18.2283	*	*	18.2283
230065	1.4044	1.0362	23.3413	26.3217	27.9179	25.8395
230066	1.2958	1.0689	23.2790	23.9696	25.8517	24.3500
230069	1.2332	1.0956	25.0212	26.0438	27.6815	26.3138
230070	1.5570	0.9868	21.2476	22.8588	25.1587	23.0392

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
230071	1.1075	1.1165	23.6398	23.6674	24.7707	24.0188
230072	1.3000	1.0689	22.6533	22.9626	24.1560	23.2832
230075	1.3952	0.9995	22.3632	22.6799	24.1482	23.1037
230076	***	*	26.9662	*	*	26.9662
230077	1.9644	0.9868	22.6781	29.2041	27.3117	26.2749
230078	0.9974	0.8783	19.1638	20.5427	21.9200	20.5211
230080	1.2567	0.9418	19.1810	20.2405	21.2840	20.2442
230081	1.2054	0.8783	20.0464	20.4289	20.6777	20.3869
230082	1.0365	0.8783	18.2165	21.3100	23.1240	20.5945
230085	1.1640	1.0689	24.5765	24.2802	22.2569	23.8243
230086	1.1843	0.8783	20.1461	27.8923	20.8759	22.7158
230087	***	*	20.6619	22.2688	*	21.4725
230089	1.2966	1.0756	23.1023	23.3847	23.9486	23.4962
230092	1.3092	0.9522	22.3437	22.3122	24.3768	23.0025
230093	1.0804	0.9471	21.0274	25.1213	24.5055	23.6184
230095	1.3796	0.8783	18.0582	19.1810	19.2244	18.8313
230096	1.2128	1.0689	24.3004	26.7156	26.7578	25.9257
230097	1.7844	1.0689	22.5006	22.9902	25.2104	23.5897
230099	1.2181	1.0204	22.3422	23.5490	25.0390	23.6331
230100	1.0924	0.8783	18.2477	19.8016	20.4565	19.4563
230101	1.1301	0.8783	22.5159	22.3310	23.1349	22.6681
230103	0.9854	0.9653	18.5254	19.4434	18.4304	18.8026
230104	1.5642	1.0756	25.5606	27.4119	27.8864	26.9371
230105	1.8513	0.9579	23.0086	23.9851	24.6853	23.8845
230106	1.1180	1.0689	22.9909	23.1962	24.1128	23.4616
230107	***	*	18.9985	*	*	18.9985
230108	1.1852	0.8783	21.4593	19.9842	22.4966	21.3245
230110	1.2003	0.8783	21.0925	21.5523	22.7621	21.8215
230115	***	*	21.0360	*	*	21.0360
230116	***	*	15.6064	*	*	15.6064
230117	1.8266	1.0689	25.5154	28.1220	29.6361	27.8196
230118	1.1318	0.8783	20.2769	22.2208	21.4886	21.2999
230119	1.3560	1.0756	23.9898	25.3562	29.2509	26.0773
230120 ^h	1.1024	1.1037	20.6105	22.7243	21.7894	21.6905
230121	1.2512	1.0313	21.4616	22.3708	23.4394	22.3826
230124	1.2484	0.8783	20.9641	22.0097	23.0508	22.0233
230128	***	*	24.4952	*	*	24.4952
230130	1.7164	1.1165	23.5123	23.7854	26.9907	24.7832
230132	1.4095	1.1165	27.3637	29.0292	29.9106	28.7452
230133	1.4250	0.8783	19.0770	20.4801	21.2273	20.3343
230135	0.7730	1.0756	18.4193	19.8290	23.9000	20.7751
230141	1.6732	1.1165	24.4560	23.9885	30.4643	26.1847
230142	1.3168	1.0362	25.0282	22.9036	25.6044	24.5033
230143	1.2304	0.8783	18.2700	19.5446	19.5387	19.0814
230144	2.0675	1.1037	23.3294	23.6959	*	23.4682
230145	1.1389	0.8783	17.9811	15.8192	17.2181	17.0037
230146	1.2731	1.0756	22.3838	21.3539	24.3891	22.7325
230147	***	*	26.5260	*	*	26.5260
230149	0.9663	0.8783	19.9577	20.8933	21.4753	20.6964
230151	1.3464	1.1165	24.3705	23.8527	26.4669	24.9134
230153	1.1199	0.9653	20.0098	22.8584	22.3404	21.7585
230154	***	*	16.7152	*	*	16.7152
230155	1.0101	*	20.7546	18.0743	24.0404	20.6807
230156	1.6277	1.1037	27.2254	27.7164	29.4855	28.1771
230162	***	*	22.7983	*	*	22.7983
230165	1.7558	1.0756	24.7959	25.9534	27.3164	26.0332
230167	1.5888	0.9653	24.1344	24.7935	26.6828	25.1753
230169	0.8789	1.0362	28.1039	24.9265	27.1172	26.6659
230171	1.0578	0.9743	16.1129	19.9097	22.0635	19.2941
230172	1.3494	1.0689	22.1709	23.0023	24.0236	23.0917
230174	1.4022	1.0689	23.5025	24.4671	26.2770	24.7878
230175	***	*	14.4932	22.5964	*	17.8784
230176	1.2886	1.0756	24.9032	24.6675	25.6777	25.0799
230178	***	*	17.3428	*	*	17.3428
230180	1.1089	0.8783	19.6062	20.9832	22.5454	21.1065
230184	1.1427	0.9522	20.6406	21.4031	21.9346	21.3289
230186	***	*	19.1289	21.6147	27.1126	21.8760

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
230188	0.9144	*	16.8687	18.8076	*	17.7537
230189	0.9955	0.8783	19.1989	22.7783	20.8605	20.9106
230190	0.8672	1.0689	24.4643	27.3430	28.7365	26.8514
230191	***	*	20.6633	*	*	20.6633
230193	1.2613	1.0171	21.5358	22.8916	24.3181	22.8751
230195	1.4232	1.0253	23.4647	25.3285	27.1266	25.3452
230197	1.5604	1.1165	25.5311	26.9840	28.3439	26.9390
230199	1.4403	*	22.4592	*	*	22.4592
230201	***	*	18.2486	*	*	18.2486
230204	1.2846	1.0253	24.5127	24.4095	25.9871	24.9363
230205	***	*	18.1552	*	*	18.1552
230207	1.3830	1.1165	20.9059	22.2848	22.2854	21.8187
230208	1.1439	0.9418	17.8118	20.3171	20.9420	19.5928
230211	***	*	21.1245	*	*	21.1245
230212	0.9976	1.1037	24.6420	26.0656	27.3686	26.0098
230213	***	*	17.1061	*	*	17.1061
230216	1.6133	1.0171	22.2137	23.4262	26.1468	23.9896
230217	1.2812	0.9995	24.1455	24.3650	26.7929	25.1576
230219	***	*	18.1278	*	*	18.1278
230222 ^h	1.3431	1.0096	23.2545	24.6101	24.8925	24.2397
230223	1.3247	1.1165	25.2666	28.5549	27.1503	26.9929
230227	1.4769	1.0253	25.8826	27.7510	28.1105	27.3168
230230	1.5005	0.9653	22.1703	23.9568	25.4471	23.8560
230235	1.0327	0.9418	17.5940	19.9118	19.6046	19.0101
230236	1.3741	1.0689	25.3251	25.7463	26.3988	25.8422
230239	1.1770	0.8783	18.9790	19.8370	21.1643	20.0287
230241	1.1876	1.0171	21.8472	24.2063	25.8671	24.0176
230244	1.3542	1.0362	23.1175	23.9004	25.3817	24.1026
230253	***	*	22.7706	*	*	22.7706
230254	1.2919	1.1165	23.3714	24.2594	26.4431	24.6731
230257	1.0090	1.0253	23.1794	24.8069	25.4086	24.4123
230259	1.1927	1.1037	23.1768	24.8598	24.3067	24.1364
230264	1.7309	1.0253	18.6598	17.4847	19.9992	18.8239
230269	1.3097	1.1165	24.3772	25.3367	27.4732	25.8057
230270	1.2468	1.0756	25.2665	22.8842	26.1113	24.7620
230273	1.4601	1.0756	24.1279	25.8466	30.2209	26.7182
230275	0.4945	0.9868	32.0039	29.4180	30.2244	30.4949
230276	***	*	22.3312	23.4928	*	22.8019
230277	1.3467	1.1165	24.3351	25.3378	26.9231	25.5299
230279	0.5682	1.0956	18.3256	21.2467	23.1636	20.9394
230283	1.5162	1.0362	*	25.0038	24.9272	24.9608
230286	***	*	47.5929	*	*	47.5929
230287	***	*	22.5420	*	*	22.5420
230288	***	*	*	30.3422	*	30.3422
230290	***	*	*	*	29.4792	29.4792
240001	1.5289	1.1044	26.6372	28.2239	29.9123	28.3421
240002	1.8224	1.0337	24.2214	24.7674	26.9608	25.3565
240004	1.5584	1.1044	25.6238	26.8197	27.8796	26.8110
240005	***	*	20.2390	*	*	20.2390
240006	1.0815	1.1490	25.7288	29.5789	30.2330	28.5587
240007	1.2479	0.9335	20.7188	21.4367	23.7588	21.9952
240008	***	*	22.7436	*	*	22.7436
240009	***	*	17.4517	*	*	17.4517
240010	1.9486	1.1490	28.3796	29.0955	30.4139	29.3172
240011	1.0681	1.1044	22.5188	24.0364	22.9561	23.1473
240013	1.2858	1.1044	25.1560	27.3855	28.7202	27.0932
240014	0.9836	0.9789	25.2306	26.5144	28.3788	26.7740
240016	1.2982	0.9335	23.3773	25.2629	24.9211	24.5328
240017	1.2374	0.9335	19.3431	21.6243	23.3314	21.4335
240018	1.1976	1.1044	23.6092	27.3634	27.9218	26.3276
240019	1.1479	1.0337	24.0613	25.1331	27.5441	25.5142
240020	1.0790	1.1044	20.6819	24.7516	28.1568	24.2026
240021	0.8789	0.9335	19.0470	23.9568	23.7096	22.1009
240022	1.1030	0.9335	23.0394	23.4702	23.7368	23.4177
240023	***	*	22.3002	*	*	22.3002
240025	1.1243	0.9335	20.7672	21.2597	27.8656	23.1173
240027	0.9378	0.9335	18.3837	18.3340	20.2531	19.0019

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
240029	1.0575	0.9335	23.0440	21.2342	24.3017	22.7230
240030	1.2776	1.0095	20.9799	22.0200	23.3753	22.1631
240031	0.9625	1.0271	21.7621	23.4389	26.7242	23.9687
240036	1.6283	1.0271	22.5436	23.4857	27.0821	24.4899
240037	1.0061	1.1044	21.4275	21.8392	24.3986	22.5980
240038	1.5304	1.1044	26.4513	28.9676	29.8465	28.4070
240040	1.1092	1.0337	22.8191	21.3870	26.3177	23.3958
240041	***	*	21.9055	*	*	21.9055
240043	1.1960	0.9335	18.0186	19.5532	20.7155	19.4893
240044	1.1103	1.0203	22.5751	22.7482	24.3009	23.2474
240045	1.1206	1.0337	24.2936	25.9223	26.1743	25.4770
240047	1.5703	1.0337	25.3233	29.6184	29.1211	27.9364
240050	1.0713	1.1044	23.1109	24.7589	26.6687	24.8796
240051	***	*	23.2612	*	*	23.2612
240052	1.2656	0.9335	22.3485	23.5898	24.9870	23.6640
240053	1.5103	1.1044	24.4191	26.7122	28.4733	26.5849
240056	1.2330	1.1044	24.8549	28.5169	30.8619	28.2766
240057	1.8434	1.1044	25.3984	27.7600	29.4870	27.5534
240058	***	*	19.0505	*	*	19.0505
240059	1.0831	1.1044	25.3847	27.0517	28.6340	27.0658
240061	1.7788	1.1490	27.9151	28.7372	30.0031	28.9358
240063	1.5283	1.1044	25.8594	26.7960	29.9603	27.5204
240064	1.2109	1.0337	24.6785	24.9928	26.6996	25.4635
240065	***	*	14.4624	*	*	14.4624
240066	1.3543	1.1044	25.5163	27.4066	30.2716	27.7718
240069	1.1677	1.1490	23.3373	25.6943	27.4990	25.5949
240071	1.1348	1.1044	22.6332	24.8036	26.4780	24.6454
240072	***	*	21.5455	*	*	21.5455
240073	***	*	17.9013	*	*	17.9013
240075	1.2091	1.0095	21.9159	24.4084	26.6607	24.3331
240076	1.0010	1.1044	23.6159	26.7112	28.4519	26.3651
240077	0.9793	*	22.1508	18.9735	*	20.4876
240078	1.5748	1.1044	26.2576	27.5066	30.5339	28.0679
240079	0.9619	0.9335	18.2929	20.6644	20.9220	19.9304
240080	1.7302	1.1044	26.3071	27.8807	29.6274	27.9923
240082	***	*	20.2018	*	*	20.2018
240083	1.3026	0.9335	22.3484	24.4352	25.0214	23.9450
240084	1.1202	1.0337	23.1951	23.9942	24.7856	24.0011
240085	***	*	20.7535	*	*	20.7535
240086	***	*	18.1497	*	*	18.1497
240087	0.9825	0.9335	21.2116	20.1002	24.8479	21.9890
240088	1.2719	1.0095	24.6260	25.5587	27.6323	25.9708
240089	0.9631	*	21.3950	23.4028	*	22.3786
240090	***	*	21.0856	*	*	21.0856
240093	1.3136	1.1044	20.7138	22.3968	23.7785	22.3760
240094	1.0559	1.1044	22.5923	24.4166	27.3974	24.9803
240096	***	*	20.2993	*	*	20.2993
240097	***	*	29.7596	34.2810	*	32.1316
240098	***	*	23.9626	*	*	23.9626
240099	***	*	18.8140	*	*	18.8140
240100	1.2473	0.9335	24.1875	24.7500	25.3269	24.7716
240101	1.1422	0.9335	22.1328	24.3455	26.6078	24.4827
240102	***	*	15.5114	*	*	15.5114
240103	1.0784	0.9335	21.0182	20.2324	22.5416	21.3014
240104	1.1789	1.1044	25.1139	27.4946	30.1392	27.7883
240106	1.4218	1.1044	23.9677	25.5890	27.5171	25.6898
240107	0.9092	0.9335	21.2164	24.5583	25.5199	23.6935
240108	***	*	17.6501	*	*	17.6501
240109	1.0016	0.9335	15.1369	14.5892	15.2076	14.9741
240110	***	*	21.7341	*	*	21.7341
240111	0.7418	*	19.9711	*	*	19.9711
240112	***	*	17.2437	*	*	17.2437
240114	***	*	18.3415	*	*	18.3415
240115	1.6037	1.1044	24.6529	27.0312	29.0261	26.9116
240116	***	*	17.3461	*	*	17.3461
240117	1.1381	0.9335	18.6677	20.1436	22.0463	20.2868
240119	***	*	23.0231	*	*	23.0231

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
240121	0.9252	*	22.4857	24.5455	*	23.5692
240122	0.9816	*	20.7795	23.5331	*	22.1431
240123	0.9980	0.9335	18.9494	20.0721	20.5755	19.8674
240124	0.9707	*	21.2023	23.5139	23.9297	22.9159
240125	***	*	17.3846	*	*	17.3846
240127	***	*	16.4293	19.3857	24.4824	19.3629
240128	1.0764	0.9335	17.5611	20.1960	21.2638	19.6259
240129	***	*	17.7243	*	*	17.7243
240130	***	*	17.7634	*	*	17.7634
240132	1.2700	1.1044	24.5633	26.7063	29.5310	26.9732
240133	1.1813	0.9654	20.8958	23.6068	26.1836	23.5528
240135	***	*	15.6297	17.8573	16.1837	16.4756
240137	1.1472	0.9335	21.6644	23.1752	23.8666	22.9619
240138	***	*	19.1677	*	*	19.1677
240139	1.0721	0.9335	21.0164	22.4473	23.7898	22.3964
240141	1.0577	1.1044	23.6498	25.1597	26.7173	25.2942
240142	***	*	24.0719	*	*	24.0719
240143	0.8466	0.9335	20.7306	18.9442	21.1180	20.2640
240144	***	*	23.1661	*	*	23.1661
240145	0.8909	*	17.6748	22.6063	*	19.6707
240146	0.9301	*	17.3275	*	*	17.3275
240148	***	*	19.5373	*	*	19.5373
240150	***	*	23.3860	*	*	23.3860
240152	0.9065	1.1044	24.1819	25.4031	27.3445	25.8008
240153	1.0152	*	18.6556	*	*	18.6556
240154	0.9989	0.9473	21.5860	21.3809	23.9643	22.3156
240155	***	*	23.6945	*	*	23.6945
240157	***	*	20.0572	*	*	20.0572
240160	***	*	16.4991	*	*	16.4991
240161	***	*	18.0542	*	*	18.0542
240162	1.1168	0.9335	19.3296	20.4807	22.3136	20.7370
240163	***	*	22.2008	*	*	22.2008
240166	1.1737	0.9335	19.4496	21.5002	23.4265	21.5102
240170	1.1160	*	21.5993	*	*	21.5993
240171	***	*	19.6732	*	*	19.6732
240172	***	*	20.3700	*	*	20.3700
240173	***	*	18.3184	*	*	18.3184
240179	0.9075	*	17.7558	19.8249	20.8449	19.5680
240184	***	*	17.6979	*	*	17.6979
240187	1.1815	1.1044	23.2471	24.8879	26.5129	24.9025
240193	***	*	26.6383	*	*	26.6383
240196	0.8034	1.1044	26.2793	27.2901	28.9380	27.4933
240200	***	*	18.7518	*	*	18.7518
240207	1.1673	1.1044	26.0927	27.4330	29.2395	27.6775
240210	1.2434	1.1044	25.6060	26.6545	29.7227	27.3569
240211	0.9471	1.1044	34.7852	32.8801	44.4214	36.8131
240213	1.2626	1.1044	*	27.5104	31.3974	29.6909
250001	1.8210	0.8341	20.2019	20.9338	21.9176	21.0357
250002	0.8982	0.8764	19.6081	21.6643	20.1310	20.4867
250003	1.1025	*	18.7332	*	*	18.7332
250004	1.7624	0.8887	19.2913	20.9295	20.6828	20.3135
250005	***	*	13.7341	*	*	13.7341
250006	1.0487	0.7649	19.4531	20.3061	21.4038	20.4281
250007	1.2469	0.8934	20.9757	21.2226	23.6933	21.9450
250008	***	*	15.8096	*	*	15.8096
250009	1.2599	0.8707	18.0463	19.7610	20.4329	19.4066
250010	0.9608	0.7649	16.0234	17.6204	19.4130	17.6683
250012	0.9276	0.9223	17.4032	15.6117	20.0493	17.5650
250015	1.0121	0.7649	16.6522	19.3794	20.6931	18.8218
250017	1.1211	0.7649	18.8850	19.0436	18.1013	18.7097
250018	0.8029	0.7649	14.7291	16.8783	17.0689	16.1969
250019	1.5375	0.8934	19.9070	22.9085	22.8358	21.8655
250020	0.9883	0.7649	19.6575	19.1877	19.3390	19.3843
250021	***	*	12.7242	15.8485	15.1242	14.6970
250023	0.8244	0.8764	13.8210	14.7355	16.1820	14.8564
250024	***	*	14.8395	*	*	14.8395
250025	1.0750	0.7649	21.9075	21.2651	20.6892	21.3410

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
250027	0.9798	0.7649	15.1789	17.5937	17.3313	16.6017
250029	***	*	14.8216	*	*	14.8216
250030	0.9455	0.8285	25.5090	27.2140	*	26.3295
250031	1.2022	0.8285	19.8778	21.0894	22.0850	21.0390
250033	***	*	16.9131	*	*	16.9131
250034	1.5734	0.8887	18.8231	20.3681	20.6752	19.9903
250035	0.8870	0.7649	18.3861	17.1071	14.6149	16.8695
250036	0.9915	0.7974	17.6247	17.0469	17.8313	17.5077
250037	0.9173	0.7649	14.3993	16.6347	17.4463	16.0667
250038	0.9197	0.8341	18.8434	16.8610	18.0209	17.8977
250039	0.9190	0.8285	16.4502	16.8729	15.2939	16.1717
250040	1.4283	0.8600	19.6513	20.8178	21.3451	20.5892
250042	1.1976	0.8887	18.3858	19.4367	21.4117	19.6933
250043	0.9709	0.7649	18.4025	17.7554	18.3322	18.1745
250044	1.0248	0.7649	19.0321	20.3711	21.1198	20.1830
250045	1.1083	0.8976	22.7225	25.3236	25.0863	24.3774
250047	***	*	16.0108	*	*	16.0108
250048	1.5210	0.8341	19.4976	19.3635	21.6547	20.2109
250049	0.8821	0.7649	12.8275	13.4396	17.8154	14.4831
250050	1.2465	0.7649	16.0234	16.6723	18.3170	16.9581
250051	0.8651	0.7649	10.1213	10.5027	10.6908	10.4296
250057	1.1812	0.7649	16.6316	19.0571	19.6789	18.3965
250058	1.2585	0.7649	16.2623	16.5565	17.5160	16.7878
250059	1.0262	0.7649	17.9507	19.0733	17.7270	18.2189
250060	0.8054	0.7649	12.6893	14.0155	20.8115	15.6620
250061	0.8749	0.7649	12.0186	11.4573	15.2515	12.6156
250063	***	*	15.0894	*	*	15.0894
250065	0.8425	0.8285	15.0507	16.2010	16.1984	15.7944
250066	0.8715	*	17.2712	16.1044	*	16.6790
250067	1.0608	0.7649	18.3773	20.0430	20.1261	19.5253
250068	0.7989	0.7649	13.2644	16.3759	16.9585	15.3561
250069	1.4732	0.8285	18.5782	21.2224	21.6617	20.4340
250071	0.8644	0.7649	13.1934	13.7056	17.7149	14.5872
250072	1.4474	0.8341	21.0601	20.7827	22.9316	21.5386
250077	0.9182	0.7649	13.9478	14.0318	14.2271	14.0673
250078 ²	1.5887	0.8764	17.4118	17.5186	18.6563	17.8895
250079	0.8752	0.7649	16.1482	21.3506	27.2549	21.7941
250081	1.2428	0.8285	18.1848	20.4513	21.3830	19.9239
250082	1.3414	0.8381	17.3096	19.5962	20.5212	19.1730
250083	0.9279	0.7649	16.3054	19.5217	19.9484	18.7790
250084	1.2236	0.7649	21.0870	22.4632	21.8001	21.7655
250085	0.8976	0.7649	16.7377	18.0473	18.7367	17.8011
250088	1.1295	*	19.3976	*	*	19.3976
250089	1.0852	*	15.0238	16.0203	*	15.4939
250093	1.0880	0.7649	16.8646	17.4413	18.8001	17.6889
250094	1.5257	0.8764	18.9681	19.9619	22.3312	20.3838
250095	1.0066	0.7649	18.4943	18.6616	19.9553	19.0359
250096	1.0958	0.8341	19.3631	20.7246	22.7458	20.9856
250097	1.2403	0.8339	16.3328	18.8399	19.4534	18.1764
250098	0.9024	*	18.8163	17.9561	*	18.4603
250099	1.2190	0.8285	15.9867	18.2504	19.0333	17.7927
250100	1.3641	0.8390	19.7559	18.8877	22.0328	20.2437
250101	***	*	17.6704	*	21.2234	18.8444
250102	1.5316	0.8341	19.8487	21.3213	22.5518	21.2770
250104	1.4176	0.8285	19.0165	20.5035	21.4431	20.3503
250105	0.9275	0.7649	16.1480	17.0136	17.9468	17.0611
250107	0.8754	0.7649	16.5635	16.7104	16.5369	16.6028
250109	1.0420	*	24.5759	*	*	24.5759
250112	0.9317	0.7649	16.6447	16.8696	19.6172	17.7475
250117	1.0637	0.8764	15.9335	18.8863	19.9774	18.1808
250119	1.0052	*	16.5700	17.1373	*	16.8232
250120	1.0264	0.7649	18.1428	22.9071	22.7607	21.1120
250122	1.0493	0.8764	19.8033	19.7966	23.7230	21.1196
250123	1.2451	0.8934	22.1376	22.2184	22.0486	22.1300
250124	0.8835	0.8285	14.4008	15.6866	15.4343	15.1817
250125	1.2993	0.8934	21.9366	25.3415	26.8379	24.7515
250126	0.9195	0.9223	19.0168	20.1118	20.4085	19.8874

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
250128	0.9107	0.7649	15.9957	15.8352	15.9344	15.9238
250131	0.9074	*	11.2470	11.5396	*	11.3947
250134	0.6990	0.8341	21.4489	22.0310	23.5608	22.2594
250136	0.9183	0.8341	20.0333	21.9977	22.5832	21.5555
250138	1.2824	0.8341	19.3446	21.2490	22.7902	21.2040
250141	1.5248	0.9231	21.6835	22.5187	24.5772	23.0806
250145	***	*	11.2021	*	*	11.2021
250146	0.8731	0.7649	15.4061	16.9341	17.2328	16.4757
250148	***	*	23.1460	*	*	23.1460
250149	0.8932	0.7649	15.7537	16.4228	15.0367	15.7586
250151	0.8378	0.7649	*	20.4581	21.8697	21.2291
260001	1.6822	0.8725	20.9620	22.6646	25.3084	22.9817
260002	2.0064	0.9083	23.4259	24.6812	27.2329	25.2692
260003	1.0086	*	16.2023	16.5931	17.6339	16.8056
260004	0.9702	0.8026	15.2735	16.4423	16.7742	16.1582
260005	1.4680	0.9083	22.5860	25.5927	24.6142	24.3121
260006	1.4983	0.8026	22.1692	24.1078	26.4948	24.2935
260008	***	*	18.2114	21.6256	17.6040	19.0121
260009	1.2070	0.9623	19.0655	20.1679	21.2729	20.1559
260011	1.3639	0.8388	20.3279	21.1625	21.4409	21.0002
260012	1.0620	0.8026	17.3810	17.7854	19.3389	18.1986
260013	1.0770	0.8725	17.3772	18.4857	19.2065	18.3369
260015	1.0373	0.8229	18.3849	21.7581	22.4450	20.7897
260017	1.2115	0.8973	17.9796	20.7837	21.1359	19.9994
260018	1.0432	0.8026	13.6120	14.3278	14.8425	14.3197
260019	***	*	18.3629	*	*	18.3629
260020	1.7570	0.9083	21.0314	22.4709	25.7898	23.1903
260021	1.3631	0.9083	23.3527	27.2478	27.8332	26.1600
260022	1.2535	0.8388	18.7707	20.5417	21.7707	20.2789
260023	1.2561	0.9083	18.5665	19.6324	21.2519	19.8065
260024	1.1354	0.8026	15.6095	16.9968	17.5351	16.7699
260025	1.3052	0.8973	18.2804	19.3535	20.0901	19.2450
260027	1.6128	0.9623	23.1505	22.9973	24.7605	23.6610
260029	1.0856	0.9623	20.1832	22.0390	22.2892	21.4941
260030	***	*	12.8349	*	*	12.8349
260031	***	*	22.5379	24.3626	24.2877	23.7143
260032	1.8668	0.9083	20.3847	21.8830	23.1125	21.7951
260034	0.9466	0.9623	20.5440	21.6108	23.3034	21.8987
260035	0.9300	0.8026	15.1611	15.0468	16.8502	15.6305
260036	1.0016	0.9623	20.1242	19.4559	20.1324	19.8959
260039	***	*	15.9689	*	*	15.9689
260040	1.5697	0.8581	18.5132	20.0422	21.9452	20.2866
260042	***	*	20.8821	*	*	20.8821
260044	0.9492	0.8026	16.7879	18.2413	20.0686	18.3982
260047	1.4615	0.8388	20.2724	22.4585	22.6169	21.7792
260048	1.3195	0.9623	22.4800	26.6363	25.8089	25.0130
260050	1.1796	0.8026	17.8143	20.8510	20.6364	19.7728
260052	1.3316	0.9083	19.1044	21.1297	22.5809	20.9707
260053	1.1469	0.8725	17.4111	18.9606	20.0051	18.8348
260054	***	*	23.0188	*	*	23.0188
260055	***	*	17.9547	*	*	17.9547
260057	1.0589	0.9623	16.5704	15.8404	16.4875	16.2994
260059	1.1772	0.8026	16.2074	17.2807	18.6379	17.4832
260061	1.0978	0.8026	17.1343	18.7280	19.6674	18.5409
260062	1.1998	0.9623	22.0091	25.2958	26.0439	24.4854
260063	1.0465	0.9623	19.7231	21.1284	22.0826	20.9933
260064	1.4186	0.8388	18.3749	17.5188	19.1587	18.3587
260065	1.7428	0.8581	20.6671	22.0058	23.6969	22.1561
260066	***	*	15.3139	*	*	15.3139
260067	0.8961	0.8026	14.5499	14.9792	16.5364	15.4234
260068	1.7328	0.8388	20.7947	22.0951	23.9340	22.3208
260070	0.9429	0.8026	18.7384	11.2251	14.3881	14.6273
260073	1.0174	0.8026	16.9496	17.8185	19.2744	18.1009
260074	1.1971	0.8184	20.4033	18.7639	23.9301	20.9378
260077	1.6321	0.9083	20.5831	21.9947	23.5466	22.0549
260078	1.2338	0.8267	16.0586	16.9217	18.4017	17.1590
260079	***	*	16.4817	*	*	16.4817

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
260080	0.9040	0.8026	13.1618	13.6815	11.2817	12.6066
260081	1.5131	0.9083	20.2471	22.6627	23.7447	22.3053
260082	***	*	18.2853	*	*	18.2853
260085	1.5948	0.9623	21.5137	22.7394	24.6046	22.9726
260086	0.9145	0.8026	16.7579	17.2048	17.1202	17.0209
260091	1.5506	0.9083	22.0772	23.9975	26.1149	24.1619
260094	1.5294	0.8267	19.7308	20.1043	20.6805	20.1924
260095	1.3768	0.9623	21.6999	22.8156	23.8671	22.7898
260096	1.4865	0.9623	22.8259	23.5009	25.9932	24.2365
260097	1.1867	0.8451	18.6965	19.6203	21.5077	20.0518
260100	***	*	16.5439	*	*	16.5439
260102	0.8573	0.9623	21.2133	24.1041	22.9283	22.8396
260103	***	*	19.9144	21.6192	23.3175	21.6496
260104	1.5307	0.9083	21.6625	22.4769	24.0038	22.8609
260105	1.7058	0.9083	22.8005	24.6572	28.4652	25.2799
260107	1.3550	0.9623	22.5214	23.1564	24.2001	23.2709
260108	1.8711	0.9083	20.9029	22.7975	24.0936	22.6668
260109	***	*	15.9723	*	*	15.9723
260110	1.7028	0.8973	19.5633	22.0026	22.2730	21.2780
260113	1.1135	0.8347	16.1346	16.3440	19.2467	17.1861
260115	1.1758	0.9083	19.3873	20.4880	21.7450	20.5275
260116	1.0963	0.8347	16.0187	16.9807	17.2698	16.7695
260119	1.2782	0.8026	18.0725	18.7959	22.1588	20.4457
260120	***	*	17.6811	18.7651	*	18.2293
260122	1.1431	0.9623	16.3700	16.1637	17.3270	16.6586
260123	1.0091	*	15.2927	17.7996	16.1169	16.4004
260127	0.9439	0.8184	18.1343	19.7946	22.5328	20.0604
260128	***	*	13.2941	*	*	13.2941
260131	***	*	18.0395	*	*	18.0395
260134	1.0849	0.9083	17.1341	18.4511	18.1531	17.8579
260137	1.6246	0.8725	19.5976	20.7638	21.3426	20.6063
260138	1.8855	0.9623	23.6502	25.6579	27.8229	25.7137
260141	1.8743	0.8388	19.0444	21.0771	21.1511	20.3643
260142	1.1131	0.8026	18.2023	18.6412	19.6582	18.8679
260143	***	*	15.4688	*	*	15.4688
260147	0.8671	0.8026	15.8522	16.1171	17.2291	16.3854
260148	***	*	12.6651	*	*	12.6651
260158	0.8897	*	13.9789	*	*	13.9789
260159	0.5650	0.9083	20.9636	23.1093	26.8924	23.1564
260160	1.0235	0.8026	18.4007	18.8723	19.4997	18.8893
260162	1.4730	0.9083	20.7331	22.5705	24.1246	22.5642
260163	1.2042	0.8026	16.8300	18.1310	19.2885	18.1088
260164	1.0826	0.8026	16.3874	16.9403	19.5539	17.5103
260166	1.2396	0.9623	22.4070	22.8409	25.5151	23.6547
260172	0.9078	0.8026	16.4854	17.1504	18.1438	17.2714
260173	***	*	15.5733	*	*	15.5733
260175	1.1023	0.8026	18.3632	19.7939	21.1257	19.7861
260176	1.5770	0.9083	23.2414	25.7802	29.2184	26.2801
260177	1.1986	0.9623	22.9112	24.0550	25.0724	24.0729
260178	1.6838	0.8388	20.8189	21.7704	21.4781	21.3851
260179	1.5570	0.9083	21.4470	23.2824	24.8541	23.2090
260180	1.6199	0.9083	19.5983	21.8585	21.9679	21.1229
260183	1.6593	0.8973	23.7057	24.2330	23.3924	23.7504
260186	1.5726	0.8388	21.0675	21.6620	23.4317	22.1454
260188	***	*	23.7476	*	*	23.7476
260190	1.2091	0.9623	21.6995	24.5014	25.1653	23.8711
260191	1.2966	0.9083	19.6784	21.1331	22.4369	21.1555
260193	1.1754	0.9623	22.2030	22.9556	24.4705	23.3155
260195	1.2688	0.8562	*	20.0889	20.1327	20.1097
260198	1.1607	0.9083	21.7925	25.3390	27.6116	24.9011
260200	1.2343	0.9083	21.7031	22.3913	25.1134	23.2876
260207	1.1052	0.8581	*	18.5247	19.2467	18.9047
260208	***	*	*	28.3158	*	28.3158
260209	1.1184	0.8332	*	*	21.8396	21.8396
270002 ²	1.1959	0.9630	19.0221	19.7588	20.7620	19.8570
270003	1.2367	0.8831	20.7277	23.0396	24.2823	22.5792
270004	1.6922	0.8973	20.1821	21.5577	22.9081	21.5975

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
270006	0.8901	*	15.1006	*	*	15.1006
270007	1.0065	*	15.5781	*	*	15.5781
270009	0.9560	*	20.7031	21.5655	*	21.1389
270011	1.0272	0.8831	21.8086	21.4031	22.0710	21.7607
2700122	1.5176	0.9630	20.7913	21.7634	23.1697	21.8940
270014	1.8935	0.9630	20.4321	20.3456	25.0650	21.8404
270016	***	*	17.9985	*	*	17.9985
270017	1.2848	0.9630	22.1046	23.2320	24.6186	23.3312
270019	***	*	18.5112	*	*	18.5112
270021	0.9946	0.8973	18.0515	21.1624	21.6758	20.2193
270023	1.5284	0.9630	22.7162	23.7486	25.5525	24.0410
270026	0.7927	*	20.1673	*	*	20.1673
270027	0.9441	*	17.2005	*	*	17.2005
270028	***	*	19.6212	*	*	19.6212
270029	***	*	18.2097	*	*	18.2097
270032	1.0683	0.8973	19.3937	20.1801	18.2377	19.2851
270033	***	*	20.7060	*	*	20.7060
270035	***	*	17.9822	*	*	17.9822
270036	0.8762	0.8693	16.1030	18.8785	21.8255	19.0132
270039	***	*	20.3801	*	*	20.3801
270040	1.1579	*	20.1887	20.7240	*	20.4544
270044	***	*	19.2939	*	*	19.2939
270048	1.0311	*	17.4506	*	*	17.4506
270049	1.6932	0.8973	22.0263	22.9524	24.6556	23.2731
270050	1.0504	0.8973	19.6317	21.0901	22.4195	21.0251
270051	1.5449	0.9630	20.0386	22.2580	26.4457	22.8948
270052	***	*	17.1933	*	*	17.1933
270057	1.2904	0.8973	20.1507	21.9997	22.6251	21.6504
270058	***	*	18.4781	*	*	18.4781
270059	***	*	16.9302	*	*	16.9302
270060	0.9381	*	21.3776	*	16.6592	18.6801
270063	1.0420	*	16.4554	*	*	16.4554
270073	1.1432	*	16.6082	*	*	16.6082
270079	0.9251	*	19.5493	*	21.6382	20.5609
270080	***	*	16.6010	*	*	16.6010
270081	0.9461	0.8693	18.0544	15.6833	17.3174	17.0500
270082	0.9988	*	23.3209	21.0150	19.6173	21.5392
270083	***	*	16.8421	*	*	16.8421
270084 ²	1.0520	0.9630	15.7062	19.6104	22.2340	19.1167
280001	***	*	18.7137	*	*	18.7137
280003	1.9103	1.0180	23.6058	26.0937	27.2844	25.9539
280005	***	*	22.8981	23.9753	*	23.4559
280009	1.8748	0.9720	23.2300	23.8046	25.3162	24.1158
280010	***	*	22.0137	23.8325	22.6516	22.8505
280011	***	*	16.2281	*	*	16.2281
280013	1.7801	0.9740	24.0852	23.4920	24.5214	24.0427
280014	***	*	16.7109	*	*	16.7109
280015	1.1211	*	18.0207	*	*	18.0207
280017	***	*	16.9884	*	*	16.9884
280018	***	*	16.6439	*	*	16.6439
280020	2.0285	1.0180	21.9587	23.4577	25.7522	23.8363
280021	1.0629	0.9040	19.1263	21.5215	22.2864	20.9839
280022	***	*	15.3785	*	*	15.3785
280023	1.4175	0.9720	21.5761	19.6265	22.7207	21.3403
280024	***	*	15.8747	*	*	15.8747
280025	***	*	22.2213	*	*	22.2213
280026	***	*	18.7258	*	*	18.7258
280028	***	*	19.1080	*	*	19.1080
280029	***	*	17.1350	*	*	17.1350
280030	1.8367	0.9740	26.3542	29.2221	32.5601	29.4404
280031	***	*	9.6951	*	*	9.6951
280032	1.3374	0.9720	20.5246	21.5150	22.6510	21.6070
280033	***	*	17.9841	*	*	17.9841
280035	***	*	18.6088	*	*	18.6088
280037	***	*	14.8049	*	*	14.8049
280038	***	*	18.9305	*	*	18.9305
280039	***	*	17.0153	*	*	17.0153

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
280040	1.6045	0.9740	21.5426	23.6597	25.2965	23.5484
280041	***	*	16.6890	*	*	16.6890
280042	***	*	16.4684	*	*	16.4684
280043	***	*	16.8186	*	*	16.8186
280045	***	*	17.7407	*	*	17.7407
280046	***	*	17.9751	*	*	17.9751
280047	1.1550	*	21.3143	19.5815	*	20.3583
280048	***	*	17.9319	*	*	17.9319
280049	***	*	19.4589	*	*	19.4589
280051	***	*	19.6206	*	*	19.6206
280052	***	*	14.9903	*	*	14.9903
280054	1.0888	0.9720	19.4049	23.1191	22.4241	21.7488
280055	***	*	14.2046	*	*	14.2046
280056	***	*	15.6441	*	*	15.6441
280057	0.8171	0.9720	21.4754	22.5481	23.6793	22.5948
280058	***	*	22.8105	*	*	22.8105
280060	1.6127	0.9740	22.4677	23.1128	25.2288	23.6231
280061	1.4140	0.9172	20.2066	21.2901	23.9110	21.8390
280062	***	*	16.1708	*	*	16.1708
280064	***	*	18.2196	*	*	18.2196
280065	1.2759	0.9732	21.6999	23.8128	27.9937	24.5319
280066	***	*	12.2224	*	*	12.2224
280068	***	*	10.5104	*	*	10.5104
280070	***	*	18.7211	*	*	18.7211
280073	***	*	18.3495	*	*	18.3495
280074	***	*	13.6025	*	*	13.6025
280075	0.9362	*	13.3154	*	*	13.3154
280076	***	*	16.1940	*	*	16.1940
280077	1.3611	0.9740	21.1883	22.7244	24.0516	22.6707
280079	***	*	17.1518	*	*	17.1518
280080	***	*	16.1902	*	*	16.1902
280081	1.7302	0.9740	23.3805	24.3199	25.1973	24.3116
280082	***	*	15.4420	*	*	15.4420
280083	***	*	20.8995	*	*	20.8995
280084	***	*	13.2158	*	*	13.2158
280085	***	*	20.8532	21.8473	*	21.3832
280089	***	*	19.9004	*	*	19.9004
280091	***	*	16.3456	*	*	16.3456
280092	***	*	13.3032	*	*	13.3032
280094	***	*	16.9179	*	*	16.9179
280097	***	*	14.1870	*	*	14.1870
280098	***	*	12.4995	*	*	12.4995
280101	***	*	10.5153	*	*	10.5153
280104	***	*	15.5949	*	*	15.5949
280105	1.3267	0.9740	23.7103	25.1401	25.0445	24.6739
280106	***	*	16.3564	*	*	16.3564
280108	1.0504	0.9040	18.5135	20.9016	22.5584	20.6213
280110	***	*	13.0279	*	*	13.0279
280111	1.2125	0.9040	19.7688	20.7398	22.1424	20.9228
280114	***	*	17.1155	*	*	17.1155
280115	***	*	18.3465	*	*	18.3465
280117	1.0472	0.9040	20.3820	20.5464	22.0611	21.0176
280118	0.9405	*	17.8892	19.3466	*	18.6609
280123	0.9634	0.9177	23.6682	24.3539	27.5207	25.1734
280125	1.4651	0.9040	17.2718	20.0643	21.8385	19.6628
280126	***	*	*	33.8918	*	33.8918
290001	1.7081	1.0446	24.3681	25.9590	27.3105	25.9828
290002	0.9005	0.9899	16.7948	16.8363	16.8433	16.8264
290003	1.7343	1.1345	25.4303	27.4732	27.1099	26.7040
290005	1.3692	1.1345	22.7804	24.6877	27.1531	24.9521
290006	1.2050	0.9558	22.4832	24.2211	26.3617	24.4733
290007	1.5431	1.1345	34.9911	35.1020	35.4193	35.1815
290008	1.0962	1.1193	26.9216	27.0115	26.4086	26.7837
290009	1.8842	1.0446	24.8816	26.9020	27.6011	26.5276
290010	1.1051	1.1345	20.8387	25.4598	23.8733	23.4339
290011	***	*	19.7409	*	*	19.7409
290012	1.3155	1.1345	25.5647	25.8036	27.2675	26.1745

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
290013	***	*	20.2915	*	*	20.2915
290014	***	*	20.2762	*	*	20.2762
290015	***	*	20.2335	*	*	20.2335
290016	1.0105	0.9558	21.8030	22.5111	25.1726	23.2081
290019	1.4023	1.0446	22.5584	25.1684	27.2484	25.0270
290020 ^h	0.9391	1.1345	19.5038	24.2373	21.3094	21.5238
290021	1.7729	1.1345	24.1396	26.2510	28.3837	26.2448
290022	1.5996	1.1345	25.3914	27.5364	29.8144	27.5392
290027	0.9706	0.9558	13.1462	13.5031	17.8850	14.5858
290032	1.3916	1.0446	26.9846	27.5425	29.4164	28.0295
290038	***	*	26.0836	*	*	26.0836
290039	1.5148	1.1345	26.6283	28.7599	29.6801	28.5389
290041	1.3280	1.1345	27.7740	28.6294	30.1346	28.9832
290042	0.8932	1.1345	18.7669	*	*	18.7669
290045	1.5329	1.1345	*	26.5644	26.9319	26.7596
300001	1.5568	1.0959	25.7142	27.1312	29.4130	27.4975
300003	2.0799	1.0907	25.3252	26.7859	27.8059	26.6925
300005	1.4072	1.0907	22.3258	22.8163	25.1869	23.4713
300006	1.1125	0.9931	22.2642	22.0187	20.6787	21.6236
300007	1.2716	1.0959	21.3633	23.6919	25.3125	23.5198
300008	***	*	20.9207	*	*	20.9207
300009	1.1516	*	0.1486	*	*	20.1486
300010	1.1387	0.9931	21.0316	24.6295	26.9346	24.1897
300011	1.3292	1.0959	23.8390	25.0979	27.3325	25.4685
300012	1.4085	1.0959	25.8581	26.3914	28.4234	27.0366
300013	1.0725	1.0959	20.0269	21.3397	23.1529	21.3864
300014	1.2061	1.0793	21.6705	23.7144	25.5059	23.7417
300015	1.1614	0.9931	22.8966	24.4869	24.0620	23.8264
300016	1.3103	*	15.1310	18.9756	24.5498	19.6714
300017	1.3730	1.1154	23.9651	26.1104	28.3959	26.2982
300018	1.3891	1.0793	22.8379	25.7851	28.0308	25.7129
300019	1.2523	0.9931	20.5801	23.8076	25.3845	23.2890
300020	1.2070	1.0959	23.0806	24.8189	26.8402	25.0029
300021	***	*	20.2585	*	*	20.2585
300022	1.1227	0.9931	20.1209	22.3918	23.5948	22.1272
300023	1.3997	1.1154	22.1896	24.9992	25.4873	24.2775
300024	1.2263	0.9931	22.2235	22.4883	23.9205	22.8688
300028	***	*	21.4207	*	*	21.4207
300029	1.8572	1.1154	23.8415	24.5772	26.9484	25.2559
300033	***	*	17.4836	*	*	17.4836
300034	2.1231	1.0959	25.2355	26.9093	28.5375	26.9064
310001	1.7406	1.3318	31.1568	30.1786	33.9360	31.7932
310002	1.8593	1.3457	28.7786	33.9058	35.4567	32.8160
310003	1.2278	1.3457	29.3522	30.4234	31.1040	30.3282
310005	1.3402	1.1734	23.9477	26.0227	27.5690	25.8791
310006	1.2089	1.3318	24.1538	25.9000	27.0436	25.6806
310008	1.2966	1.3318	26.4989	28.0970	29.5857	28.0438
310009	1.2728	1.2085	23.2420	24.6353	29.7760	25.9692
310010	1.2591	1.1533	24.5471	26.7889	25.3139	25.5666
310011	1.2457	1.1533	25.4900	26.1586	28.5241	26.7393
310012	1.7065	1.3318	28.1367	31.1705	33.1622	30.8495
310013	1.3047	1.2085	23.2424	25.0951	28.5016	25.6662
310014	1.7096	1.1533	31.0834	29.1931	32.7222	31.0153
310015	1.9124	1.3318	29.1340	30.1767	32.4980	30.6162
310016	1.2750	1.3318	26.0738	25.7368	28.9788	26.9614
310017	1.2836	1.1734	25.1634	25.2636	28.0930	26.1920
310018	1.1937	1.2085	24.1428	25.9108	26.9399	25.6851
310019	1.5685	1.3318	28.5952	26.8663	31.0524	28.8078
310020	1.4172	1.3318	25.0803	25.0147	29.3392	26.4027
310021	1.6807	1.3318	27.8958	29.4003	29.6308	28.9597
310022	1.2264	1.1533	23.3412	26.7487	26.1914	25.4453
310024	1.3840	1.1734	27.0459	26.9499	27.5278	27.1558
310025	1.1936	1.3318	25.5227	26.8719	27.7960	26.7093
310026	1.2473	1.3318	23.2895	24.6697	25.3970	24.4038
310027	1.3248	1.1734	24.4437	22.1935	27.0982	24.4083
310028	1.2098	1.3457	26.1931	25.7246	29.1101	27.0306
310029	1.9148	1.1533	24.4290	25.9606	29.1439	26.5104

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
310031	2.9737	1.1533	26.7174	29.5581	30.2345	28.8302
310032	1.2921	1.1533	24.9133	25.7088	27.8754	26.3271
310034	1.3284	1.1533	24.8567	26.5224	27.8517	26.3613
310036	***	*	23.0320	*	*	23.0320
310037	1.3772	1.3318	28.7738	30.1264	32.1471	30.3789
310038	2.0208	1.3457	28.1756	32.3865	32.1977	30.9538
310039	1.2564	1.1883	23.6604	24.6045	27.1054	25.2002
310040	1.2784	1.3318	26.5769	27.4041	28.0068	27.3674
310041	1.2705	1.1533	23.8857	26.8145	29.7335	26.9343
310042	1.1856	1.3318	24.9702	26.9695	29.0207	26.9949
310043	***	*	24.0238	*	*	24.0238
310044	1.3145	1.1533	23.1489	25.1618	27.7752	25.4042
310045	1.5707	1.3457	29.4877	31.7376	32.6359	31.3391
310047	1.3362	1.1533	25.9777	26.1353	28.3415	26.8511
310048	1.2859	1.1679	23.4189	27.4050	28.4715	26.4187
310049	***	*	25.6733	26.5332	32.7666	26.4914
310050	1.3124	1.3457	23.7735	25.3772	27.2276	25.4612
310051	1.3746	1.3457	28.6248	29.2386	32.0113	29.9783
310052	1.3070	1.1533	24.9773	27.0324	28.1498	26.6609
310054	1.3086	1.2085	27.6290	28.1880	30.6905	28.8624
310057	1.3233	1.1533	22.2630	26.3903	26.4606	25.1234
310058	1.1022	1.3318	25.3983	28.1753	26.4816	26.7012
310060	1.3046	1.3457	21.4455	22.1914	23.2146	22.2638
310061	1.2201	1.1533	23.4283	24.9678	27.5400	25.2492
310063	1.4393	1.1734	21.2618	25.9868	28.3457	24.9266
310064	1.5198	1.1533	25.9350	27.8388	29.5979	27.8612
310067	0.8041	1.1734	24.1943	26.3624	26.8068	25.5496
310069	1.2972	1.1533	25.3464	25.7690	27.9656	26.3324
310070	1.3998	1.3457	29.5101	30.1917	32.1806	30.6644
310072	***	*	24.4480	25.3145	26.3520	25.4066
310073	1.8302	1.1533	26.7954	28.8791	29.6611	28.4561
310074	1.3914	1.3318	24.2009	27.6789	28.4361	26.8022
310075	1.2820	1.1533	23.9771	25.7726	26.2479	25.3255
310076	1.6301	1.3457	29.6667	32.4533	34.9428	32.3614
310077	1.6813	1.3318	26.7092	28.7352	30.7465	28.7735
310078	1.3141	1.2085	24.5862	24.7753	26.9589	25.4404
310081	1.2584	1.1533	23.3310	24.6083	26.4259	24.8147
310083	1.2747	1.2085	25.0191	25.2465	24.6563	24.9766
310084	1.2146	1.1533	25.4946	27.3680	29.9437	27.6722
310086	1.2484	1.1533	23.4966	25.2751	27.3601	25.4003
310087	***	*	20.6847	*	*	20.6847
310088	1.1932	1.1533	23.0610	23.7846	25.5274	24.1094
310090	1.2913	1.1734	23.6661	25.3640	27.1661	25.4163
310091	1.2468	1.1533	24.5357	25.6405	27.1115	25.7617
310092	1.4317	1.1533	22.9721	23.2226	25.7071	23.9323
310093	1.1882	1.2085	23.9404	24.6942	25.8727	24.8091
310096	2.1797	1.2085	26.6588	28.4705	30.3675	28.4801
310105	1.1887	1.3318	28.1317	28.7333	30.9968	29.2991
310108	1.3882	1.1883	25.1368	24.9090	29.1548	26.3880
310110	1.3098	1.1533	23.3461	26.4175	27.8707	26.0751
310111	1.2084	1.1533	23.3646	26.2496	28.8692	26.2009
310112	1.2407	1.1533	24.2999	27.8796	28.9928	27.1351
310113	1.2455	1.1533	24.2708	25.9143	27.5203	25.9693
310115	1.1808	1.3457	23.5148	24.5413	26.2803	24.8233
310116	1.2402	1.3318	24.2696	25.1189	26.6287	25.2849
310118	1.3742	1.3318	26.8760	28.0517	28.1238	27.6760
310119	1.8296	1.3457	29.1045	34.7468	35.6786	33.0142
310120	1.1107	1.3457	22.6526	24.7078	27.2010	24.6839
320001	1.5356	1.0486	21.5564	23.0290	26.1962	23.6128
320002	1.4328	1.0885	25.5144	26.7332	28.6963	27.0266
320003	1.1539	0.8684	16.4961	20.7939	22.3911	19.8184
320004	1.3957	0.8684	21.3681	19.4799	24.0362	21.7826
320005	1.3891	1.0211	22.4178	22.1677	21.2164	21.8840
320006	1.3441	1.0066	19.8672	21.1222	22.5615	21.1735
320009	1.5217	1.0486	20.3783	21.5870	24.4237	22.0786
320011	1.1657	0.8684	19.1476	20.7714	23.1539	21.0040
320012	***	*	17.1317	*	*	17.1317

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
320013	1.2063	1.0066	25.5403	19.4487	27.8671	23.6493
320014	1.0852	0.8684	22.9026	19.7656	26.7112	22.9160
320016	1.1185	0.8684	18.8763	19.9326	21.7001	20.2256
320017	1.2764	1.0486	20.4390	22.5460	23.6861	22.2615
320018	1.5555	0.8822	20.3141	21.4650	23.0915	21.6545
320019	1.4216	1.0486	25.1210	26.6900	31.2250	27.8202
320021	1.6532	1.0486	20.0089	21.0913	28.5620	22.6646
320022	1.1402	0.8684	20.9797	20.7919	22.1492	21.3155
320030	1.0381	0.8684	18.1556	16.8696	18.0990	17.7109
320031	***	*	18.2244	*	*	18.2244
320032	***	*	21.4815	*	*	21.4815
320033	1.1738	1.0316	21.9804	24.2703	24.1185	23.5050
320035	***	*	17.8059	*	*	17.8059
320037	1.2146	1.0486	17.6724	19.6466	21.6080	19.6916
320038	1.2325	0.8684	23.1987	19.2962	21.2181	21.2842
320046	1.1266	0.8684	19.4732	21.5915	22.9114	21.3161
320063	1.2932	0.9495	18.5600	20.7804	24.9141	21.2497
320065	1.1524	0.9495	22.5428	19.9012	21.6189	21.2280
320067	0.8954	0.8684	16.8015	13.9459	20.4431	17.1123
320068	***	*	15.6864	*	*	15.6864
320069	1.0993	0.8684	15.7349	18.5375	19.7296	18.0124
320074	0.9863	1.0486	22.3403	28.3086	35.5980	28.6515
320079	1.0490	1.0486	20.2473	21.9090	23.8092	22.0034
320083	2.4598	1.0486	*	20.6771	*	20.6771
330001	1.2203	1.1924	28.6213	30.8509	31.3735	30.3151
330002	1.5638	1.3457	27.1811	28.0882	29.3459	28.1842
330003	1.2782	0.8668	19.3972	20.2744	21.6506	20.4229
330004	1.1905	1.1034	22.5082	24.3703	23.9959	23.6278
330005	1.5895	0.9332	22.6137	24.3578	25.9287	24.2561
330006	1.3539	1.3457	26.2970	28.3904	29.7509	28.0795
330008	1.1413	0.9332	19.6770	20.6816	21.3269	20.5700
330009	1.2673	1.3457	30.9087	33.3605	35.8367	33.3091
330010	***	*	17.8935	19.8211	17.9178	18.5214
330011	1.3317	0.8464	18.7995	19.8035	20.3641	19.6558
330013	2.1558	0.8668	19.0995	21.2063	23.9070	21.3625
330014	1.2950	1.3457	32.4496	32.0824	35.4053	33.3269
330016	0.9883	0.8292	18.7194	18.1603	18.9388	18.6085
330019	1.3429	1.3457	31.5927	31.9042	32.3413	31.9607
330020	***	*	16.6952	*	*	16.6952
330023	1.5352	1.3318	26.6997	29.4538	29.2669	28.5413
330024	1.6830	1.3457	35.7485	35.3598	36.5648	35.8841
330025	1.0685	0.9332	17.6169	18.7663	19.7561	18.7397
330027	1.4016	1.3457	35.1046	34.1281	35.1325	34.7868
330028	1.3860	1.3457	31.7699	31.8452	33.5312	32.3867
330029	0.6848	0.9332	19.4377	18.4354	18.6623	18.8626
330030	1.4117	0.9283	18.0866	22.0574	22.4368	21.1341
330033	1.1685	0.8292	19.5836	18.6316	21.3762	19.8548
330034	***	*	38.2451	*	*	38.2451
330036	1.1574	1.3457	25.5888	27.0970	27.6813	26.7707
330037	1.0861	0.9283	18.3260	18.3557	19.6385	18.7781
330038	***	*	16.2997	*	*	16.2997
330041	1.1980	1.3457	29.5305	34.5461	36.2481	33.2332
330043	1.3371	1.2928	28.9622	31.7873	34.1039	31.6023
330044	1.2563	0.8367	19.9807	22.0465	23.1450	21.9885
330045	1.3277	1.2928	28.5267	30.9046	34.4956	31.3516
330046	1.4334	1.3457	38.1184	41.6759	42.0900	40.5965
330047 ^h	1.2461	0.8668	19.5561	20.1646	21.1244	20.2913
330048	***	*	19.6129	*	*	19.6129
330049	1.2924	1.3457	22.1523	24.7766	25.7022	24.1410
330053	1.1222	0.9283	17.9161	18.1728	19.6807	18.5861
330055	1.5986	1.3457	34.2159	34.9709	35.1393	34.7960
330056	1.5122	1.3457	29.8377	32.0982	32.9295	31.5709
330057	1.6943	0.8668	20.0995	20.9282	22.6519	21.2763
330058	1.2804	0.9283	18.1008	19.2916	19.5520	18.9822
330059	1.5740	1.3457	35.0121	36.4176	38.1019	36.5176
330061	1.2288	1.3457	26.8580	28.6725	32.7427	29.4511
330062	1.0996	0.9291	18.4662	20.0222	21.4270	19.8293

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
330064	1.1757	1.3457	35.1422	36.0976	38.5719	36.6222
330065	1.2153	0.9332	20.1615	20.5958	21.9192	20.8930
330066	1.3222	0.8668	19.3644	20.9990	23.0916	21.1815
330067 ²	1.3671	1.3318	23.6836	24.8927	34.8416	26.8995
330072	1.4219	1.3457	30.3737	32.9665	32.7905	32.0147
330073	1.1433	0.9283	16.5166	18.4162	19.0781	18.2217
330074	1.2724	0.9283	18.9326	21.7299	20.2874	20.2926
330075	1.1621	0.9482	19.2938	19.9781	22.0240	20.4396
330078	1.4763	0.9332	18.0362	20.8379	22.7762	20.5288
330079	1.2922	0.8292	18.9398	21.1153	22.1064	20.7085
330080	1.2128	1.3457	34.6880	33.5537	36.1171	34.7934
330084	1.1181	0.9104	19.0262	19.2135	22.6365	20.2736
330085	1.1656	0.9246	20.9332	21.8271	23.2927	22.0314
330086	1.2502	1.3457	26.2979	27.1585	28.8424	27.4015
330088	1.0160	1.2928	26.7583	29.5181	31.2631	29.1966
330090	1.3957	0.8464	20.1344	20.9327	22.7721	21.3033
330091	1.3861	0.9332	21.6004	22.9396	22.5796	22.3583
330092	***	*	17.2083	*	*	17.2083
330094	1.3404	0.9070	18.8941	21.3659	22.1495	20.7647
330095	***	*	21.1809	28.9794	28.9914	24.2022
330096	1.0999	0.8292	20.0370	21.1648	22.4895	21.2735
330097	1.1459	0.8292	16.1946	18.6291	19.2233	17.9357
330100	1.0376	1.3457	28.9956	31.5775	32.8406	31.1270
330101	1.8432	1.3457	35.3618	38.4810	39.2601	37.6430
330102	1.3750	0.9332	21.0057	23.5254	23.6141	22.6543
330103	1.1077	0.8292	17.3511	17.9017	18.8763	18.0443
330104	1.3473	1.3457	31.9746	36.8451	33.7556	34.2521
330106	1.7360	1.5118	36.2526	38.7822	39.8554	38.3049
330107	1.2276	1.2928	28.9225	29.1958	31.8528	29.9600
330108	1.1632	0.8464	18.5849	20.2536	21.4680	20.0799
330111	1.0200	0.9332	13.3352	17.7020	17.6185	16.0043
330114	***	*	19.1163	19.2566	*	19.1861
330115	1.1678	0.9482	18.5911	18.5544	20.5101	19.2463
330116	***	*	16.8567	*	*	16.8567
330119	1.7722	1.3457	33.5653	34.6591	36.5873	34.9464
330121	0.8869	0.8292	17.1869	17.9757	19.7388	18.2903
330122	***	*	23.0384	25.6500	26.3849	25.0295
330125	1.7759	0.9283	20.5922	22.8078	24.6945	22.6738
330126	1.3100	1.3457	25.1175	27.7155	28.8299	27.2669
330127	1.3072	1.3457	40.0112	42.2836	43.7479	42.0426
330128	1.2876	1.3457	34.3468	32.7050	34.5289	33.8578
330132	1.0685	0.8292	14.8704	16.0311	16.3088	15.7538
330133	1.3445	1.3457	37.5191	35.3136	44.0704	38.5796
330135	1.2456	1.3457	23.5662	25.6504	26.9969	25.3890
330136	1.4708	0.9246	20.4124	21.4225	22.5447	21.4723
330140	1.8401	0.9482	21.1841	21.1787	23.5774	21.9755
330141	1.3453	1.2928	27.5960	29.3283	30.6616	29.2342
330144	0.9884	0.8292	17.1513	17.3920	20.1805	18.1420
330148	1.0131	0.8367	16.7251	17.6560	18.5443	17.5842
330151	1.1156	0.8292	15.2233	16.4028	17.6782	16.4170
330152	1.3469	1.3457	33.5587	32.3332	32.0616	32.6475
330153	1.7810	0.8668	19.4417	21.2843	21.9935	20.8626
330157	1.3710	0.9246	23.1743	23.5522	23.6939	23.4682
330158	1.5754	1.3457	29.3163	32.7159	33.0067	31.6476
330159	1.3367	0.9482	20.2753	22.5580	24.1916	22.2881
330160	1.5698	1.3457	30.7893	32.1266	34.0373	32.2900
330162	1.3036	1.3457	27.9705	29.6042	31.3812	29.6808
330163	1.2260	0.9332	21.4143	21.1517	22.4644	21.6514
330164	1.3623	0.9283	22.0699	23.5427	24.4306	23.4206
330166 ^h	1.1010	0.8292	17.0637	18.4262	18.8777	18.1243
330167	1.7640	1.3065	32.0541	30.9667	33.7365	32.3049
330169	1.4318	1.3457	36.3690	36.2725	38.3498	36.9765
330171	1.1125	1.3457	25.1567	25.9946	27.7810	26.2476
330175	1.1609	0.8292	18.8701	20.4628	21.1944	20.1626
330177	0.9285	0.8292	16.6059	19.0005	20.1850	18.5998
330179	***	*	16.0113	*	*	16.0113
330180	1.2778	0.8668	19.2670	19.8951	21.9641	20.3522

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
330181	1.4007	1.3457	34.6065	37.1218	35.9334	35.8908
330182	2.3673	1.3457	33.3363	35.2416	36.3831	35.0376
330183	***	*	20.3520	*	*	20.3520
330184	1.4150	1.3457	28.4726	30.7479	33.2843	30.7469
330185	1.2876	1.2928	27.8894	28.9787	31.0179	29.3910
330188	1.2264	0.9332	20.2849	21.1196	22.6803	21.4090
330189	1.0849	0.8668	23.5589	19.0726	19.2538	20.4146
330191	1.3016	0.8512	19.5623	20.9392	22.3719	20.9783
330193	1.2751	1.3457	32.5496	36.2427	36.9866	35.2805
330194	1.8416	1.3457	35.6486	38.5372	39.9177	38.0927
330195	1.6674	1.3457	34.4689	36.4249	38.6867	36.4221
330196	1.3233	1.3457	28.9488	31.1915	32.5883	30.9084
330197	1.0751	0.8292	19.2237	20.8386	22.3117	20.8064
330198	1.3746	1.3065	25.6668	25.3622	29.5359	26.8751
330199	1.1023	1.3457	28.0374	34.1354	32.7870	31.5385
330201	1.7608	1.3457	30.0524	29.3745	33.3215	30.8636
330202	1.2840	1.3457	35.4943	30.7990	34.3545	33.6766
330203	1.4563	0.9482	25.9211	24.7422	26.2459	25.6084
330204	1.3233	1.3457	31.1366	30.3699	30.3273	30.6070
330205	1.2519	1.3457	24.9040	29.0622	30.0101	27.9917
330208	1.2096	1.3457	27.3170	30.6158	28.2667	28.6888
330209	1.1635	1.1924	27.0257	27.7071	28.7213	27.8300
330211	1.0955	0.8292	20.0006	20.8224	21.1094	20.6576
330212	1.3741	1.3457	24.8554	24.9434	27.0585	25.3302
330213	1.0760	0.8292	20.1166	20.7967	21.7208	20.8889
330214	1.8983	1.3457	32.3130	32.7647	33.7670	32.9626
330215	1.2834	0.8367	19.0726	19.9226	20.6343	19.8739
330218	1.1052	0.9482	21.4747	20.6012	21.4095	21.1631
330219	1.5946	0.9332	25.1792	28.7448	27.7400	27.1911
330221	1.3163	1.3457	32.5044	34.9345	34.7033	34.0507
330222	1.2774	0.8668	19.3148	23.5491	25.9825	22.9166
330223	1.0447	0.8292	19.1604	18.8253	18.4291	18.7955
330224	1.2892	1.1070	20.5881	22.7847	23.9379	22.4034
330225	1.2012	1.3065	28.0523	29.1744	28.9952	28.7284
330226	1.3629	0.9283	21.6368	23.5405	23.4783	23.0374
330229 ^h	1.1747	0.8292	18.2554	18.5590	19.5670	18.7993
330230	0.9625	1.3457	30.6937	32.5997	32.1101	31.7923
330231	1.0904	1.3457	32.4164	30.2184	33.9324	32.2300
330232	1.2465	0.8668	20.0924	21.1277	21.4765	20.9246
330233	1.4624	1.3457	43.1186	39.5133	41.9968	41.5604
330234	2.3207	1.3457	35.8327	37.7135	36.8500	36.7850
330235	1.1463	0.9329	20.1255	21.4643	22.1217	21.2329
330236	1.3841	1.3457	32.1246	31.8491	32.9391	32.3105
330238	1.1779	0.9283	17.8867	18.3846	19.2407	18.5495
330239	1.2248	0.8502	18.9953	19.7561	20.4936	19.7492
330240	1.2423	1.3457	35.6576	37.3866	40.7478	37.8704
330241	1.9229	0.9482	24.7545	26.7598	27.7213	26.4610
330242	1.3027	1.3457	28.3561	30.5172	32.2178	30.3520
330245	1.8532	0.8367	20.7605	20.2037	21.6857	20.9062
330246	1.3688	1.2928	29.8777	31.8857	31.6763	31.1525
330247	1.1246	1.3457	32.5858	25.6063	32.1733	30.2124
330249	1.1959	0.9482	17.6846	19.1469	21.4345	19.4505
330250	1.2821	0.9104	20.8742	22.1272	23.0641	22.0678
330254	***	*	15.7864	*	*	15.7864
330258	***	*	32.6745	*	*	32.6745
330259	1.4785	1.3065	26.3620	27.4131	30.0488	27.9503
330261	1.2615	1.3457	30.0489	30.4771	30.9356	30.5044
330263	1.0079	0.8292	19.5057	20.0831	20.8456	20.1541
330264	1.1449	1.2928	24.9713	26.3652	28.1501	26.4763
330265	1.2730	0.9283	21.1215	18.2547	19.9414	19.7494
330267	1.4073	1.3457	27.8255	29.0499	30.3709	29.1173
330268	0.9588	0.8668	16.8358	18.7991	18.9142	18.2286
330270	2.0661	1.3457	33.0375	36.5976	38.2605	36.0496
330273	1.2979	1.3457	27.0454	28.8548	29.5106	28.4612
330276	1.1251	0.8355	19.6572	20.7973	21.7826	20.7570
330277	1.1274	0.8292	20.7851	21.8866	25.1438	22.6221
330279	1.4029	0.9332	21.7827	23.8793	23.4816	23.0796

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
330285	1.9079	0.9283	24.5388	26.0446	27.1260	25.9586
330286	1.3874	1.2928	28.0995	31.1344	32.3244	30.5728
330290	1.6856	1.3457	34.3439	35.5617	36.3764	35.4278
330293	***	*	17.3180	17.6506	19.0290	18.0111
330304	1.2941	1.3457	29.2207	31.1146	33.4431	31.2960
330306	1.4680	1.3457	29.6641	30.4426	30.7551	30.2963
330307	1.2573	0.9640	23.2838	23.8583	25.4128	24.2157
330314	1.1741	1.2928	25.5405	26.2954	26.0150	25.9486
330316	1.2851	1.3457	27.9277	33.7857	33.1512	31.5975
330327	***	*	20.1705	19.3465	*	19.7556
330331	1.2433	1.3065	32.3249	34.6302	34.7052	33.8757
330332	1.1981	1.3065	27.6954	30.5104	31.8389	30.2518
330333	0.9893	1.3065	28.8819	29.7725	33.7637	30.4380
330336	***	*	27.9163	32.9548	*	30.4243
330338	1.2902	1.3457	23.6142	25.4319	27.3859	25.4439
330339	0.9776	0.8668	20.2382	20.8424	22.2812	21.1384
330340	1.2005	1.2928	28.2732	29.8140	31.4322	29.8422
330350	1.4881	1.3457	33.5493	35.5656	39.3541	36.2620
330353	1.2151	1.3457	34.2260	35.6821	38.6962	36.2694
330357	1.3544	1.3457	36.8598	36.5461	34.3965	35.8599
330372	1.3002	1.3065	23.5381	28.2490	30.1505	27.2489
330385	1.0942	1.3457	37.5523	44.3387	42.6671	41.4753
330386	1.1954	1.1034	21.4363	25.2064	25.9228	24.2190
330389	1.9261	1.3457	33.1192	32.2112	34.7552	33.3831
330390	1.1602	1.3457	31.7344	32.7450	33.2628	32.5510
330393	1.6669	1.2928	31.9272	33.0953	34.8213	33.3446
330394	1.6139	0.8464	19.6892	21.3678	23.3505	21.4848
330395	1.3676	1.3457	33.2318	32.1089	35.4619	33.4108
330396	1.3164	1.3457	32.8517	31.2429	32.5345	32.2160
330397	1.3745	1.3457	34.6435	40.0884	34.5110	36.2414
330399	1.1543	1.3457	32.7149	32.1248	33.6753	32.8679
330400	***	*	16.8168	*	*	16.8168
330401	1.2287	1.2928	*	33.8633	35.7435	34.8514
330402	0.8039	0.9961	*	*	21.3302	21.3302
340001	1.5014	0.9698	22.0257	21.6113	23.2436	22.3143
340002	1.6838	0.9628	22.9425	24.0145	25.1099	24.0577
340003	1.1241	0.8570	19.6545	20.8205	21.5562	20.7086
340004	1.4378	0.9267	23.0890	23.3756	24.2055	23.5853
340005	1.0405	0.8570	16.6909	20.8150	22.9830	19.8775
340006	***	*	16.1378	*	*	16.1378
340007	0.5551	0.9209	18.3760	19.5208	21.1519	19.6545
340008	1.1018	0.9003	22.6570	22.7338	24.2089	23.2028
340009	***	*	20.6154	*	*	20.6154
340010	1.3403	0.9780	20.6547	21.3024	23.1349	21.7023
340011	1.0537	0.8570	17.4534	18.1926	18.1843	17.9572
340012	1.2396	0.8570	19.3651	19.6350	22.0583	20.3718
340013	1.2346	0.9628	21.5130	21.0066	22.4787	21.6596
340014	1.5852	0.9410	21.9804	22.6757	24.4831	23.0786
340015 ^h	1.3541	0.9965	20.3493	24.3410	24.3870	22.9723
340016	1.1855	0.8570	19.4160	20.2859	22.7574	20.8332
340017	1.2637	0.9250	20.6263	21.7083	22.8879	21.7832
340018	1.1200	0.9378	16.4611	17.3480	20.3840	18.0737
340019	0.9998	0.9410	15.9037	16.7901	17.8768	16.8598
340020	1.1563	0.8777	19.2392	21.3385	24.1955	21.6666
340021	1.2701	0.9628	22.0220	22.9208	23.6884	22.9128
340022	1.0255	*	20.6484	19.9078	*	20.2858
340023	1.3641	0.9250	19.9023	22.3590	23.2844	21.8867
340024	1.1577	0.8570	19.1430	20.4906	21.2671	20.3132
340025	1.2658	0.9208	19.1770	20.2864	20.9915	20.1604
340027	1.1579	0.9179	19.4907	21.0975	22.6107	21.0093
340028	1.5564	0.9363	20.6496	22.2028	24.6836	22.5102
340030	2.0448	1.0322	23.9505	26.7753	27.4664	26.0871
340031	***	*	15.4935	*	*	15.4935
340032	1.4538	0.9698	22.0245	23.2204	24.8031	23.4106
340035	1.0010	0.8570	18.5883	16.4821	21.2407	18.5593
340036	1.1519	1.0129	18.4203	20.8313	22.2089	20.6350
340037	1.0461	0.8786	18.3655	21.9524	22.5089	21.0772

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
340038	1.2057	0.8570	20.3091	13.9936	14.0203	15.4496
340039	1.2275	0.9628	22.4020	24.8246	25.6605	24.3326
340040	1.8857	0.9179	21.1397	22.4777	24.1523	22.5957
340041	1.1977	0.9510	16.3200	17.6319	23.0497	18.8452
340042	1.1151	0.8570	19.1386	21.1107	22.1107	20.7523
340044	0.9412	0.8570	18.9562	18.2154	21.7089	19.4477
340045	1.0180	0.8570	20.2642	17.4066	14.5004	16.7029
340047	1.9521	0.9410	21.5178	22.5199	25.3727	23.1966
340049	1.9631	1.0322	17.2986	21.2734	22.3082	20.5126
340050	1.0499	0.9003	20.6831	20.3262	21.4511	20.8336
340051	1.2252	0.9344	19.0282	20.3057	21.9069	20.4742
340052	***	*	26.2243	*	*	26.2243
340053	1.5631	0.9698	23.2410	24.9768	26.9361	25.0126
340054	***	*	16.6208	*	*	16.6208
340055	1.1554	0.9510	20.8254	23.2990	24.3728	22.8810
340060	1.0457	0.9209	20.8570	20.8077	22.4303	21.3720
340061	1.8361	1.0322	23.7173	25.1081	26.6657	25.1862
340063	***	*	26.4131	*	*	26.4131
340064	1.0979	0.8570	17.6106	19.4523	22.3631	19.7545
340065	1.2496	0.8570	23.2605	20.3296	20.8413	21.2925
340067	***	*	22.4054	22.2565	*	22.3296
340068	1.1676	0.9225	18.8758	19.4487	20.8600	19.7382
340069	1.8629	1.0182	22.5995	24.4650	27.5045	24.9498
340070	1.2792	0.9587	21.3511	22.2605	23.6045	22.4345
340071	1.1113	0.9780	19.3679	19.9561	22.1854	20.5344
340072	1.1430	0.8570	18.7920	19.2773	21.3320	19.7735
340073	1.3598	1.0182	24.0794	26.6829	29.4189	26.8823
340075	1.2293	0.9510	19.7450	23.2904	24.1297	22.4060
340084	1.1121	0.9698	19.6087	20.8175	21.3227	20.5838
340085 ^h	1.1633	0.9644	20.3684	21.7112	23.0890	21.7447
340087	1.1837	0.8570	20.2445	17.8215	18.4202	18.8428
340088	1.3263	0.9250	22.6462	22.8687	24.3299	23.2665
340089	***	*	16.1321	*	*	16.1321
340090	1.1651	1.0129	18.7701	20.3261	21.7173	20.3119
340091	1.5160	0.9267	21.2665	23.1430	24.9411	23.1446
340093	***	*	16.5452	*	*	16.5452
340094	***	*	21.0091	*	*	21.0091
340096 ^h	1.2582	0.9644	20.9686	22.1174	23.6345	22.2303
340097	1.1352	0.8570	20.0302	20.8690	22.5775	21.2019
340098	1.5191	0.9698	23.4949	24.2262	25.4823	24.4428
340099	1.2267	0.8570	16.9979	17.5114	20.0178	18.2218
340101	***	*	20.7841	*	*	20.7841
340104	0.9366	0.8786	12.1845	12.9949	14.3252	13.2123
340106	1.0942	0.8570	19.1147	20.1076	22.6979	20.7362
340107	1.2610	0.8997	20.7601	21.0960	22.5583	21.4887
340109	1.2500	0.8928	19.3357	20.4341	22.3826	20.7535
340111	***	*	17.2127	*	*	17.2127
340112	1.1575	*	16.9592	*	*	16.9592
340113	1.8741	0.9698	24.4222	25.0729	26.0776	25.2153
340114	1.5464	1.0182	21.7750	19.9142	25.4533	22.2560
340115	1.5434	1.0213	24.7924	23.8284	25.1907	24.6005
340116	1.6503	0.9510	21.6744	23.9643	26.1641	23.9942
340119	1.1663	0.9698	20.5394	21.2239	22.4821	21.4447
340120	1.0821	0.8570	16.9847	19.9860	21.8548	19.6503
340121	1.0306	0.9225	19.0420	19.9409	20.3701	19.8086
340123	1.1735	0.9267	21.5041	22.3711	23.1879	22.4178
340124	1.0790	0.9780	17.5411	17.5691	18.3866	17.8294
340126	1.2412	0.9780	21.2045	21.4271	23.5405	22.0691
340127	1.1328	1.0213	21.4797	22.9672	24.6096	23.1058
340129	1.2708	0.9628	21.0773	22.3260	24.1356	22.7251
340130	1.3665	0.9698	20.5851	22.7687	23.0937	22.1960
340131	1.4555	0.9179	23.2478	24.1370	25.2989	24.2606
340132	1.2057	0.8570	17.7110	17.8771	20.4222	18.6810
340133	1.0005	0.8570	17.5170	23.1444	22.1588	20.7607
340137	1.0508	0.9510	39.9826	33.1751	29.9903	33.7889
340138	0.8802	1.0182	*	29.5286	27.4767	28.5643
340141	1.5965	0.9225	23.2961	24.2033	24.8132	24.1655

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Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
340142	1.1900	0.8570	18.1824	20.4320	22.1298	20.3003
340143	1.4520	0.9510	21.9304	23.0416	24.8904	23.2152
340144	1.2472	0.9628	22.8634	25.4598	25.6538	24.6620
340145	1.3442	0.9628	21.5958	21.8120	23.7028	22.3475
340146	1.0590	*	19.1306	20.7252	18.8354	19.5242
340147	1.2291	0.9780	21.5912	22.6057	23.9998	22.7397
340148	1.3415	0.9410	20.6790	20.8156	22.4205	21.3545
340151	1.1846	0.8570	19.0779	19.2593	22.2613	20.1580
340153	1.8698	0.9698	21.7375	23.7426	25.7078	23.6658
340155	1.4158	1.0322	25.0965	26.3663	28.8758	26.7492
340158	1.0776	0.9225	20.0921	21.7489	23.4724	21.9061
340159	1.1192	1.0322	19.4992	21.2983	22.1872	21.0139
340160	1.2688	0.8570	17.1963	18.7569	19.1330	18.4042
340166	1.3427	0.9698	22.0519	22.8349	25.7398	23.6431
340168	0.5159	0.9225	15.4249	16.8278	16.8076	16.3574
340171	1.1592	0.9698	22.7304	25.9603	27.2074	25.4029
340173	1.1944	1.0182	23.3690	23.7037	26.6128	24.7042
340176	***	*	*	26.5277	*	26.5277
350001	***	*	15.6193	*	*	15.6193
350002	1.7340	0.9189	19.1931	20.4398	20.6474	20.1088
350003	1.1656	0.9189	20.0664	21.0585	25.3076	21.9679
350004	***	*	25.1976	28.3773	27.5891	26.8643
350005	***	*	20.7468	*	*	20.7468
350006	1.6242	0.9189	19.1257	19.7577	19.5870	19.5034
350007	***	*	13.9966	*	*	13.9966
350008	***	*	23.4052	*	*	23.4052
350009	1.0938	0.9189	19.3668	20.2558	20.7014	20.1101
350010	1.0984	0.9189	16.7774	17.2489	18.5682	17.5061
350011	1.9597	0.9189	20.6809	21.9111	22.3896	21.6745
350012	***	*	16.0990	*	*	16.0990
350013	***	*	17.8145	*	*	17.8145
350014	1.0054	0.9189	18.6787	16.1718	18.5360	17.8143
350015	1.7563	0.9189	17.5658	18.5437	18.6381	18.2634
350017	1.4094	0.9189	18.0840	19.1952	20.1943	19.1643
350018	***	*	16.3211	*	*	16.3211
350019 ²	1.6877	0.9189	20.6743	21.3589	24.2382	22.0663
350021	***	*	16.3394	*	*	16.3394
350023	***	*	18.3252	*	*	18.3252
350024	***	*	15.7510	*	*	15.7510
350025	***	*	14.6098	*	*	14.6098
350027	1.0440	0.7750	17.5881	17.6731	14.2262	16.1496
350030	0.9876	0.9189	18.7993	18.8822	19.2282	18.9737
350033	***	*	16.0903	*	*	16.0903
350035	***	*	12.6495	*	*	12.6495
350038	***	*	19.5497	*	*	19.5497
350039	***	*	14.8599	*	*	14.8599
350041	***	*	23.1151	*	*	23.1151
350042	***	*	19.3370	*	*	19.3370
350043	***	*	17.6722	18.8378	20.9732	19.2355
350044	***	*	10.9690	*	*	10.9690
350047	***	*	19.9749	*	*	19.9749
350049	***	*	16.8321	*	*	16.8321
350050	***	*	25.2746	*	*	25.2746
350051	***	*	16.9202	*	*	16.9202
350053	***	*	16.7455	*	*	16.7455
350055	***	*	16.1690	*	*	16.1690
350056	***	*	15.7752	*	*	15.7752
350058	0.9729	*	16.1013	15.0196	*	15.5930
350060	***	*	10.5325	*	*	10.5325
350061	1.0064	0.9189	19.6460	18.8494	18.6546	19.0761
350070	1.9966	0.9189	*	*	24.4464	24.4464
360001	1.2736	0.9536	20.3515	22.2387	23.7750	22.1149
360002	1.1570	0.8726	19.6145	20.7586	22.6923	21.0349
360003	1.8330	0.9536	23.2905	24.4144	26.3180	24.6795
360006	2.0806	0.9743	22.6333	24.0814	25.7041	24.2279
360007	***	*	15.3656	19.1315	*	16.9837
360008	1.2665	0.9009	19.8034	21.3795	23.2545	21.5453

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
360009	1.6061	0.9324	19.6277	22.4076	23.2659	21.7253
360010	1.2628	0.9042	20.5934	20.6290	22.0262	21.1184
360011	1.2851	0.9610	19.5383	21.4293	22.4482	21.0624
360012	1.4081	0.9743	23.0125	24.3618	25.5913	24.3980
360013	1.1568	0.8892	22.3407	24.4232	25.1588	24.0203
360014	1.1880	0.9610	22.9930	22.9372	23.8305	23.2633
360016	1.4531	0.9536	21.3967	22.8430	24.6587	22.9717
360017	1.8165	0.9743	22.7446	23.6181	25.4969	24.0980
360018	***	*	24.6694	29.9085	*	26.7695
360019	1.2342	0.9042	21.4708	23.3006	24.1105	22.9686
360020	1.6248	0.9042	21.6607	21.5085	22.3795	21.8568
360024	***	*	20.9408	22.5356	24.0612	22.4920
360025	1.4124	0.9644	20.9266	21.6676	23.6574	22.1153
360026	1.2550	0.9299	18.6739	20.8825	22.3303	20.6482
360027	1.5275	0.9042	22.8098	23.5907	24.7093	23.7205
360029	1.1258	0.9514	19.7466	20.4924	20.8778	20.3858
360030	1.3437	*	19.0551	*	*	19.0551
360031	***	*	21.0481	24.3482	24.4324	23.1415
360032 ^h	1.1070	0.9324	19.8366	21.1743	22.9759	21.3486
360034	1.0605	0.8989	19.4981	21.5621	25.1366	22.0889
360035	1.7101	0.9743	22.6982	24.2433	25.6895	24.2489
360036	1.1871	0.9644	21.4486	22.3567	25.0910	22.9963
360037	1.4119	0.9644	23.7504	32.6245	25.1615	26.4392
360038	1.4399	0.9536	21.4804	23.4855	24.8294	23.3535
360039	1.4598	0.9610	19.3703	23.4642	22.5921	21.7380
360040	1.1722	0.8726	19.9750	21.3307	22.8729	21.3907
360041	1.4621	0.9644	21.9093	22.1352	23.2625	22.4537
360042	***	*	19.3774	*	*	19.3774
360044	1.1444	0.8726	17.8417	19.7212	20.4724	19.3262
360045	***	*	22.8112	*	*	22.8112
360046	1.1984	0.9536	21.4291	22.8425	23.8918	22.7344
360047	1.0200	0.8726	15.8279	17.5885	17.1973	16.8947
360048	1.7893	0.9514	25.6259	24.7150	27.2274	25.8563
360049	1.1497	0.9644	*	22.4939	24.2605	23.4456
360050	***	*	15.6847	*	*	15.6847
360051	1.5895	0.9299	21.2225	23.0658	25.1785	23.2129
360052	1.4469	0.9299	19.8037	22.5005	23.3285	21.9559
360054	1.2291	0.8726	17.5714	19.2884	20.3176	19.0797
360055	1.4135	0.9375	22.8755	23.5586	25.1475	23.8579
360056	1.5302	0.9536	23.4405	22.4475	23.4638	23.0837
360057	***	*	16.0395	*	*	16.0395
360058	1.1185	0.8726	19.0439	21.0768	22.7943	20.9248
360059	1.5032	0.9644	23.2129	23.0775	25.5222	23.9103
360062	1.4660	0.9743	24.4898	24.5746	26.8091	25.3833
360063	***	*	20.2671	*	*	20.2671
360064	1.5924	0.9375	20.7659	21.3424	22.8729	21.7149
360065	1.1301	0.9644	22.3443	22.9727	24.0868	23.1688
360066	1.5487	0.9324	24.1295	24.6806	25.2316	24.7073
360067	***	*	17.3734	*	*	17.3734
360068	1.8446	0.9514	22.6027	22.1110	23.7895	22.8545
360069	1.1486	0.9514	18.5382	20.5349	25.7032	21.5261
360070	1.6719	0.8936	19.4700	21.8228	23.1687	21.4701
360071 ^h	1.1921	0.9324	19.6873	21.4478	21.6176	20.8985
360072	1.3906	0.9743	20.8819	21.3736	23.0464	21.8052
360074	1.3426	0.9514	19.9947	22.2368	23.6172	22.0110
360075	1.2394	0.9644	27.6991	23.8492	24.7610	26.5971
360076	1.3894	0.9536	21.0402	22.5863	22.5943	22.0934
360077	1.5055	0.9644	22.2964	23.3686	24.7086	23.4752
360078	1.2278	0.9644	22.7743	23.3799	24.6821	23.6285
360079	1.8003	0.9299	23.9491	25.9623	25.8762	25.3121
360080	1.0870	0.8726	18.0392	18.7213	19.5436	18.7880
360081	1.3183	0.9514	20.7477	22.1973	25.1439	22.6318
360082	1.3535	0.9644	22.9390	25.2254	27.4264	25.3363
360084	1.6099	0.8936	22.1699	23.3257	25.2059	23.6474
360085	2.0102	0.9743	24.8010	24.6618	27.5792	25.7394
360086	1.4981	0.9152	20.5858	21.5983	22.3005	21.4743
360087	1.4253	0.9644	21.1621	23.9638	25.9131	23.6955

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
360088	***	*	20.5703	*	*	20.5703
360089	1.1447	0.8726	19.5261	21.0229	21.0253	20.5486
360090	1.5173	0.9514	21.2072	22.6236	24.4291	22.7782
360091	1.2673	0.9644	22.6510	23.5759	26.0541	24.1194
360092	1.1988	0.9734	20.9588	21.9732	23.5100	22.2071
360093	1.0906	0.8846	21.0134	21.4623	24.1238	22.2032
360094	***	*	21.1952	22.6440	27.1864	23.2312
360095	1.3057	0.9324	21.3505	23.6518	24.6984	23.2479
360096	1.1030	0.9292	20.9838	22.0673	22.2333	21.7682
360098	1.4675	0.9644	20.8049	22.7644	23.6413	22.4024
360099	0.9935	*	20.8801	20.8524	*	20.8660
360100	1.2083	0.8936	19.9768	21.5911	19.0616	20.0911
360101	1.3676	0.9644	24.1551	26.2875	27.7584	26.2742
360106	1.0821	0.8726	18.9779	19.8658	21.6450	20.1693
360107	1.0517	0.9514	21.9938	23.6880	24.5365	23.4443
360108	***	*	19.0649	*	*	19.0649
360109	1.0849	0.8726	17.3565	23.0178	24.3236	21.3953
360112	1.8968	1.0756	25.7920	25.5910	26.7880	26.0555
360113	1.2167	0.9536	22.8088	22.3348	23.5138	22.8738
360114	1.0799	*	19.4212	*	*	19.4212
360115	1.3556	0.9644	21.0104	22.3926	24.0232	22.5083
360116	1.1454	0.9536	20.1408	21.3809	23.4049	21.6591
360118	1.5235	0.9200	21.0235	23.0070	24.2526	22.8104
360121	1.2626	1.0756	21.9111	23.2515	25.2037	23.4630
360123	1.3538	0.9644	21.9985	23.1310	24.1761	23.2095
360125	1.2091	0.9644	21.6675	21.1408	22.6871	21.8339
360126	***	*	*	22.2409	*	22.2409
360127	***	*	18.2150	*	*	18.2150
360128	1.0295	0.8726	17.5556	18.0356	18.5954	18.0896
360129	0.9209	0.8726	17.2309	17.9151	19.5336	18.2748
360130	1.4417	0.9644	19.8906	20.1257	21.7015	20.5164
360131	1.2853	0.8936	20.4123	21.7838	23.1730	21.8056
360132	1.2634	0.9536	21.0162	23.4179	25.7991	23.4733
360133	1.6759	0.9299	22.1957	22.0958	23.9457	22.7800
360134	1.6455	0.9536	21.6081	23.6817	25.3013	23.5609
360136	***	*	18.5687	*	*	18.5687
360137	1.7473	0.9644	23.1867	23.8947	25.7647	24.2713
360140	***	*	18.3463	*	*	18.3463
360141	1.6710	0.9375	23.5979	25.1442	31.0127	26.6136
360142	0.9526	0.8726	19.6189	20.6728	21.2084	20.5522
360143	1.2767	0.9644	20.9158	22.2275	23.8938	22.3918
360144	1.3167	0.9644	20.9386	24.7973	26.7160	24.2347
360145	1.8405	0.9644	21.2931	22.4813	23.4743	22.4343
360147	1.3298	0.8726	18.7258	20.0409	22.7172	20.6003
360148	1.0954	0.8726	20.3120	21.3211	24.4873	22.0112
360150	1.2507	0.9042	23.1859	24.8485	25.8703	24.6077
360151	1.4367	0.8936	20.5594	21.7215	22.2179	21.4897
360152	1.4352	0.9743	20.9704	22.9352	24.9894	22.8599
360153	1.0290	0.8726	16.1021	17.3367	19.0844	17.4210
360154	0.9907	*	14.9605	16.2416	17.1274	16.0897
360155	1.4551	0.9644	22.3347	23.0020	23.9466	23.1289
360156	1.1456	0.8939	19.9382	21.2853	22.6709	21.3292
360159	1.2760	0.9610	22.7992	23.3359	25.7108	23.9547
360161	1.3332	0.9375	19.6266	21.5114	22.6005	21.2840
360163	1.8699	0.9536	22.1012	23.1500	25.7966	23.6640
360165	***	*	19.6205	*	*	19.6205
360170	1.1018	0.9743	19.7980	22.2815	22.9359	21.6975
360172	1.3805	0.9644	22.3294	22.7104	23.4727	22.8461
360174	1.2312	0.9299	20.5874	21.7129	22.8167	21.7487
360175	1.1817	0.9610	22.0274	22.7887	24.6152	23.1831
360176	0.9906	*	17.6743	*	*	17.6743
360177	1.1901	0.8726	19.6992	20.8194	23.4256	21.3525
360178	1.1917	*	18.0773	18.2393	*	18.1595
360179	1.5283	0.9536	21.3520	23.0678	25.9429	23.4000
360180	2.3386	0.9644	22.9260	25.1499	26.8720	25.0696
360185	1.1585	0.9292	20.0848	21.1245	21.8641	21.0491
360186	***	*	18.1254	*	*	18.1254

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
360187	1.5751	0.9152	20.8423	21.9499	23.8362	22.2169
360188	***	*	16.4330	*	*	16.4330
360189	1.1223	0.9743	19.0481	20.0275	24.2512	21.0645
360192	1.3028	0.9644	23.9969	24.9995	26.2976	25.1276
360194 ^h	1.1460	0.9200	19.3901	20.3677	22.3297	20.7198
360195	1.0473	0.9644	21.2801	23.1897	25.8043	23.5294
360197	1.1044	0.9610	21.6110	23.1378	24.7539	23.1866
360200	***	*	19.5866	*	*	19.5866
360203	1.1062	0.8726	17.9698	19.3642	21.5564	19.6801
360210	1.2267	0.9743	21.5961	25.0811	26.5665	24.3949
360211	1.5079	0.8726	22.0011	22.4529	23.0884	22.5358
360212	1.3547	0.9644	21.0632	22.8041	24.5310	22.7981
360213	***	*	20.5448	*	*	20.5448
360218	1.1962	0.9743	20.7709	22.8060	24.4720	22.7107
360230	1.5573	0.9644	21.2417	24.7681	26.6444	24.2478
360231	***	*	12.7388	*	*	12.7388
360234	1.2357	0.9536	21.0472	22.1787	23.3325	22.1974
360236	1.1633	0.9536	20.5683	22.8821	21.3795	21.6061
360239	1.2556	0.9299	20.9440	23.5802	24.4398	23.1383
360241	0.4470	0.9042	23.7678	23.4061	24.8089	23.8245
360245	0.6142	0.9644	16.7956	18.1015	18.7966	17.9691
360247	0.3999	0.9743	*	*	25.1083	25.1083
360250	***	*	50.5105	*	*	50.5105
360253	2.1828	0.9299	*	31.3006	28.2555	29.5019
360254	***	*	*	30.0792	*	30.0792
360255	***	*	*	15.0963	*	15.0963
360257	1.1157	*	*	*	17.9652	17.9652
370001	1.6954	0.8737	22.0586	25.5838	26.2391	24.5772
370002	1.2309	0.7711	16.1854	18.9544	19.7718	18.3382
370004	1.0763	0.8573	22.5027	21.5041	24.7694	22.8865
370006	1.1187	0.7711	15.7367	15.6333	16.9469	16.0911
370007	1.1420	0.7711	14.4961	16.7598	17.2084	16.1203
370008	1.4296	0.8985	18.5253	22.1596	22.7419	21.1312
370011	1.0500	0.8985	16.1757	17.1458	19.2266	17.5769
370012	***	*	13.3824	*	*	13.3824
370013	1.5187	0.8985	19.3237	21.1512	22.6451	21.1093
370014	1.0679	0.9106	22.7976	21.8473	24.8138	23.1705
370015	0.9755	0.8737	18.9169	20.3966	21.1833	20.1480
370016 ^h	1.5395	0.9008	20.0888	20.4407	24.2737	21.4955
370018	1.4003	0.8737	18.7928	20.8357	23.4286	20.9864
370019	1.2871	0.7711	16.1367	18.1260	19.6761	17.9639
370020	1.2279	0.7711	15.6057	16.8631	17.4835	16.6385
370022	1.2059	0.7711	18.2109	20.2432	18.4217	18.9710
370023	1.2613	0.7795	18.1255	19.3386	20.6002	19.3777
370025	1.3201	0.8737	19.1013	20.2845	22.0287	20.4896
370026 ^h	1.4813	0.9008	18.6982	21.9140	22.5734	21.1360
370028	1.8620	0.8985	22.1766	24.1009	24.8661	23.7388
370029	1.0880	0.7711	19.3285	19.5811	22.1163	20.3535
370030	1.0382	0.7711	18.4568	18.6541	20.3315	19.1241
370032	1.5094	0.8985	18.9050	20.0827	21.6029	20.2653
370033	***	*	15.3857	*	*	15.3857
370034	1.1721	0.8069	16.2204	16.1540	17.6247	16.6662
370036	0.9989	0.7711	11.7668	16.5844	16.9222	14.7407
370037	1.6554	0.8985	20.6493	21.0719	23.1256	21.6938
370038	***	*	15.4551	*	*	15.4551
370039	1.0958	0.8737	22.7015	20.3137	21.0793	21.3263
370040	0.9928	0.8300	16.8127	18.981	21.1061	18.9865
370041	0.8160	0.8737	14.7346	19.0144	22.0082	18.4514
370042	0.9123	0.7711	15.9006	14.0899	15.3613	15.1518
370043	0.9218	*	20.0992	20.2929	21.5588	20.6699
370045	0.9724	0.7711	11.6163	12.6613	14.6370	13.0002
370047	1.3905	0.9106	18.4743	19.4856	19.7112	19.2324
370048	1.0571	0.7711	17.0785	15.4768	17.7273	16.7427
370049	1.2966	0.8985	20.3405	20.4826	21.6878	20.8339
370051	1.0694	0.7711	11.4943	12.0397	14.6254	12.6833
370054	1.3428	0.8985	19.2294	20.3788	21.5521	20.4057
370056	1.6562	0.8249	19.2867	20.4872	21.7647	20.4979

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
370057	0.9702	0.8717	16.0301	17.3020	18.0426	17.1260
370059	***	*	21.3104	*	*	21.3104
370060	0.9088	0.8737	17.9469	23.1897	23.8007	21.6796
370064	0.9214	0.7711	11.6347	11.9044	14.1879	12.5621
370065	1.0298	0.7832	18.2405	18.3966	20.6537	19.0797
370072	0.8005	0.7711	12.5765	12.5765	14.6387	13.1913
370076	***	*	15.4067	19.0230	21.5461	18.6317
370078	1.5751	0.8737	15.2513	22.2318	23.9507	19.9554
370079	***	*	17.5915	*	*	17.5915
370080	0.8985	0.7711	14.3546	16.1444	17.4857	15.9989
370082	0.8901	*	16.9716	12.6060	*	14.6866
370083	0.9133	0.7711	15.6824	18.5669	15.3447	16.4561
370084	0.9818	0.7711	15.6184	16.1278	17.2735	16.4207
370085	***	*	13.7216	*	*	13.7216
370089	1.0950	0.7711	17.9243	18.0505	19.9021	18.6220
370091	1.7254	0.8737	20.8536	24.2117	22.9893	22.6115
370092	1.0042	*	16.8432	*	*	16.8432
370093	1.6738	0.8985	22.1966	23.5685	25.7296	23.9073
370094	1.3687	0.8985	19.5565	20.6507	22.0591	20.8273
370095	0.8682	0.7711	14.5909	14.3563	16.5310	15.1591
370097	1.3135	0.8249	19.3793	20.3218	21.7150	20.5580
370099	1.0724	0.8737	18.1468	20.2001	20.5217	19.6505
370100	0.9245	0.7711	12.9784	13.0681	14.1883	13.4294
370103	0.9190	0.7997	23.1347	15.6110	16.1408	18.5649
370105	1.8775	0.8985	25.1252	22.4493	22.1584	23.1230
370106	1.4050	0.8985	21.8937	24.1115	24.2393	23.4303
370108	0.9232	*	14.0191	13.8170	*	13.9197
370112	0.9216	0.8310	14.3385	16.5965	15.4941	15.4208
370113	1.1237	0.8670	20.3439	21.4267	23.3011	21.7070
370114	1.5699	0.8737	17.9757	19.4933	21.0603	19.5551
370121	***	*	20.5488	*	*	20.5488
370123	1.2398	0.8985	19.7958	20.5180	22.8174	20.9622
370125	0.8961	0.7711	14.4664	17.9240	17.2013	16.4581
370133	***	*	16.1855	*	*	16.1855
370138	1.0106	0.7711	17.4574	19.0403	19.8308	18.8087
370139	0.9557	0.7711	16.0897	16.3224	17.8900	16.7539
370140	***	*	17.4950	*	*	17.4950
370141	***	*	19.8607	24.7859	*	22.3186
370146	***	*	13.9900	*	*	13.9900
370148	1.5111	0.8985	22.6237	22.8526	24.6194	23.4089
370149 ^h	1.2141	0.9341	18.0699	18.2260	21.0608	19.1566
370153	1.0745	0.7711	16.5267	17.9692	18.5417	17.6547
370154	0.9940	*	16.6687	17.4760	*	17.0679
370156	1.0239	0.7711	15.4303	15.9647	16.6572	16.0354
370158	1.0245	0.8985	16.3637	17.3412	17.3161	17.0080
370159	***	*	25.5592	*	*	25.5592
370165	***	*	12.9569	*	*	12.9569
370166	1.0132	0.8737	19.4219	21.3628	21.9070	20.8888
370169	0.9497	0.7711	14.8385	16.5607	15.7686	15.6596
370176	1.2029	0.8737	19.6537	22.1456	23.0324	21.6545
370177	1.0313	0.7711	14.1303	14.0279	15.6723	14.6097
370178	0.9194	0.7711	9.8655	12.9635	14.9767	12.3473
370179	0.8932	0.8025	23.8404	21.9673	22.8322	22.7553
370183	1.0559	0.8717	16.6061	17.9270	20.5025	18.2704
370186	0.9334	*	16.3671	16.3879	*	16.3778
370190	1.5008	0.8737	20.6399	22.3326	24.9455	22.7536
370192	1.8186	0.8985	21.8343	24.3832	26.1338	24.1955
370196	0.8685	0.8985	*	23.6334	29.4383	26.7910
370199	0.8349	0.8985	*	20.7075	23.7340	22.1631
370200	1.2117	0.8985	18.3941	16.7164	18.1008	17.7363
370201	1.7545	0.8985	18.2548	18.9906	23.1240	20.2434
370202	1.6128	0.8737	16.5384	24.0239	24.4920	21.7342
370203	1.3803	0.8985	23.5454	19.8772	21.2426	21.3889
370206	1.4950	0.8985	*	22.3471	27.4495	25.1813
370207	***	*	*	26.3746	*	26.3746
370209	***	*	*	*	32.8278	32.8278
370210	2.1978	0.8737	*	*	20.0360	20.0360

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
380001	1.2209	1.1371	25.1542	20.9585	27.8554	24.5459
380002	1.2023	1.0313	23.2479	25.2629	26.3348	24.9837
380003	1.0667	*	23.8074	24.6377	*	24.2467
380004	1.7469	1.1371	24.5418	27.5184	28.2466	26.9046
380005	1.3208	1.0533	24.7476	26.3472	28.0682	26.4708
380006	1.2163	*	20.5914	24.7492	26.0475	23.9121
380007	1.7717	1.1371	25.9239	30.0497	31.5207	29.2603
380008	1.0438	1.0333	21.6134	24.6149	25.4494	23.9225
380009	1.9599	1.1371	25.1040	26.0012	30.4198	27.2701
380010	0.9982	1.1371	24.1931	25.5234	27.5291	25.7081
380011	1.2142	*	20.6759	21.9382	*	21.3065
380013	1.1653	*	19.9607	24.1491	*	22.0350
380014	1.7917	1.0526	26.6038	28.4536	27.7255	27.6280
380017	1.7814	1.1371	21.9236	29.2543	31.7440	27.8002
380018	1.7234	1.0533	24.8661	27.5171	27.8952	26.7548
380019	1.0564	*	21.1743	*	*	21.1743
380020	1.3584	1.0921	23.9978	23.7066	25.8320	24.5420
380021	1.4229	1.1371	24.4365	28.0334	29.3001	27.3785
380022	1.1775	1.0434	25.6255	26.4794	27.8683	26.7236
380023	1.1087	1.0183	23.4328	23.0079	23.7073	23.3913
380025	1.3689	1.1371	26.9398	28.8525	30.2628	28.7925
380026	1.1238	1.0183	22.7561	23.8666	26.5217	24.4150
380027	1.2749	1.0528	22.2573	21.5822	23.8758	22.6072
380029	1.1354	1.0549	22.0371	24.2939	26.2070	24.3253
380031	***	*	23.7634	*	*	23.7634
380033	1.6503	1.0921	26.6899	30.4783	29.7995	29.0661
380035	1.0772	1.0183	25.6016	26.2434	26.4784	26.1363
380037	1.1737	1.1371	23.4798	25.0200	27.1884	25.4038
380038	1.2137	1.1371	28.1436	29.1804	30.5903	29.3667
380039	1.1084	1.1371	25.7614	27.5115	30.1544	27.7918
380040	1.1651	1.0230	22.6412	21.5958	28.4373	23.9593
380042	***	*	21.6793	*	*	21.6793
380047	1.7478	1.0560	25.2591	26.5017	27.8385	26.6198
380048	***	*	18.2774	*	*	18.2774
380050	1.3828	1.0248	22.1089	23.1332	24.2416	23.1844
380051	1.6179	1.0549	24.4081	26.2384	28.1305	26.2423
380052	1.1548	1.0183	20.7431	21.2567	22.6799	21.5642
380056	0.9898	1.0549	20.7895	22.3571	25.0068	22.7858
380060	1.4106	1.1371	23.0107	27.8551	30.2507	27.1740
380061	1.5940	1.1371	24.1121	27.3827	29.5145	27.3048
380062	***	*	26.1368	*	*	26.1368
380064	***	*	27.0628	*	*	27.0628
380065	***	*	23.3147	*	*	23.3147
380066	1.2297	*	23.1175	23.3581	27.5412	24.6926
380069	***	*	21.2057	*	*	21.2057
380070	1.0908	*	29.9706	34.1039	*	31.8503
380071	1.3173	1.1371	25.9113	27.9055	29.5740	27.8172
380072	0.8885	1.0183	20.6569	21.9516	22.5275	21.7458
380075	1.3286	1.0533	23.1910	25.1930	27.4795	25.5348
380078	***	*	22.6995	*	*	22.6995
380081	1.1161	1.0183	22.9805	22.1822	21.0708	22.0536
380082	1.1927	1.1371	23.7927	28.0668	30.2721	27.4694
380083	***	*	22.4058	*	*	22.4058
380084	***	*	31.0111	*	*	31.0111
380087	1.0549	*	21.3119	*	*	21.3119
380088	***	*	24.8158	*	*	24.8158
380089	1.3120	1.1371	26.1967	29.6989	30.8396	28.9774
380090	1.2651	1.2777	30.4223	31.8702	33.6822	32.0289
380091	1.3732	1.1371	28.7846	31.2807	35.7002	31.8737
390001	1.7219	0.9519	20.3350	21.5154	22.4407	21.4391
390002	1.2315	0.8733	20.8831	22.0646	23.0113	22.0050
390003 ^h	1.2141	0.9519	18.0436	19.1857	21.3182	19.4990
390004	1.4405	0.9354	20.0557	21.3475	23.4063	21.6582
390005	0.9970	0.8700	19.0218	19.0727	19.0318	19.0406
390006	1.8572	0.9201	21.7867	23.0378	23.3960	22.7699
390008 ^h	1.1019	0.8723	19.5439	19.9417	21.0021	20.1821
390009	1.7989	0.8700	22.5580	21.9459	24.2789	22.9311

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
390010	1.2118	0.8733	18.1275	19.4377	21.6273	19.7671
390011	1.3750	0.8377	18.2751	18.6548	19.8602	18.9263
390012	1.2667	1.0855	22.2060	28.5114	*	25.1714
390013	1.2090	0.9201	20.2186	22.1679	23.3180	21.9609
390015	***	*	14.3138	*	*	14.3138
390016 ^h	1.2230	0.8723	17.4931	18.1536	19.9899	18.5387
390017 ^h	0.9847	0.8723	18.5869	19.1962	20.6575	19.3772
390018	***	*	20.0672	19.9117	*	19.9884
390019	1.1507	0.9538	18.7609	21.2806	21.5137	20.5386
390022	1.2743	1.0855	25.2980	27.5504	31.0971	27.8825
390023	1.2550	1.0855	23.9246	25.3767	27.1600	25.5087
390024	0.9263	1.0855	27.7643	25.9806	37.4330	27.8095
390025	0.5044	1.0855	14.0077	14.8690	15.0282	14.6252
390026	1.2177	1.0855	23.6317	24.0326	27.0802	24.9026
390027	1.5049	1.0855	29.4334	33.2139	28.9159	30.4025
390028	1.7231	0.8733	22.7820	24.6796	23.6616	23.7171
390029	***	*	24.4753	*	24.4276	24.4542
390030	1.2190	0.9519	18.9122	20.0598	20.9859	20.0085
390031	1.1869	0.9074	19.2040	20.3568	21.2949	20.2727
390032	1.1917	0.8733	18.5545	20.8450	20.9971	20.2277
390035	1.2372	1.0855	21.9325	23.2173	24.7281	23.2819
390036	1.4612	0.8733	20.2103	20.5751	23.3858	21.3729
390037	1.3459	0.8733	19.9175	20.1665	22.9008	20.9883
390039 ^h	1.1127	0.8365	17.6181	18.4580	17.8461	17.9758
390040	***	*	17.4450	20.5371	23.1807	20.2698
390041	1.2789	0.8733	19.6159	21.0074	20.6789	20.4540
390042	1.4485	0.8733	22.0668	22.2351	23.9632	22.7692
390043	1.1829	0.8328	17.6739	19.8641	20.9835	19.5455
390044	1.6896	0.9418	21.3382	22.4235	24.2586	22.7073
390045	1.5545	0.8476	20.2107	20.2082	22.2582	20.9227
390046	1.5538	0.9250	21.3960	23.1271	25.0825	23.2769
390048	1.0813	0.9201	18.9776	20.3523	23.6622	20.8911
390049	1.5964	0.9538	22.8196	24.0933	25.4056	24.1179
390050	2.1274	0.8733	24.9156	22.6951	24.5424	24.0190
390052	1.1965	0.8452	21.2729	22.1380	21.6736	21.6933
390054	1.1754	0.9896	19.4686	19.8602	21.4983	20.2491
390055	1.8647	0.8733	25.7327	23.5292	25.5675	24.9295
390056	1.0844	0.8370	21.4121	21.4239	*	21.4180
390057	1.2614	1.0855	21.6693	24.8235	25.1901	23.9478
390058	1.2497	0.9354	20.7930	22.0113	25.3415	22.6800
390061	1.5755	0.9896	22.8728	24.4550	25.5012	24.2558
390062	1.1169	0.8452	17.4710	17.6303	19.0692	18.1151
390063	1.8159	0.8700	20.1696	21.7120	23.5469	21.8619
390065	1.2660	1.0895	20.2930	23.1384	23.4021	22.3979
390066	1.2722	0.9288	19.0132	21.7717	23.0891	21.2658
390067	1.8797	0.9354	21.9885	23.5136	25.4576	23.6219
390068	1.3214	0.9896	21.6408	21.1177	25.9890	22.9757
390070	1.3640	1.0855	22.7909	24.4403	26.9235	24.7175
390071	1.0587	0.8476	18.9416	17.8117	20.9443	19.1807
390072 ^h	1.0246	0.9519	16.9445	20.0561	22.0155	19.6409
390073	1.6546	0.8452	22.2703	22.7073	24.8013	23.2334
390074	1.1655	0.8733	19.7446	21.8456	21.0941	20.9138
390075	***	*	19.5840	19.9775	22.6530	20.6849
390076	1.3003	1.0855	19.7719	21.2039	18.1276	19.5539
390078	***	*	20.6483	*	*	20.6483
390079	1.9359	0.8328	19.5982	19.9169	21.4323	20.3290
390080	1.2560	1.0855	22.2449	23.3742	25.0921	23.5729
390081	1.2411	1.0855	25.6575	28.1056	28.7974	27.6375
390083	***	*	26.1660	*	*	26.1660
390084	1.2472	0.8328	17.0197	18.3551	20.7799	18.7270
390086	1.5559	0.8328	19.7645	19.6488	20.7383	20.0554
390090	1.9289	0.8733	20.5433	22.4688	20.7474	21.2532
390091	1.1508	0.8733	19.0355	19.7361	20.8243	19.8629
390093	1.1844	0.8733	20.0135	19.9209	21.0427	20.3418
390095	1.1684	0.9519	17.9697	18.3939	21.0754	19.1551
390096	1.5018	0.9418	22.2974	22.9502	24.4145	23.2510
390097	1.1739	1.0855	24.7853	24.5304	25.3012	24.8948

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
390100	1.8100	0.9896	21.1186	23.4155	26.7267	23.8493
390101	1.2878	0.9250	19.0180	20.1271	20.1694	19.7929
390102	1.3419	0.8733	19.3111	20.9807	21.6629	20.7249
390103	1.0523	0.8733	20.4422	21.0637	18.6703	20.1263
390104	1.0295	0.8328	16.2440	16.5081	19.1803	17.3735
390106	***	*	17.4747	*	*	17.4747
390107	1.3507	0.8733	20.6024	21.5852	23.1023	21.8035
390108	1.2699	1.0855	22.0444	23.7842	24.7486	23.4864
390109	1.1616	0.9519	17.4539	17.2667	18.7558	17.8372
390110	1.5508	0.8733	21.6005	22.3968	23.3355	22.4480
390111	2.0532	1.0855	27.1429	30.5814	30.6809	29.4124
390112 ^h	1.1710	0.8365	14.8634	15.6710	16.6113	15.7094
390113	1.2892	0.9237	19.9496	20.1160	21.7729	20.6233
390114	1.3063	0.8733	19.8004	23.6162	22.6630	22.0271
390115	1.4581	1.0855	22.3545	24.1951	26.4751	24.3612
390116	1.2859	1.0855	22.6783	24.9581	28.5563	25.3858
390117	1.1874	0.8328	18.9764	19.0983	20.0040	19.3648
390118	1.1494	0.8328	17.2669	17.8460	19.3332	18.1499
390119	1.3113	0.9519	19.3946	20.3034	21.2761	20.3765
390121	1.6433	0.8452	20.6253	20.8017	22.0556	21.1770
390122	1.1742	0.8328	15.5438	18.5130	21.6981	18.4209
390123	1.2515	1.0855	21.8897	23.2232	25.2209	23.4588
390125	1.2261	0.8328	17.0975	18.2411	19.4406	18.2772
390127	1.2068	1.0855	22.8787	25.0836	28.9238	25.7842
390128	1.1667	0.8733	19.9764	21.3668	21.8837	21.0753
390130	1.1705	0.8377	18.5519	19.4835	21.0694	19.6285
390131	1.2706	0.8733	19.1931	19.5296	21.2164	20.0445
390132	1.4834	1.0855	24.1878	24.6889	26.8153	25.2651
390133	1.6879	0.9538	24.1590	25.2110	26.1458	25.1883
390135	1.2206	1.0855	22.2501	24.0445	*	23.1441
390136	1.0536	0.8733	16.8505	21.9531	24.8042	20.8277
390137	1.4595	0.9519	19.4769	19.5457	21.8830	20.2627
390138	1.1853	1.0895	20.7726	21.4705	22.7210	21.7019
390139	1.3717	1.0855	24.8347	26.3622	28.2089	26.5057
390142	1.5692	1.0855	28.4680	29.8874	32.0827	30.1680
390145	1.4517	0.8733	20.4964	20.6580	22.4255	21.2144
390146	1.2459	0.8381	20.1788	21.4580	22.3260	21.2951
390147	1.2232	0.8733	21.7600	22.3135	23.6380	22.5753
390150	1.1083	0.8723	20.8970	20.0261	24.5256	21.8864
390151	1.2565	1.0895	23.6072	24.7843	25.1422	24.5408
390152	0.9953	0.8452	20.2581	21.5474	11.7774	16.4240
390153	1.3868	1.0855	23.9039	25.3391	27.5167	25.6598
390154	1.3180	0.8328	17.8774	19.1300	20.4408	19.1543
390156	1.3356	1.0855	24.0034	25.0801	27.8096	25.6221
390157	1.2866	0.8733	20.2647	20.6933	22.0222	21.0052
390160	1.2544	0.8733	19.4793	19.3598	19.5942	19.4793
390162	1.5384	0.9538	21.3379	24.0291	*	22.6994
390163	1.2584	0.8733	18.1831	18.8585	19.8863	18.9837
390164	2.1093	0.8733	26.1698	24.2334	25.1277	25.1322
390166	1.2143	0.8733	19.8899	19.8531	20.9510	20.2267
390168	1.4802	0.8733	19.6875	20.6777	21.9344	20.8088
390169	1.4028	0.9519	22.7920	22.7695	24.1682	23.2427
390173	1.1721	0.8328	18.8265	20.6958	21.6562	20.4167
390174	1.7411	1.0855	26.3891	28.4490	30.3725	28.4625
390176	1.1752	0.8733	21.7650	18.0752	17.1387	19.0248
390178	1.3257	0.9234	17.1142	17.2384	19.2731	17.9067
390179	1.3843	1.0855	21.5792	24.0501	24.8350	23.5283
390180	1.4143	1.0855	26.7743	28.4842	30.4264	28.6343
390181	1.0383	0.8328	18.8681	*	25.7357	21.6826
390183	1.0864	0.8328	17.4535	21.6811	22.0117	20.3045
390184	1.0618	0.8733	21.1941	21.1962	21.3407	21.2460
390185	1.2471	0.9896	20.3301	20.4476	21.8871	20.8622
390189	1.1215	0.8328	19.6186	20.1365	21.2711	20.3629
390191	1.1520	0.8328	17.1919	18.5972	19.2308	18.2816
390192	1.0722	0.9519	16.6469	19.1883	20.0395	18.6928
390193	0.9732	0.8700	17.3804	18.9764	18.5516	18.2455
390194	1.2048	0.9538	21.0549	21.5850	23.1814	21.9829

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
390195	1.6262	1.0855	24.2891	26.2024	28.3480	26.3145
390197	1.4715	0.9538	22.1974	22.8349	24.9234	23.2844
390198	1.1659	0.8700	16.6803	17.3937	16.8529	16.9777
390199	1.2082	0.8328	17.7782	18.9787	19.9653	18.9342
390200	0.9555	0.9896	18.2456	19.4471	23.1486	20.2397
390201	1.2207	1.1569	21.3291	22.7849	24.8222	22.9843
390203	1.5721	1.0855	22.4685	26.9436	28.2741	26.1234
390204	1.2498	1.0855	22.7282	23.9673	25.6342	24.1116
390209	***	*	16.8200	*	*	16.8200
390211	1.3118	0.9234	19.4552	21.0450	22.4472	21.0292
390213	***	*	20.1152	*	*	20.1152
390215	***	*	23.5953	25.2617	26.4180	25.0589
390217	1.1770	0.8733	19.7578	21.4058	21.3281	20.8248
390219	1.2700	0.8733	20.1311	20.0594	22.8559	21.0258
390220	1.1191	1.0855	22.7618	23.4385	24.7553	23.6001
390222	1.2538	1.0855	22.7491	24.9345	27.0954	24.9578
390223	1.8952	1.0855	18.9493	22.8725	28.2538	23.2409
390224	0.8620	0.8464	17.2173	16.1289	18.1226	17.1793
390225	1.2148	0.9896	19.0364	20.9232	23.4945	21.2611
390226	1.7511	1.0855	22.8588	25.6917	27.0061	25.2172
390228	1.3377	0.8733	19.6212	21.0164	22.5999	21.1220
390231	1.4529	1.0855	21.0757	24.7757	27.0576	24.3277
390233	1.3285	0.9250	20.5801	21.8043	22.8667	21.7653
390235	***	*	19.9925	23.7068	*	21.4674
390236	1.1860	0.8328	19.1427	19.8687	21.9199	20.3483
390237	1.5418	0.9519	21.7847	23.2054	24.6316	23.2303
390238	***	*	18.1956	19.2171	26.4748	21.1243
390244	***	*	14.2137	*	*	14.2137
390246	1.1561	0.8328	22.3892	22.0687	23.3275	22.6010
390249	0.8542	*	14.1062	14.7215	*	14.4157
390256	1.8497	0.9354	22.3540	22.6146	24.2331	23.1349
390258	1.6157	1.0855	23.8318	25.0634	27.2038	25.4263
390262	***	*	18.8943	21.3264	*	20.1664
390263	1.4810	0.9538	20.6348	22.0008	23.4202	22.0938
390265	1.4471	0.8733	20.4760	20.5948	21.6751	20.9436
390266	1.2788	0.9234	17.6223	18.2424	19.2836	18.3942
390267	1.2116	0.8733	20.2424	21.4801	22.5464	21.3891
390268	1.2936	0.8465	22.2046	23.1124	24.2050	23.1957
390270	1.5401	0.9896	20.7957	22.5258	24.0837	22.5608
390278	0.5694	1.0855	18.5776	21.1387	21.6893	20.4268
390279	1.0750	0.8465	15.8080	16.0510	15.3569	15.7368
390285	1.7276	1.0855	29.1270	30.6300	33.5347	31.0662
390286	1.1635	1.0855	22.9746	25.4499	27.4090	25.2567
390287	1.4961	1.0855	30.3252	32.9709	35.7147	33.0283
390288	1.1476	1.0855	26.9662	28.0957	28.5267	27.6344
390289	1.3089	1.0855	22.8963	25.1658	28.4577	25.4209
390290	1.9543	1.0855	30.5037	31.0967	36.4991	32.6843
390291	0.9597	0.8733	20.0272	21.0057	21.3015	20.7433
390293	***	*	23.5284	*	*	23.5284
390294	***	*	*	33.3537	*	33.3537
390295	***	*	*	26.8862	*	26.8862
390296	***	*	*	25.6981	*	25.6981
390297	***	*	*	25.7318	*	25.7318
390298	***	*	*	*	26.8290	26.8290
390299	***	*	*	*	31.9423	31.9423
390300	***	*	*	*	40.4697	40.4697
400001	1.2760	0.4723	10.7531	11.7572	16.1114	12.6374
400002	1.6567	0.5006	13.3684	11.6804	14.8607	13.2481
400003	1.3922	0.5006	11.2726	10.5963	13.0776	11.6305
400004	1.1633	0.4723	9.0781	11.4041	10.4716	10.2554
400005	1.0738	0.4723	9.7802	10.5356	10.2878	10.1683
400006	1.1473	0.4723	10.4988	9.2852	8.9919	9.5595
400007	1.1920	0.4723	8.1974	8.6022	8.7152	8.4943
400009	1.0542	0.4029	8.7341	9.4413	9.2007	9.1221
400010	0.9114	0.4274	9.1359	9.2799	10.9354	9.7131
400011	1.0976	0.4723	8.6253	8.9111	8.5868	8.7030
400012	1.5139	0.4723	8.6538	9.0740	8.3580	8.6862

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
400013	1.3895	0.4644	9.8197	9.9905	9.5584	9.7808
400014	1.4319	0.4628	10.2712	11.4580	11.7023	11.0983
400015	1.2170	0.4723	15.5827	*	15.6066	15.5949
400016	1.3378	0.4723	13.7001	14.6491	15.3497	14.5879
400017	1.1908	0.4723	9.9167	10.7475	10.1238	10.2629
400018	1.1912	0.4644	10.5583	10.8254	10.7948	10.7210
400019	1.3565	0.4723	12.1251	13.7007	14.9892	13.5048
400021	1.3754	0.5230	12.7462	13.5224	13.8643	13.3877
400022	1.3187	0.5006	13.0915	15.2904	16.0539	14.7599
400024	0.8680	0.4628	9.0826	9.8650	9.1316	9.3569
400026	1.0267	0.4029	7.4280	5.9206	5.2085	6.0594
400028	1.2396	0.5006	8.9567	9.5266	10.3354	9.5963
400032	1.1882	0.4723	10.1898	10.7100	10.7195	10.5472
400044	1.2936	0.5006	12.8671	9.0275	10.7890	11.1534
400048	1.1418	0.4029	11.5104	10.8618	14.0887	12.1974
400061	1.8543	0.4723	10.3664	16.5895	15.1639	13.5869
400079	1.1704	0.4281	8.7218	8.7218	9.4218	8.9758
400087	1.2148	0.4644	8.6480	10.7118	9.5860	9.7657
400094	***	*	9.4600	9.2871	8.8646	9.2684
400098	1.3321	0.4723	10.4312	13.8036	13.7938	12.4239
400102	1.1639	0.4723	8.5289	10.9973	10.1795	9.9095
400103	1.7285	0.4628	11.8454	11.5797	12.8288	11.9672
400104	1.2151	0.4644	7.9552	7.1781	8.2758	7.7122
400105	1.3446	0.4723	10.6028	11.5608	12.7725	11.5397
400106	1.2175	0.4723	9.8694	10.1241	9.6902	9.8878
400109	1.5284	0.4723	12.2080	12.8921	14.2169	13.0754
400110	1.1675	0.4724	10.7228	12.0159	11.8458	11.5366
400111	1.1086	0.4281	12.3311	12.7701	13.4777	12.8573
400112	1.1368	0.4723	11.0634	12.2859	8.9469	10.5739
400113	1.2555	0.5006	9.3000	10.4416	10.0830	10.0531
400114	1.0875	0.4723	9.9477	9.7444	12.1920	10.5611
400115	1.1199	0.4723	7.2203	7.0411	9.1132	7.7507
400117	1.0915	0.4644	11.3351	9.7314	10.2911	10.4382
400118	1.1965	0.4723	11.4317	12.4590	11.9324	11.9508
400120	1.3580	0.4723	10.9315	11.8837	11.9714	11.5878
400121	0.9198	0.4723	8.7584	8.3575	8.6665	8.5907
400122	1.2393	0.4723	9.1638	9.6644	9.6463	9.4879
400123	1.2755	0.4628	10.9047	10.5643	11.8135	11.0940
400124	2.8781	0.4723	12.7323	14.3496	17.2258	14.7157
400125	1.2216	0.4372	10.5997	10.6642	10.7425	10.6781
400126	1.3107	0.5230	*	*	13.3932	13.3932
410001	1.3046	1.1574	22.4972	24.0033	27.0309	24.5144
410004	1.2680	1.1574	23.5408	23.6409	25.4578	24.2461
410005	1.3095	1.1574	24.0086	24.6522	27.1171	25.2309
410006	1.2900	1.1574	22.8959	26.1372	27.1842	25.4515
410007	1.6959	1.1574	24.9846	27.7171	30.1360	27.6083
410008	1.2274	1.1574	24.4792	25.4183	28.4245	26.1072
410009	1.3583	1.1574	24.3760	26.9135	27.7337	26.3703
410010	1.1614	1.1677	29.7315	30.3860	30.7826	30.3110
410011	1.3412	1.1574	27.4880	29.7664	28.5875	28.6114
410012	1.7780	1.1574	26.4570	28.1791	32.1679	29.0178
410013	1.1918	1.1574	25.3688	28.9386	31.7482	28.6887
420002	1.5711	0.9698	22.6182	25.1067	27.9312	25.2809
420004	1.9036	0.9415	22.4680	23.4579	26.0279	23.9918
420005	1.0202	0.8705	17.8202	19.5521	19.8167	19.0868
420006	0.9839	0.9415	18.7153	22.7896	22.8920	20.8925
420007	1.6167	0.9522	19.0199	22.0228	25.0395	22.1268
420009	1.3495	0.9532	21.2566	18.6866	23.8668	21.1617
420010	1.1302	0.8857	19.3267	19.1746	21.6478	20.1082
420011	1.1179	0.9532	16.7523	17.7300	20.8895	18.4244
420014	1.0459	0.9402	19.0455	21.2045	21.5658	20.5983
420015	1.3017	0.9532	20.8736	23.1274	24.7383	23.0190
420016	0.9864	0.8705	16.6448	17.0051	17.3837	17.0282
420018	1.7425	0.9431	20.7779	20.4649	23.6356	21.5401
420019	1.0964	0.8705	19.0199	19.6836	20.5472	19.7562
420020	1.2403	0.9415	20.5801	22.1616	24.6592	22.6091
420023	1.6333	0.9532	20.8600	23.2568	25.1035	23.1328

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
420026	1.8482	0.9431	23.3073	23.7406	29.2961	25.4193
420027	1.5131	0.9254	19.7322	21.0637	22.8322	21.2332
420030	1.2258	0.9415	22.5159	22.6766	24.2847	23.2152
420031	***	*	15.3604	*	*	15.3604
420033	1.1130	0.9532	23.7974	26.2711	27.5740	25.9481
420036	1.2183	0.9628	19.8285	20.6649	21.9641	20.8131
420037	1.1890	0.9532	23.5244	25.5492	26.8750	25.3942
420038	1.2511	0.9532	19.9829	21.6133	22.6741	21.4329
420039	0.9956	0.9378	18.0055	21.9737	24.0637	21.0824
420043 ^h	1.1088	0.9698	19.6835	21.8816	22.9764	21.4992
420048	1.2678	0.9402	20.5531	21.9517	23.1515	21.9592
420049	1.2153	0.9017	20.1765	21.2604	23.2156	21.6075
420051	1.4807	0.8920	19.8549	20.6629	23.9455	21.5002
420053	1.1983	0.8705	19.0780	19.9013	21.1177	20.0816
420054	1.0646	0.8705	20.2275	20.8471	24.0653	21.6973
420055	1.0609	0.8705	18.6782	19.6817	20.3599	19.5840
420056	1.3085	0.8705	16.5491	20.0527	21.1640	19.3255
420057	1.0690	0.8857	22.1312	17.6727	19.7653	19.9387
420059	1.0988	0.8705	18.2093	20.2917	21.4260	19.8682
420061	1.0705	0.8705	17.7048	19.9789	20.8684	19.5679
420062	1.0499	0.8705	20.9032	17.4764	25.6683	20.9147
420064	1.1734	0.9017	19.7067	20.9057	22.1290	21.0653
420065	1.3750	0.9415	19.2150	22.0784	22.8674	21.4485
420066	0.9870	0.8920	19.5366	20.7782	20.5893	20.2967
420067	1.2723	0.8705	20.8524	22.8104	24.6038	22.8556
420068	1.3919	0.9055	20.2580	21.7257	22.2638	21.4213
420069	1.0148	0.8705	18.9017	17.6291	19.6959	18.7426
420070	1.2804	0.9320	19.2186	20.3664	22.4370	20.6984
420071	1.3653	0.9055	20.1897	21.8579	23.1727	21.7981
420072	1.0540	0.8705	18.2531	16.2578	17.5899	17.3137
420073	1.3435	0.9431	20.2697	21.4718	24.0274	21.8516
420074	***	*	18.1839	18.7010	*	18.4327
420075	0.8785	0.9183	15.0133	15.9889	16.4816	15.8351
420078	1.7660	0.9532	22.7157	24.3273	25.3032	24.1113
420079	1.4719	0.9415	21.3177	23.3992	25.2939	23.4159
420080	1.4227	0.9464	23.2871	26.7489	28.4569	26.2852
420082	1.4859	0.9183	22.8516	23.6936	26.1221	24.1956
420083	1.4335	0.9522	24.4499	24.8508	25.3043	24.8899
420085	1.6004	0.9225	22.0071	24.4040	25.3180	23.9946
420086	1.4402	0.9431	23.5303	24.5760	25.1372	24.4026
420087	1.8047	0.9415	20.8217	22.4526	23.2230	22.1596
420088	***	*	21.8979	23.5174	23.1273	22.7509
420089	1.2804	0.9415	21.3954	23.3240	25.2729	23.4187
420091	1.3688	0.8920	21.8367	23.7936	23.4710	23.0379
420093	1.0612	0.9522	19.1299	21.4678	25.1457	21.8615
420095	***	*	33.4634	*	*	33.4634
420096	***	*	26.4864	*	*	26.4864
420097	***	*	*	*	24.7809	24.7809
430004	***	*	19.2737	*	*	19.2737
430005	1.2129	0.8919	17.3401	18.2647	19.9454	18.5045
430007	1.1935	*	15.1494	*	*	15.1494
430008 ²	1.0759	0.9414	18.5234	20.0124	20.9442	19.8486
430010	***	*	16.5751	*	*	16.5751
430011	1.2776	0.8390	18.3648	19.9835	20.6597	19.6267
430012	1.3116	0.9414	19.2921	21.2588	22.7530	21.0857
430013 ²	1.1666	0.9414	18.8978	21.3389	22.9675	21.0284
430014	1.2556	0.9189	20.9118	22.0285	25.5387	22.8018
430015	1.0867	0.9414	18.8998	20.5849	23.2035	20.8489
430016	1.5956	0.9414	22.7585	24.2450	26.1495	24.3994
430018	0.9210	*	15.9423	17.9850	*	16.8625
430022	***	*	14.0661	*	*	14.0661
430023	0.9540	*	16.7850	18.8816	*	17.7231
430024	0.9794	*	17.4815	18.8357	*	18.1274
430027	1.6975	0.9414	20.8666	22.1807	23.8477	22.3051
430028	***	*	18.2829	*	*	18.2829
430029	0.9451	0.8390	17.4931	18.9464	20.2708	18.9533
430031 ²	0.9271	0.9414	13.2104	15.2321	15.6112	14.6711

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
430033	0.9016	*	18.3978	21.6254	*	20.1419
430034	***	*	13.8535	*	*	13.8535
430036	***	*	16.7826	*	*	16.7826
430037	***	*	18.7008	*	*	18.7008
430040	***	*	14.7860	*	*	14.7860
430043	1.1446	*	17.0193	17.9672	17.2722	17.3947
430047	0.9878	0.8390	17.5377	18.2774	21.9116	19.2363
430048	1.2405	0.9414	19.0261	20.0607	21.1718	20.1127
430049	***	*	14.9025	*	*	14.9025
430051	***	*	18.8696	*	*	18.8696
430054	0.8992	*	15.0100	17.8871	*	16.4122
430056	***	*	14.1913	*	*	14.1913
430057	***	*	18.8777	*	*	18.8777
430060	0.9402	0.9414	9.7677	10.6492	10.2704	10.2206
430064	0.9792	0.9414	13.8666	14.3407	16.4314	14.8874
430066	***	*	14.5958	*	*	14.5958
430073	***	*	16.5112	*	*	16.5112
430076	***	*	15.2453	*	*	15.2453
430077	1.6571	0.9414	20.4361	21.6786	23.4835	21.9080
430079	***	*	14.4155	*	*	14.4155
430089	1.3704	0.9054	17.5100	19.8572	21.1109	19.5864
430090	1.4069	0.9414	23.5180	25.6873	26.0851	25.1793
430091	2.6128	0.9414	21.6239	22.2824	23.8897	22.8409
430092	1.8963	0.8390	19.7645	19.7354	20.2570	19.9313
430093	1.2310	0.8919	23.3009	23.8820	23.1526	23.4368
430094	1.3886	0.9172	*	20.8743	18.5429	19.6576
430095	2.4142	0.9414	*	*	24.7074	24.7074
440001	1.1510	0.8184	17.2283	18.9833	17.4802	17.8507
440002	1.6645	0.8891	21.4299	22.0178	23.2177	22.2412
440003	1.1702	1.0085	20.3756	21.6336	24.5168	22.2321
440006	1.3645	1.0085	23.1483	24.3173	26.7983	24.8025
440007	0.9738	0.7899	14.0611	14.8015	13.7042	14.1639
440008	0.9583	0.8707	20.3303	20.9237	22.1405	21.0927
440009	1.1294	0.7899	18.4068	19.6564	21.1274	19.7792
440010	0.9465	0.7899	13.3692	16.7270	16.9060	15.5468
440011	1.3667	0.8564	19.3165	20.5036	21.6861	20.5719
440012	1.4653	0.8235	19.8949	21.1213	21.4769	20.8338
440014	***	*	15.0657	*	*	15.0657
440015	1.8816	0.8564	21.6106	23.4485	22.5583	22.4945
440016	0.9832	0.7899	14.6142	20.1504	20.0982	17.9834
440017	1.7976	0.8235	20.4705	21.8033	22.5313	21.6064
440018	1.1878	0.8184	18.1620	21.2242	21.7239	20.4131
440019	1.7782	0.8564	22.8463	21.8854	23.8802	22.8779
440020	1.0820	0.8838	20.2188	21.1075	23.1718	21.5541
440023	0.9449	0.7899	15.6603	15.5410	17.0335	16.1069
440024	1.2253	0.8286	18.4276	19.9751	20.3658	19.4829
440025	1.1705	0.7899	17.0996	19.1478	19.5995	18.6582
440026	***	*	25.6489	25.1655	26.9149	25.8839
440029	1.3262	1.0085	22.2889	24.1379	25.8538	24.1320
440030	1.2273	0.7899	17.6297	19.9056	20.0586	19.2409
440031	1.0373	0.7899	17.2555	17.0289	18.0944	17.4732
440032	0.9799	0.8235	13.9785	14.7683	16.0734	14.9379
440033	1.0687	0.7899	16.4679	17.2637	18.7749	17.5539
440034	1.5309	0.8564	21.1672	22.2478	23.1121	22.1453
440035	1.3525	0.8550	20.4168	21.4990	22.3230	21.4456
440039	1.9419	1.0085	22.4158	25.0874	26.4647	24.7983
440040	0.9438	0.7899	17.6781	16.9886	17.7647	17.4777
440041	0.9622	0.7899	14.6684	15.5784	17.4074	15.9463
440046	1.1662	1.0085	20.5562	22.3380	25.5329	22.6880
440047	0.9132	0.8398	18.7469	18.7962	20.4812	19.3502
440048	1.8360	0.9231	21.6132	23.1553	24.3283	22.8907
440049	1.5491	0.9231	19.6920	21.1930	22.9755	21.3330
440050	1.2838	0.9250	19.7915	21.1397	21.8972	20.9864
440051	0.9770	0.7899	17.7067	19.0165	20.7948	19.1302
440052	0.9884	0.7899	18.6589	18.1935	20.1875	19.0406
440053	1.2491	1.0085	21.5253	22.0345	23.9083	22.5642
440054	1.1210	0.7899	15.2154	15.4208	20.5992	16.7281

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
440056	1.0934	0.8220	20.4902	19.3108	20.4088	20.0592
440057	1.0134	0.7899	14.4363	14.1477	14.6242	14.4056
440058	1.1416	0.9208	20.7722	21.7512	22.6014	21.7216
440059	1.4872	0.9758	20.8882	22.4248	23.9301	22.5028
440060	1.1056	0.8707	20.7627	20.2189	22.7133	21.2566
440061	1.1241	0.7899	16.9234	19.5458	21.2085	19.1926
440063	1.6792	0.8195	18.8072	19.7468	21.8578	20.1214
440064	1.0113	0.9208	18.2678	19.4020	20.9742	19.5551
440065	1.2195	1.0085	19.2282	19.9099	21.4794	20.2516
440067	1.1050	0.8564	18.2973	19.5643	22.1410	20.0664
440068	1.1387	0.9208	19.5428	20.9188	23.1705	21.2887
440070	0.9982	0.7899	18.0065	18.3717	19.0240	18.4723
440072	1.2626	0.8887	20.0692	19.6579	20.9294	20.2371
440073	1.2627	0.9758	19.6290	20.7181	22.2959	20.9196
440078	***	*	17.1646	*	*	17.1646
440081 ^h	1.1252	0.8564	17.2905	18.3141	19.0328	18.2536
440082	2.1528	1.0085	22.5590	26.1497	28.7828	25.7853
440083	0.8872	0.7899	13.7630	15.7015	16.0956	15.2202
440084	1.1957	0.7899	13.8085	15.0510	15.2825	14.7396
440091	1.6703	0.9208	20.1359	23.0296	26.1122	23.0433
440100	***	*	15.9969	*	*	15.9969
440102	1.1187	0.7899	16.0783	16.6548	17.5140	16.7703
440104	1.7660	0.9208	21.7135	21.9870	23.3731	22.4046
440105	0.9786	0.8195	18.1375	19.2902	20.7821	19.4185
440109	0.9976	0.7899	17.6398	17.3578	18.2508	17.7611
440110	1.0384	0.8564	18.4998	19.9715	20.9039	19.8794
440111	1.2877	1.0085	23.2111	24.9883	25.8821	24.7444
440114	0.9957	0.8422	18.5327	20.1152	21.4271	20.0395
440115	0.9634	0.8398	18.7054	18.5389	20.0642	19.1240
440120	1.6053	0.8564	19.8997	22.4031	23.9003	22.1539
440125	1.5806	0.8564	20.0599	21.1018	21.9337	21.0514
440130	1.1599	0.7899	19.0905	20.6363	21.6480	20.4269
440131	1.1976	0.9231	19.9883	21.0640	22.4119	21.1882
440132	1.1909	0.7899	17.9186	18.9580	20.5716	19.2225
440133	1.5991	1.0085	22.2257	23.3600	27.5019	24.3449
440135	1.1136	1.0085	22.5452	23.9749	25.3928	24.0426
440137	1.0382	0.7899	15.3530	16.5529	18.2073	16.7614
440141	0.9502	0.7899	17.6818	19.2607	19.4528	18.8615
440142	0.9890	*	17.1483	17.7587	*	17.4315
440143	1.0380	0.8347	18.6844	19.2978	21.0374	19.6715
440144	1.2279	0.7899	18.8127	19.7938	22.3671	20.3348
440145	0.9567	0.7899	18.3850	18.2019	20.9863	19.1762
440147	***	*	25.3766	25.0780	28.9038	26.3164
440148	1.0872	0.9758	19.3769	20.7693	23.0697	21.1482
440149	1.0174	0.7899	19.8304	18.1316	19.8020	19.2476
440150	1.3336	1.0085	21.2942	22.8733	25.4952	23.2526
440151	1.1207	0.9758	19.8977	21.1576	23.3037	21.4131
440152	1.9622	0.9231	21.7382	22.7498	25.9495	23.4904
440153	1.0786	0.7899	18.1781	19.9486	22.7744	20.3362
440156	1.4514	0.9208	21.9374	23.7799	25.6333	23.8575
440157	***	*	15.5316	*	*	15.5316
440159	1.4839	0.9231	21.4914	20.5719	21.1073	21.0376
440161	1.7809	1.0085	23.6805	26.1354	28.6774	26.2391
440162	***	*	19.8075	20.3909	16.5305	18.7606
440166	1.5383	0.9231	19.6632	23.1692	27.1355	23.2638
440168	0.9458	0.9231	21.1946	21.2113	22.1764	21.5046
440173	1.6321	0.8564	21.0284	20.8442	20.8723	20.9103
440174	0.9083	0.8271	19.3966	19.2201	20.7960	19.8084
440175	1.0406	0.8838	19.9022	22.3331	24.0005	22.1386
440176	1.3118	0.8235	19.8448	20.4861	22.0079	20.8356
440180	1.1374	0.8564	20.2057	21.2398	21.9781	21.1205
440181	0.9359	0.8306	19.0915	19.6133	21.1406	19.9832
440182	0.9034	0.7899	18.1953	19.3928	20.2630	19.3055
440183	1.5311	0.9231	22.2401	24.9282	27.7769	25.1513
440184	0.9961	0.8195	18.6891	21.4484	20.8219	20.2526
440185	1.2166	0.9208	21.1227	22.1845	23.4172	22.3432
440186	1.0406	1.0074	20.8601	23.0193	24.6773	22.8366

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
440187	1.0886	0.7899	18.3730	19.9478	21.7637	20.0131
440189	1.5080	0.8891	22.2555	23.2866	24.7851	23.4729
440192	1.0136	0.9758	19.1977	21.3228	25.1119	21.9712
440193	1.2721	1.0085	19.9078	22.0345	24.3911	22.1757
440194	1.3030	1.0085	21.9609	24.4508	26.2498	24.3097
440197	1.2935	1.0085	22.5282	24.2660	26.4999	24.4607
440200	0.9334	1.0074	18.7301	16.7752	17.0633	17.5400
440203	0.9687	0.7899	16.9819	*	17.7639	17.4648
440210	***	*	12.7622	*	*	12.7622
440217	1.2869	0.9231	19.2834	23.3544	25.9667	22.9440
440218	0.8932	1.0085	*	20.1377	26.3741	23.1475
440220	***	*	*	21.9117	*	21.9117
440222	0.9402	0.9231	*	*	28.3879	28.3879
450002	1.4398	0.9213	21.5141	24.0411	25.4975	23.7614
450004	***	*	15.9452	*	*	15.9452
450005	1.1747	0.8617	16.6354	21.7110	23.4049	20.4575
450007	1.2518	0.9010	18.0269	18.3738	19.2875	18.5831
450008	1.3678	0.9276	19.3745	0.1816	22.0934	20.5757
450010	1.5227	0.8603	19.8998	20.3023	22.4133	20.8466
450011	1.6058	0.9246	20.2963	22.1472	24.1576	22.1560
450014	1.0619	0.8456	19.8845	20.6936	22.5001	21.0077
450015	1.4798	1.0068	22.9820	23.9526	24.0730	23.7009
450016	***	*	19.1522	20.1232	22.1368	20.5103
450018	1.4076	0.9975	21.9921	22.9019	24.6443	23.1862
450020	0.9666	0.9597	18.4643	19.1087	17.7148	18.3747
450021	1.8177	1.0068	23.7663	25.0769	28.5578	25.8179
450023	1.4495	0.8456	19.2808	19.1645	20.9278	19.8132
450024	1.3744	0.9213	19.5584	20.7727	22.4178	20.8622
450028	1.5530	1.0158	19.5905	22.7775	25.6030	22.6061
450029	1.5563	0.8775	19.9505	19.9198	23.9709	21.2865
450031	1.4370	1.0068	29.6772	21.7621	27.0328	25.7450
450032	1.1934	0.8657	20.8525	20.5217	20.8306	20.7391
450033	1.5852	1.0158	21.3765	26.5990	29.0541	25.5917
450034	1.6129	0.8617	19.5233	21.6097	23.4615	21.5599
450035	1.5063	1.0049	20.3146	24.1860	25.4580	23.2683
450037	1.5536	0.8802	19.6532	23.1179	23.1176	21.9845
450039	1.3882	0.9596	20.4660	22.0058	23.3034	21.9244
450040	1.7877	0.8774	24.8621	21.2990	23.8047	23.2129
450042	1.6485	0.8162	20.6041	21.8886	22.6936	21.7552
450044	1.6335	1.0068	23.4476	24.1127	25.8403	24.4770
450046	1.5552	0.8645	20.2917	20.9239	22.0695	21.1294
450047	0.8525	1.0158	15.9525	21.8840	22.7242	19.8728
450050	0.9347	0.8747	19.1390	19.5171	21.6933	20.0180
450051	1.7020	1.0068	23.0010	24.5533	27.2523	25.0048
450052	0.9680	0.8151	20.3702	17.6543	19.7185	19.3316
450053	0.9360	0.7997	19.3347	18.6556	19.4978	19.1905
450054	1.6789	0.9276	25.3285	23.2915	25.1229	24.5396
450055	1.1830	0.7997	16.4789	18.2235	20.5235	18.3296
450056	1.6581	0.9597	22.5341	24.4197	25.6685	24.2958
450058	1.5100	0.9010	20.0424	22.0158	24.7442	22.0807
450059	1.3102	0.9083	21.4873	22.8792	26.8209	23.7097
450063	***	*	15.1780	*	*	15.1780
450064	1.4062	0.9596	21.3929	19.1271	24.2920	21.5383
450065	***	*	23.8471	*	*	23.8471
450068	2.0540	1.0049	22.5626	24.0925	26.2864	24.3345
450072	1.1647	1.0049	20.0134	20.3683	22.5010	20.9458
450073	0.9803	0.8012	23.7700	19.2398	20.0464	21.0839
450078	0.9165	0.7997	13.9324	14.8285	17.2196	15.2045
450079	1.4873	1.0068	22.0609	24.0085	27.0443	24.3554
450080	1.1279	0.8595	19.8414	21.0353	21.2482	20.7306
450081	1.0145	*	19.0276	19.2632	*	19.1505
450082	1.1098	0.7997	18.0688	16.6566	20.9113	18.5395
450083	1.7442	0.9516	20.7446	22.5063	24.9182	22.7494
450085	1.0022	0.7997	17.5001	18.1922	19.4524	18.3451
450087	1.3785	0.9596	23.4141	24.5976	26.4203	24.9041
450090	1.2557	0.7997	15.6090	17.1073	17.6506	16.7782
450092	1.1491	0.7997	17.2058	16.0199	20.4921	17.8070

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
450094	1.1345	1.0068	25.2158	25.8313	25.3618	25.4717
450096	1.4254	0.8617	19.4430	19.8012	22.8722	20.7423
450097	1.4792	1.0049	20.7653	22.2467	24.9380	22.7911
450098	0.9530	0.8595	19.8469	20.4795	22.9005	21.0374
450099	1.1798	0.9177	19.3493	21.4482	24.0293	21.5855
450101	1.5706	0.8162	17.6368	20.1473	20.6575	19.4579
450102	1.6797	0.9516	21.4361	20.9900	23.1773	21.9125
450104	1.1372	0.9010	17.8219	19.7126	22.5165	19.9656
450107	1.4708	0.9213	24.5035	23.2209	23.8770	23.8423
450108	1.1113	0.9010	17.9596	18.8084	19.3561	18.7257
450109	0.9128	*	18.1084	15.1459	*	16.6203
450112	***	*	17.9624	20.2627	22.5552	20.0426
450113	0.9213	0.8192	20.7782	37.8944	*	21.5318
450119	1.3038	0.8603	20.1436	20.8840	24.1392	21.7232
450121	1.5433	0.9596	22.0485	24.6090	25.8826	24.1019
450123	1.1673	0.8617	17.5051	17.8629	19.5872	18.3311
450124	1.7073	0.9597	22.9853	24.2788	26.0280	24.5318
450126	1.2764	1.0049	22.9423	24.1961	27.3021	24.7548
450128	1.2445	0.8603	18.7067	*	21.4190	20.0474
450130	1.2823	0.9010	20.2613	19.6199	20.2777	20.0577
450131	1.1970	0.8645	18.1401	20.0434	23.2317	20.4988
450132	1.5727	0.9797	20.8908	22.4680	26.8476	23.3010
450133	1.5759	0.9507	24.5319	25.3928	25.0972	25.0119
450135	1.6225	0.9596	21.7038	22.5673	24.3858	22.9013
450137	1.5203	0.9596	22.8653	24.9732	27.0081	24.8468
450140	0.8446	*	19.6205	18.3835	22.4695	20.0510
450143	0.9959	0.9597	17.8206	18.4204	19.7487	18.6730
450144	1.0974	0.9495	21.9135	21.3896	20.9599	21.4342
450145	***	*	18.0437	*	*	18.0437
450146	0.9970	*	17.4391	16.6808	*	17.0573
450147	1.3326	0.8456	20.3019	21.7248	24.6203	22.3284
450148	1.1467	0.9499	21.4982	22.1351	23.5037	22.3848
450149	***	*	22.6138	*	*	22.6138
450150	***	*	17.8804	*	*	17.8804
450151	1.1300	0.7997	16.3279	17.9127	20.1356	18.0008
450152	1.1752	0.9276	19.6105	20.0146	21.6351	20.4933
450153	***	*	20.9651	*	*	20.9651
450154	1.3278	0.7997	16.8748	16.5204	18.6058	17.3243
450155	0.9510	0.7997	20.2582	18.4021	17.9306	18.7994
450157	1.0482	*	16.8569	17.8764	17.8812	17.5479
450160	0.9270	0.7997	18.7780	20.7736	21.9118	20.5083
450162	1.2607	0.8774	20.5032	26.0570	31.0645	25.3250
450163	0.9664	0.8131	19.7675	19.8194	20.3280	19.9738
450164	***	*	18.7104	*	*	18.7104
450165	1.0507	0.9000	16.1010	16.1632	20.2414	17.6336
450166	***	*	12.6626	*	*	12.6626
450170	***	*	15.8526	*	*	15.8526
450176	1.2753	0.8603	19.2397	19.1823	20.9392	19.8386
450177	1.1518	0.7997	16.4504	17.2637	19.7657	17.8436
450178	0.9722	0.7997	15.8597	19.1186	20.2992	18.3516
450181	***	*	18.3601	*	*	18.3601
450184	1.4895	1.0049	22.7744	24.0596	25.3935	24.1435
450185	0.9044	*	13.2016	14.3594	15.5838	14.3683
450187	1.1659	1.0049	20.8105	22.6275	24.2400	22.5476
450188	0.9459	0.7997	16.9800	17.6158	18.9586	17.8483
450191	1.1319	0.9597	20.5883	23.2261	25.9078	23.4298
450192	1.0650	1.0068	20.8315	20.7118	22.5118	21.1968
450193	2.0519	1.0049	25.1215	26.6580	29.2751	27.0516
450194	1.3307	1.0068	20.7152	22.7310	22.3348	21.9624
450196	1.4049	1.0068	21.1226	20.1938	23.6170	21.9785
450200	1.4023	0.8440	19.6496	20.4656	22.0923	20.7838
450201	0.9458	0.7997	18.0646	19.5907	20.3350	19.3230
450203	1.1966	0.9499	19.7978	22.9226	23.3953	22.0468
450209	1.8804	0.9177	21.3218	23.4794	24.4977	23.1149
450210	1.0249	0.7997	16.8532	16.7851	19.6340	17.7677
450211	1.3959	1.0049	18.7305	20.0280	20.7982	19.8738
450213	1.7480	0.9010	19.3440	21.1280	21.7930	20.7593

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
450214	1.1932	1.0049	21.3448	22.4543	23.9112	22.5593
450217	***	*	13.1840	*	*	13.1840
450219	0.9768	0.7997	18.5534	21.0691	20.8255	19.8662
450221	1.2212	0.7997	16.2308	19.6778	20.6887	18.8514
450222	1.4712	1.0049	23.2778	23.5033	26.2975	24.4619
450224	1.5284	0.9335	20.1723	20.4453	22.2250	20.9972
450229	1.5939	0.8012	17.0346	17.9811	19.8279	18.2473
450231	1.5330	0.9177	20.7709	21.3086	23.9532	21.9604
450234	1.0254	0.7997	17.9478	22.3954	23.6695	20.9373
450235	0.9371	0.7997	17.0143	18.7028	19.1453	18.1955
450236	1.1034	0.7997	18.4551	17.7373	19.2987	18.4425
450237	1.6870	0.9010	21.6497	22.4477	25.1504	23.0545
450239	0.9376	0.9276	18.8416	19.3655	21.8595	19.9604
450241	0.9592	0.7997	16.6047	17.4151	18.1155	17.3548
450243	0.9491	0.7997	11.2034	13.0790	14.0589	12.7339
450246	***	*	22.7940	*	*	22.7940
450249	0.9828	*	10.6467	13.1222	16.5616	13.2706
450250	0.8234	*	18.3361	13.3731	*	15.7019
450253	1.0239	0.9975	14.5493	16.6523	19.6379	16.7624
450258	1.0230	*	17.0724	*	*	17.0724
450264	0.9227	*	17.2826	13.5345	15.4111	15.1916
450269	1.1027	*	12.2970	12.6907	14.8204	13.1634
450270	0.9028	0.7997	13.8881	13.9053	15.0879	14.2216
450271	1.1475	0.9476	17.9570	18.3659	19.4299	18.6204
450272	1.2350	0.9597	20.5888	21.4520	23.7933	21.9875
450276	0.9026	0.8365	14.0779	12.8895	16.0264	14.3627
450278	***	*	14.3933	*	*	14.3933
450280	1.6007	1.0068	22.2648	23.1664	27.4523	24.3279
450283	1.0896	1.0068	15.8223	17.1013	20.0069	17.8906
450288	0.9655	*	17.4817	*	*	17.4817
450289	1.3090	1.0049	22.4656	23.7108	27.3864	24.5132
450292	1.2543	1.0068	21.1511	23.4257	23.5330	22.6387
450293	0.8968	0.7997	16.4077	17.7673	20.0898	18.1304
450296	1.0956	1.0049	21.5998	20.4483	29.2006	23.4414
450299	1.4996	0.9246	21.2754	22.9849	25.8183	23.3391
450303	0.8093	*	14.3353	16.1330	*	15.1611
450306	0.9725	0.7997	13.6333	17.6821	14.6699	14.8595
450307	***	*	17.6758	*	*	17.6758
450309	***	*	16.0363	*	*	16.0363
450315	0.7527	1.0068	23.8151	26.4677	27.9780	26.0395
450320	***	*	24.8601	26.8089	*	25.9698
450321	***	*	17.2290	*	*	17.2290
450322	***	*	28.9837	*	*	28.9837
450324	1.5052	0.9619	20.9081	23.8523	23.6362	22.8230
450327	0.9476	*	11.0984	14.3848	*	12.5388
450330	1.2447	1.0049	21.0921	22.9947	24.4310	22.8955
450334	***	*	13.9812	*	*	13.9812
450340	1.3890	0.8174	19.2611	20.0621	22.7826	20.7373
450341	***	*	20.8814	*	*	20.8814
450346	1.4005	0.8617	19.2769	20.1921	21.9717	20.5501
450347	1.1293	1.0049	20.1899	21.7142	22.8133	21.6287
450348	1.0155	0.8151	15.0069	15.6324	17.0198	15.8269
450351	1.2311	0.9499	21.2842	22.2597	23.5895	22.4158
450352	1.1032	1.0068	21.2035	21.8138	23.4297	22.1886
450353	1.2431	0.7997	17.3274	19.5263	20.9271	19.2854
450355	***	*	12.8876	*	*	12.8876
450358	2.0251	1.0049	25.5767	25.9105	29.3408	26.8796
450362	0.9872	0.8483	18.7687	20.6340	22.0223	20.5410
450369	0.9642	0.7997	16.0667	16.5636	17.5360	16.6961
450370	1.2664	0.8255	18.7540	19.0340	22.6815	20.0753
450371	***	*	17.7591	17.3415	*	17.5551
450372	1.3414	1.0068	21.4051	22.9079	26.8019	23.5016
450373	0.9150	0.7997	18.5716	17.7955	20.5789	18.8742
450374	0.9476	0.7997	15.0145	15.0670	17.4509	15.9358
450378	1.4945	1.0049	24.4143	25.8048	29.5108	26.7423
450379	1.3263	1.0068	25.1931	29.0865	31.1573	28.5998
450381	0.8997	0.9597	16.7237	19.0584	20.9200	19.1262

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
450388	1.6812	0.9010	20.7989	22.4441	24.1598	22.5213
450389	1.2486	1.0068	19.3156	20.7160	22.3803	20.8835
450393	0.7394	0.9619	21.4405	23.8237	24.6872	23.0294
450395	1.0289	0.8481	17.5236	19.1938	23.9689	20.2490
450399	0.9406	0.7997	16.3333	19.1571	19.5928	18.3623
450400	1.2207	0.8162	19.1345	20.1376	22.0103	20.4970
450403	1.2468	1.0068	24.7656	24.6215	27.8138	25.7251
450411	0.9448	0.7997	15.9165	16.9558	17.6570	16.8391
450417	0.8685	1.0049	15.2713	16.1957	17.8078	16.4591
450418	1.2981	1.0049	22.2511	25.1306	27.0283	24.8277
450419	1.1547	0.9596	22.9522	26.7662	28.4122	25.8839
450422	1.2683	1.0068	28.0395	29.0032	29.5592	28.8846
450424	1.2704	1.0049	20.7634	22.0682	23.1253	22.0479
450431	1.5734	0.9597	22.6766	22.9545	24.7346	23.4876
450438	1.1362	0.8255	21.0474	19.2165	22.0476	20.7899
450446	0.6617	1.0049	13.8011	14.1684	14.9983	14.3810
450447	1.2380	1.0068	19.7532	21.0247	22.5602	21.1150
450451	1.0841	0.9499	18.9518	21.1046	22.3834	20.8182
450460	0.9408	0.7997	15.9446	17.9487	19.5709	17.8777
450462	1.6891	1.0068	22.5413	24.0081	25.6952	24.1223
450464	0.8991	*	15.8120	16.1987	*	16.0151
450465	1.1324	0.8432	19.3927	19.4486	23.0130	20.6020
450467	***	*	18.9388	*	*	18.9388
450469	1.4320	0.9619	22.0389	24.0794	26.6781	24.4855
450473	***	*	18.3814	18.6002	*	18.4883
450475	0.9821	0.8802	19.0010	20.9443	20.7983	20.2431
450484	1.4166	1.0049	19.5505	23.2881	23.0604	21.9994
450488	1.2114	0.8802	22.0927	22.5650	22.3949	22.3502
450489	1.0238	0.7997	17.8778	18.5941	19.6884	18.6822
450497	1.0660	0.7997	15.9654	17.1327	17.6614	16.9069
450498	0.8943	0.7997	15.9479	19.2984	16.4358	17.1305
450508	1.3852	0.9335	19.3274	20.8183	23.5066	21.2786
450514	1.1104	0.8617	20.7064	21.0116	21.4034	21.0848
450517	0.9481	0.7997	17.6011	14.4246	15.2707	15.8340
450518	1.6579	0.8617	20.7355	21.1015	22.2587	21.3748
450523	***	*	23.8270	22.3034	28.6387	24.7751
450530	1.1345	0.9975	21.8988	23.3005	26.1998	23.9178
450534	0.8868	0.9177	19.7411	22.5156	20.4715	20.8041
450535	***	*	21.5449	23.7255	29.4427	24.8048
450537	1.2990	1.0068	20.8849	22.5972	23.9256	22.5688
450539	1.1750	0.7997	19.3681	18.4299	20.0343	19.2836
450544	***	*	22.7282	*	*	22.7282
450545	***	*	21.0792	21.7762	22.8130	21.8739
450547	0.9874	1.0068	20.5049	22.6557	21.8106	21.5951
450551	***	*	16.1437	*	*	16.1437
450558	1.8300	0.8012	21.3116	21.4201	25.0837	22.5736
450563	1.2944	1.0068	21.9935	27.5671	27.9427	25.9404
450565	1.2400	0.7997	17.8058	17.2171	22.1971	18.9318
450571	1.5807	0.8174	19.5325	21.5688	20.9651	20.6563
450573	1.0640	0.7997	17.6157	18.6233	21.6974	19.2261
450574	***	*	14.8549	*	*	14.8549
450575	***	*	24.0386	*	*	24.0386
450578	0.8831	0.7997	17.2864	17.3010	20.0454	18.1424
450580	1.1749	0.7997	17.8225	18.5225	20.4293	18.9338
450583	***	*	15.9429	*	*	15.9429
450584	1.0431	0.7997	14.9237	16.9021	19.0373	16.8758
450586	0.9744	0.7997	14.7433	14.9061	14.6574	14.7690
450587	1.1796	0.7997	18.0014	19.0648	19.9712	19.0147
450591	1.2399	1.0049	18.6714	19.6229	22.4991	20.2798
450596 ^h	1.1136	1.0307	21.9445	24.3714	24.7477	23.6852
450597	0.9409	0.8074	19.0641	19.9596	22.9337	20.7276
450603	0.6645	*	23.4923	20.6138	*	22.1102
450604	1.2989	0.7997	18.7465	19.5288	20.5273	19.6575
450605	1.0608	0.8645	19.7400	22.0210	23.8820	21.8483
450609	0.9630	*	14.1776	16.6870	18.3856	16.4088
450610	1.6657	1.0049	23.5626	24.7706	22.5451	23.6806
450614	***	*	*	18.5895	*	18.5895

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
450615	0.9780	0.7997	15.0622	17.2717	18.2166	16.8506
450617	1.4062	1.0049	21.5004	22.7514	25.2211	23.3012
450620	0.9737	0.7997	16.4330	17.1333	18.1819	17.2486
450623	1.0938	1.0068	25.1122	25.1400	28.3354	26.1673
450626	1.0397	0.8291	20.5225	17.7454	21.4445	19.7342
450628	***	*	20.0411	*	*	20.0411
450630	1.4345	1.0049	23.1839	24.8096	27.8856	25.4113
450631	***	*	21.8940	22.8637	24.5409	23.2078
450632	0.9340	*	15.1416	*	*	15.1416
450634	1.5660	1.0068	23.0470	24.8258	27.0412	25.1506
450638	1.5151	1.0049	23.8335	26.3653	29.5385	26.7076
450639	1.4713	0.9596	23.0496	24.2919	27.3593	24.9656
450641	1.0082	0.7997	15.3652	17.4072	17.0805	16.6319
450643	1.4045	0.8775	18.9087	20.2000	20.9674	20.0693
450644	1.3943	1.0049	24.5834	24.4574	27.2047	25.5189
450646	1.4203	0.9213	23.1240	21.8500	22.6541	22.5274
450647	1.8226	1.0068	25.0549	26.8276	28.8881	26.9827
450648	0.9385	0.9597	14.4884	17.3678	18.2826	16.5630
450649	0.9182	*	16.8505	17.5761	18.1118	17.5193
450651	1.5824	1.0068	25.4679	26.9215	28.9829	27.2344
450653	1.0603	0.9294	20.2436	22.7236	21.8654	21.6446
450654	0.8767	0.7997	15.5858	16.3057	19.6054	17.1762
450656	1.3781	0.9335	18.5874	20.7824	22.7284	20.7254
450658	0.8919	0.7997	19.4139	19.6855	19.9597	19.6879
450659	1.4392	1.0049	22.9344	26.0224	28.8671	26.1618
450661	1.8419	0.9797	19.5504	20.0716	21.5537	20.4105
450662	1.5205	1.0158	20.7973	26.3794	24.5815	23.8635
450665	0.8494	0.7997	14.5158	15.8571	17.2566	15.8982
450668	1.4817	0.9213	21.2002	24.0081	26.4508	23.8861
450669	1.2416	1.0068	22.5150	25.0200	25.6411	24.4545
450670	1.3039	1.0049	19.7696	19.9621	22.0495	20.6739
450672	1.6848	0.9596	23.2623	25.3106	26.7785	25.1345
450673	0.9333	0.8397	14.9115	16.3319	19.4030	16.8314
450674	0.9907	*	21.9624	24.8137	26.8081	24.6823
450675	1.3593	0.9596	23.3954	24.8661	26.1555	24.9243
450677	1.3669	0.9596	21.7366	22.9529	24.0218	22.9672
450678	1.4635	1.0068	25.1841	28.1917	30.1134	27.9547
450683	1.1567	1.0068	22.1965	24.5013	24.0080	23.5689
450684	1.2177	1.0049	22.2380	23.8945	26.2906	24.1786
450686	1.5877	0.8774	17.4746	17.9181	21.0565	18.8784
450688	1.2664	1.0068	21.7691	21.7922	23.7796	22.5071
450690	1.4216	0.9516	27.2400	33.1576	28.7529	29.4196
450694	1.0988	1.0049	18.5520	21.4784	22.3081	20.6353
450697	1.3527	0.9010	19.4424	20.8951	21.2662	20.5334
450698	0.8866	0.7997	16.5111	18.1764	18.5436	17.7240
450700	0.9303	0.7997	14.2055	17.3458	18.6373	16.7946
450702	1.5185	0.8802	19.8094	22.2953	24.8628	22.2909
450704	***	*	18.1835	*	*	18.1835
450705	***	*	18.7139	*	*	18.7139
450706	***	*	22.4329	*	*	22.4329
450709	1.3104	1.0049	22.0123	23.4246	25.0932	23.6034
450711	1.6279	0.8603	20.8047	22.1489	24.8277	22.7192
450712	***	*	11.1086	18.4547	*	14.0322
450713	1.5106	0.9597	23.6189	24.4002	26.7190	25.0030
450715	1.2928	1.0068	24.8068	*	16.1897	19.3291
450716	1.2347	1.0049	20.8913	24.8614	28.8043	24.9291
450717	***	*	22.0243	*	*	22.0243
450718	1.1684	0.9597	23.0051	24.9162	27.6672	25.3843
450723	1.3991	1.0068	22.0633	24.1618	27.0055	24.6219
450724	***	*	23.3800	21.9630	*	22.9078
450727	0.9854	*	24.6125	16.0843	*	20.1195
450728	***	*	14.9265	*	*	14.9265
450730	1.2151	1.0068	24.5952	27.8476	30.7567	27.8690
450733	***	*	21.9921	23.8143	25.5624	23.9940
450742	1.1797	1.0068	22.8135	25.1295	26.3414	24.8619
450743	1.4562	1.0068	20.5017	23.7424	24.7397	23.1028
450746	0.9339	0.7997	14.6684	11.1672	16.9209	13.8671

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
450747	1.2274	1.0068	20.3871	21.5883	24.2674	22.2731
450749	0.9840	0.7997	18.7138	17.8696	18.4095	18.3352
450751	1.2619	0.8440	19.8170	23.3154	22.9070	21.7213
450754	0.9249	0.7997	17.8496	19.2827	21.3043	19.3844
450755	0.9588	0.8774	20.0667	19.2768	19.5168	19.6579
450757	***	*	15.6425	*	*	15.6425
450758	1.4970	1.0068	22.6196	22.8713	24.0226	23.2343
450760	1.2721	0.9213	20.4209	23.2959	25.7453	22.5615
450761	0.8391	0.7997	14.6511	15.5151	16.2605	15.5097
450763	1.0952	0.8233	18.9713	19.8939	21.4171	20.1109
450766	2.0221	1.0068	25.4057	27.2499	28.8576	27.1616
450769	***	*	17.9878	*	*	17.9878
450770	1.1438	0.9597	20.0632	19.9412	20.1763	20.0588
450771	1.7106	1.0068	21.6946	25.0490	26.0618	24.4491
450774	1.7649	1.0049	*	21.7906	24.8562	23.1807
450775	1.2350	1.0049	22.6526	23.6621	25.3924	23.9677
450776	0.9317	*	13.4263	14.6695	*	14.0544
450777	***	*	18.3118	*	*	18.3118
450779	1.2072	0.9596	22.6216	23.8882	22.5857	23.0128
450780	1.9387	0.9010	20.0825	21.9046	22.8688	21.6527
450788	1.5610	0.8645	19.9817	21.4467	24.2643	21.8383
450795	0.9709	1.0049	27.0250	19.1371	28.1448	24.2717
450796	1.3957	0.9177	26.8540	22.4973	24.7564	24.6166
450797	0.6550	1.0049	20.2356	18.6839	23.8708	20.8801
450801	1.5175	0.8440	18.0598	19.7790	22.2426	20.0150
450802	***	*	18.2461	*	*	18.2461
450803	1.2415	1.0049	37.0925	23.8343	26.3054	26.9644
450804	1.7569	1.0049	20.5225	22.8275	26.0003	23.2192
450806	***	*	20.7906	*	*	20.7906
450807	***	*	18.4410	*	*	18.4410
450808	1.6675	0.9597	18.1728	18.6555	22.8247	19.8162
450809	1.5722	0.9597	21.9845	23.8758	24.7763	23.5889
450811	1.8538	0.8603	21.6115	22.7583	23.1022	22.8702
450813	1.1168	0.8192	15.3780	21.7208	22.1326	19.2421
450817	***	*	*	28.4441	*	28.4441
450820	1.2534	1.0049	24.6543	26.9121	27.9187	26.6816
450822	1.1644	1.0068	24.8702	26.7821	29.7067	27.2626
450823	***	*	17.9757	*	*	17.9757
450824	2.1439	0.9597	25.7488	24.5885	*	25.1472
450825	1.6965	0.8603	16.0793	18.8510	18.7069	18.0461
450827	1.4851	0.8397	20.1309	29.5838	21.1788	23.2490
450828	1.2210	0.7997	19.2902	20.9509	21.4128	20.5895
450829	1.5522	0.9010	14.7122	14.4463	18.2860	15.8810
450830	0.9906	0.9495	*	24.7834	26.9917	25.9027
450831	1.3559	1.0049	*	*	20.0581	20.0581
450832	1.1592	1.0049	*	24.8572	26.4725	25.7594
450833	1.1502	1.0068	*	18.3196	26.1256	22.1880
450834	1.3748	0.9246	*	21.7217	22.7691	22.2578
450835	***	*	*	24.8374	*	24.8374
450837	***	*	*	24.2964	*	24.2964
450838	1.0158	0.7997	*	*	15.0454	15.0454
450839	0.9396	0.7997	*	*	21.1905	21.1905
450840	0.9864	1.0068	*	*	29.5215	29.5215
450841	1.5484	1.0158	*	*	17.6635	17.6635
450842	***	*	*	*	23.0945	23.0945
450844	1.2806	1.0049	*	*	34.4235	34.4235
450845	1.8945	0.9213	*	*	26.5040	26.5040
450846	***	*	*	*	24.0791	24.0791
450847	1.2042	1.0049	*	*	26.8892	26.8892
450848	1.1906	1.0049	*	*	26.5609	26.5609
460001	1.8660	0.9584	23.5485	24.8844	25.6932	24.7231
460003	1.5954	0.9564	22.9549	26.5141	24.3527	24.5631
460004	1.5985	0.9360	23.1289	24.3409	25.2191	24.2476
460005	1.4699	0.9360	23.0188	25.0063	22.6809	23.5124
460006	1.3067	0.9564	22.1648	23.4200	24.4350	23.3445
460007	1.3436	0.8576	22.0409	23.3603	24.2875	23.2582
460008	1.2756	0.9564	22.6808	24.8233	24.4453	24.0703

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
460009	1.8803	0.9564	23.1933	24.5865	25.0984	24.3386
460010	2.0773	0.9564	24.0907	25.1240	26.2331	25.1718
460011	1.2751	0.8576	25.3817	21.2634	22.3601	22.7359
460013	1.4494	0.9584	21.2360	23.1467	23.4765	22.6085
460014	1.0525	0.9564	*	22.6125	23.9400	23.3280
460015	1.2621	0.9105	22.4872	23.1068	24.0939	23.2464
460016	1.0550	*	19.0911	18.7453	*	18.9162
460017	1.3177	0.8968	19.0724	20.7789	21.7082	20.4673
460018 ^h	0.8685	1.0777	17.0384	16.7143	18.8942	17.5469
460019	1.1002	0.8576	19.3442	18.1995	20.3625	19.3088
460020	1.0095	0.8576	18.1541	15.2162	19.4960	17.3822
460021	1.4605	1.1193	23.1368	23.8565	24.9725	24.0284
460022	***	*	20.7539	*	*	20.7539
460023	1.2307	0.9584	24.1825	25.0874	25.0376	24.7787
460025	0.7371	*	17.4069	22.3098	18.7978	19.3343
460026	0.9785	0.8576	21.1759	21.9316	22.7589	21.9614
460027	***	*	21.4834	*	*	21.4834
460029	0.9575	*	23.7147	24.4379	*	24.0897
460030	1.2008	0.8576	18.7655	21.2546	22.6129	20.8722
460032	1.0308	*	21.0286	21.2715	22.8987	21.8139
460033	0.9414	0.8576	20.2389	21.7216	22.7816	21.6013
460035	1.0141	0.8576	15.6979	16.9657	16.9019	16.5037
460036	1.1592	0.9584	24.2650	23.9910	25.2647	24.5560
460037	0.9595	0.8576	19.0115	20.0323	19.8478	19.6325
460039	1.0511	0.9360	24.5133	26.3795	27.5912	26.1517
460041	1.3111	0.9360	21.6676	23.5132	24.0431	23.1679
460042	1.3229	0.9360	19.7531	22.0844	23.5819	21.8396
460043	1.3596	0.9584	25.1366	26.0277	26.6870	25.9656
460044	1.1627	0.9564	23.6604	24.7138	25.7342	24.7272
460047	1.6566	0.9564	23.5447	24.9214	25.1721	24.5805
460049	1.9714	0.9564	21.5241	21.9357	23.0683	22.1699
460051	1.1293	0.9564	21.8950	22.7540	23.4970	22.7470
460052	1.4351	0.9584	20.1989	23.1717	24.0797	22.5844
460053	***	*	*	23.2274	*	23.2274
460054	1.8236	0.9105	*	*	23.5227	23.5227
470001	1.2955	0.9931	21.7774	23.5882	24.5499	23.3386
470003	1.8836	1.1574	23.3612	24.1739	24.6660	24.1004
470004	***	*	17.3576	*	*	17.3576
470005	1.3107	0.9487	22.6589	24.9625	25.7288	24.4991
470006	1.1581	0.9487	21.0835	21.6036	26.0884	22.9868
470008	1.2162	0.9487	20.3833	20.7659	21.8951	21.0036
470010	1.1241	0.9487	22.3913	23.2072	22.9777	22.8664
470011	1.2233	1.1235	24.1306	24.6034	25.9246	24.8995
470012	1.2157	0.9998	19.8831	20.5072	22.9159	21.1606
470015	***	*	21.8204	*	*	21.8204
470018	1.1898	0.9774	24.8493	21.2904	25.9300	23.9018
470020	***	*	21.9910	*	*	21.9910
470023	1.2984	0.9605	22.5334	24.1395	26.7486	24.4681
470024	1.1819	0.9487	23.2738	22.4659	23.7745	23.1766
490001	1.0876	0.8883	21.4952	22.3622	21.7111	21.8554
490002	0.9977	0.8276	16.5198	17.5098	18.5220	17.5132
490003	***	*	20.7688	20.9783	23.8112	21.7944
490004	1.2692	0.9931	20.7616	22.7154	24.4580	22.6368
490005	1.6634	1.0895	23.1708	25.2213	27.6425	25.3820
490006	1.1973	1.0008	19.8978	13.4277	16.7679	16.7044
490007	2.1677	0.8928	20.7896	22.2526	24.9533	22.6733
490009	1.9220	1.0292	24.7602	25.2181	27.5905	25.9257
490011	1.4778	0.8928	19.8179	20.0136	22.4410	20.8027
490012	1.0594	0.8276	16.0994	15.8346	18.3697	16.7390
490013	1.2471	0.8883	18.3901	19.5094	21.4838	19.8088
490014	***	*	27.8907	*	*	27.8907
490015	***	*	21.4500	21.2557	22.5641	21.8030
490017	1.4370	0.8928	19.6594	20.7691	22.9632	21.1556
490018	1.2450	0.9931	19.8955	22.0810	23.2215	21.7561
490019 ^h	1.1195	1.2266	21.6789	23.3077	24.4524	23.1884
490020	1.2642	0.9379	20.9212	21.2094	23.6611	21.9411
490021	1.4496	0.9026	21.2263	22.2537	23.5930	22.3427

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
490022	1.4578	1.1026	24.3008	24.4682	25.0277	24.6098
490023	1.2351	1.1026	22.8400	24.9734	28.8354	25.6975
490024	1.7038	0.8660	19.7491	21.2619	21.7268	20.9489
490027	1.0380	0.8276	17.5178	20.3644	19.8345	19.2346
490031	1.0643	0.8276	17.4262	18.4826	22.4300	19.4616
490032	1.8396	0.9379	22.2041	23.6489	22.8942	22.9119
490033	1.0684	1.1026	23.2088	24.4370	27.6355	25.2732
490037	1.1906	0.8276	17.2117	17.5104	19.0583	17.9072
490038	1.1767	0.8298	18.6012	18.1405	19.6427	18.8091
490040	1.4675	1.1026	25.5461	27.0513	30.1820	27.6998
490041	1.3607	0.8928	17.9942	19.9314	22.2955	20.1369
490042	1.2743	0.8276	18.1864	19.5127	20.5845	19.4782
490043	1.1725	1.1026	23.5367	25.4354	28.2969	25.8840
490044	1.4048	0.8928	18.4845	20.8739	22.1324	20.5289
490045	1.2683	1.1026	22.5238	24.7131	27.2132	25.0560
490046	1.5811	0.8928	19.8518	22.0040	24.6391	22.2200
490047	1.0638	1.0895	20.1660	19.8220	21.9156	20.5714
490048	1.4818	0.8472	20.9110	22.3138	24.1639	22.4975
490050	1.4521	1.1026	23.8519	26.1521	29.4660	26.5941
490052	1.6514	0.8928	18.5693	19.2480	21.4035	19.7955
490053	1.2635	0.8362	17.7363	18.6541	20.9367	19.1048
490054	***	*	22.5137	*	*	22.5137
490057	1.5757	0.8928	21.1871	22.1612	25.1898	22.8972
490059	1.5796	0.9379	24.1516	23.3895	26.1518	24.6049
490060	1.0416	0.8276	19.3525	20.6028	21.0828	20.3614
490063	1.8606	1.1026	28.0906	31.0162	29.4216	29.5081
490066	1.3386	0.8928	21.5920	22.1034	23.3835	22.4139
490067	1.2244	0.9379	18.6469	20.4058	21.8730	20.3061
490069	1.5074	0.9379	18.8335	20.6957	24.4542	21.4769
490071	1.3285	0.9379	24.1882	25.4678	27.0374	25.7270
490073	1.5549	1.1026	*	27.6711	25.2859	26.3942
490075	1.4146	0.8660	20.5801	22.3230	22.8303	21.9455
490077	1.2620	1.0292	21.9175	22.2643	24.8309	23.0671
490079	1.3205	0.9288	17.5839	19.2196	19.8100	18.8750
490084	1.2111	0.8443	18.9679	19.8598	22.7945	20.5990
490085	1.1119	*	19.4261	*	*	19.4261
490088	1.0821	0.9026	19.1924	19.7549	21.4818	20.1811
490089	1.0404	0.8472	19.7936	21.1522	21.2123	20.7332
490090	1.1484	0.8276	19.2094	20.3015	21.3410	20.2879
490091	***	*	23.7493	*	*	23.7493
490092	1.1192	0.8928	27.1805	23.8364	21.6466	23.7947
490093	1.3985	0.8928	19.1131	20.7388	23.6779	21.1919
490094	1.0138	0.9379	20.2020	21.9886	26.0755	22.9864
490097	1.0614	0.8276	16.6563	18.1022	23.5366	19.1790
490098	1.2149	0.8276	18.5133	19.7116	20.9805	19.7219
490099	***	*	19.2604	*	*	19.2604
490101	1.2436	1.1026	25.7804	28.5200	30.1800	28.2701
490104	0.8197	0.9379	17.1683	28.0286	33.1215	23.5098
490105	0.6547	0.8298	28.7831	40.6821	38.2813	34.2636
490106	0.8754	0.8276	31.8566	31.6541	30.1492	31.1715
490107	1.2814	1.1026	23.9962	26.5312	28.7296	26.4969
490108	0.9833	0.9026	24.8596	28.7277	27.9090	27.0862
490109	0.9700	0.8928	23.0609	28.0978	28.0548	26.1389
490110	1.2746	0.8358	18.8042	23.6080	21.3126	21.1209
490111	1.2973	0.8276	19.9552	19.4041	20.6373	19.9970
490112	1.6877	0.9379	23.2843	23.6028	25.8312	24.2910
490113	1.3172	1.1026	26.1839	28.0893	29.1786	27.8347
490114	0.9832	0.8276	18.8920	19.9725	20.0555	19.6640
490115	1.1753	0.8276	18.4499	19.9151	20.3615	19.5843
490116	1.1302	0.8276	18.2935	19.7007	21.3083	19.7208
490117	1.1312	0.8276	17.1723	15.6078	17.4111	16.7391
490118	1.6691	0.9379	24.2668	25.2230	26.8810	25.5499
490119	1.3222	0.8928	18.9535	21.3883	23.7813	21.3499
490120	1.4139	0.8928	20.6828	22.2389	23.1535	22.0430
490122	1.4081	1.1026	26.6681	27.3509	28.7020	27.6120
490123	1.0995	0.8276	20.0920	20.9506	22.9511	21.3238
490124	***	*	23.6526	21.3713	29.7939	25.0114

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
490126	1.2896	0.8472	19.0782	20.4660	23.1423	20.8236
490127	1.1285	0.8276	17.6437	17.8070	19.4005	18.3215
490130	1.2545	0.8928	18.6406	18.6038	22.0769	19.7787
490132	0.9895	*	19.1742	19.5849	*	19.3732
500001	1.5796	1.1476	25.3478	26.6420	26.7502	26.2513
500002	1.4138	1.0280	22.9942	24.0374	25.0665	24.0399
500003	1.2861	1.1476	25.1200	27.3435	28.4174	27.0189
500005	1.8278	1.1476	26.2066	28.9512	31.4415	28.8241
500007	1.3562	1.0762	24.7889	23.5774	26.1318	24.8346
500008	1.9577	1.1476	27.2852	28.9380	31.0128	29.1404
500011	1.2910	1.1476	25.7263	27.6762	28.3391	27.2631
500012	1.6692	1.0317	24.5450	26.2263	29.2045	26.7750
500014	1.6639	1.1476	25.0490	27.4248	30.1061	27.6453
500015	1.3430	1.1476	25.9465	27.3397	30.1596	27.8164
500016	1.6894	1.1476	25.1227	27.7863	29.3634	27.4840
500019	1.2341	1.0163	23.5730	25.7691	26.9702	25.5143
500021	1.3271	1.1129	25.9403	26.4648	28.5926	27.0872
500023	1.1391	1.0508	32.3079	23.9513	27.3823	27.4282
500024	1.6774	1.1028	26.2112	27.2967	29.3946	27.6313
500025	1.6616	1.1476	27.3697	29.0400	31.7335	29.3183
500026	1.4508	1.1476	26.6107	28.7532	31.4152	28.8819
500027	1.5638	1.1476	27.7429	30.6901	29.5939	29.3679
500028	0.9873	*	19.0262	*	*	19.0262
500029	***	*	19.3130	*	*	19.3130
500030	1.5062	1.1605	28.5297	29.0487	30.5926	29.4402
500031	1.2102	1.1005	25.8542	26.0740	28.5398	26.8226
500033	1.3141	0.9950	23.8994	25.4345	26.6704	25.3752
500036	1.3890	1.0317	25.1255	25.4753	26.0223	25.5683
500037	1.0673	1.0317	22.1773	23.5414	24.6548	23.4783
500039	1.3809	1.1476	25.4225	26.1409	27.9651	26.5977
500041	1.2860	1.1371	24.7070	24.9004	26.9101	25.5610
500043	***	*	24.1746	*	*	24.1746
500044	1.9499	1.0643	24.7816	27.0880	26.9323	26.3085
500045	***	*	24.6265	*	*	24.6265
500048	***	*	20.6332	*	*	20.6332
500049	1.3569	0.9950	26.5857	26.6407	25.6104	26.2339
500050	1.4327	1.1371	23.0804	25.0907	26.8971	25.0817
500051	1.7605	1.1476	26.7628	26.9538	29.0100	27.6121
500053	1.2915	1.0508	24.2492	26.0112	26.8074	25.7709
500054	2.0600	1.0643	25.7815	27.1965	28.8062	27.2788
500055	1.2108	*	23.7988	25.3095	*	24.5719
500057	1.3154	0.9950	20.5812	21.0357	21.4393	21.0436
500058	1.6345	1.0508	26.5679	27.3411	28.4247	27.4800
500059	1.0800	*	25.3528	*	*	25.3528
500060	1.3409	1.1476	29.6030	31.7480	33.5169	31.6877
500061	***	*	24.5910	*	*	24.5910
500062	0.9638	*	19.1685	*	*	19.1685
500064	1.7368	1.1476	27.5791	29.2539	31.1459	29.3398
500065	1.2243	*	24.0966	26.5880	26.0960	25.5962
500068	***	*	20.9277	*	*	20.9277
500069	***	*	22.4158	*	*	22.4158
500071	1.2536	*	22.3252	23.2071	*	22.7789
500072	1.1624	1.1476	25.7734	27.5706	29.3087	27.5911
500073	***	*	22.5221	*	*	22.5221
500074	1.1522	*	20.6120	21.9019	*	21.2901
500077	1.4682	1.0643	24.5695	26.5692	27.8819	26.4080
500079	1.3471	1.1129	24.7946	27.1775	28.4934	26.8607
500080	***	*	18.8186	*	*	18.8186
500084	1.1869	1.1476	25.0556	26.5864	27.6306	26.5011
500085	***	*	20.7422	*	*	20.7422
500086	1.2794	*	24.2556	25.9705	*	25.1196
500088	1.3552	1.1476	26.4212	30.1689	31.2757	29.2831
500089	***	*	20.3478	*	*	20.3478
500090	***	*	21.7715	*	*	21.7715
500092	1.0307	1.0949	20.3057	20.8601	23.2466	21.5343
500094	***	*	17.6624	*	*	17.6624
500096	***	*	25.1135	*	*	25.1135

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
500097	***	*	21.4424	*	*	21.4424
500098	0.9576	*	17.8453	*	*	17.8453
500101	***	*	19.8615	*	*	19.8615
500102	***	*	23.1306	*	*	23.1306
500104	1.2157	1.1476	24.7875	26.8007	27.0034	26.2068
500106	***	*	17.1066	*	*	17.1066
500107	1.3063	*	17.4641	*	*	17.4641
500108	1.6685	1.1129	26.1609	27.4156	28.7206	27.5253
500110	1.2268	0.9950	23.5940	24.8448	25.4785	24.6519
500118	1.1280	1.1005	24.7875	26.1971	28.1074	26.3776
500119	1.3727	1.0643	23.9939	25.1576	27.2335	25.4960
500122	1.1724	1.1476	24.4462	26.9006	27.4405	26.3044
500123	***	*	21.7133	*	*	21.7133
500124	1.3939	1.1476	24.6591	24.8357	28.6598	26.0871
500125	***	*	15.6304	*	*	15.6304
500129	1.5830	1.1129	25.2082	27.8351	30.0223	27.7387
500132	***	*	21.9915	*	*	21.9915
500134	0.4723	1.1476	15.9791	21.3921	24.2990	19.3507
500139	1.5359	1.1028	23.7993	27.7281	29.2357	26.9617
500141	1.3017	1.1476	28.1014	28.2968	30.7478	29.0880
500143	0.4877	1.1028	18.7523	19.0982	20.7093	19.5721
500147	1.0420	1.1476	*	*	16.3669	16.3669
500148	1.0826	0.9950	*	*	18.2168	18.2168
510001	1.9197	0.8742	20.2514	21.4247	22.9351	21.5933
510002	1.1382	0.8462	19.1516	20.9822	22.4751	20.8575
510005	0.9090	*	13.8641	*	*	13.8641
510006	1.2069	0.8733	19.9760	21.0214	22.2947	21.1209
510007	1.5868	0.9560	22.9326	23.4411	24.3499	23.5775
510008	1.1699	1.0357	19.9176	22.7595	24.5293	22.4939
510012	1.0105	0.7991	15.8596	16.7710	18.5816	17.0389
510013	1.0987	0.7991	18.3486	19.7937	19.9710	19.3746
510015	0.8453	0.8877	17.1595	17.9040	*	17.5225
510018	1.0369	0.8572	18.3023	19.9490	21.8475	19.9638
510020	***	*	15.7513	*	*	15.7513
510022	1.8850	0.8877	21.4336	22.7534	24.1481	22.8162
510023	1.2539	0.8274	17.6516	17.9267	19.4321	18.3486
510024	1.6416	0.8742	19.6521	21.3662	23.3115	21.4774
510026	1.0323	0.7991	14.8785	16.5389	18.0855	16.3991
510027	***	*	20.5222	*	*	20.5222
510028	0.9931	0.8576	22.4826	24.6544	23.0518	23.3477
510029	1.2795	0.8877	18.9000	19.8202	21.7527	20.1940
510030	1.1158	0.7991	19.2558	19.8220	22.3658	20.5065
510031	1.3472	0.8877	19.3049	20.5743	21.6294	20.5646
510033	1.2451	0.8315	19.6900	19.6921	21.0707	20.1607
510035	***	*	21.8290	*	*	21.8290
510036	***	*	15.0266	*	*	15.0266
510038	1.0298	0.7991	15.9821	16.1016	16.8744	16.3342
510039	1.2298	0.8103	17.4002	17.6173	19.1280	18.0494
510043	0.9017	0.7991	14.4202	15.5857	16.0586	15.3708
510046	1.2894	0.8576	18.7424	19.2802	21.2792	19.7476
510047	1.1347	0.8733	21.2885	22.1953	23.2093	22.2288
510048	1.1264	0.9009	15.2886	16.3761	17.6785	16.3570
510050	1.5451	0.8103	18.3964	18.9990	20.1943	19.1823
510053	1.1785	0.7991	18.1046	18.1054	20.7538	19.0352
510055	1.3773	0.9560	25.6333	27.7422	29.3962	27.5818
510058	1.2521	0.8315	18.6025	20.1104	21.9352	20.2417
510059	0.8951	0.8877	17.3845	18.1543	18.8712	18.1655
510061	1.0406	0.8652	14.6773	14.8848	15.3355	14.9619
510062	1.1744	0.7991	19.7202	21.3405	21.1568	20.7558
510067	1.1341	0.7991	17.8816	18.0113	22.1582	19.3232
510068	1.1305	1.1026	19.4299	19.0566	20.0007	19.7893
510070	1.1877	0.8576	18.6226	20.0974	21.1895	19.9485
510071	1.2636	0.8576	18.8766	19.4029	21.5439	19.9719
510072	1.0994	0.7991	16.5279	18.4566	19.7990	18.3003
510077	1.1010	0.7991	20.4521	20.9153	22.8104	21.4077
510080	***	*	19.7132	*	*	19.7132
510081	***	*	10.4972	*	*	10.4972

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
510082	1.0868	0.7991	16.0014	17.2891	16.4742	16.5925
510084	***	*	14.9683	*	*	14.9683
510085	1.1958	0.8877	19.0175	20.6364	22.6563	20.7858
510086	1.1407	0.7991	16.3413	16.3051	17.8234	16.8059
510088	1.0417	0.8132	16.2850	16.4373	18.3401	16.9647
520002	1.2611	1.0101	20.2691	22.0838	23.7316	22.0951
520003	1.2258	0.9507	18.7507	20.4234	21.8662	20.4106
520004	1.3392	0.9507	21.1549	22.8530	24.4711	22.8120
520006	***	*	22.4098	*	*	22.4098
520007	***	*	18.3959	*	*	18.3959
520008	1.6245	1.0081	24.4927	26.0931	27.8127	26.2114
520009	1.7112	0.9507	19.8142	21.5169	23.4265	21.4895
520010	1.1054	1.1044	25.5623	26.3965	28.5569	26.8692
520011	1.1731	0.9507	21.6945	22.7880	23.7785	22.7758
520013	1.3685	0.9507	22.1009	23.1173	24.4766	23.2975
520014	1.0842	1.0346	19.2760	20.4281	22.1064	20.5989
520015	1.1489	0.9507	21.0428	22.8094	23.0403	22.3080
520016	***	*	19.5656	*	*	19.5656
520017	1.1165	0.9507	21.1409	21.7542	23.4044	22.1313
520018	***	*	22.1929	*	*	22.1929
520019	1.3172	0.9507	21.8870	22.6895	24.9871	23.2496
520021	1.4634	1.0709	22.8484	24.1284	25.4872	24.1735
520024	1.0681	0.9507	16.4879	17.5368	18.5072	17.5412
520025	1.1649	*	21.9529	*	*	21.9529
520026	1.0437	1.1044	22.4778	25.0504	26.1056	24.6797
520027	1.3028	1.0081	22.1450	22.2089	26.2516	23.6649
520028	1.2451	1.0216	22.0333	24.3592	25.7778	24.0839
520029	***	*	21.5561	*	*	21.5561
520030	1.7463	1.0101	22.7239	23.9474	25.3807	24.1138
520031	***	*	21.2809	*	*	21.2809
520032	1.1802	1.0301	24.1093	22.7220	25.3059	24.0543
520033	1.2742	0.9507	21.0088	22.2650	23.9791	22.4469
520034	1.1667	0.9507	21.5275	22.6160	23.6563	22.7412
520035	1.2897	0.9584	19.8917	20.8563	23.2625	21.3855
520037	1.7735	1.0101	23.0801	25.0587	28.6984	25.6949
520038	1.2513	1.0081	21.4207	23.1036	24.6650	23.0878
520039	1.0367	*	21.1719	*	*	21.1719
520040	1.4877	1.0081	23.0710	21.5671	23.8501	22.8325
520041	1.1123	1.0301	18.2997	22.6216	22.8236	21.1921
520042	1.0456	0.9625	20.6354	21.9935	24.0788	22.2801
520044	1.3433	0.9584	21.4913	22.7627	24.9387	23.0821
520045	1.4929	0.9507	21.9812	24.1624	24.5844	23.5679
520047	0.9221	*	21.0370	22.5686	25.5346	22.9761
520048	1.5881	0.9507	20.3488	20.5069	23.1653	21.3231
520049	2.1332	0.9578	21.8271	22.7424	24.1083	22.9284
520051	1.7119	1.0081	23.4366	27.6695	28.8249	26.6240
520053	1.0741	*	18.9512	*	*	18.9512
520054	***	*	16.6278	*	*	16.6278
520057	1.1637	0.9625	20.6959	21.2729	23.3205	21.7619
520058	0.9858	*	23.6795	23.2907	*	23.4859
520059	1.2281	0.9954	22.1618	24.1863	26.5596	24.3566
520060	1.2750	0.9507	20.3357	21.1271	22.0132	21.1555
520062	1.2805	1.0081	21.2865	23.7166	24.9988	23.4303
520063	1.1750	1.0081	21.2774	23.3037	25.3674	23.3828
520064	1.5740	1.0081	23.8181	24.3043	27.1120	25.0681
520066	1.5823	1.0216	25.4528	23.9212	25.8812	25.0523
520068	0.8844	0.9507	20.6112	21.4413	23.4746	21.8694
520069	***	*	21.7234	32.6484	*	23.3764
520070	1.7448	0.9507	20.0096	22.0590	23.9908	22.0417
520071	1.2141	0.9954	22.0066	23.4832	26.3154	23.9774
520074	***	*	21.6636	*	*	21.6636
520075	1.5289	0.9578	22.1894	23.7322	26.0600	24.0635
520076	1.2198	1.0216	20.6155	22.2993	24.0879	22.3450
520077	***	*	18.1078	*	*	18.1078
520078	1.4920	1.0081	21.7414	23.4414	25.7662	23.6608
520083	1.7213	1.0346	24.2401	25.7108	27.0012	25.6711
520084	1.0956	1.0301	21.8102	24.7909	25.5777	24.0737

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
520087	1.6511	0.9507	22.2579	22.8974	24.5280	23.2906
520088	1.2383	0.9954	22.3921	23.8938	26.0882	24.1811
520089	1.4841	1.0346	23.2335	24.4435	26.6013	24.7981
520090	***	*	20.9070	*	*	20.9070
520091	1.2775	0.9507	22.2218	22.8914	24.8269	23.2617
520092	1.0770	0.9507	19.7181	21.8662	23.4043	21.6961
520094	0.7086	0.9954	21.3082	22.3925	25.3166	23.0681
520095	1.2460	0.9625	21.9177	25.1402	28.6376	25.2206
520096	1.3954	0.9954	21.6803	21.1759	22.9929	21.9962
520097	1.3744	0.9578	22.2375	23.6512	25.1135	23.7343
520098	2.0588	1.0346	25.0055	25.8184	28.0730	26.3435
520100	1.2846	0.9597	20.5366	21.7072	24.5914	22.3070
520101	***	*	20.0164	*	*	20.0164
520102	1.0935	1.0709	22.3640	23.7739	25.6146	23.9640
520103	1.4569	1.0081	22.2765	23.5984	25.5361	23.8393
520107	1.2042	0.9578	23.8421	25.7379	27.7413	25.7022
520109	1.0887	0.9507	20.3208	20.6357	22.4048	21.1687
520110	***	*	22.3923	*	*	22.3923
520111	***	*	18.2745	26.9666	26.3095	23.4810
520112	1.1223	*	17.6226	19.1409	20.4034	19.0701
520113	1.3241	0.9578	23.1852	24.0822	26.7926	24.7178
520114	1.1317	0.9507	18.5767	21.9847	22.0536	20.8110
520115	***	*	21.4279	*	*	21.4279
520116	1.1277	0.9954	22.2741	23.9066	26.3057	24.2317
520117	1.0221	0.9507	19.3653	21.9915	22.0023	21.1630
520118	***	*	13.9919	*	*	13.9919
520121	***	*	20.9423	*	*	20.9423
520122	***	*	16.9906	*	*	16.9906
520123	0.9823	1.1044	19.8134	21.2360	22.2430	21.0893
520124	***	*	19.2621	*	*	19.2621
520130	1.0399	*	18.8845	20.0277	*	19.4750
520131	***	*	21.0400	*	*	21.0400
520132	1.0670	0.9584	18.2634	19.5140	21.6025	19.7126
520134	1.0387	*	19.6881	20.8502	*	20.2719
520135	0.9254	0.9507	18.1027	18.8254	18.5618	18.4970
520136	1.6033	1.0081	21.3966	23.2573	25.5145	23.3630
520138	1.8924	1.0081	23.1498	25.1434	26.9047	25.1023
520139	1.2475	1.0081	22.8070	23.7727	25.4424	24.0456
520140	1.7057	1.0081	22.5459	23.9176	26.1616	24.1382
520142	***	*	21.4119	*	*	21.4119
520144	***	*	20.5863	*	*	20.5863
520145	***	*	20.3461	25.0770	*	22.1616
520146	***	*	18.6337	*	*	18.6337
520148	1.1618	0.9507	20.5075	22.4299	26.2258	23.1750
520149	***	*	13.8615	*	*	13.8615
520151	0.9872	*	19.3362	20.1995	22.9592	20.8447
520152	1.1196	0.9578	26.2403	22.5440	23.2493	23.6507
520153	***	*	18.5986	*	*	18.5986
520154	1.2433	*	21.0486	23.2635	23.7160	22.6643
520156	1.0496	1.1044	20.7808	23.7157	24.9258	23.1775
520157	***	*	21.6822	*	*	21.6822
520159	***	*	21.8784	*	*	21.8784
520160	1.7496	0.9507	21.5871	22.9475	24.3528	23.0151
520161	0.9823	*	21.4038	22.1857	24.0673	22.5684
520170	1.2952	1.0081	23.0867	25.5470	25.6124	24.7828
520171	***	*	18.1843	*	*	18.1843
520173	1.0997	1.0337	23.2955	24.4723	26.2224	24.6910
520177	1.7587	1.0081	25.0908	27.5560	28.4663	27.1450
520178	0.9998	0.9507	23.1510	22.3193	23.0419	22.8408
520189	1.2190	1.0709	22.0889	23.1658	26.3172	23.9818
520192	***	*	*	22.5641	*	22.5641
530002	1.1371	0.9327	23.0582	23.8852	25.2983	24.1608
530003	***	*	17.1646	*	*	17.1646
530004	***	*	17.4672	19.7857	*	18.6222
530005	***	*	18.4391	*	*	18.4391
530006	1.1205	0.9172	20.7660	21.3429	22.8344	21.7092
530007	1.1220	0.9172	18.5286	22.3309	19.3476	20.0667

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2005; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case mix index	FY 2005 wage index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage** (3 yrs)
530008 ²	1.1989	0.9327	19.5386	21.8714	23.8271	21.6879
530009	0.9343	0.9327	23.5840	22.0450	24.2426	23.1873
530010 ²	1.1996	0.9327	17.8687	21.4890	23.9255	21.1225
530011	1.0775	0.9172	19.9212	22.5720	24.1396	22.2280
530012	1.6312	0.9327	22.5084	22.4716	24.3454	23.1035
530014	1.5379	0.9172	20.0422	21.7314	23.6907	21.9153
530015	1.3519	0.9980	24.6527	25.3915	26.3107	25.4597
530016	1.2753	*	20.3647	21.0666	21.6575	21.0210
530017	0.8948	0.9172	20.9407	19.5630	23.5415	21.2874
530018	1.0564	*	20.1225	*	*	20.1225
530019	0.8190	*	18.1492	*	*	18.1492
530022	1.0845	*	19.7903	*	*	19.7903
530023	1.2331	0.9172	21.6352	22.5535	24.1493	22.9629
530025	1.3127	1.0230	22.4816	25.4693	27.7988	25.3095
530026	1.0519	*	20.9918	21.0732	*	21.0346
530029	1.0001	*	20.3045	19.9691	*	20.1402
530031	0.8719	*	23.2766	16.8825	16.3472	18.9622
530032	***	*	20.9856	19.4449	22.6584	21.0115

¹ Based on salaries adjusted for Occupational Mix, according to the calculation in section III F.

² These hospitals are assigned a wage index value according to sections IV.N.2, IV.N.3, IV.N.4 of the Preamble.

^h These hospitals are assigned a wage index value according to section III.B.3.d of the Preamble.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.

*** Denotes MedPAR data not available for the provider for FY 2003.

13. On page 49424, top of the page, the heading and parenthetical statement "Table 3A₁—FY 2005 and 3-Year Average Hourly Wage for Urban Areas by MSA [*Based on the sum of the

salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]" are corrected by moving these items to the top of page 49425.

14. On pages 49425 through 49433, in Table 3A₁—FY 2005 and 3-Year Average Hourly Wage for Urban Areas by MSA, the table is corrected to read as follows:

TABLE 3A₁.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY MSA

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

MSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
0040	Abilene, TX	21.1577	19.3334
0060	Aguadilla, PR	11.3020	10.8733
0080	Akron, O.H	23.8369	22.9977
0120	Albany, GA	29.7283	27.0834
0160	Albany-Schenectady-Troy, NY	22.6387	21.0359
0200	Albuquerque, NM	27.6443	24.0113
0220	Alexandria, LA	21.5591	19.8744
0240	Allentown-Bethlehem-Easton, PA	25.1946	23.8968
0280	Altoona, PA	22.2816	21.8301
0320	Amarillo, TX	24.1938	22.4289
0380	Anchorage, AK	31.9163	30.3728
0440	Ann Arbor, MI	28.5487	27.2400
0450	Anniston, AL	20.8219	19.8381
0460	Appleton-Oshkosh-Neenah, WI	23.9441	22.3556
0470	Arecibo, PR	9.9028	10.0856
0480	Asheville, NC	25.1099	24.0577
0500	Athens, GA	26.8182	24.9377
0520	Atlanta, GA	26.2565	24.8531
0560	Atlantic-Cape May, NJ	28.7277	27.0377
0580	Auburn-Opelika, AL	21.6724	20.7210
0600	Augusta-Aiken, GA-SC	24.2777	23.9694
0640	Austin-San Marcos, TX	25.3002	23.8713
0680	Bakersfield, CA	26.4960	24.5074
0720	Baltimore, MD	26.0788	24.5965
0733	Bangor, ME	26.1955	24.3676
0743	Barnstable-Yarmouth, MA	32.4977	31.7748

TABLE 3A₁.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY MSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

MSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
0760	Baton Rouge, LA	22.0284	20.6767
0840	Beaumont-Port Arthur, TX	22.7175	21.0039
0860	Bellingham, WA	30.5926	29.4402
0870	Benton Harbor, MI	23.4663	22.1611
0875	Bergen-Passaic, NJ	31.5245	29.5626
0880	Billings, MT	23.6549	22.3049
0920	Biloxi-Gulfport-Pascagoula, MS	22.7701	21.8025
0960	Binghamton, NY	22.3129	20.8466
1000	Birmingham, AL	24.2491	22.8025
1010	Bismarck, ND	19.7863	19.3434
1020	Bloomington, IN	22.6866	21.6323
1040	Bloomington-Normal, IL	24.0155	22.3819
1080	Boise City, ID	24.6185	23.0658
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	29.7504	27.9023
1125	Boulder-Longmont, CO	26.4797	24.7278
1145	Brazoria, TX	22.5003	20.7798
1150	Bremerton, WA	27.9651	26.5977
1240	Brownsville-Harlingen-San Benito, TX	26.7783	24.2568
1260	Bryan-College Station, TX	24.3736	22.3929
1280	Buffalo-Niagara Falls, NY	24.6007	23.3311
1303	Burlington, VT	24.5679	23.9933
1310	Caguas, PR	10.7080	10.3764
1320	Canton-Massillon, OH	23.4839	22.2554
1350	Casper, WY	24.3454	23.1035
1360	Cedar Rapids, IA	23.6287	22.2110
1400	Champaign-Urbana, IL	25.0840	24.7646
1440	Charleston-North Charleston, SC	24.8209	23.1060
1480	Charleston, WV	23.4018	22.0431
1520	Charlotte-Gastonia-Rock Hill, NC-SC	25.4946	24.1708
1540	Charlottesville, VA	27.1314	25.4529
1560	Chattanooga, TN-GA	24.2734	22.5686
1580	Cheyenne, WY	23.6907	21.9153
1600	Chicago, IL	28.5999	27.0745
1620	Chico-Paradise, CA	27.8007	25.2115
1640	Cincinnati, OH-KY-IN	25.2390	23.4336
1660	Clarksville-Hopkinsville, TN-KY	21.0993	20.3461
1680	Cleveland-Lorain-Elyria, OH	25.3602	23.9107
1720	Colorado Springs, CO	25.7592	24.4078
1740	Columbia, MO	22.1116	21.0936
1760	Columbia, SC	24.9367	22.7846
1800	Columbus, GA-AL	22.9123	21.3158
1840	Columbus, OH	25.7052	24.1235
1880	Corpus Christi, TX	22.7911	21.2677
1890	Corvallis, OR	27.7255	27.6280
1900	Cumberland, MD-WV	22.8097	20.3393
1920	Dallas, TX	26.4890	24.8477
1950	Danville, VA	22.8303	21.9455
1960	Davenport-Moline-Rock Island, IA-IL	23.0884	21.8862
2000	Dayton-Springfield, OH	24.3246	23.1419
2020	Daytona Beach, FL	23.4652	22.3396
2030	Decatur, AL	23.4431	21.9912
2040	Decatur, IL	21.4057	20.1127
2080	Denver, CO	28.6809	26.7542
2120	Des Moines, IA	24.4271	22.3772
2160	Detroit, MI	26.9749	25.3863
2180	Dothan, AL	20.1197	19.3968
2190	Dover, DE	26.0092	24.0021
2200	Dubuque, IA	23.0146	21.7876
2240	Duluth-Superior, MN-WI	27.2709	25.4677
2281	Dutchess County, NY	30.7365	27.3957
2290	Eau Claire, WI	24.0833	22.4349
2320	El Paso, TX	24.2877	22.8733
2330	Elkhart-Goshen, IN	24.4045	23.7551
2335	Elmira, NY	22.3121	20.8644
2340	Enid, OK	23.7484	21.4662
2360	Erie, PA	22.9348	21.6611
2400	Eugene-Springfield, OR	28.7913	27.5434
2440	Evansville, Henderson, IN-KY	22.1670	20.6668

TABLE 3A₁.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY MSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

MSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
2520	Fargo-Moorhead, ND-MN	24.0059	23.5687
2560	Fayetteville, NC	24.6836	22.5102
2580	Fayetteville-Springdale-Rogers, AR	22.8204	20.8376
2620	Flagstaff, AZ-UT	27.9534	26.9850
2640	Flint, MI	29.4342	27.3473
2650	Florence, AL	20.8432	19.3533
2655	Florence, SC	23.6803	21.8918
2670	Fort Collins-Loveland, CO	26.8550	25.1003
2680	Fort Lauderdale, FL	26.7655	25.3394
2700	Fort Myers-Cape Coral, FL	24.6180	23.8009
2710	Fort Pierce-Port St. Lucie, FL	26.5014	24.6970
2720	Fort Smith, AR-OK	21.9328	20.3484
2750	Fort Walton Beach, FL	23.1499	22.6357
2760	Fort Wayne, IN	25.6542	23.8045
2800	Fort Worth-Arlington, TX	25.1026	23.4015
2840	Fresno, CA	27.7035	25.5968
2880	Gadsden, AL	21.2931	20.4831
2900	Gainesville, FL	24.9007	23.9505
2920	Galveston-Texas City, TX	24.7476	23.2315
2960	Gary, IN	24.6159	23.3816
2975	Glens Falls, NY	22.3719	20.8059
2980	Goldsboro, NC	23.1349	21.7023
2985	Grand Forks, ND-MN	24.1141	21.9652
2995	Grand Junction, CO	26.1825	24.0316
3000	Grand Rapids-Muskegon-Holland, MI	25.1053	23.5491
3040	Great Falls, MT	23.1697	21.8940
3060	Greeley, CO	24.9410	23.3105
3080	Green Bay, WI	25.2368	23.6194
3120	Greensboro-Winston-Salem-High Point, NC	24.5813	22.9687
3150	Greenville, NC	24.1523	22.5957
3160	Greenville-Spartanburg-Anderson, SC	24.7370	23.0274
3180	Hagerstown, MD	26.3144	23.5483
3200	Hamilton-Middletown, OH	23.8712	22.8398
3240	Harrisburg-Lebanon-Carlisle, PA	24.5148	22.8968
3283	Hartford, CT	29.1831	28.2110
3285	Hattiesburg, MS	19.4268	18.4484
3290	Hickory-Morganton-Lenoir, NC	25.0709	22.9415
3320	Honolulu, HI	29.0314	27.6725
3350	Houma, LA	20.4599	19.7165
3360	Houston, TX	26.6849	24.7044
3400	Huntington-Ashland, WV-KY-OH	25.2028	23.7565
3440	Huntsville, AL	23.2686	22.2984
3480	Indianapolis, IN	26.4492	24.5303
3500	Iowa City, IA	25.4379	23.7870
3520	Jackson, MI	24.0762	22.8010
3560	Jackson, MS	22.1330	20.9460
3580	Jackson, TN	23.4395	22.4155
3600	Jacksonville, FL	25.1835	23.5707
3605	Jacksonville, NC	22.1107	20.7523
3610	Jamestown, NY	20.0214	19.2447
3620	Janesville-Beloit, WI	25.2993	23.7265
3640	Jersey City, NJ	28.8029	27.4044
3660	Johnson City-Kingsport-Bristol, TN-VA	21.6324	20.4165
3680	Johnstown, PA	21.0171	20.1659
3700	Jonesboro, AR	21.6029	19.6779
3710	Joplin, MO	23.0000	21.5147
3720	Kalamazoo-Battlecreek, MI	27.2974	25.9867
3740	Kankakee, IL	27.9907	26.2821
3760	Kansas City, KS-MO	25.3849	24.0397
3800	Kenosha, WI	25.7422	24.0731
3810	Killeen-Temple, TX	24.4535	23.7218
3840	Knoxville, TN	22.4720	21.7145
3850	Kokomo, IN	23.7864	22.3286
3870	La Crosse, WI-MN	24.4482	23.0908
3880	Lafayette, LA	21.3950	20.4768
3920	Lafayette, IN	23.8615	22.5782
3960	Lake Charles, LA	21.0302	19.6387
3980	Lakeland-Winter Haven, FL	23.5755	22.3634

TABLE 3A₁.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY MSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

MSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
4000	Lancaster, PA	26.0887	23.4449
4040	Lansing-East Lansing, MI	25.4480	24.0082
4080	Laredo, TX	23.1326	20.9638
4100	Las Cruces, NM	23.0915	21.6545
4120	Las Vegas, NV-AZ	29.2425	28.2177
4150	Lawrence, KS ¹		
4200	Lawton, OK	21.7459	20.5192
4243	Lewiston-Auburn, ME	25.1817	23.2820
4280	Lexington, KY	24.2477	21.8301
4320	Lima, OH	24.3556	23.3287
4360	Lincoln, NE	26.8365	24.9396
4400	Little Rock-North Little Rock, AR	23.3045	22.1511
4420	Longview-Marshall, TX	23.0485	21.8788
4480	Los Angeles-Long Beach, CA	30.9555	29.3504
4520	Louisville, KY-IN	24.1628	22.9068
4600	Lubbock, TX	23.1298	21.9601
4640	Lynchburg, VA	23.7939	22.5802
4680	Macon, GA	25.3731	22.9224
4720	Madison, WI	27.3895	25.7237
4800	Mansfield, OH	24.0266	22.4554
4840	Mayaguez, PR	12.5604	11.9266
4880	McAllen-Edinburg-Mission, TX	22.6802	21.2147
4890	Medford-Ashland, OR	27.7676	26.3312
4900	Melbourne-Titusville-Palm Bay, FL	25.3742	24.4755
4920	Memphis, TN-AR-MS	24.3569	22.4580
4940	Merced, CA	27.7502	24.8641
5000	Miami, FL	26.0142	24.4497
5015	Middlesex-Somerset-Hunterdon, NJ	29.9549	28.0450
5080	Milwaukee-Waukesha, WI	26.5760	24.7743
5120	Minneapolis-St. Paul, MN-WI	29.1150	27.2497
5140	Missoula, MT	25.2548	22.6510
5160	Mobile, AL	20.9166	19.8422
5170	Modesto, CA	31.6157	28.1277
5190	Monmouth-Ocean, NJ	28.7059	26.8760
5200	Monroe, LA	20.8701	19.8091
5240	Montgomery, AL	21.9110	19.7100
5280	Muncie, IN	22.6545	21.9840
5330	Myrtle Beach, SC	23.7717	22.4723
5345	Naples, FL	27.7634	25.0778
5360	Nashville, TN	26.6158	24.4724
5380	Nassau-Suffolk, NY	34.0823	32.5255
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	32.3508	30.6041
5523	New London-Norwich, CT	30.6511	28.9405
5560	New Orleans, LA	23.9896	22.5670
5600	New York, NY	35.8391	34.6399
5640	Newark, NJ	30.6275	28.4864
5660	Newburgh, NY-PA	29.4487	28.1329
5720	Norfolk-Virginia Beach-Newport News, VA-NC	23.5357	21.6164
5775	Oakland, CA	40.0833	37.4042
5790	Ocala, FL	24.1861	23.3591
5800	Odessa-Midland, TX	25.3896	23.4185
5880	Oklahoma City, OK	23.6423	22.2226
5910	Olympia, WA	29.0127	27.1964
5920	Omaha, NE-IA	25.6762	24.3327
5945	Orange County, CA	30.5827	28.5075
5960	Orlando, FL	25.6522	24.0297
5990	Owensboro, KY	22.2750	20.8090
6015	Panama City, FL	21.4111	20.7660
6020	Parkersburg-Marietta, WV-OH	21.9198	20.2268
6080	Pensacola, FL	21.9439	21.2526
6120	Peoria-Pekin, IL	23.3618	21.7673
6160	Philadelphia, PA-NJ	28.5060	26.7567
6200	Phoenix-Mesa, AZ	26.3231	24.7449
6240	Pine Bluff, AR	22.9350	20.2395
6280	Pittsburgh, PA	23.0498	22.2789
6323	Pittsfield, MA	27.4980	25.5304
6340	Pocatello, ID	25.2803	23.0886
6360	Ponce, PR	13.0621	12.2264

TABLE 3A₁.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY MSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

MSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
6403	Portland, ME	26.6320	24.6820
6440	Portland-Vancouver, OR-WA	29.9778	27.6154
6483	Providence-Warwick, RI	29.1212	27.1720
6520	Provo-Orem, UT	25.2964	24.3959
6560	Pueblo, CO	23.0664	21.7742
6580	Punta Gorda, FL	24.9155	23.3140
6600	Racine, WI	23.8665	22.5320
6640	Raleigh-Durham-Chapel Hill, NC	26.9527	24.9768
6660	Rapid City, SD	23.5131	21.9999
6680	Reading, PA	24.3005	22.8524
6690	Redding, CA	31.1869	28.4468
6720	Reno, NV	27.5394	26.3029
6740	Richland-Kennewick-Pasco, WA	27.7016	26.9438
6760	Richmond-Petersburg, VA	24.7263	23.3140
6780	Riverside-San Bernardino, CA	28.9444	27.8436
6800	Roanoke, VA	22.2568	21.2913
6820	Rochester, MN	30.2905	29.1941
6840	Rochester, NY	24.2491	22.9441
6880	Rockford, IL	25.3273	23.8481
6895	Rocky Mount, NC	23.7190	22.5353
6920	Sacramento, CA	31.1842	29.0605
6960	Saginaw-Bay City-Midland, MI	25.6369	24.2492
6980	St. Cloud, MN	27.0759	24.4151
7000	St. Joseph, MO ¹		
7040	St. Louis, MO-IL	23.9496	22.3011
7080	Salem, OR	27.8099	26.0075
7120	Salinas, CA	36.4327	35.3276
7160	Salt Lake City-Ogden, UT	25.0150	24.2344
7200	San Angelo, TX	21.5498	20.6816
7240	San Antonio, TX	23.7781	22.0040
7320	San Diego, CA	29.6834	27.7274
7360	San Francisco, CA	38.7358	35.8090
7400	San Jose, CA	38.8426	35.9923
7440	San Juan-Bayamon, PR	12.6559	11.9159
7460	San Luis Obispo-Atascadero-Paso Robles, CA	29.3008	27.9344
7480	Santa Barbara-Santa Maria-Lompoc, CA	28.3575	26.1997
7485	Santa Cruz-Watsonville, CA	38.9076	34.1932
7490	Santa Fe, NM	27.8508	26.4038
7500	Santa Rosa, CA	34.1075	32.1396
7510	Sarasota-Bradenton, FL	25.3343	23.9849
7520	Savannah, GA	24.9492	23.4106
7560	Scranton-Wilkes Barre-Hazleton, PA	22.4206	21.0640
7600	Seattle-Bellevue-Everett, WA	30.2189	28.5125
7610	Sharon, PA	20.7690	19.4352
7620	Sheboygan, WI	23.6253	21.7349
7640	Sherman-Denison, TX	25.3572	23.6883
7680	Shreveport-Bossier City, LA	24.0112	22.3569
7720	Sioux City, IA-NE	23.9347	22.3968
7760	Sioux Falls, SD	24.8177	23.1430
7800	South Bend, IN	24.8698	23.9976
7840	Spokane, WA	28.0569	26.7659
7880	Springfield, IL	23.0210	21.7501
7920	Springfield, MO	22.6730	21.1271
8003	Springfield, MA	26.8260	26.1078
8050	State College, PA	22.3162	21.5732
8080	Steubenville-Weirton, OH-WV	21.8130	21.0260
8120	Stockton-Lodi, CA	27.8990	26.0691
8140	Sumter, SC	22.4370	20.6984
8160	Syracuse, NY	24.8091	23.5510
8200	Tacoma, WA	29.1935	27.4023
8240	Tallahassee, FL	22.8581	21.2074
8280	Tampa-St. Petersburg-Clearwater, FL	23.9223	22.4911
8320	Terre Haute, IN	22.6233	21.0317
8360	Texarkana, AR-Texarkana, TX	22.1839	20.3901
8400	Toledo, OH	25.0819	23.6884
8440	Topeka, KS	23.4531	22.4604
8480	Trenton, NJ	27.0688	25.7907
8520	Tucson, AZ	23.5817	22.1299

TABLE 3A₁.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY MSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

MSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
8560	Tulsa, OK	23.0826	21.6558
8600	Tuscaloosa, AL	22.2518	20.4815
8640	Tyler, TX	25.0872	23.5788
8680	Utica-Rome, NY	21.9221	20.7967
8720	Vallejo-Fairfield-Napa, CA	35.6028	33.2856
8735	Ventura, CA	29.2591	27.4874
8750	Victoria, TX	22.2685	20.9146
8760	Vineland-Millville-Bridgeton, NJ	27.8754	25.5794
8780	Visalia-Tulare-Porterville, CA	26.3758	24.1781
8800	Waco, TX	21.4872	20.3295
8840	Washington, DC-MD-VA-WV	28.9176	27.0886
8920	Waterloo-Cedar Falls, IA	22.7478	20.6139
8940	Wausau, WI	25.3807	24.1138
8960	West Palm Beach-Boca Raton, FL	27.2800	25.0185
9000	Wheeling, OH-WV	19.6365	18.6490
9040	Wichita, KS	25.0430	23.3312
9080	Wichita Falls, TX	22.2189	20.8432
9140	Williamsport, PA	22.3438	20.7407
9160	Wilmington-Newark, DE-MD	29.4516	27.4534
9200	Wilmington, NC	24.3196	23.4749
9260	Yakima, WA	27.1993	25.8591
9270	Yolo, CA	24.7035	23.1020
9280	York, PA	24.1275	22.5965
9320	Youngstown-Warren, OH	25.0869	23.2293
9340	Yuba City, CA	27.3673	25.5360
9360	Yuma, AZ	23.5229	21.8802

15. On pages 49434 through 49444, in Hourly Wage for Urban Areas by CBSA,
Table 3A₂—FY 2005 and 3-Year Average the table is corrected to read as follows:

TABLE 3A₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
10180	Abilene, TX	20.7515	18.9928
10380	Aguadilla-Isabela-San Sebastián, PR	11.2674	10.7459
10420	Akron, OH	23.8369	22.9977
10500	Albany, GA	29.7283	26.9191
10580	Albany-Schenectady-Troy, NY	22.8516	21.1392
10740	Albuquerque, NM	27.6443	24.0113
10780	Alexandria, LA	21.5591	19.8744
10900	Allentown-Bethlehem-Easton, PA-NJ	25.0931	23.8171
11020	Altoona, PA	22.2816	21.8301
11100	Amarillo, TX	24.1938	22.4289
11180	Ames, IA	24.9920	23.3897
11260	Anchorage, AK	32.0676	30.6035
11300	Anderson, IN	23.0760	22.0316
11340	Anderson, SC	22.8322	21.2332
11460	Ann Arbor, MI	29.0959	27.7221
11500	Anniston-Oxford, AL	20.8219	19.8381
11540	Appleton, WI	23.9805	22.2548
11700	Asheville, NC	24.2749	23.2076
12020	Athens-Clarke County, GA	26.8182	24.9377
12060	Atlanta-Sandy Springs-Marietta, GA	26.2565	24.8379
12100	Atlantic City, NJ	28.7791	27.1158
12220	Auburn-Opelika, AL	21.6724	20.7210
12260	Augusta-Richmond County, GA-SC	24.1375	23.8386
12420	Austin-Round Rock, TX	25.3002	23.8713
12540	Bakersfield, CA	26.4960	24.5074
12580	Baltimore-Towson, MD	26.0788	24.5965
12620	Bangor, ME	26.1955	24.3676
12700	Barnstable Town, MA	32.4977	31.7748

TABLE 3A₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
12940	Baton Rouge, LA	21.9396	20.6087
12980	Battle Creek, MI	24.6356	23.3675
13020	Bay City, MI	25.2518	24.2327
13140	Beaumont-Port Arthur, TX	22.7175	21.0039
13380	Bellingham, WA	30.5926	29.4402
13460	Bend, OR	27.8385	26.6198
13644	Bethesda-Frederick-Gaithersburg, MD	28.8277	27.1263
13740	Billings, MT	23.6549	22.2825
13780	Binghamton, NY	22.3129	20.8466
13820	Birmingham-Hoover, AL	24.1402	22.6809
13900	Bismarck, ND	19.7863	19.3434
13980	Blacksburg-Christiansburg-Radford, VA	20.9989	20.0257
14020	Bloomington, IN	22.6866	21.5657
14060	Bloomington-Normal, IL	24.0155	22.3819
14260	Boise City-Nampa, ID	24.6185	23.0570
14484	Boston-Quincy, MA	31.0169	29.1519
14500	Boulder, CO	26.4797	24.7278
14540	Bowling Green, KY	21.4624	20.8111
14740	Bremerton-Silverdale, WA	27.9651	26.5977
14860	Bridgeport-Stamford-Norwalk, CT	33.8641	32.2932
15180	Brownsville-Harlingen, TX	26.7783	24.2568
15260	Brunswick, GA	31.5253	25.9559
15380	Buffalo-Niagara Falls, NY	24.6007	23.3311
15500	Burlington, NC	23.6045	22.4345
15540	Burlington-South Burlington, VT	24.5679	23.9933
15764	Cambridge-Newton-Framingham, MA	29.4829	27.2387
15804	Camden, NJ	28.1040	26.6719
15940	Canton-Massillon, OH	23.4839	22.2554
15980	Cape Coral-Fort Myers, FL	24.6180	23.8009
16180	Carson City, NV	27.2484	25.0270
16220	Casper, WY	24.3454	23.1035
16300	Cedar Rapids, IA	23.6287	22.1690
16580	Champaign-Urbana, IL	25.0840	24.4109
16620	Charleston, WV	23.4018	21.9919
16700	Charleston-North Charleston, SC	24.8209	23.1060
16740	Charlotte-Gastonia-Concord, NC-SC	25.5672	24.2580
16820	Charlottesville, VA	27.1314	25.4529
16860	Chattanooga, TN-GA	24.2734	22.5686
16940	Cheyenne, WY	23.6907	21.9153
16974	Chicago-Naperville-Joliet, IL	28.6412	27.1125
17020	Chico, CA	27.8007	25.2115
17140	Cincinnati-Middletown, OH-KY-IN	25.0363	23.3451
17300	Clarksville, TN-KY	21.0993	20.3004
17420	Cleveland, TN	20.7246	19.6917
17460	Cleveland-Elyria-Mentor, OH	25.4231	23.9810
17660	Coeur d'Alene, ID	24.5841	23.4851
17780	College Station-Bryan, TX	24.3736	22.3394
17820	Colorado Springs, CO	25.7592	24.4078
17860	Columbia, MO	22.1116	21.0936
17900	Columbia, SC	24.7855	22.7140
17980	Columbus, GA-AL	22.9123	21.3158
18020	Columbus, IN	24.7455	23.4673
18140	Columbus, OH	25.6619	24.0749
18580	Corpus Christi, TX	22.7911	21.2677
18700	Corvallis, OR	27.7255	27.6280
19060	Cumberland, MD-WV	22.8097	20.3393
19124	Dallas-Plano-Irving, TX	26.5409	24.8971
19140	Dalton, GA	25.1657	23.8067
19180	Danville, IL	22.1540	21.4792
19260	Danville, VA	22.8303	21.9455
19340	Davenport-Moline-Rock Island, IA-IL	23.0884	21.8581
19380	Dayton, OH	24.5133	23.3405
19460	Decatur, AL	23.4431	21.9912
19500	Decatur, IL	21.4057	20.1127
19660	Deltona-Daytona Beach-Ormond Beach, FL	23.4589	22.3163
19740	Denver-Aurora, CO	28.6809	26.7542
19780	Des Moines, IA	24.4271	22.3592
19804	Detroit-Livonia-Dearborn, MI	27.3167	25.8059

TABLE 3A₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
20020	Dothan, AL	19.9600	19.1962
20100	Dover, DE	26.0092	24.0021
20220	Dubuque, IA	23.0146	21.7876
20260	Duluth, MN-WI	27.2299	25.4414
20500	Durham, NC	27.2113	25.6815
20740	Eau Claire, WI	24.0833	22.4349
20764	Edison, NJ	29.3631	27.4877
20940	El Centro, CA	23.5103	22.5130
21060	Elizabethtown, KY	22.9096	20.9578
21140	Elkhart-Goshen, IN	24.4045	23.7551
21300	Elmira, NY	22.3121	20.8644
21340	El Paso, TX	24.2877	22.8733
21500	Erie, PA	22.9348	21.6611
21604	Essex County, MA	28.0863	26.1325
21660	Eugene-Springfield, OR	28.7913	27.5434
21780	Evansville, IN-KY	22.1063	20.5433
21820	Fairbanks, AK	29.3419	28.1074
21940	Fajardo, PR	10.3919	10.2699
22020	Fargo, ND-MN	24.0059	23.5687
22140	Farmington, NM	21.2164	21.8840
22180	Fayetteville, NC	24.6836	22.5102
22220	Fayetteville-Springdale-Rogers, AR-MO	22.8204	20.8376
22380	Flagstaff, AZ	28.4112	27.5032
22420	Flint, MI	29.4342	27.3473
22500	Florence, SC	23.3485	21.6413
22520	Florence-Muscle Shoals, AL	20.8432	19.3533
22540	Fond du Lac, WI	26.0882	23.9005
22660	Fort Collins-Loveland, CO	26.8550	25.1003
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	26.7655	25.3394
22900	Fort Smith, AR-OK	21.8812	20.2565
23020	Fort Walton Beach-Crestview-Destin, FL	23.1499	22.6357
23060	Fort Wayne, IN	25.8397	23.9144
23104	Fort Worth-Arlington, TX	24.9812	23.2966
23420	Fresno, CA	28.0694	25.8965
23460	Gadsden, AL	21.2931	20.4831
23540	Gainesville, FL	24.9007	23.9505
23580	Gainesville, GA	25.2335	23.2102
23844	Gary, IN	24.5332	23.3187
24020	Glens Falls, NY	22.3719	20.8059
24140	Goldsboro, NC	23.1349	21.7023
24220	Grand Forks, ND-MN	24.1141	21.9652
24300	Grand Junction, CO	26.1825	24.0316
24340	Grand Rapids-Wyoming, MI	24.8287	23.3299
24500	Great Falls, MT	23.1697	21.8940
24540	Greeley, CO	24.9410	23.3105
24580	Green Bay, WI	25.2501	23.5467
24660	Greensboro-High Point, NC	24.2763	22.8820
24780	Greenville, NC	24.1523	22.5957
24860	Greenville, SC	25.1285	23.6850
25020	Guayama, PR	10.5663	9.9161
25060	Gulfport-Biloxi, MS	23.5513	22.4957
25180	Hagerstown-Martinsburg, MD-WV	25.6882	23.1481
25260	Hanford-Corcoran, CA	24.5799	21.7472
25420	Harrisburg-Carlisle, PA	24.6595	23.0671
25500	Harrisonburg, VA	24.4580	22.6368
25540	Hartford-West Hartford-East Hartford, CT	29.1831	28.2110
25620	Hattiesburg, MS	19.4268	18.4175
25860	Hickory-Lenoir-Morganton, NC	25.0709	22.9415
25980	Hinesville-Fort Stewart, GA	20.3760	19.3446
26100	Holland-Grand Haven, MI	24.8437	23.6232
26180	Honolulu, HI	29.0314	27.6725
26300	Hot Springs, AR	24.4318	22.4802
26380	Houma-Bayou Cane-Thibodaux, LA	20.4599	19.7165
26420	Houston-Baytown-Sugar Land, TX	26.2968	24.3837
26580	Huntington-Ashland, WV-KY-OH	25.2028	23.7565
26620	Huntsville, AL	23.2686	22.2984
26820	Idaho Falls, ID	16.7951	20.0540
26900	Indianapolis, IN	26.6370	24.6710

TABLE 3A₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
26980	Iowa City, IA	25.4379	23.7408
27060	Ithaca, NY	25.4128	24.2157
27100	Jackson, MI	24.0762	22.8010
27140	Jackson, MS	21.8425	20.7103
27180	Jackson, TN	23.4395	22.4155
27260	Jacksonville, FL	25.1835	23.5707
27340	Jacksonville, NC	22.1107	20.7523
27500	Janesville, WI	25.2993	23.7265
27620	Jefferson City, MO	21.9644	21.2903
27740	Johnson City, TN	21.5178	20.0167
27780	Johnstown, PA	22.0530	21.0775
27860	Jonesboro, AR	21.6029	19.6779
27900	Joplin, MO	23.0000	21.5147
28020	Kalamazoo-Portage, MI	28.1795	26.8885
28100	Kankakee-Bradley, IL	27.9907	26.2821
28140	Kansas City, MO-KS	25.3519	24.0016
28420	Kennewick-Richland-Pasco, WA	27.7016	26.9438
28660	Killeen-Temple-Fort Hood, TX	24.4535	23.7218
28700	Kingsport-Bristol-Bristol, TN-VA	21.7086	20.6905
28740	Kingston, NY	23.7314	22.8254
28940	Knoxville, TN	22.5777	21.8173
29020	Kokomo, IN	23.7864	22.3286
29100	La Crosse, WI-MN	24.4482	23.0908
29140	Lafayette, IN	23.8615	22.6327
29180	Lafayette, LA	21.8776	20.8073
29340	Lake Charles, LA	20.9330	19.5433
29404	Lake County-Kenosha County, IL-WI	27.2795	25.7802
29460	Lakeland, FL	23.5755	22.3634
29540	Lancaster, PA	26.0887	23.4449
29620	Lansing-East Lansing, MI	25.4480	24.0082
29700	Laredo, TX	23.1326	20.9638
29740	Las Cruces, NM	23.0915	21.6545
29820	Las Vegas-Paradise, NV	29.9079	28.9339
29940	Lawrence, KS ¹		
30020	Lawton, OK	21.7459	20.5192
30140	Lebanon, PA	23.0891	21.2658
30300	Lewiston, ID-WA	24.5162	23.4736
30340	Lewiston-Auburn, ME	25.1817	23.2820
30460	Lexington-Fayette, KY	24.6113	22.1104
30620	Lima, OH	24.5429	23.6021
30700	Lincoln, NE	26.8365	24.9150
30780	Little Rock-North Little Rock, AR	23.3045	22.1511
30860	Logan, UT-ID	24.0017	22.9972
30980	Longview, TX	23.2037	21.8928
31020	Longview, WA	26.9101	25.5610
31084	Los Angeles-Long Beach-Glendale, CA	30.9555	29.3504
31140	Louisville, KY-IN	24.0574	22.7968
31180	Lubbock, TX	23.1298	21.9081
31340	Lynchburg, VA	23.7939	22.5802
31420	Macon, GA	26.1577	23.2785
31460	Madera, CA	22.4713	21.5487
31540	Madison, WI	27.1566	25.5029
31700	Manchester-Nashua, NH	28.0313	26.2826
31900	Mansfield, OH	24.2526	22.8104
32420	Mayagüez, PR	11.8420	11.2714
32580	McAllen-Edinburg-Pharr, TX	22.6802	21.2147
32780	Medford, OR	27.7676	26.3312
32820	Memphis, TN-MS-AR	24.3141	22.4194
32900	Merced, CA	27.7502	24.8641
33124	Miami-Miami Beach-Kendall, FL	26.0142	24.4497
33140	Michigan City-La Porte, IN	24.6001	23.6121
33260	Midland, TX	24.7346	24.4654
33340	Milwaukee-Waukesha-West Allis, WI	26.5760	24.7743
33460	Minneapolis-St. Paul-Bloomington, MN-WI	29.1150	27.2497
33540	Missoula, MT	25.2548	22.6510
33660	Mobile, AL	21.0813	19.9442
33700	Modesto, CA	31.6157	28.1277
33740	Monroe, LA	20.8477	19.7670

TABLE 3A₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
33780	Monroe, MI	25.0390	23.6331
33860	Montgomery, AL	21.9110	19.7100
34060	Morgantown, WV	23.0442	21.4291
34100	Morristown, TN	20.5505	19.5797
34580	Mount Vernon-Anacortes, WA	27.8223	26.4352
34620	Muncie, IN	22.6545	21.9840
34740	Muskegon-Norton Shores, MI	25.6860	24.0867
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	23.7717	22.4723
34900	Napa, CA	32.9983	30.3959
34940	Naples-Marco Island, FL	27.7634	25.0778
34980	Nashville-Davidson—Murfreesboro, TN	26.5587	24.3795
35004	Nassau-Suffolk, NY	34.0823	32.5255
35084	Newark-Union, NJ-PA	30.7905	28.6229
35300	New Haven-Milford, CT	31.1880	29.3581
35380	New Orleans-Metairie-Kenner, LA	23.9896	22.5708
35644	New York-Wayne-White Plains, NY-NJ	35.1091	33.8258
35660	Niles-Benton Harbor, MI	23.4663	22.1611
35980	Norwich-New London, CT	30.6511	28.9405
36084	Oakland-Fremont-Hayward, CA	40.0833	37.4042
36100	Ocala, FL	24.1861	23.3591
36140	Ocean City, NJ	28.5241	26.7393
36220	Odessa, TX	25.8284	22.7857
36260	Ogden-Clearfield, UT	24.2908	23.6381
36420	Oklahoma City, OK	23.6865	22.3037
36500	Olympia, WA	29.0127	27.1964
36540	Omaha-Council Bluffs, NE-IA	25.6762	24.2824
36740	Orlando, FL	25.6522	24.0297
36780	Oshkosh-Neenah, WI	23.9064	22.4648
36980	Owensboro, KY	22.2750	20.8090
37100	Oxnard-Thousand Oaks-Ventura, CA	29.2591	27.4874
37340	Palm Bay-Melbourne-Titusville, FL	25.3742	24.4755
37460	Panama City-Lynn Haven, FL	21.4111	20.7660
37620	Parkersburg-Marietta, WV-OH	21.9198	20.2268
37700	Pascagoula, MS	21.0222	20.2797
37860	Pensacola-Ferry Pass-Brent, FL	21.9439	21.2526
37900	Peoria, IL	23.3618	21.7673
37964	Philadelphia, PA	28.6169	26.7879
38060	Phoenix-Mesa-Scottsdale, AZ	26.3231	24.7449
38220	Pine Bluff, AR	22.9350	20.2395
38300	Pittsburgh, PA	22.9969	22.2222
38340	Pittsfield, MA	27.4980	25.5304
38540	Pocatello, ID	25.2803	23.0385
38660	Ponce, PR	13.1981	12.3009
38860	Portland-South Portland-Biddeford, ME	26.6320	24.6820
38900	Portland-Vancouver-Beaverton, OR-WA	29.9778	27.6154
38940	Port St. Lucie-Fort Pierce, FL	26.5014	24.6970
39100	Poughkeepsie-Newburgh-Middletown, NY	29.9576	27.8202
39140	Prescott, AZ	25.5205	23.8026
39300	Providence-New Bedford-Fall River, RI-MA	28.7766	26.9672
39340	Provo-Orem, UT	25.2345	24.3349
39380	Pueblo, CO	23.0664	21.7742
39460	Punta Gorda, FL	24.9155	23.3140
39540	Racine, WI	23.8665	22.5320
39580	Raleigh-Cary, NC	26.4514	23.8622
39660	Rapid City, SD	23.5131	21.9434
39740	Reading, PA	24.3005	22.8524
39820	Redding, CA	31.1869	28.4468
39900	Reno-Sparks, NV	27.5394	26.3029
40060	Richmond, VA	24.7263	23.3140
40140	Riverside-San Bernardino-Ontario, CA	28.9444	27.8436
40220	Roanoke, VA	22.2210	21.2719
40340	Rochester, MN	30.2905	29.1539
40380	Rochester, NY	24.4734	23.1796
40420	Rockford, IL	25.3273	23.8898
40484	Rockingham County-Strafford County, NH	26.9025	25.0930
40580	Rocky Mount, NC	23.7190	22.5353
40660	Rome, GA	23.3830	22.2060
40900	Sacramento—Arden-Arcade—Roseville, CA	30.7939	28.6869

TABLE 3A₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
40980	Saginaw-Saginaw Township North, MI	26.0142	24.2581
41060	St. Cloud, MN	27.0759	24.4151
41100	St. George, UT	24.9725	24.0284
41140	St. Joseph, MO-KS ¹		
41180	St. Louis, MO-IL	23.9366	22.2848
41420	Salem, OR	27.8099	25.9297
41500	Salinas, CA	36.4327	35.3276
41540	Salisbury, MD	24.0196	22.6069
41620	Salt Lake City, UT	25.2133	24.4014
41660	San Angelo, TX	21.5498	20.6816
41700	San Antonio, TX	23.7269	21.9214
41740	San Diego-Carlsbad-San Marcos, CA	29.6834	27.7274
41780	Sandusky, OH	23.7856	22.2413
41884	San Francisco-San Mateo-Redwood City, CA	38.7358	35.8090
41900	San Germán-Cabo Rojo, PR	13.7887	13.3880
41940	San Jose-Sunnyvale-Santa Clara, CA	38.7847	35.9472
41980	San Juan-Caguas-Guaynabo, PR	12.2440	11.6133
42020	San Luis Obispo-Paso Robles, CA	29.3008	27.9344
42044	Santa Ana-Anaheim-Irvine, CA	30.5827	28.5075
42060	Santa Barbara-Santa Maria-Goleta, CA	28.3575	26.1997
42100	Santa Cruz-Watsonville, CA	38.9076	34.1932
42140	Santa Fe, NM	28.6963	27.0266
42220	Santa Rosa-Petaluma, CA	34.1075	32.1396
42260	Sarasota-Bradenton-Venice, FL	25.3343	23.9849
42340	Savannah, GA	24.9492	23.4106
42540	Scranton--Wilkes-Barre, PA	22.4737	21.1694
42644	Seattle-Bellevue-Everett, WA	30.2542	28.5401
43100	Sheboygan, WI	23.6253	21.7349
43300	Sherman-Denison, TX	25.3572	23.6883
43340	Shreveport-Bossier City, LA	24.0680	22.4055
43580	Sioux City, IA-NE-SD	23.8692	22.3369
43620	Sioux Falls, SD	24.8177	23.1241
43780	South Bend-Mishawaka, IN-MI	24.8698	23.9698
43900	Spartanburg, SC	25.0993	22.7045
44060	Spokane, WA	28.0569	26.7659
44100	Springfield, IL	23.0210	21.7501
44140	Springfield, MA	26.8296	26.0807
44180	Springfield, MO	22.5708	21.0960
44220	Springfield, OH	23.0445	21.8275
44300	State College, PA	22.3162	21.5732
44700	Stockton, CA	27.8990	26.0691
44940	Sumter, SC	22.4370	20.6984
45060	Syracuse, NY	24.9975	23.7141
45104	Tacoma, WA	29.1935	27.4023
45220	Tallahassee, FL	22.8581	21.2074
45300	Tampa-St. Petersburg-Clearwater, FL	23.9223	22.4911
45460	Terre Haute, IN	22.4530	20.9222
45500	Texarkana, TX-Texarkana, AR	22.1839	20.3901
45780	Toledo, OH	25.0819	23.6623
45820	Topeka, KS	23.4531	22.4202
45940	Trenton-Ewing, NJ	27.0688	25.7907
46060	Tucson, AZ	23.5817	22.1299
46140	Tulsa, OK	22.9793	21.5440
46220	Tuscaloosa, AL	21.9842	20.2474
46340	Tyler, TX	25.0872	23.5788
46540	Utica-Rome, NY	21.9221	20.7967
46660	Valdosta, GA	21.9706	20.7415
46700	Vallejo-Fairfield, CA	37.6173	35.5959
46940	Vero Beach, FL	25.0220	24.0746
47020	Victoria, TX	22.2922	20.9240
47220	Vineland-Millville-Bridgeton, NJ	27.8754	25.5794
47260	Virginia Beach-Norfolk-Newport News, VA-NC	23.5357	21.6164
47300	Visalia-Porterville, CA	26.3758	24.1781
47380	Waco, TX	21.4872	20.3295
47580	Warner Robins, GA	22.3972	21.5398
47644	Warren-Farmington Hills-Troy, MI	26.6502	24.9390
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	29.0679	27.2078
47940	Waterloo-Cedar Falls, IA	22.7478	20.5447

TABLE 3A₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Urban area	FY 2005 average hourly wage	3-Year average hourly wage
48140	Wausau, WI	25.3807	24.1138
48260	Weirton-Steubenville, WV-OH	21.8130	21.0260
48300	Wenatchee, WA	28.8637	26.6935
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	27.2800	25.0185
48540	Wheeling, WV-OH	19.6365	18.6490
48620	Wichita, KS	24.9692	23.2564
48660	Wichita Falls, TX	22.0520	20.6849
48700	Williamsport, PA	22.3438	20.7407
48864	Wilmington, DE-MD-NJ	29.2489	27.3031
48900	Wilmington, NC	24.3196	23.3958
49020	Winchester, VA-WV	27.6425	25.2798
49180	Winston-Salem, NC	24.8079	22.9742
49340	Worcester, MA	29.0017	27.5814
49420	Yakima, WA	27.1993	25.8591
49500	Yauco, PR	11.8458	11.5366
49620	York-Hanover, PA	24.1275	22.5965
49660	Youngstown-Warren-Boardman, OH-PA	24.3420	22.4728
49700	Yuba City, CA	27.3673	25.5360
49740	Yuma, AZ	23.5229	21.8802

16. On pages 49445 through 49446, in Hourly Wage for Rural Areas by MSA,
Table 3B₁—FY 2005 and 3-Year Average the table is corrected to read as follows:

TABLE 3B₁.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY MSA

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

MSA code	Nonurban area	FY 2005 average hourly wage	3-Year average hourly wage
01	Alabama	20.1828	18.8297
02	Alaska	30.6504	29.5048
03	Arizona	24.1175	22.2145
04	Arkansas	20.3743	19.0511
05	California	27.0539	24.8593
06	Colorado	24.6657	22.7921
07	Connecticut	30.5346	29.2218
08	Delaware	25.0556	23.2847
10	Florida	22.9534	21.7186
11	Georgia	21.7759	20.4853
12	Hawaii	27.8337	25.3986
13	Idaho	23.2509	21.8066
14	Illinois	22.0071	20.4092
15	Indiana	23.0411	21.6547
16	Iowa	22.5463	20.6904
17	Kansas	21.4307	19.7998
18	Kentucky	20.7111	19.7115
19	Louisiana	19.2908	18.4210
20	Maine	23.7968	22.0513
21	Maryland	24.1906	22.5573
22	Massachusetts	26.8798	26.2772
23	Michigan	23.0411	21.9302
24	Minnesota	24.6192	22.8783
25	Mississippi	20.0355	19.0001
26	Missouri	21.1963	19.9057
27	Montana	22.9175	21.2189
28	Nebraska	23.8325	21.1358
29	Nevada	25.9120	24.0635
30	New Hampshire	26.1804	24.5240
31	New Jersey ¹ .....	.....	.....
32	New Mexico	22.4969	21.1857
33	New York	22.1922	21.0285
34	North Carolina	22.4236	21.1612
35	North Dakota	20.4303	19.1062
36	Ohio	23.0905	21.5944
37	Oklahoma	19.9435	18.7148

TABLE 3B₁.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY MSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

MSA code	Nonurban area	FY 2005 average hourly wage	3-Year average hourly wage
38	Oregon	26.4640	24.9475
39	Pennsylvania	22.0021	20.7865
40	Puerto Rico	10.6730	10.2369
41	Rhode Island ¹ .....	.....	.....
42	South Carolina	22.8364	21.3054
43	South Dakota	22.1024	19.9511
44	Tennessee	20.8301	19.5557
45	Texas	20.9376	19.4034
46	Utah	23.3426	22.4148
47	Vermont	24.6639	23.0968
49	Virginia	22.3781	21.0389
50	Washington	26.5290	25.1835
51	West Virginia	21.3518	19.8653
52	Wisconsin	25.0336	23.0266
53	Wyoming	24.1793	22.4538

17. On pages 49446 through 49447, in Hourly Wage for Rural Areas by CBSA,
Table 3B₂—FY 2005 and 3-Year Average the table is corrected to read as follows:

TABLE 3B₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Nonurban area	FY 2005 average hourly wage	3-Year average hourly wage
01	Alabama	20.1577	18.9066
02	Alaska	30.9321	29.6809
03	Arizona	23.9955	22.3189
04	Arkansas	19.5944	18.4393
05	California	27.5494	25.2862
06	Colorado	24.6657	22.7921
07	Connecticut	30.5346	29.2218
08	Delaware	25.0556	23.2847
10	Florida	22.5266	21.2538
11	Georgia	20.4374	19.3617
12	Hawaii	27.8337	25.3986
13	Idaho	22.4747	21.0307
14	Illinois	22.0034	20.3684
15	Indiana	22.8209	21.4486
16	Iowa	22.3507	20.5462
17	Kansas	21.4151	19.7892
18	Kentucky	20.4810	19.4910
19	Louisiana	19.4279	18.5986
20	Maine	23.7968	22.0513
21	Maryland	24.3189	22.5211
22	Massachusetts ¹ .....	.....	.....
23	Michigan	23.1554	22.0537
24	Minnesota	24.5953	22.8418
25	Mississippi	20.1658	19.0953
26	Missouri	21.1133	19.7570
27	Montana	22.9175	21.2310
28	Nebraska	23.8325	21.1480
29	Nevada	24.4792	23.1846
30	New Hampshire	26.1804	24.5240
31	New Jersey ¹ .....	.....	.....
32	New Mexico	22.8943	21.1454
33	New York	21.5274	20.4389
34	North Carolina	22.5935	21.3130
35	North Dakota	20.4303	19.1062
36	Ohio	22.9154	21.4872
37	Oklahoma	20.3290	18.9642
38	Oregon	26.1815	24.6963
39	Pennsylvania	21.9033	20.6829
40	Puerto Rico ¹ .....	.....	.....
41	Rhode Island ¹ .....	.....	.....
42	South Carolina	22.9476	21.3634

TABLE 3B₂.—FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2003, 2004, and 2005]

CBSA code	Nonurban area	FY 2005 average hourly wage	3-Year average hourly wage
43	South Dakota	22.1186	19.9772
44	Tennessee	20.8158	19.5266
45	Texas	21.0808	19.5790
46	Utah	21.8721	20.9987
47	Vermont	24.6639	23.0968
49	Virginia	21.2530	20.1368
50	Washington	25.9340	24.7995
51	West Virginia	20.7798	19.3952
52	Wisconsin	25.0166	23.0125
53	Wyoming	24.1793	22.4538

18. On pages 49448 through 49480, in Urban Areas by MSA, the table is
 Table 4A₁—Wage Index and Capital corrected to read as follows:
 Geographic Adjustment Factor (GAF) for

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA

MSA code	Urban area (constituent counties)	Wage index	GAF
0040	Abilene, TX	0.8026	0.8602
0060	Taylor, TX		
0060	Aguadilla, PR	0.4287	0.5599
0080	Aguada, PR		
0080	Aguadilla, PR		
0080	Moca, PR		
0080	Akron, OH	0.9042	0.9334
0120	Portage, OH		
0120	Summit, OH		
0120	Albany, GA	1.1277	1.0858
0160	Dougherty, GA		
0160	Lee, GA		
0160	Albany-Schenectady-Troy, NY	0.8587	0.9009
0200	Albany, NY		
0200	Montgomery, NY		
0200	Rensselaer, NY		
0200	Saratoga, NY		
0200	Schenectady, NY		
0200	Schoharie, NY		
0200	Albuquerque, NM	1.0486	1.0330
0220	Bernalillo, NM		
0220	Sandoval, NM		
0220	Valencia, NM		
0220	Alexandria, LA	0.8178	0.8713
0240	Rapides, LA		
0240	Allentown-Bethlehem-Easton, PA	0.9557	0.9694
0280	Carbon, PA		
0280	Lehigh, PA		
0280	Northampton, PA		
0280	Altoona, PA	0.8452	0.8912
0320	Blair, PA		
0320	Amarillo, TX, Potter, TX	0.9177	0.9429
0380	Randall, TX		
0380	Anchorage, AK	1.2164	1.1436
0440	Anchorage, AK		
0440	Ann Arbor, MI	1.0829	1.0561
0450	Lenawee, MI		
0450	Livingston, MI		
0450	Washtenaw, MI		
0450	Anniston, AL	0.7949	0.8545
0460	Calhoun, AL		
0460	Appleton-Oshkosh-Neenah, WI ²	0.9496	0.9652
0470	Calumet, WI		
0470	Outagamie, WI		
0470	Winnebago, WI		
0470	Arecibo, PR ²	0.4049	0.5384
0470	Arecibo, PR		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
0480	Camuy, PR Hatillo, PR Asheville, NC Buncombe, NC	0.9525	0.9672
0500	Madison, NC Athens, GA Clarke, GA Madison, GA Oconee, GA	1.0173	1.0118
0520	Atlanta, GA ¹ Barrow, GA Bartow, GA Carroll, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA DeKalb, GA Douglas, GA Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Henry, GA Newton, GA Paulding, GA Pickens, GA Rockdale, GA Spalding, GA Walton, GA	0.9960	0.9973
0560	Atlantic-Cape May, NJ ² Atlantic, NJ Cape May, NJ	1.1788	1.1192
0580	Auburn-Opelika, AL Lee, AL	0.8221	0.8745
0600	Augusta-Aiken, GA-SC Columbia, GA McDuffie, GA Richmond, GA Aiken, SC Edgefield, SC	0.9209	0.9451
0640	Austin-San Marcos, TX ¹ Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9597	0.9722
0680	Bakersfield, CA ² Kern, CA	1.0262	1.0179
0720	Baltimore, MD ¹ Anne Arundel, MD Baltimore, MD Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Anne's, MD	0.9892	0.9926
0733	Bangor, ME Penobscot, ME	0.9937	0.9957
0743	Barnstable-Yarmouth, MA Barnstable, MA	1.2327	1.1540
0760	Baton Rouge, LA Ascension, LA East Baton Rouge, LA Livingston, LA West Baton Rouge, LA	0.8356	0.8843
0840	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8617	0.9031

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
0860	Bellingham, WA	1.1605	1.1073
	Whatcom, WA		
0870	Benton Harbor, MI	0.8901	0.9234
	Berrien, MI		
0875	Bergen-Passaic, NJ ¹	1.2011	1.1337
	Bergen, NJ		
	Passaic, NJ		
0880	Billings, MT	0.8973	0.9285
	Yellowstone, MT		
0920	Biloxi-Gulfport-Pascagoula, MS	0.8637	0.9045
	Hancock, MS		
	Harrison, MS		
	Jackson, MS		
0960	Binghamton, NY	0.8464	0.8921
	Broome, NY		
	Tioga, NY		
1000	Birmingham, AL	0.9198	0.9444
	Blount, AL		
	Jefferson, AL		
	St. Clair, AL		
	Shelby, AL		
1010	Bismarck, ND ²	0.7750	0.8398
	Burleigh, ND		
	Morton, ND		
1020	Bloomington, IN ²	0.8740	0.9119
	Monroe, IN		
1040	Bloomington-Normal, IL	0.9110	0.9382
	McLean, IL		
1080	Boise City, ID	0.9338	0.9542
	Ada, ID		
	Canyon, ID		
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH ¹	1.1285	1.0863
	Bristol, MA		
	Essex, MA		
	Middlesex, MA		
	Norfolk, MA		
	Plymouth, MA		
	Suffolk, MA		
	Worcester, MA		
	Hillsborough, NH		
	Merrimack, NH		
	Rockingham, NH		
	Strafford, NH		
1125	Boulder-Longmont, CO	1.0044	1.0030
	Boulder, CO		
1145	Brazoria, TX	0.8535	0.8972
	Brazoria, TX		
1150	Bremerton, WA	1.0608	1.0412
	Kitsap, WA		
1240	Brownsville-Harlingen-San Benito, TX	1.0158	1.0108
	Cameron, TX		
1260	Bryan-College Station, TX	0.9246	0.9477
	Brazos, TX		
1280	Buffalo-Niagara Falls, NY ¹	0.9332	0.9538
	Erie, NY		
	Niagara, NY		
1303	Burlington, VT ²	0.9487	0.9646
	Chittenden, VT		
	Franklin, VT		
	Grand Isle, VT		
1310	Caguas, PR	0.4062	0.5396
	Caguas, PR		
	Cayey, PR		
	Cidra, PR		
	Gurabo, PR		
	San Lorenzo, PR		
1320	Canton-Massillon, OH	0.8908	0.9239
	Carroll, OH		
	Stark, OH		
1350	Casper, WY	0.9327	0.9534

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
1360	Natrona, WY		
	Cedar Rapids, IA	0.8963	0.9278
	Linn, IA		
1400	Champaign-Urbana, IL	0.9515	0.9665
	Champaign, IL		
1440	Charleston-North Charleston, SC	0.9415	0.9596
	Berkeley, SC		
	Charleston, SC		
	Dorchester, SC		
1480	Charleston, WV	0.8877	0.9217
	Kanawha, WV		
	Putnam, WV		
1520	Charlotte-Gastonia-Rock Hill, NC-SC ¹	0.9671	0.9774
	Cabarrus, NC		
	Gaston, NC		
	Lincoln, NC		
	Mecklenburg, NC		
	Rowan, NC		
	Stanly, NC		
	Union, NC		
	York, SC		
1540	Charlottesville, VA	1.0292	1.0199
	Albemarle, VA		
	Charlottesville City, VA		
	Fluvanna, VA		
	Greene, VA		
1560	Chattanooga, TN-GA	0.9208	0.9451
	Catoosa, GA		
	Dade, GA		
	Walker, GA		
	Hamilton, TN		
	Marion, TN		
1580	Cheyenne, WY ²	0.9172	0.9425
	Laramie, WY		
1600	Chicago, IL ¹	1.0849	1.0574
	Cook, IL		
	DeKalb, IL		
	DuPage, IL		
	Grundy, IL		
	Kane, IL		
	Kendall, IL		
	Lake, IL		
	McHenry, IL		
	Will, IL		
1620	Chico-Paradise, CA	1.0546	1.0371
	Butte, CA		
1640	Cincinnati, OH-KY-IN ¹	0.9574	0.9706
	Dearborn, IN		
	Ohio, IN		
	Boone, KY		
	Campbell, KY		
	Gallatin, KY		
	Grant, KY		
	Kenton, KY		
	Pendleton, KY		
	Brown, OH		
	Clermont, OH		
	Hamilton, OH		
	Warren, OH		
1660	Clarksville-Hopkinsville, TN-KY	0.8109	0.8663
	Christian, KY		
	Montgomery, TN		
1680	Cleveland-Lorain-Elyria, OH ¹	0.9620	0.9738
	Ashtabula, OH		
	Cuyahoga, OH		
	Geauga, OH		
	Lake, OH		
	Lorain, OH		
	Medina, OH		
1720	Colorado Springs, CO	0.9771	0.9843

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
1740	El Paso, CO		
	Columbia, MO	0.8388	0.8866
1760	Boone, MO		
	Columbia, SC	0.9459	0.9626
	Lexington, SC		
	Richland, SC		
1800	Columbus, GA-AL	0.8691	0.9084
	Russell, AL		
	Chattahoochee, GA		
	Harris, GA		
	Muscogee, GA		
1840	Columbus, OH ¹	0.9751	0.9829
	Delaware, OH		
	Fairfield, OH		
	Franklin, OH		
	Licking, OH		
	Madison, OH		
	Pickaway, OH		
1880	Corpus Christi, TX	0.8645	0.9051
	Nueces, TX		
	San Patricio, TX		
1890	Corvallis, OR	1.0534	1.0363
	Benton, OR		
1900	Cumberland, MD-WV (MD Hospitals) ²	0.9176	0.9428
	Allegany, MD		
	Mineral, WV		
1900	Cumberland, MD-WV (WV Hospitals)	0.8652	0.9056
	Allegany, MD		
	Mineral, WV		
1920	Dallas, TX ¹	1.0048	1.0033
	Collin, TX		
	Dallas, TX		
	Denton, TX		
	Ellis, TX		
	Henderson, TX		
	Hunt, TX		
	Kaufman, TX		
	Rockwall, TX		
1950	Danville, VA	0.8660	0.9062
	Danville City, VA		
	Pittsylvania, VA		
1960	Davenport-Moline-Rock Island, IA-IL	0.8758	0.9132
	Scott, IA		
	Henry, IL		
	Rock Island, IL		
2000	Dayton-Springfield, OH	0.9227	0.9464
	Clark, OH		
	Greene, OH		
	Miami, OH		
	Montgomery, OH		
2020	Daytona Beach, FL	0.8901	0.9234
	Flagler, FL		
	Volusia, FL		
2030	Decatur, AL	0.8893	0.9228
	Lawrence, AL		
	Morgan, AL		
2040	Decatur, IL ²	0.8348	0.8837
	Macon, IL		
2080	Denver, CO	1.0879	1.0594
	Adams, CO		
	Arapahoe, CO		
	Broomfield, CO		
	Denver, CO		
	Douglas, CO		
	Jefferson, CO		
2120	Des Moines, IA	0.9266	0.9491
	Dallas, IA		
	Polk, IA		
	Warren, IA		
2160	Detroit, MI ¹	1.0232	1.0158

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
2180	Lapeer, MI Macomb, MI Monroe, MI Oakland, MI St. Clair, MI Wayne, MI Dothan, AL ²	0.7656	0.8328
2190	Dale, AL Houston, AL Dover, DE	0.9866	0.9908
2200	Kent, DE Dubuque, IA	0.8730	0.9112
2240	Dubuque, IA Duluth-Superior, MN-WI	1.0345	1.0235
2281	St. Louis, MN Douglas, WI Dutchess County, NY	1.1659	1.1108
2290	Dutchess, NY Eau Claire, WI ²	0.9496	0.9652
2320	Chippewa, WI Eau Claire, WI El Paso, TX	0.9213	0.9454
2330	El Paso, TX Elkhart-Goshen, IN	0.9257	0.9485
2335	Elkhart, IN Elmira, NY	0.8464	0.8921
2340	Chemung, NY Enid, OK	0.9008	0.9310
2360	Garfield, OK Erie, PA	0.8700	0.9090
2400	Erie, PA Eugene-Springfield, OR	1.0921	1.0622
2440	Lane, OR Evansville-Henderson, IN-KY (IN Hospitals) ²	0.8740	0.9119
2440	Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY Evansville-Henderson, IN-KY (KY Hospitals)	0.8409	0.8881
2520	Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY Fargo-Moorhead, ND-MN (ND Hospitals)	0.9189	0.9437
2520	Clay, MN Cass, ND Fargo-Moorhead, ND-MN (MN Hospitals) ²	0.9339	0.9542
2560	Clay, MN Cass, ND Fayetteville, NC	0.9363	0.9559
2580	Cumberland, NC Fayetteville-Springdale-Rogers, AR	0.8670	0.9069
2620	Benton, AR Washington, AR Flagstaff, AZ-UT	1.0603	1.0409
2640	Coconino, AZ Kane, UT Flint, MI	1.1165	1.0784
2650	Genesee, MI Florence, AL	0.7906	0.8514
2655	Colbert, AL Lauderdale, AL Florence, SC	0.8983	0.9292
2670	Florence, SC Fort Collins-Loveland, CO	1.0230	1.0157
2680	Larimer, CO Ft. Lauderdale, FL ¹	1.0382	1.0260
2700	Broward, FL Fort Myers-Cape Coral, FL	0.9338	0.9542
	Lee, FL		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
2710	Fort Pierce-Port St. Lucie, FL	1.0093	1.0064
	Martin, FL		
	St. Lucie, FL		
2720	Fort Smith, AR-OK	0.8320	0.8817
	Crawford, AR		
	Sebastian, AR		
	Sequoyah, OK		
2750	Fort Walton Beach, FL	0.8781	0.9148
	Okaloosa, FL		
2760	Fort Wayne, IN	0.9731	0.9815
	Adams, IN		
	Allen, IN		
	De Kalb, IN		
	Huntington, IN		
	Wells, IN		
	Whitley, IN		
2800	Forth Worth-Arlington, TX ¹	0.9522	0.9670
	Hood, TX		
	Johnson, TX		
	Parker, TX		
	Tarrant, TX		
2840	Fresno, CA	1.0509	1.0346
	Fresno, CA		
	Madera, CA		
2880	Gadsden, AL	0.8077	0.8639
	Etowah, AL		
2900	Gainesville, FL	0.9446	0.9617
	Alachua, FL		
2920	Galveston-Texas City, TX	0.9387	0.9576
	Galveston, TX		
2960	Gary, IN	0.9337	0.9541
	Lake, IN		
	Porter, IN		
2975	Glens Falls, NY	0.8486	0.8937
	Warren, NY		
	Washington, NY		
2980	Goldsboro, NC	0.8776	0.9145
	Wayne, NC		
2985	Grand Forks, ND-MN (ND Hospitals)	0.9147	0.9408
	Polk, MN		
2985	Grand Forks, ND		
	Grand Forks, ND-MN (MN Hospitals) ²	0.9339	0.9542
	Polk, MN		
	Grand Forks, ND		
2995	Grand Junction, CO	0.9932	0.9953
	Mesa, CO		
3000	Grand Rapids-Muskegon-Holland, MI ¹	0.9523	0.9671
	Allegan, MI		
	Kent, MI		
	Muskegon, MI		
	Ottawa, MI		
3040	Great Falls, MT	0.8831	0.9184
	Cascade, MT		
3060	Greeley, CO	0.9732	0.9816
	Weld, CO		
3080	Green Bay, WI	0.9573	0.9706
	Brown, WI		
3120	Greensboro-Winston-Salem-High Point, NC ¹	0.9324	0.9532
	Alamance, NC		
	Davidson, NC		
	Davie, NC		
	Forsyth, NC		
	Guilford, NC		
	Randolph, NC		
	Stokes, NC		
	Yadkin, NC		
3150	Greenville, NC	0.9179	0.9430
	Pitt, NC		
3160	Greenville-Spartanburg-Anderson, SC	0.9383	0.9573
	Anderson, SC		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
3180	Cherokee, SC Greenville, SC Pickens, SC Spartanburg, SC Hagerstown, MD Washington, MD	0.9982	0.9988
3200	Hamilton-Middletown, OH Butler, OH	0.9126	0.9393
3240	Harrisburg-Lebanon-Carlisle, PA Cumberland, PA Dauphin, PA Lebanon, PA Perry, PA	0.9299	0.9514
3283	Hartford, CT ^{1 2} Hartford, CT Litchfield, CT Middlesex, CT Tolland, CT	1.1583	1.1059
3285	Hattiesburg, MS ² Forrest, MS Lamar, MS	0.7600	0.8287
3290	Hickory-Morganton-Lenoir, NC Alexander, NC Burke, NC Caldwell, NC Catawba, NC	0.9510	0.9662
3320	Honolulu, HI Honolulu, HI	1.1033	1.0696
3350	Houma, LA Lafourche, LA Terrebonne, LA	0.7761	0.8407
3360	Houston, TX ¹ Chambers, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX	1.0122	1.0083
3400	Huntington-Ashland, WV-KY-OH Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	0.9560	0.9697
3440	Huntsville, AL Limestone, AL Madison, AL	0.8826	0.9180
3480	Indianapolis, IN ¹ Boone, IN Hamilton, IN Hancock, IN Hendricks, IN Johnson, IN Madison, IN Marion, IN Morgan, IN Shelby, IN	1.0033	1.0023
3500	Iowa City, IA Johnson, IA	0.9649	0.9758
3520	Jackson, MI Jackson, MI	0.9133	0.9398
3560	Jackson, MS Hinds, MS Madison, MS Rankin, MS	0.8396	0.8872
3580	Jackson, TN Madison, TN Chester, TN	0.8891	0.9227
3600	Jacksonville, FL ¹	0.9553	0.9692

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
3605	Clay, FL Duval, FL Nassau, FL St. Johns, FL Jacksonville, NC ² Onslow, NC	0.8506	0.8951
3610	Jamestown, NY ² Chautauqua, NY	0.8418	0.8888
3620	Janesville-Beloit, WI Rock, WI	0.9597	0.9722
3640	Jersey City, NJ ² Hudson, NJ	1.1788	1.1192
3660	Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals) Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA	0.8206	0.8734
3660	Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals) ² Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA	0.8489	0.8939
3680	Johnstown, PA ² Cambria, PA Somerset, PA	0.8346	0.8835
3700	Jonesboro, AR Craighead, AR	0.8229	0.8750
3710	Joplin, MO Jasper, MO Newton, MO	0.8725	0.9108
3720	Kalamazoo-Battlecreek, MI Calhoun, MI Kalamazoo, MI Van Buren, MI	1.0355	1.0242
3740	Kankakee, IL Kankakee, IL	1.0618	1.0419
3760	Kansas City, KS-MO ¹ Johnson, KS Leavenworth, KS Miami, KS Wyandotte, KS Cass, MO Clay, MO Clinton, MO Jackson, MO Lafayette, MO Platte, MO Ray, MO	0.9629	0.9744
3800	Kenosha, WI	0.9765	0.9838
3810	Kenosha, WI Killeen-Temple, TX Bell, TX Coryell, TX	0.9276	0.9498
3840	Knoxville, TN Anderson, TN Blount, TN Knox, TN Loudon, TN Sevier, TN Union, TN	0.8524	0.8964
3850	Kokomo, IN Howard, IN	0.9023	0.9320

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
3870	Tipton, IN La Crosse, WI-MN ²	0.9496	0.9652
3880	Houston, MN La Crosse, WI Lafayette, LA	0.8116	0.8668
3920	Acadia, LA Lafayette, LA St. Landry, LA St. Martin, LA Lafayette, IN	0.9051	0.9340
3960	Clinton, IN Tippecanoe, IN Lake Charles, LA	0.7977	0.8566
3980	Calcasieu, LA Lakeland-Winter Haven, FL	0.8943	0.8264
4000	Polk, FL Lancaster, PA	0.9896	0.9929
4040	Lancaster, PA Lansing-East Lansing, MI	0.9653	0.9761
4080	Clinton, MI Eaton, MI Ingham, MI Laredo, TX	0.8775	0.9144
4100	Webb, TX Las Cruces, NM	0.8759	0.9133
4120	Dona Ana, NM Las Vegas, NV-AZ ¹	1.1092	1.0736
4150	Mohave, AZ Clark, NV Nye, NV Lawrence, KS ²	0.8129	0.8677
4200	Douglas, KS Lawton, OK	0.8249	0.8765
4243	Comanche, OK Lewiston-Auburn, ME	0.9552	0.9691
4280	Androscoggin, ME Lexington, KY	0.9198	0.9444
4320	Bourbon, KY Clark, KY Fayette, KY Jessamine, KY Madison, KY Scott, KY Woodford, KY Lima, OH	0.9239	0.9472
4360	Allen, OH Auglaize, OH Lincoln, NE	1.0180	1.0123
4400	Lancaster, NE Little Rock-North Little Rock, AR	0.8840	0.9190
4420	Faulkner, AR Lonoke, AR Pulaski, AR Saline, AR Longview-Marshall, TX	0.8743	0.9121
4480	Gregg, TX Harrison, TX Upshur, TX Los Angeles-Long Beach, CA ¹	1.1742	1.1162
4520	Los Angeles, CA Louisville, KY-IN ¹	0.9166	0.9421
4600	Clark, IN Floyd, IN Harrison, IN Scott, IN Bullitt, KY Jefferson, KY Oldham, KY Lubbock, TX	0.8774	0.9143
	Lubbock, TX		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
4640	Lynchburg, VA	0.9026	0.9322
	Amherst, VA		
	Bedford, VA		
	Bedford City, VA		
	Campbell, VA		
	Lynchburg City, VA		
4680	Macon, GA	0.9625	0.9742
	Bibb, GA		
	Houston, GA		
	Jones, GA		
	Peach, GA		
	Twiggs, GA		
4720	Madison, WI	1.0390	1.0265
	Dane, WI		
4800	Mansfield, OH	0.9114	0.9384
	Crawford, OH		
	Richland, OH		
4840	Mayaguez, PR	0.4764	0.6018
	Anasco, PR		
	Cabo Rojo, PR		
	Hormigueros, PR		
	Mayaguez, PR		
	Sabana Grande, PR		
	San German, PR		
4880	McAllen-Edinburg-Mission, TX	0.8603	0.9021
	Hidalgo, TX		
4890	Medford-Ashland, OR	1.0533	1.0362
	Jackson, OR		
4900	Melbourne-Titusville-Palm Bay, FL	0.9625	0.9742
	Brevard, FL		
4920	Memphis, TN-AR-MS ¹	0.9239	0.9472
	Crittenden, AR		
	DeSoto, MS		
	Fayette, TN		
	Shelby, TN		
	Tipton, TN		
4940	Merced, CA	1.0526	1.0357
	Merced, CA		
5000	Miami, FL ¹	0.9870	0.9911
	Dade, FL		
5015	Middlesex-Somerset-Hunterdon, NJ ^{1 2}	1.1788	1.1192
	Hunterdon, NJ		
	Middlesex, NJ		
	Somerset, NJ		
5080	Milwaukee-Waukesha, WI ¹	1.0081	1.0055
	Milwaukee, WI		
	Ozaukee, WI		
	Washington, WI		
	Waukesha, WI		
5120	Minneapolis-St. Paul, MN-WI ¹	1.1044	1.0704
	Anoka, MN		
	Carver, MN		
	Chisago, MN		
	Dakota, MN		
	Hennepin, MN		
	Isanti, MN		
	Ramsey, MN		
	Scott, MN		
	Sherburne, MN		
	Washington, MN		
	Wright, MN		
	Pierce, WI		
	St. Croix, WI		
5140	Missoula, MT	0.9630	0.9745
	Missoula, MT		
5160	Mobile, AL	0.7934	0.8534
	Baldwin, AL		
	Mobile, AL		
5170	Modesto, CA	1.1993	1.1325
	Stanislaus, CA		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
5190	Monmouth-Ocean, NJ ^{1 2}	1.1788	1.1192
	Monmouth, NJ		
	Ocean, NJ		
5200	Monroe, LA	0.7917	0.8522
	Ouachita, LA		
5240	Montgomery, AL	0.8311	0.8810
	Autauga, AL		
	Elmore, AL		
	Montgomery, AL		
5280	Muncie, IN ²	0.8740	0.9119
	Delaware, IN		
5330	Myrtle Beach, SC	0.9017	0.9316
	Horry, SC		
5345	Naples, FL	1.0531	1.0361
	Collier, FL		
5360	Nashville, TN ¹	1.0096	1.0066
	Cheatham, TN		
	Davidson, TN		
	Dickson, TN		
	Robertson, TN		
	Rutherford TN		
	Sumner, TN		
	Williamson, TN		
	Wilson, TN		
5380	Nassau-Suffolk, NY ¹	1.2928	1.1923
	Nassau, NY		
	Suffolk, NY		
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT ¹	1.2272	1.1505
	Fairfield, CT		
	New Haven, CT		
5523	New London-Norwich, CT	1.1627	1.1087
	New London, CT		
5560	New Orleans, LA ¹	0.9100	0.9375
	Jefferson, LA		
	Orleans, LA		
	Plaquemines, LA		
	St. Bernard, LA		
	St. Charles, LA		
	St. James, LA		
	St. John The Baptist, LA		
	St. Tammany, LA		
5600	New York, NY ¹	1.3595	1.2341
	Bronx, NY		
	Kings, NY		
	New York, NY		
	Putnam, NY		
	Queens, NY		
	Richmond, NY		
	Rockland, NY		
	Westchester, NY		
5640	Newark, NJ ^{1 2}	1.1788	1.1192
	Essex, NJ		
	Morris, NJ		
	Sussex, NJ		
	Union, NJ		
	Warren, NJ		
5660	Newburgh, NY-PA	1.1171	1.0788
	Orange, NY		
	Pike, PA		
5720	Norfolk-Virginia Beach-Newport News, VA-NC ¹	0.8928	0.9253
	Currituck, NC		
	Chesapeake City, VA		
	Gloucester, VA		
	Hampton City, VA		
	Isle of Wight, VA		
	James City, VA		
	Mathews, VA		
	Newport News City, VA		
	Norfolk City, VA		
	Poquoson City, VA		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
	Portsmouth City, VA Suffolk City, VA Virginia Beach City VA Williamsburg City, VA York, VA		
5775	Oakland, CA ¹	1.5338	1.3403
	Alameda, CA Contra Costa, CA		
5790	Ocala, FL	0.9174	0.9427
	Marion, FL		
5800	Odessa-Midland, TX	0.9631	0.9746
	Ector, TX Midland, TX		
5880	Oklahoma City, OK ¹	0.8968	0.9281
	Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK		
5910	Olympia, WA	1.1005	1.0678
	Thurston, WA		
5920	Omaha, NE-IA	0.9740	0.9821
	Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE		
5945	Orange County, CA ¹	1.1701	1.1136
	Orange, CA		
5960	Orlando, FL ¹	0.9731	0.9815
	Lake, FL Orange, FL Osceola, FL Seminole, FL		
5990	Owensboro, KY	0.8450	0.8911
	Daviess, KY		
6015	Panama City, FL ²	0.8707	0.9095
	Bay, FL		
6020	Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8315	0.8813
	Washington, OH Wood, WV		
6020	Parkersburg-Marietta, WV-OH (OH Hospitals) ²	0.8759	0.9133
	Washington, OH Wood, WV		
6080	Pensacola, FL ²	0.8707	0.9095
	Escambia, FL Santa Rosa, FL		
6120	Peoria-Pekin, IL	0.8913	0.9242
	Peoria, IL Tazewell, IL Woodford, IL		
6160	Philadelphia, PA-NJ (PA Hospitals) ¹	1.0813	1.0550
	Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA		
6160	Philadelphia, PA-NJ (NJ Hospitals) ^{1 2}	1.1788	1.1192
	Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
6200	Montgomery, PA Philadelphia, PA Phoenix-Mesa, AZ ¹ Maricopa, AZ Pinal, AZ	0.9985	0.9990
6240	Pine Bluff, AR	0.8700	0.9090
6280	Jefferson, AR Pittsburgh, PA ¹ Allegheny, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	0.8743	0.9121
6323	Pittsfield, MA Berkshire, MA	1.0431	1.0293
6340	Pocatello, ID Bannock, ID	0.9589	0.9717
6360	Ponce, PR Guayanilla, PR Juana Diaz, PR Penuelas, PR Ponce, PR Villalba, PR Yauco, PR	0.4955	0.6183
6403	Portland, ME Cumberland, ME Sagadahoc, ME York, ME	1.0102	1.0070
6440	Portland-Vancouver, OR-WA ¹ Clackamas, OR Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Clark, WA	1.1371	1.0920
6483	Providence-Warwick-Pawtucket, RI ¹ Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	1.1046	1.0705
6520	Provo-Orem, UT	0.9596	0.9722
6560	Utah, UT Pueblo, CO ² Pueblo, CO	0.9356	0.9554
6580	Punta Gorda, FL Charlotte, FL	0.9451	0.9621
6600	Racine, WI ² Racine, WI	0.9496	0.9652
6640	Raleigh-Durham-Chapel Hill, NC ¹ Chatham, NC Durham, NC Franklin, NC Johnston, NC Orange, NC Wake, NC	1.0224	1.0153
6660	Rapid City, SD Pennington, SD	0.8919	0.9246
6680	Reading, PA Berks, PA	0.9218	0.9458
6690	Redding, CA Shasta, CA	1.1830	1.1220
6720	Reno, NV Washoe, NV	1.0446	1.0303
6740	Richland-Kennewick-Pasco, WA Benton, WA Franklin, WA	1.0508	1.0345
6760	Richmond-Petersburg, VA Charles City County, VA	0.9379	0.9570

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
6780	Chesterfield, VA Colonial Heights City, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA Hopewell City, VA New Kent, VA Petersburg City, VA Powhatan, VA Prince George, VA Richmond City, VA Riverside-San Bernardino, CA ¹	1.0979	1.0660
6800	Riverside, CA San Bernardino, CA Roanoke, VA ² Botetourt, VA Roanoke, VA Roanoke City, VA Salem City, VA	0.8489	0.8939
6820	Rochester, MN	1.1490	1.0998
6840	Olmsted, MN Rochester, NY ¹ Genesee, NY Livingston, NY Monroe, NY Ontario, NY Orleans, NY Wayne, NY	0.9198	0.9444
6880	Rockford, IL Boone, IL Ogle, IL Winnebago, IL	0.9607	0.9729
6895	Rocky Mount, NC Edgecombe, NC Nash, NC	0.8997	0.9302
6920	Sacramento, CA ¹ El Dorado, CA Placer, CA Sacramento, CA	1.1829	1.1219
6960	Saginaw-Bay City-Midland, MI Bay, MI Midland, MI Saginaw, MI	0.9725	0.9811
6980	St. Cloud, MN Benton, MN Stearns, MN	1.0271	1.0185
7000	St. Joseph, MO ² Andrew, MO Buchanan, MO	0.8041	0.8613
7040	St. Louis, MO-IL ¹ Clinton, IL Jersey, IL Madison, IL Monroe, IL St. Clair, IL Franklin, MO Jefferson, MO Lincoln, MO St. Charles, MO St. Louis, MO St. Louis City, MO Warren, MO	0.9085	0.9364
7080	Salem, OR Marion, OR Polk, OR	1.0549	1.0373
7120	Salinas, CA	1.3820	1.2480
7160	Monterey, CA Salt Lake City-Ogden, UT ¹ Davis, UT	0.9491	0.9649

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
7200	Salt Lake, UT Weber, UT San Angelo, TX	0.8174	0.8710
7240	Tom Green, TX San Antonio, TX ¹ Bexar, TX Comal, TX Guadalupe, TX Wilson, TX	0.9020	0.9318
7320	San Diego, CA ¹ San Diego, CA	1.1260	1.0847
7360	San Francisco, CA ¹ Marin, CA San Francisco, CA San Mateo, CA San Jose, CA ¹	1.4694	1.3015
7400	Santa Clara, CA	1.4734	1.3040
7440	San Juan-Bayamon, PR ¹ Aguas Buenas, PR Barceloneta, PR Bayamon, PR Canovanas, PR Carolina, PR Catano, PR Ceiba, PR Comerio, PR Corozal, PR Dorado, PR Fajardo, PR Florida, PR Guaynabo, PR Humacao, PR Juncos, PR Los Piedras, PR Loiza, PR Luguillo, PR Manati, PR Morovis, PR Naguabo, PR Naranjito, PR Rio Grande, PR San Juan, PR Toa Alta, PR Toa Baja, PR Trujillo Alto, PR Vega Alta, PR Vega Baja, PR Yabucoa, PR	0.4801	0.6050
7460	San Luis Obispo-Atascadero-Paso Robles, CA	1.1115	1.0751
7480	San Luis Obispo, CA Santa Barbara-Santa Maria-Lompoc, CA	1.0757	1.0512
7485	Santa Barbara, CA Santa Cruz-Watsonville, CA	1.4759	1.3055
7490	Santa Cruz, CA Santa Fe, NM Los Alamos, NM	1.0565	1.0384
7500	Santa Fe, NM Santa Rosa, CA	1.2938	1.1929
7510	Sonoma, CA Sarasota-Bradenton, FL	0.9610	0.9731
7520	Manatee, FL Sarasota, FL Savannah, GA	0.9464	0.9630
7560	Bryan, GA Chatham, GA Effingham, GA Scranton-Wilkes-Barre-Hazleton, PA	0.8505	0.8950
	Columbia, PA Lackawanna, PA Luzerne, PA		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
7600	Wyoming, PA Seattle-Bellevue-Everett, WA ¹	1.1463	1.0980
	Island, WA King, WA Snohomish, WA		
7610	Sharon, PA ²	0.8346	0.8835
	Mercer, PA		
7620	Sheboygan, WI ²	0.9496	0.9652
	Sheboygan, WI		
7640	Sherman-Denison, TX	0.9619	0.9737
	Grayson, TX		
7680	Shreveport-Bossier City, LA	0.9108	0.9380
	Bossier, LA Caddo, LA Webster, LA		
7720	Sioux City, IA-NE	0.9079	0.9360
	Woodbury, IA Dakota, NE		
7760	Sioux Falls, SD	0.9414	0.9595
	Lincoln, SD Minnehaha, SD		
7800	South Bend, IN	0.9434	0.9609
	St. Joseph, IN		
7840	Spokane, WA	1.0643	1.0436
	Spokane, WA		
7880	Springfield, IL	0.8732	0.9113
	Menard, IL Sangamon, IL		
7920	Springfield, MO	0.8600	0.9019
	Christian, MO Greene, MO Webster, MO		
8003	Springfield, MA ²	1.0196	1.0134
	Hampden, MA Hampshire, MA		
8050	State College, PA	0.8465	0.8922
	Centre, PA		
8080	Steubenville-Weirton, OH-WV (OH Hospitals) ²	0.8759	0.9133
	Jefferson, OH Brooke, WV Hancock, WV		
8080	Steubenville-Weirton, OH-WV (WV Hospitals)	0.8274	0.8783
	Jefferson, OH Brooke, WV Hancock, WV		
8120	Stockton-Lodi, CA	1.0583	1.0396
	San Joaquin, CA		
8140	Sumter, SC ²	0.8662	0.9063
	Sumter, SC		
8160	Syracuse, NY	0.9411	0.9593
	Cayuga, NY Madison, NY Onondaga, NY Oswego, NY		
8200	Tacoma, WA	1.1074	1.0724
	Pierce, WA		
8240	Tallahassee, FL ²	0.8707	0.9095
	Gadsden, FL Leon, FL		
8280	Tampa-St. Petersburg-Clearwater, FL ¹	0.9074	0.9356
	Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL		
8320	Terre Haute, IN ²	0.8740	0.9119
	Clay, IN Vermillion, IN Vigo, IN		
8360	Texarkana, AR-Texarkana, TX	0.8440	0.8903
	Miller, AR		

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
8400	Bowie, TX Toledo, OH	0.9514	0.9665
	Fulton, OH Lucas, OH Wood, OH		
8440	Topeka, KS	0.8896	0.9230
	Shawnee, KS		
8480	Trenton, NJ ²	1.1788	1.1192
	Mercer, NJ		
8520	Tucson, AZ ²	0.9148	0.9408
	Pima, AZ		
8560	Tulsa, OK	0.8756	0.9130
	Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK		
8600	Tuscaloosa, AL	0.8441	0.8904
	Tuscaloosa, AL		
8640	Tyler, TX	0.9516	0.9666
	Smith, TX		
8680	Utica-Rome, NY ²	0.8418	0.8888
	Herkimer, NY Oneida, NY		
8720	Vallejo-Fairfield-Napa, CA	1.3802	1.2469
	Napa, CA Solano, CA		
8735	Ventura, CA	1.1099	1.0740
	Ventura, CA		
8750	Victoria, TX	0.8456	0.8915
	Victoria, TX		
8760	Vineland-Millville-Bridgeton, NJ	1.1788	1.1192
	Cumberland, NJ		
8780	Visalia-Tulare-Porterville, CA ²	1.0262	1.0179
	Tulare, CA		
8800	Waco, TX	0.8172	0.8709
	McLennan, TX		
8840	Washington, DC-MD-VA-WV ¹	1.0969	1.0654
	District of Columbia, DC Calvert, MD Charles, MD Frederick, MD Montgomery, MD Prince Georges, MD Alexandria City, VA Arlington, VA Clarke, VA Culpeper, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Fauquier, VA Fredericksburg City, VA King George, VA Loudoun, VA Manassas City, VA Manassas Park City, VA Prince William, VA Spotsylvania, VA Stafford, VA Warren, VA Berkeley, WV Jefferson, WV		
8920	Waterloo-Cedar Falls, IA	0.8629	0.9040
	Black Hawk, IA		
8940	Wausau, WI	1.0101	1.0069
	Marathon, WI		
8960	West Palm Beach-Boca Raton, FL ¹	1.0348	1.0237
	Palm Beach, FL		
9000	Wheeling, WV-OH (WV Hospitals) ²	0.8099	0.8656

TABLE 4A₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY MSA—
Continued

MSA code	Urban area (constituent counties)	Wage index	GAF
9000	Belmont, OH Marshall, WV Ohio, WV Wheeling, WV-OH (OH Hospitals) ²	0.8759	0.9133
9040	Belmont, OH Marshall, WV Ohio, WV Wichita, KS	0.9499	0.9654
9080	Butler, KS Harvey, KS Sedgwick, KS Wichita Falls, TX	0.8428	0.8895
9140	Archer, TX Wichita, TX Williamsport, PA	0.8476	0.8929
9160	Lycoming, PA Wilmington-Newark, DE-MD	1.1172	1.0788
9200	New Castle, DE Cecil, MD Wilmington, NC	0.9225	0.9463
9260	New Hanover, NC Brunswick, NC Yakima, WA	1.0317	1.0216
9270	Yakima, WA Yolo, CA ²	1.0262	1.0179
9280	Yolo, CA York, PA	0.9152	0.9411
9320	York, PA Youngstown-Warren, OH	0.9516	0.9666
9340	Columbiana, OH Mahoning, OH Trumbull, OH Yuba City, CA	1.0381	1.0259
9360	Sutter, CA Yuba, CA Yuma, AZ ²	0.9148	0.9408
	Yuma, AZ		

19. On pages 49481 through 49521, in Urban Areas by CBSA, the table is
Table 4A₂—Wage Index and Capital corrected to read as follows:
Geographic Adjustment Factor (GAF) for

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA

CBSA code	Urban area (constituent counties)	Wage index	GAF
10180	Abilene, TX ²	0.7997	0.8581
	Callahan County, TX Jones County, TX Taylor County, TX		
10380	Aguadilla-Isabela-San Sebastián, PR	0.4274	0.5587
	Aguada Municipio, PR Aguadilla Municipio, PR Anasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR		
10420	Akron, OH	0.9042	0.9334
	Portage County, OH Summit County, OH		
10500	Albany, GA	1.1277	1.0858
	Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
10580	Worth County, GA Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8668	0.9067
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	1.0486	1.0330
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8178	0.8713
10900	Allentown-Bethlehem-Easton, PA-NJ (PA Hospitals) Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9519	0.9668
10900	Allentown-Bethlehem-Easton, PA-NJ (NJ Hospitals) ² Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	1.1277	1.0858
11020	Altoona, PA Blair County, PA	0.8452	0.8912
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9177	0.9429
11180	Ames, IA Story County, IA	0.9480	0.9641
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2164	1.1436
11300	Anderson, IN Madison County, IN	0.8753	0.9128
11340	Anderson, SC ² Anderson County, SC	0.8705	0.9094
11460	Ann Arbor, MI Washtenaw County, MI	1.1037	1.0699
11500	Anniston-Oxford, AL Calhoun County, AL	0.7949	0.8545
11540	Appleton, WI ² Calumet County, WI Outagamie County, WI	0.9507	0.9660
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9208	0.9451
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0173	1.0118
12060	Atlanta-Sandy Springs-Marietta, GA ¹ Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA	0.9960	0.9973

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA		
12100	Atlantic City, NJ ²	1.1277	1.0858
12220	Atlantic County, NJ Auburn-Opelika, AL	0.8221	0.8745
12260	Lee County, AL Augusta-Richmond County, GA-SC	0.9156	0.9414
	Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC		
12420	Austin-Round Rock, TX ¹	0.9597	0.9722
	Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX		
12540	Bakersfield, CA ²	1.0450	1.0306
12580	Kern County, CA Baltimore-Towson, MD ¹	0.9892	0.9926
	Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD		
12620	Bangor, ME	0.9937	0.9957
	Penobscot County, ME		
12700	Barnstable Town, MA	1.2327	1.1540
	Barnstable County, MA		
12940	Baton Rouge, LA	0.8322	0.8818
	Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA		
12980	Battle Creek, MI	0.9345	0.9547
	Calhoun County, MI		
13020	Bay City, MI	0.9579	0.9710
	Bay County, MI		
13140	Beaumont-Port Arthur, TX	0.8617	0.9031
	Hardin County, TX Jefferson County, TX Orange County, TX		
13380	Bellingham, WA	1.1605	1.1073
	Whatcom County, WA		
13460	Bend, OR	1.0560	1.0380
	Deschutes County, OR		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
13644	Bethesda-Frederick-Gaithersburg, MD ¹	1.0935	1.0631
	Frederick County, MD		
	Montgomery County, MD		
13740	Billings, MT	0.8973	0.9285
	Carbon County, MT		
	Yellowstone County, MT		
13780	Binghamton, NY	0.8464	0.8921
	Broome County, NY		
	Tioga County, NY		
13820	Birmingham-Hoover, AL ¹	0.9157	0.9415
	Bibb County, AL		
	Blount County, AL		
	Chilton County, AL		
	Jefferson County, AL		
	St. Clair County, AL		
	Shelby County, AL		
	Walker County, AL		
13900	Bismarck, ND ²	0.7750	0.8398
	Burleigh County, ND		
	Morton County, ND		
13980	Blacksburg-Christiansburg-Radford, VA ²	0.8062	0.8628
	Giles County, VA		
	Montgomery County, VA		
	Pulaski County, VA		
	Radford City, VA		
14020	Bloomington, IN ²	0.8657	0.9060
	Greene County, IN		
	Monroe County, IN		
	Owen County, IN		
14060	Bloomington-Normal, IL	0.9110	0.9382
	McLean County, IL		
14260	Boise City-Nampa, ID	0.9338	0.9542
	Ada County, ID		
	Boise County, ID		
	Canyon County, ID		
	Gem County, ID		
	Owyhee County, ID		
14484	Boston-Quincy, MA ¹	1.1766	1.1178
	Norfolk County, MA		
	Plymouth County, MA		
	Suffolk County, MA		
14500	Boulder, CO	1.0044	1.0030
	Boulder County, CO		
14540	Bowling Green, KY	0.8141	0.8686
	Edmonson County, KY		
	Warren County, KY		
14740	Bremerton-Silverdale, WA	1.0608	1.0412
	Kitsap County, WA		
14860	Bridgeport-Stamford-Norwalk, CT	1.2846	1.1871
	Fairfield County, CT		
15180	Brownsville-Harlingen, TX	1.0158	1.0108
	Cameron County, TX		
15260	Brunswick, GA	1.1958	1.1303
	Brantley County, GA		
	Glynn County, GA		
	McIntosh County, GA		
15380	Buffalo-Niagara Falls, NY	0.9332	0.9538
	Erie County, NY		
	Niagara County, NY		
15500	Burlington, NC	0.8954	0.9271
	Alamance County, NC		
15540	Burlington-South Burlington, VT ²	0.9487	0.9646
	Chittenden County, VT		
	Franklin County, VT		
	Grand Isle County, VT		
15764	Cambridge-Newton-Framingham, MA ¹	1.1184	1.0796
	Middlesex County, MA		
15804	Camden, NJ ^{1 2}	1.1277	1.0858
	Burlington County, NJ		
	Camden County, NJ		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
15940	Gloucester County, NJ Canton-Massillon, OH	0.8908	0.9239
15980	Carroll County, OH Stark County, OH Cape Coral-Fort Myers, FL	0.9338	0.9542
16180	Lee County, FL Carson City, NV	1.0336	1.0229
16220	Carson City, NV Casper, WY	0.9327	0.9534
16300	Natrona County, WY Cedar Rapids, IA	0.8963	0.9278
16580	Benton County, IA Jones County, IA Linn County, IA Champaign-Urbana, IL	0.9515	0.9665
16620	Champaign County, IL Ford County, IL Piatt County, IL Charleston, WV	0.8877	0.9217
16700	Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV Charleston-North Charleston, SC	0.9415	0.9596
16740	Berkeley County, SC Charleston County, SC Dorchester County, SC Charlotte-Gastonia-Concord, NC-SC ¹	0.9698	0.9792
16820	Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC Charlottesville, VA	1.0292	1.0199
16860	Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA Chattanooga, TN-GA	0.9208	0.9451
16940	Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN Cheyenne, WY ²	0.9172	0.9425
16974	Laramie County, WY Chicago-Naperville-Joliet, IL ¹	1.0864	1.0584
17020	Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL Chico, CA	1.0546	1.0371
17140	Butte County, CA Cincinnati-Middletown, OH-KY-IN ¹	0.9497	0.9653
	Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
17300	Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH Clarksville, TN-KY	0.8109	0.8663
17420	Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN Cleveland, TN ²	0.7896	0.8506
17460	Bradley County, TN Polk County, TN Cleveland-Elyria-Mentor, OH ¹	0.9644	0.9755
17660	Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH Coeur d'Alene, ID	0.9325	0.9533
17780	Kootenai County, ID College Station-Bryan, TX	0.9246	0.9477
17820	Brazos County, TX Burleson County, TX Robertson County, TX Colorado Springs, CO	0.9771	0.9843
17860	El Paso County, CO Teller County, CO Columbia, MO	0.8388	0.8866
17900	Boone County, MO Howard County, MO Columbia, SC	0.9402	0.9587
17980	Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC Columbus, GA-AL	0.8691	0.9084
18020	Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA Columbus, IN	0.9387	0.9576
18140	Bartholomew County, IN Columbus, OH ¹	0.9734	0.9817
18580	Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH Corpus Christi, TX	0.8645	0.9051
18700	Aransas County, TX Nueces County, TX San Patricio County, TX Corvallis, OR	1.0517	1.0351
19060	Benton County, OR Cumberland, MD-WV (MD Hospitals) ²	0.9225	0.9463
19060	Allegany County, MD Mineral County, WV Cumberland, MD-WV (WV Hospitals)	0.8652	0.9056
19124	Allegany County, MD Mineral County, WV Dallas-Plano-Irving, TX ¹	1.0068	1.0047

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
19140	Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX Dalton, GA	0.9546	0.9687
19180	Murray County, GA Whitfield County, GA Danville, IL	0.8404	0.8877
19260	Vermilion County, IL Danville, VA	0.8660	0.9062
19340	Pittsylvania County, VA Danville City, VA Davenport-Moline-Rock Island, IA-IL	0.8758	0.9132
19380	Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA Dayton, OH	0.9299	0.9514
19460	Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH Decatur, AL	0.8893	0.9228
19500	Lawrence County, AL Morgan County, AL Decatur, IL ²	0.8346	0.8835
19660	Macon County, IL Deltona-Daytona Beach-Ormond Beach, FL	0.8899	0.9232
19740	Volusia County, FL Denver-Aurora, CO ¹	1.0879	1.0594
19780	Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO Des Moines, IA	0.9266	0.9491
19804	Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA Detroit-Livonia-Dearborn, MI ¹	1.0362	1.0247
20020	Wayne County, MI Dothan, AL ²	0.7646	0.8321
20100	Geneva County, AL Henry County, AL Houston County, AL Dover, DE	0.9866	0.9908
20220	Kent County, DE Dubuque, IA	0.8730	0.9112
20260	Dubuque County, IA Duluth, MN-WI	1.0329	1.0224
20500	Carlton County, MN St. Louis County, MN Douglas County, WI Durham, NC	1.0322	1.0219
20740	Chatham County, NC Durham County, NC Orange County, NC Person County, NC Eau Claire, WI ²	0.9507	0.9660

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
20764	Chippewa County, WI Eau Claire County, WI Edison, NJ ^{1 2}	1.1277	1.0858
20940	Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ El Centro, CA ¹	1.0450	1.0306
21060	Imperial County, CA Elizabethtown, KY	0.8690	0.9083
21140	Hardin County, KY Larue County, KY Elkhart-Goshen, IN	0.9257	0.9485
21300	Elkhart County, IN Elmira, NY	0.8464	0.8921
21340	Chemung County, NY El Paso, TX	0.9213	0.9454
21500	El Paso County, TX Erie, PA	0.8700	0.9090
21604	Erie County, PA Essex County, MA	1.0654	1.0443
21660	Essex County, MA Eugene-Springfield, OR	1.0921	1.0622
21780	Lane County, OR Evansville, IN-KY (IN Hospitals) ²	0.8657	0.9060
21780	Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY Evansville, IN-KY (KY Hospitals)	0.8386	0.8864
21820	Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY Fairbanks, AK ²	1.1733	1.1157
21940	Fairbanks North Star Borough, AK Fajardo, PR	0.3942	0.5286
22020	Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR Fargo, ND-MN	0.9330	0.9536
22140	Clay County, MN Cass County, ND Farmington, NM ²	0.8684	0.9079
22180	San Juan County, NM Fayetteville, NC	0.9363	0.9559
22220	Cumberland County, NC Hoke County, NC Fayetteville-Springdale-Rogers, AR-MO	0.8670	0.9069
22380	Benton County, AR Madison County, AR Washington County, AR McDonald County, MO Flagstaff, AZ	1.0777	1.0526
22420	Coconino County, AZ Flint, MI	1.1165	1.0784
22500	Genesee County, MI Florence, SC	0.8857	0.9202
22520	Darlington County, SC Florence County, SC Florence-Muscle Shoals, AL	0.7906	0.8514
22540	Colbert County, AL Lauderdale County, AL Fond du Lac, WI	0.9896	0.9929
22660	Fond du Lac County, WI Fort Collins-Loveland, CO	1.0230	1.0157

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
22744	Larimer County, CO		
	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL ¹	1.0382	1.0260
22900	Broward County, FL		
	Fort Smith, AR-OK	0.8300	0.8802
	Crawford County, AR		
	Franklin County, AR		
	Sebastian County, AR		
	Le Flore County, OK		
	Sequoyah County, OK		
23020	Fort Walton Beach-Crestview-Destin, FL	0.8781	0.9148
	Okaloosa County, FL		
23060	Fort Wayne, IN	0.9802	0.9864
	Allen County, IN		
	Wells County, IN		
	Whitley County, IN		
23104	Fort Worth-Arlington, TX ¹	0.9476	0.9638
	Johnson County, TX		
	Parker County, TX		
	Tarrant County, TX		
	Wise County, TX		
23420	Fresno, CA	1.0648	1.0439
	Fresno County, CA		
23460	Gadsden, AL	0.8077	0.8639
	Etowah County, AL		
23540	Gainesville, FL	0.9446	0.9617
	Alachua County, FL		
	Gilchrist County, FL		
23580	Gainesville, GA	0.9572	0.9705
	Hall County, GA		
23844	Gary, IN	0.9306	0.9519
	Jasper County, IN		
	Lake County, IN		
	Newton County, IN		
	Porter County, IN		
24020	Glens Falls, NY	0.8486	0.8937
	Warren County, NY		
	Washington County, NY		
24140	Goldsboro, NC	0.8776	0.9145
	Wayne County, NC		
24220	Grand Forks, ND-MN (ND Hospitals)	0.9147	0.9408
	Polk County, MN		
	Grand Forks County, ND		
24220	Grand Forks, ND-MN (MN Hospitals) ²	0.9330	0.9536
	Polk County, MN		
	Grand Forks County, ND		
24300	Grand Junction, CO	0.9932	0.9953
	Mesa County, CO		
24340	Grand Rapids-Wyoming, MI	0.9418	0.9598
	Barry County, MI		
	Ionia County, MI		
	Kent County, MI		
	Newaygo County, MI		
24500	Great Falls, MT	0.8831	0.9184
	Cascade County, MT		
24540	Greeley, CO	0.9732	0.9816
	Weld County, CO		
24580	Green Bay, WI	0.9578	0.9709
	Brown County, WI		
	Kewaunee County, WI		
	Oconto County, WI		
24660	Greensboro-High Point, NC	0.9209	0.9451
	Guilford County, NC		
	Randolph County, NC		
	Rockingham County, NC		
24780	Greenville, NC	0.9179	0.9430
	Greene County, NC		
	Pitt County, NC		
24860	Greenville, SC	0.9532	0.9677
	Greenville County, SC		
	Laurens County, SC		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
25020	Pickens County, SC Guayama, PR	0.4008	0.5347
25060	Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR Gulfport-Biloxi, MS	0.8934	0.9257
25180	Hancock County, MS Harrison County, MS Stone County, MS Hagerstown-Martinsburg, MD-WV	0.9744	0.9824
25260	Washington County, MD Berkeley County, WV Morgan County, WV Hanford-Corcoran, CA ²	1.0450	1.0306
25420	Kings County, CA Harrisburg-Carlisle, PA	0.9354	0.9553
25500	Cumberland County, PA Dauphin County, PA Perry County, PA Harrisonburg, VA	0.9278	0.9500
25540	Rockingham County, VA Harrisonburg City, VA Hartford-West Hartford-East Hartford, CT ^{1 2}	1.1583	1.1059
25620	Hartford County, CT Litchfield County, CT Middlesex County, CT Tolland County, CT Hattiesburg, MS ²	0.7649	0.8323
25860	Forrest County, MS Lamar County, MS Perry County, MS Hickory-Lenoir-Morganton, NC	0.9510	0.9662
25980	Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC Hinesville-Fort Stewart, GA ²	0.7752	0.8400
26100	Liberty County, GA Long County, GA Holland-Grand Haven, MI	0.9424	0.9602
26180	Ottawa County, MI Honolulu, HI	1.1033	1.0696
26300	Honolulu County, HI Hot Springs, AR	0.9268	0.9493
26380	Garland County, AR Houma-Bayou Cane-Thibodaux, LA	0.7761	0.8407
26420	Lafourche Parish, LA Terrebonne Parish, LA Houston-Baytown-Sugar Land, TX ¹	0.9975	0.9983
26580	Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX Huntington-Ashland, WV-KY-OH	0.9560	0.9697
26620	Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV Huntsville, AL	0.8838	0.9189
26820	Limestone County, AL Madison County, AL Idaho Falls, ID ²	0.8525	0.8965
	Bonneville County, ID		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
26900	Jefferson County, ID Indianapolis, IN ¹	1.0104	1.0071
	Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN		
26980	Iowa City, IA	0.9649	0.9758
	Johnson County, IA Washington County, IA		
27060	Ithaca, NY	0.9640	0.9752
	Tompkins County, NY		
27100	Jackson, MI	0.9133	0.9398
	Jackson County, MI		
27140	Jackson, MS	0.8285	0.8791
	Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS		
27180	Jackson, TN	0.8891	0.9227
	Chester County, TN Madison County, TN		
27260	Jacksonville, FL ¹	0.9565	0.9700
	Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL		
27340	Jacksonville, NC ²	0.8570	0.8997
	Onslow County, NC		
27500	Janesville, WI	0.9597	0.9722
	Rock County, WI		
27620	Jefferson City, MO	0.8332	0.8825
	Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO		
27740	Johnson City, TN	0.8162	0.8702
	Carter County, TN Unicoi County, TN Washington County, TN		
27780	Johnstown, PA	0.8365	0.8849
	Cambria County, PA		
27860	Jonesboro, AR	0.8229	0.8750
	Craighead County, AR Poinsett County, AR		
27900	Joplin, MO	0.8725	0.9108
	Jasper County, MO Newton County, MO		
28020	Kalamazoo-Portage, MI	1.0689	1.0467
	Kalamazoo County, MI Van Buren County, MI		
28100	Kankakee-Bradley, IL	1.0618	1.0419
	Kankakee County, IL		
28140	Kansas City, MO-KS ¹	0.9617	0.9736
	Franklin County, KS Johnson County, KS Leavenworth County, KS County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO		
28420	Kennewick-Richland-Pasco, WA	1.0508	1.0345
	Benton County, WA Franklin County, WA		
28660	Killeen-Temple-Fort Hood, TX	0.9276	0.9498
	Bell County, TX Coryell County, TX Lampasas County, TX		
28700	Kingsport-Bristol-Bristol, TN-VA	0.8235	0.8755
	Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA		
28740	Kingston, NY	0.9002	0.9305
	Ulster County, NY		
28940	Knoxville, TN	0.8564	0.8993
	Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN		
29020	Kokomo, IN	0.9023	0.9320
	Howard County, IN Tipton County, IN		
29100	La Crosse, WI-MN (WI Hospitals) ²	0.9507	0.9660
	Houston County, MN La Crosse County, WI		
29100	La Crosse, WI-MN (MN Hospitals) ²	0.9330	0.9536
	Houston County, MN La Crosse County, WI		
29140	Lafayette, IN	0.9051	0.9340
	Benton County, IN Carroll County, IN Tippecanoe County, IN		
29180	Lafayette, LA	0.8299	0.8801
	Lafayette Parish, LA St. Martin Parish, LA		
29340	Lake Charles, LA	0.7940	0.8539
	Calcasieu Parish, LA Cameron Parish, LA		
29404	Lake County-Kenosha County, IL-WI	1.0375	1.0255
	Lake County, IL Kenosha County, WI		
29460	Lakeland, FL	0.8943	0.9264
	Polk County, FL		
29540	Lancaster, PA	0.9896	0.9929
	Lancaster County, PA		
29620	Lansing-East Lansing, MI	0.9653	0.9761
	Clinton County, MI Eaton County, MI Ingham County, MI		
29700	Laredo, TX	0.8775	0.9144
	Webb County, TX		
29740	Las Cruces, NM	0.8759	0.9133
	Dona Ana County, NM		
29820	Las Vegas-Paradise, NV ¹	1.1345	1.0903
	Clark County, NV		
29940	Lawrence, KS ²	0.8123	0.8673
	Douglas County, KS		
30020	Lawton, OK	0.8249	0.8765
	Comanche County, OK		
30140	Lebanon, PA	0.8758	0.9132
	Lebanon County, PA		
30300	Lewiston, ID-WA (ID Hospitals)	0.9300	0.9515

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
30300	Nez Perce County, ID Asotin County, WA Lewiston, ID-WA (WA Hospitals) ²	0.9837	0.9888
30340	Nez Perce County, ID Asotin County, WA Lewiston-Auburn, ME	0.9552	0.9691
30460	Androscoggin County, ME Lexington-Fayette, KY	0.9336	0.9540
30620	Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY Lima, OH	0.9324	0.9532
30700	Allen County, OH Lincoln, NE	1.0180	1.0123
30780	Lancaster County, NE Seward County, NE Little Rock-North Little Rock, AR	0.8840	0.9190
30860	Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR Logan, UT-ID	0.9105	0.9378
30980	Franklin County, ID Cache County, UT Longview, TX	0.8802	0.9163
31020	Gregg County, TX Rusk County, TX Upshur County, TX Longview, WA	1.0208	1.0142
31084	Cowlitz County, WA Los Angeles-Long Beach-Glendale, CA ¹	1.1742	1.1162
31140	Los Angeles County, CA Louisville, KY-IN ¹	0.9126	0.9393
31180	Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY Lubbock, TX	0.8774	0.9143
31340	Crosby County, TX Lubbock County, TX Lynchburg, VA	0.9026	0.9322
31420	Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA Macon, GA	0.9922	0.9947
31460	Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA Madera, CA ²	1.0450	1.0306
31540	Madera County, CA Madison, WI	1.0301	1.0205

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
31700	Columbia County, WI Dane County, WI Iowa County, WI Manchester-Nashua, NH	1.0633	1.0429
31900	Hillsborough County, NH Merrimack County, NH Mansfield, OH	0.9200	0.9445
32420	Richland County, OH Mayagüez, PR	0.4492	0.5781
32580	Hormigueros Municipio, PR Mayagüez Municipio, PR McAllen-Edinburg-Pharr, TX	0.8603	0.9021
32780	Hidalgo County, TX Medford, OR		
32820	Jackson County, OR Memphis, TN-MS-AR ¹	1.0533 0.9223	1.0362 0.9461
32900	Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN Merced, CA	1.0526	1.0357
33124	Merced County, CA Miami-Miami Beach-Kendall, FL ¹	0.9870	0.9911
33140	Miami-Dade County, FL Michigan City-La Porte, IN	0.9332	0.9538
33260	LaPorte County, IN Midland, TX	0.9383	0.9573
33340	Midland County, TX Milwaukee-Waukesha-West Allis, WI ¹	1.0081	1.0055
33460	Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI Minneapolis-St. Paul-Bloomington, MN-WI ¹	1.1044	1.0704
33540	Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI Missoula, MT	0.9630	0.9745
33660	Missoula County, MT Mobile, AL	0.7997	0.8581
33700	Mobile County, AL Modesto, CA	1.1993	1.1325
33740	Stanislaus County, CA Monroe, LA	0.7908	0.8515
33780	Ouachita Parish, LA Union Parish, LA Monroe, MI	0.9498	0.9653
33860	Monroe County, MI Montgomery, AL	0.8311	0.8810
34060	Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL Morgantown, WV	0.8741	0.9120
	Monongalia County, WV Preston County, WV		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
34100	Morristown, TN ²	0.7896	0.8506
	Grainger County, TN		
	Hamblen County, TN		
	Jefferson County, TN		
34580	Mount Vernon-Anacortes, WA	1.0554	1.0376
	Skagit County, WA		
34620	Muncie, IN ²	0.8657	0.9060
	Delaware County, IN		
34740	Muskegon-Norton Shores, MI	0.9743	0.9823
	Muskegon County, MI		
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.9017	0.9316
	Horry County, SC		
34900	Napa, CA	1.3508	1.2287
	Napa County, CA		
34940	Naples-Marco Island, FL	1.0531	1.0361
	Collier County, FL		
34980	Nashville-Davidson—Murfreesboro, TN ¹	1.0074	1.0051
	Cannon County, TN		
	Cheatham County, TN		
	Davidson County, TN		
	Dickson County, TN		
	Hickman County, TN		
	Macon County, TN		
	Robertson County, TN		
	Rutherford County, TN		
	Smith County, TN		
	Sumner County, TN		
	Trousdale County, TN		
	Williamson County, TN		
	Wilson County, TN		
35004	Nassau-Suffolk, NY ¹	1.2928	1.1923
	Nassau County, NY		
	Suffolk County, NY		
35084	Newark-Union, NJ-PA ¹	1.1680	1.1122
	Essex County, NJ		
	Hunterdon County, NJ		
	Morris County, NJ		
	Sussex County, NJ		
	Union County, NJ		
	Pike County, PA		
35300	New Haven-Milford, CT	1.1830	1.1220
	New Haven County, CT		
35380	New Orleans-Metairie-Kenner, LA ¹	0.9100	0.9375
	Jefferson Parish, LA		
	Orleans Parish, LA		
	Plaquemines Parish, LA		
	St. Bernard Parish, LA		
	St. Charles Parish, LA		
	St. John the Baptist Parish, LA		
	St. Tammany Parish, LA		
35644	New York-Wayne-White Plains, NY-NJ ¹	1.3318	1.2168
	Bergen County, NJ		
	Hudson County, NJ		
	Passaic County, NJ		
	Bronx County, NY		
	Kings County, NY		
	New York County, NY		
	Putnam County, NY		
	Queens County, NY		
	Richmond County, NY		
	Rockland County, NY		
	Westchester County, NY		
35660	Niles-Benton Harbor, MI	0.8901	0.9234
	Berrien County, MI		
35980	Norwich-New London, CT	1.1627	1.1087
	New London County, CT		
36084	Oakland-Fremont-Hayward, CA ¹	1.5338	1.3403
	Alameda County, CA		
	Contra Costa County, CA		
36100	Ocala, FL	0.9174	0.9427

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
36140	Marion County, FL	1.1277	1.0858
	Ocean City, NJ ²		
	Cape May County, NJ		
36220	Odessa, TX	0.9797	0.9861
36260	Ector County, TX	0.9228	0.9465
	Ogden-Clearfield, UT		
	Davis County, UT		
	Morgan County, UT		
36420	Weber County, UT	0.8985	0.9293
	Oklahoma City, OK ¹		
	Canadian County, OK		
	Cleveland County, OK		
	Grady County, OK		
	Lincoln County, OK		
	Logan County, OK		
	McClain County, OK		
	Oklahoma County, OK		
36500	Olympia, WA	1.1005	1.0678
36540	Thurston County, WA	0.9740	0.9821
	Omaha-Council Bluffs, NE-IA		
	Harrison County, IA		
	Mills County, IA		
	Pottawattamie County, IA		
	Cass County, NE		
	Douglas County, NE		
	Sarpy County, NE		
	Saunders County, NE		
	Washington County, NE		
36740	Orlando, FL ¹	0.9731	0.9815
	Lake County, FL	0.9507	0.9660
	Orange County, FL		
	Osceola County, FL		
36780	Seminole County, FL		
	Oshkosh-Neenah, WI ²		
36980	Winnebago County, WI	0.8450	0.8911
	Owensboro, KY		
	Daviess County, KY		
	Hancock County, KY		
37100	McLean County, KY	1.1099	1.0740
	Oxnard-Thousand Oaks-Ventura, CA		
37340	Ventura County, CA	0.9625	0.9742
	Palm Bay-Melbourne-Titusville, FL		
37460	Brevard County, FL	0.8545	0.8979
	Panama City-Lynn Haven, FL ²		
37620	Bay County, FL	0.8315	0.8813
	Parkersburg-Marietta, WV-OH (WV Hospitals)		
	Washington County, OH		
	Pleasants County, WV		
	Wirt County, WV		
37620	Wood County, WV	0.8692	0.9085
	Parkersburg-Marietta, WV-OH (OH Hospitals) ²		
	Washington County, OH		
	Pleasants County, WV		
	Wirt County, WV		
37700	Wood County, WV	0.7974	0.8564
	Pascagoula, MS		
	George County, MS		
37860	Jackson County, MS	0.8545	0.8979
	Pensacola-Ferry Pass-Brent, FL ²		
	Escambia County, FL		
37900	Santa Rosa County, FL	0.8862	0.9206
	Peoria, IL		
	Marshall County, IL		
	Peoria County, IL		
	Stark County, IL		
37964	Tazewell County, IL	1.0855	1.0578
	Woodford County, IL		
	Philadelphia, PA ¹		
	Bucks County, PA		
	Chester County, PA		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
38060	Delaware County, PA Montgomery County, PA Philadelphia County, PA Phoenix-Mesa-Scottsdale, AZ ¹	0.9985	0.9990
38220	Maricopa County, AZ Pinal County, AZ Pine Bluff, AR	0.8700	0.9090
38300	Cleveland County, AR Jefferson County, AR Lincoln County, AR Pittsburgh, PA ¹	0.8723	0.9107
38340	Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA Pittsfield, MA ²	1.0438	1.0298
38540	Berkshire County, MA Pocatello, ID	0.9589	0.9717
38660	Bannock County, ID Power County, ID Ponce, PR	0.5006	0.6226
38860	Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR Portland-South Portland-Biddeford, ME	1.0102	1.0070
38900	Cumberland County, ME Sagadahoc County, ME York County, ME Portland-Vancouver-Beaverton, OR-WA ¹	1.1371	1.0920
38940	Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA Port St. Lucie-Fort Pierce, FL	1.0093	1.0064
39100	Martin County, FL St. Lucie County, FL Poughkeepsie-Newburgh-Middletown, NY	1.1364	1.0915
39140	Dutchess County, NY Orange County, NY Prescott, AZ	0.9681	0.9780
39300	Yavapai County, AZ Providence-New Bedford-Fall River, RI-MA ¹	1.0916	1.0619
39340	Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI Provo-Orem, UT	0.9572	0.9705
39380	Juab County, UT Utah County, UT Pueblo, CO ²	0.9356	0.9554
39460	Pueblo County, CO Punta Gorda, FL	0.9451	0.9621
39540	Charlotte County, FL Racine, WI ²	0.9507	0.9660
39580	Racine County, WI Raleigh-Cary, NC	1.0034	1.0023
39660	Franklin County, NC Johnston County, NC Wake County, NC Rapid City, SD	0.8919	0.9246
	Meade County, SD Pennington County, SD		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
39740	Reading, PA	0.9218	0.9458
	Berks County, PA		
39820	Redding, CA	1.1830	1.1220
	Shasta County, CA		
39900	Reno-Sparks, NV	1.0446	1.0303
	Storey County, NV		
	Washoe County, NV		
40060	Richmond, VA ¹	0.9379	0.9570
	Amelia County, VA		
	Caroline County, VA		
	Charles City County, VA		
	Chesterfield County, VA		
	Cumberland County, VA		
	Dinwiddie County, VA		
	Goochland County, VA		
	Hanover County, VA		
	Henrico County, VA		
	King and Queen County, VA		
	King William County, VA		
	Louisa County, VA		
	New Kent County, VA		
	Powhatan County, VA		
	Prince George County, VA		
	Sussex County, VA		
	Colonial Heights City, VA		
	Hopewell City, VA		
	Petersburg City, VA		
	Richmond City, VA		
40140	Riverside-San Bernardino-Ontario, CA ¹	1.0979	1.0660
	Riverside County, CA		
	San Bernardino County, CA		
40220	Roanoke, VA	0.8455	0.8914
	Botetourt County, VA		
	Craig County, VA		
	Franklin County, VA		
	Roanoke County, VA		
	Roanoke City, VA		
	Salem City, VA		
40340	Rochester, MN	1.1490	1.0998
	Dodge County, MN		
	Olmsted County, MN		
	Wabasha County, MN		
40380	Rochester, NY ¹	0.9283	0.9503
	Livingston County, NY		
	Monroe County, NY		
	Ontario County, NY		
	Orleans County, NY		
	Wayne County, NY		
40420	Rockford, IL	0.9607	0.9729
	Boone County, IL		
	Winnebago County, IL		
40484	Rockingham County—Strafford County, NH	1.0300	1.0204
	Rockingham County, NH		
	Strafford County, NH		
40580	Rocky Mount, NC	0.8997	0.9302
	Edgecombe County, NC		
	Nash County, NC		
40660	Rome, GA	0.8909	0.9239
	Floyd County, GA		
40900	Sacramento—Arden-Arcade—Roseville, CA ¹	1.1683	1.1124
	El Dorado County, CA		
	Placer County, CA		
	Sacramento County, CA		
	Yolo County, CA		
40980	Saginaw-Saginaw Township North, MI	0.9868	0.9909
	Saginaw County, MI		
41060	St. Cloud, MN	1.0271	1.0185
	Benton County, MN		
	Stearns County, MN		
41100	St. George, UT	0.9473	0.9636

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
41140	Washington County, UT St. Joseph, MO-KS (MO Hospitals) ²	0.8011	0.8591
41140	Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	0.8123	0.8673
41180	St. Joseph, MO-KS (KS Hospitals) ²	0.9080	0.9360
41180	Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO		
41180	St. Louis, MO-IL		
41420	Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	1.0549	1.0373
41500	Salem, OR	1.3820	1.2480
41540	Marion County, OR Polk County, OR	0.9225	0.9463
41620	Salinas, CA	0.9564	0.9699
41660	Monterey County, CA Salisbury, MD ²	0.8174	0.8710
41700	Somerset County, MD Wicomico County, MD	0.9000	0.9304
41740	Salt Lake City, UT	1.1260	1.0847
41780	Salt Lake County, UT Summit County, UT Tooele County, UT	0.9023	0.9320
41884	San Angelo, TX	1.4694	1.3015
41900	Irion County, TX Tom Green County, TX	0.5230	0.6415
41940	San Antonio, TX ¹	1.4712	1.3026
41980	Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.4644	0.5914
41980	San Diego-Carlsbad-San Marcos, CA ¹		
41980	San Diego County, CA		
41980	Sandusky, OH		
41980	Erie County, OH		
41980	San Francisco-San Mateo-Redwood City, CA ¹		
41980	Marin County, CA San Francisco County, CA San Mateo County, CA		
41980	San Germán-Cabo Rojo, PR		
41980	Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR		
41980	San Jose-Sunnyvale-Santa Clara, CA ¹		
41980	San Benito County, CA Santa Clara County, CA		
41980	San Juan-Caguas-Guaynabo, PR ¹		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerio Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR		
42020	San Luis Obispo-Paso Robles, CA	1.1115	1.0751
	San Luis Obispo County, CA		
42044	Santa Ana-Anaheim-Irvine, CA ¹	1.1701	1.1136
	Orange County, CA		
42060	Santa Barbara-Santa Maria-Goleta, CA	1.0757	1.0512
	Santa Barbara County, CA		
42100	Santa Cruz-Watsonville, CA	1.4759	1.3055
	Santa Cruz County, CA		
42140	Santa Fe, NM	1.0885	1.0598
	Santa Fe County, NM		
42220	Santa Rosa-Petaluma, CA	1.2938	1.1929
	Sonoma County, CA		
42260	Sarasota-Bradenton-Venice, FL	0.9610	0.9731
	Manatee County, FL		
	Sarasota County, FL		
42340	Savannah, GA	0.9464	0.9630
	Bryan County, GA		
	Chatham County, GA		
	Effingham County, GA		
42540	Scranton—Wilkes-Barre, PA	0.8525	0.8965
	Lackawanna County, PA		
	Luzerne County, PA		
	Wyoming County, PA		
42644	Seattle-Bellevue-Everett, WA ¹	1.1476	1.0989
	King County, WA		
	Snohomish County, WA		
43100	Sheboygan, WI ²	0.9507	0.9660
	Sheboygan County, WI		
43300	Sherman-Denison, TX	0.9619	0.9737

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
43340	Grayson County, TX Shreveport-Bossier City, LA	0.9130	0.9396
43580	Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA Sioux City, IA-NE-SD	0.9054	0.9342
43620	Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD Sioux Falls, SD	0.9414	0.9595
43780	Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD South Bend-Mishawaka, IN-MI	0.9434	0.9609
43900	St. Joseph County, IN Cass County, MI Spartanburg, SC	0.9521	0.9669
44060	Spartanburg County, SC Spokane, WA	1.0643	1.0436
44100	Spokane County, WA Springfield, IL	0.8732	0.9113
44140	Menard County, IL Sangamon County, IL Springfield, MA ¹	1.0438	1.0298
44180	Franklin County, MA Hampden County, MA Hampshire County, MA Springfield, MO	0.8562	0.8991
44220	Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO Springfield, OH	0.8741	0.9120
44300	Clark County, OH State College, PA	0.8465	0.8922
44700	Centre County, PA Stockton, CA	1.0583	1.0396
44940	San Joaquin County, CA Sumter, SC ²	0.8705	0.9094
45060	Sumter County, SC Syracuse, NY	0.9482	0.9642
45104	Madison County, NY Onondaga County, NY Oswego County, NY Tacoma, WA	1.1074	1.0724
45220	Pierce County, WA Tallahassee, FL	0.8671	0.9070
45300	Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL Tampa-St. Petersburg-Clearwater, FL ¹	0.9074	0.9356
45460	Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL Terre Haute, IN ²	0.8657	0.9060
45500	Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN Texarkana, TX-Texarkana, AR	0.8440	0.8903
45780	Miller County, AR Bowie County, TX Toledo, OH	0.9514	0.9665
	Fulton County, OH Lucas County, OH		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
45820	Ottawa County, OH Wood County, OH Topeka, KS	0.8896	0.9230
	Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS		
45940	Trenton-Ewing, NJ ²	1.1277	1.0858
	Mercer County, NJ		
46060	Tucson, AZ ²	0.9102	0.9376
	Pima County, AZ		
46140	Tulsa, OK	0.8717	0.9103
	Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK		
46220	Tuscaloosa, AL	0.8339	0.8830
	Greene County, AL Hale County, AL Tuscaloosa County, AL		
46340	Tyler, TX	0.9516	0.9666
	Smith County, TX		
46540	Utica-Rome, NY	0.8316	0.8814
	Herkimer County, NY Oneida County, NY		
46660	Valdosta, GA	0.8334	0.8827
	Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA		
46700	Vallejo-Fairfield, CA	1.4269	1.2756
	Solano County, CA		
46940	Vero Beach, FL	0.9492	0.9649
	Indian River County, FL		
47020	Victoria, TX	0.8456	0.8915
	Calhoun County, TX Goliad County, TX Victoria County, TX		
47220	Vineland-Millville-Bridgeton, NJ ²	1.1277	1.0858
	Cumberland County, NJ		
47260	Virginia Beach-Norfolk-Newport News, VA-NC ¹	0.8928	0.9253
	Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA		
47300	Visalia-Porterville, CA ¹	1.0450	1.0306
	Tulare County, CA		
47380	Waco, TX	0.8151	0.8694
	McLennan County, TX		
47580	Warner Robins, GA	0.8496	0.8944
	Houston County, GA		
47644	Warren-Farmington Hills-Troy, MI ¹	1.0109	1.0075
	Lapeer County, MI Livingston County, MI		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
47894	Macomb County, MI Oakland County, MI St. Clair County, MI Washington-Arlington-Alexandria, DC-VA-MD-WV ¹	1.1026	1.0692
	District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV		
47940	Waterloo-Cedar Falls, IA	0.8629	0.9040
	Black Hawk County, IA Bremer County, IA Grundy County, IA		
48140	Wausau, WI	1.0101	1.0069
48260	Marathon County, WI Weirton-Steubenville, WV-OH (WV Hospitals)	0.8274	0.8783
	Jefferson County, OH Brooke County, WV Hancock County, WV		
48260	Weirton-Steubenville, WV-OH (OH Hospitals) ²	0.8692	0.9085
	Jefferson County, OH Brooke County, WV Hancock County, WV		
48300	Wenatchee, WA	1.0949	1.0641
	Chelan County, WA Douglas County, WA		
48424	West Palm Beach-Boca Raton-Boynton Beach, FL ¹	1.0348	1.0237
48540	Palm Beach County, FL Wheeling, WV-OH (WV Hospitals) ²	0.7882	0.8496
	Belmont County, OH Marshall County, WV Ohio County, WV		
48540	Wheeling, WV-OH (OH Hospitals) ²	0.8692	0.9085
	Belmont County, OH Marshall County, WV Ohio County, WV		
48620	Wichita, KS	0.9472	0.9635
	Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS		
48660	Wichita Falls, TX	0.8365	0.8849
	Archer County, TX Clay County, TX Wichita County, TX		
48700	Williamsport, PA	0.8476	0.8929
48864	Lycoming County, PA Wilmington, DE-MD-NJ (DE, MD Hospitals)	1.1095	1.0738
	New Castle County, DE Cecil County, MD Salem County, NJ		
48864	Wilmington, DE-MD-NJ (NJ Hospitals) ²	1.1277	1.0858
	New Castle County, DE Cecil County, MD Salem County, NJ		

TABLE 4A₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—
Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
48900	Wilmington, NC	0.9225	0.9463
	Brunswick County, NC		
	New Hanover County, NC		
	Pender County, NC		
49020	Winchester, VA-WV	1.0486	1.0330
	Frederick County, VA		
	Winchester City, VA		
	Hampshire County, WV		
49180	Winston-Salem, NC	0.9410	0.9592
	Davie County, NC		
	Forsyth County, NC		
	Stokes County, NC		
	Yadkin County, NC		
49340	Worcester, MA	1.1001	1.0675
	Worcester County, MA		
49420	Yakima, WA	1.0317	1.0216
	Yakima County, WA		
49500	Yauco, PR	0.4493	0.5782
	Guánica Municipio, PR		
	Guayanilla Municipio, PR		
	Peñuelas Municipio, PR		
	Yauco Municipio, PR		
49620	York-Hanover, PA	0.9152	0.9411
	York County, PA		
49660	Youngstown-Warren-Boardman, OH-PA	0.9234	0.9469
	Mahoning County, OH		
	Trumbull County, OH		
	Mercer County, PA		
49700	Yuba City, CA ²	1.0450	1.0306
	Sutter County, CA		
	Yuba County, CA		
49740	Yuma, AZ ²	0.9102	0.9376
	Yuma County, AZ		

20. On pages 49522 through 49523 in Rural Areas by MSA, the table is
 Table 4B₁—Wage Index and Capital corrected to read as follows:
 Geographic Adjustment Factor (GAF) for

TABLE 4B₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS BY MSA

MSA code	Nonurban area	Wage index	GAF
01	Alabama	0.7656	0.8328
02	Alaska	1.1627	1.1087
03	Arizona	0.9148	0.9408
04	Arkansas	0.7729	0.8383
05	California	1.0262	1.0179
06	Colorado	0.9356	0.9554
07	Connecticut	1.1583	1.1059
08	Delaware	0.9631	0.9746
10	Florida	0.8707	0.9095
11	Georgia	0.8260	0.8773
12	Hawaii	1.0558	1.0379
13	Idaho	0.8820	0.9176
14	Illinois	0.8348	0.8837
15	Indiana	0.8740	0.9119
16	Iowa	0.8552	0.8984
17	Kansas	0.8129	0.8677
18	Kentucky	0.7856	0.8477
19	Louisiana	0.7318	0.8075
20	Maine	0.9027	0.9323
21	Maryland	0.9176	0.9428
22	Massachusetts	1.0196	1.0134
23	Michigan	0.8740	0.9119
24	Minnesota	0.9339	0.9542
25	Mississippi	0.7600	0.8287
26	Missouri	0.8041	0.8613
27	Montana	0.8693	0.9085

TABLE 4B₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS BY MSA—
Continued

MSA code	Nonurban area	Wage index	GAF
28	Nebraska	0.9040	0.9332
29	Nevada	0.9829	0.9883
30	New Hampshire	0.9931	0.9953
31	New Jersey ¹	1.1788	1.1192
32	New Mexico	0.8534	0.8971
33	New York	0.8418	0.8888
34	North Carolina	0.8506	0.8951
35	North Dakota	0.7750	0.8398
36	Ohio	0.8759	0.9133
37	Oklahoma	0.7565	0.8261
38	Oregon	1.0215	1.0147
39	Pennsylvania	0.8346	0.8835
40	Puerto Rico	0.4049	0.5384
41	Rhode Island ¹	0.9784	0.9852
42	South Carolina	0.8662	0.9063
43	South Dakota	0.8384	0.8863
44	Tennessee	0.7901	0.8510
45	Texas	0.7942	0.8540
46	Utah	0.8854	0.9200
47	Vermont	0.9487	0.9646
49	Virginia	0.8489	0.8939
50	Washington	1.0063	1.0043
51	West Virginia	0.8099	0.8656
52	Wisconsin	0.9496	0.9652
53	Wyoming	0.9172	0.9425

21. On pages 49524 through 49525, in Rural Areas by CBSA, the table is
Table 4B₂—Wage Index and Capital corrected to read as follows:
Geographic Adjustment Factor (GAF) for

TABLE 4B₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS BY CBSA

CBSA code	Nonurban area	Wage index	GAF
01	Alabama	0.7646	0.8321
02	Alaska	1.1733	1.1157
03	Arizona	0.9102	0.9376
04	Arkansas	0.7433	0.8162
05	California	1.0450	1.0306
06	Colorado	0.9356	0.9554
07	Connecticut	1.1583	1.1059
08	Delaware	0.9631	0.9746
10	Florida	0.8545	0.8979
11	Georgia	0.7752	0.8400
12	Hawaii	1.0558	1.0379
13	Idaho	0.8525	0.8965
14	Illinois	0.8346	0.8835
15	Indiana	0.8657	0.9060
16	Iowa	0.8478	0.8931
17	Kansas	0.8123	0.8673
18	Kentucky	0.7769	0.8412
19	Louisiana	0.7370	0.8114
20	Maine	0.9027	0.9323
21	Maryland	0.9225	0.9463
22	Massachusetts ¹	1.0438	1.0298
23	Michigan	0.8783	0.9150
24	Minnesota	0.9330	0.9536
25	Mississippi	0.7649	0.8323
26	Missouri	0.8011	0.8591
27	Montana	0.8693	0.9085
28	Nebraska	0.9040	0.9332
29	Nevada	0.9286	0.9505
30	New Hampshire	0.9931	0.9953
31	New Jersey ¹	1.1277	1.0858
32	New Mexico	0.8684	0.9079
33	New York	0.8166	0.8705
34	North Carolina	0.8570	0.8997
35	North Dakota	0.7750	0.8398
36	Ohio	0.8692	0.9085

TABLE 4B₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS BY CBSA—
Continued

CBSA code	Nonurban area	Wage index	GAF
37	Oklahoma	0.7711	0.8369
38	Oregon	1.0151	1.0103
39	Pennsylvania	0.8309	0.8809
40	Puerto Rico ¹		
41	Rhode Island ¹	0.9244	0.9476
42	South Carolina	0.8705	0.9094
43	South Dakota	0.8390	0.8867
44	Tennessee	0.7896	0.8506
45	Texas	0.7997	0.8581
46	Utah	0.8297	0.8800
47	Vermont	0.9487	0.9646
49	Virginia	0.8062	0.8628
50	Washington	0.9837	0.9888
51	West Virginia	0.7882	0.8496
52	Wisconsin	0.9507	0.9660
53	Wyoming	0.9172	0.9425

22. On pages 49526 through 49530, in Table 4C₁—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified by MSA, the table is corrected to read as follows:

TABLE 4C₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE
RECLASSIFIED BY MSA

MSA code	Area	Wage index	GAF
0040	Abilene, TX	0.8026	0.8602
0080	Akron, OH	0.9042	0.9334
0200	Albuquerque, NM	1.0211	1.0144
0220	Alexandria, LA	0.8178	0.8713
0240	Allentown-Bethlehem-Easton, PA	0.9455	0.9623
0280	Altoona, PA	0.8452	0.8912
0320	Amarillo, TX	0.9177	0.9429
0380	Anchorage, AK	1.2164	1.1436
0440	Ann Arbor, MI	1.0618	1.0419
0450	Anniston, AL	0.7949	0.8545
0480	Asheville, NC	0.9292	0.9510
0500	Athens, GA	0.9831	0.9884
0520	Atlanta, GA	0.9855	0.9900
0560	Atlantic-Cape May, NJ	1.0603	1.0409
0580	Auburn-Opelika, AL	0.8070	0.8634
0600	Augusta-Aiken, GA-SC	0.9074	0.9356
0640	Austin-San Marcos, TX	0.9597	0.9722
0733	Bangor, ME	0.9937	0.9957
0743	Barnstable-Yarmouth, MA	1.2158	1.1432
0760	Baton Rouge, LA	0.8356	0.8843
0870	Benton Harbor, MI	0.8901	0.9234
0875	Bergen-Passaic, NJ	1.2011	1.1337
0920	Biloxi-Gulfport-Pascagoula, MS	0.8637	0.9045
1000	Birmingham, AL	0.9198	0.9444
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1285	1.0863
1303	Burlington, VT	0.9104	0.9377
1350	Casper, WY	0.9327	0.9534
1400	Champaign-Urbana, IL	0.9301	0.9516
1440	Charleston-North Charleston, SC	0.9415	0.9596
1480	Charleston, WV (OH Hospitals)	0.8759	0.9133
1480	Charleston, WV (WV Hospitals)	0.8579	0.9004
1520	Charlotte-Gastonia-Rock Hill, NC-SC	0.9671	0.9774
1540	Charlottesville, VA	0.9931	0.9953
1560	Chattanooga, TN-GA	0.9208	0.9451
1600	Chicago, IL	1.0703	1.0476
1640	Cincinnati, OH-KY-IN	0.9574	0.9706
1660	Clarksville-Hopkinsville, TN-KY	0.8109	0.8663
1680	Cleveland-Lorain-Elyria, OH	0.9620	0.9738
1740	Columbia, MO	0.8388	0.8866
1760	Columbia, SC	0.9341	0.9544
1800	Columbus, GA-AL	0.8357	0.8843
1840	Columbus, OH	0.9615	0.9735
1890	Corvallis, OR	1.0534	1.0363

TABLE 4C₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY MSA—Continued

MSA code	Area	Wage index	GAF
1920	Dallas, TX	1.0048	1.0033
1960	Davenport-Rock Island-Moline, IA-IL	0.8605	0.9022
2030	Decatur, AL	0.8893	0.9228
2080	Denver, CO	1.0679	1.0460
2120	Des Moines, IA	0.9101	0.9375
2160	Detroit, MI	1.0232	1.0158
2240	Duluth-Superior, MN-WI	1.0345	1.0235
2330	Elkhart-Goshen, IN	0.9134	0.9399
2360	Erie, PA	0.8502	0.8948
2400	Eugene-Springfield, OR	1.0528	1.0359
2440	Evansville-Henderson, IN-KY	0.8227	0.8749
2520	Fargo-Moorhead, ND-MN (MN Hospitals)	0.9339	0.9542
2520	Fargo-Moorhead, ND-MN (ND, SD Hospitals)	0.9189	0.9437
2560	Fayetteville, NC	0.9003	0.9306
2580	Fayetteville-Springdale-Rogers, AR	0.8670	0.9069
2620	Flagstaff, AZ-UT	1.0458	1.0311
2640	Flint, MI	1.0973	1.0657
2670	Fort Collins-Loveland, CO	1.0230	1.0157
2680	Fort Lauderdale, FL	1.0382	1.0260
2710	Fort Pierce-Port St. Lucie, FL	1.0093	1.0064
2720	Fort Smith, AR-OK	0.8071	0.8635
2800	Fort Worth-Arlington, TX	0.9522	0.9670
3000	Grand Rapids-Muskegon-Holland, MI	0.9523	0.9671
3040	Great Falls, MT	0.8831	0.9184
3060	Greeley, CO	0.9732	0.9816
3080	Green Bay, WI	0.9573	0.9706
3120	Greensboro—Winston-Salem—High Point, NC	0.9324	0.9532
3150	Greenville, NC	0.9179	0.9430
3200	Hamilton-Middletown, OH	0.9126	0.9393
3240	Harrisburg-Lebanon-Carlisle, PA	0.9172	0.9425
3283	Hartford, CT	1.0927	1.0626
3290	Hickory-Morganton-Lenoir, NC	0.9344	0.9546
3320	Honolulu, HI	1.1033	1.0696
3360	Houston, TX	1.0122	1.0083
3400	Huntington-Ashland, WY-KY-OH	0.9009	0.9310
3440	Huntsville, AL	0.8826	0.9180
3480	Indianapolis, IN	1.0033	1.0023
3500	Iowa City, IA	0.9486	0.9645
3560	Jackson, MS	0.8269	0.8780
3580	Jackson, TN	0.8707	0.9095
3600	Jacksonville, FL	0.9553	0.9692
3660	Johnson City-Kingsport-Bristol, TN-VA	0.8206	0.8734
3700	Jonesboro, AR	0.8229	0.8750
3710	Joplin, MO	0.8573	0.8999
3720	Kalamazoo-Battle Creek, MI	1.0241	1.0164
3760	Kansas City, MO-KS	0.9629	0.9744
3840	Knoxville, TN	0.8524	0.8964
3880	Lafayette, LA	0.8116	0.8668
3980	Lakeland-Winter Haven, FL	0.8943	0.9264
4120	Las Vegas, NV-AZ	1.0977	1.0659
4280	Lexington, KY	0.8853	0.9200
4320	Lima, OH	0.9239	0.9472
4360	Lincoln, NE	0.9720	0.9807
4400	Little Rock-North Little Rock, AR	0.8840	0.9190
4420	Longview-Marshall, TX	0.8620	0.9033
4480	Los Angeles-Long Beach, CA	1.1742	1.1162
4520	Louisville, KY-IN	0.9166	0.9421
4600	Lubbock, TX	0.8774	0.9143
4640	Lynchburg, VA	0.8883	0.9221
4680	Macon, GA	0.9625	0.9742
4720	Madison, WI	1.0237	1.0162
4890	Medford-Ashland, OR	1.0248	1.0169
4920	Memphis, TN-AR-MS	0.8889	0.9225
5000	Miami, FL	0.9870	0.9911
5015	Middlesex-Somerset-Hunterdon, NJ	1.1788	1.1192
5080	Milwaukee-Waukesha, WI	0.9954	0.9968
5120	Minneapolis-St. Paul, MN-WI	1.1044	1.0704
5140	Missoula, MT	0.9630	0.9745
5160	Mobile, AL	0.7934	0.8534
5170	Modesto, CA	1.1993	1.1325
5240	Montgomery, AL	0.8311	0.8810

TABLE 4C₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY MSA—Continued

MSA code	Area	Wage index	GAF
5360	Nashville, TN	0.9758	0.9834
5560	New Orleans, LA	0.9100	0.9375
5600	New York-Newark, NY-NJ-PA	1.3595	1.2341
5640	Newark, NJ	1.1788	1.1192
5660	Newburgh, NY-PA	1.0609	1.0413
5720	Norfolk-Virginia Beach-Newport News, VA-NC	0.8928	0.9253
5775	Oakland, CA	1.5338	1.3403
5790	Ocala, FL	0.9174	0.9427
5800	Odessa-Midland, TX	0.9389	0.9577
5880	Oklahoma City, OK	0.8968	0.9281
5910	Olympia, WA	1.1005	1.0678
5920	Omaha, NE-IA	0.9740	0.9821
5945	Orange County, CA	1.1701	1.1136
5960	Orlando, FL	0.9731	0.9815
6120	Peoria-Pekin, IL	0.8913	0.9242
6160	Philadelphia, PA-NJ	1.1788	1.1192
6200	Phoenix-Mesa, AZ	0.9985	0.9990
6240	Pine Bluff, AR	0.8381	0.8861
6280	Pittsburgh, PA	0.8743	0.9121
6323	Pittsfield, MA	0.9998	0.9999
6340	Pocatello, ID	0.9229	0.9465
6403	Portland, ME	0.9807	0.9867
6440	Portland-Vancouver, OR-WA	1.1371	1.0920
6520	Provo-Orem, UT	0.9596	0.9722
6640	Raleigh-Durham-Chapel Hill, NC	0.9943	0.9961
6690	Redding, CA	1.1709	1.1141
6720	Reno, NV	1.0446	1.0303
6740	Richland-Kennewick-Pasco, WA	1.0280	1.0191
6800	Roanoke, VA (VA Hospitals)	0.8489	0.8939
6800	Roanoke, VA (WV Hospitals)	0.8468	0.8924
6820	Rochester, MN	1.1490	1.0998
6880	Rockford, IL	0.9484	0.9644
6920	Sacramento, CA	1.1829	1.1219
6960	Saginaw-Bay City-Midland, MI	0.9431	0.9607
6980	St. Cloud, MN	1.0095	1.0065
7040	St. Louis, Mo-IL	0.8973	0.9285
7160	Salt Lake City-Ogden, UT	0.9491	0.9649
7240	San Antonio, TX	0.9020	0.9318
7400	San Jose, CA	1.4734	1.3040
7440	San Juan-Bayamon, PR	0.4801	0.6050
7490	Santa Fe, NM	1.0066	1.0045
7500	Santa Rosa, CA	1.2938	1.1929
7520	Savannah, GA	0.9464	0.9630
7600	Seattle-Bellevue-Everett, WA	1.1463	1.0980
7640	Sherman-Denison, TX	0.9106	0.9379
7680	Shreveport-Bossier City, LA	0.8941	0.9262
7720	Sioux City, IA-NE	0.9040	0.9332
7760	Sioux Falls, SD	0.9414	0.9595
7800	South Bend, IN	0.9434	0.9609
7840	Spokane, WA	1.0458	1.0311
7880	Springfield, IL	0.8732	0.9113
7920	Springfield, MO	0.8267	0.8778
8050	State College, PA	0.8346	0.8835
8160	Syracuse, NY	0.9246	0.9477
8360	Texarkana, TX-Texarkana, AR	0.8440	0.8903
8400	Toledo, OH	0.9514	0.9665
8440	Topeka, KS	0.8896	0.9230
8560	Tulsa, OK	0.8756	0.9130
8600	Tuscaloosa, AL	0.8441	0.8904
8640	Tyler, TX	0.9335	0.9540
8720	Vallejo-Fairfield-Napa, CA	1.3802	1.2469
8750	Victoria, TX	0.8456	0.8915
8800	Waco, TX	0.8172	0.8709
8840	Washington, DC-MD-VA-WV	1.0866	1.0585
8940	Wausau, WI	1.0101	1.0069
8960	West Palm Beach-Boca Raton, FL	1.0348	1.0237
9040	Wichita, KS	0.9195	0.9441
9160	Wilmington-Newark, DE-MD	1.0955	1.0645
9200	Wilmington, NC	0.9225	0.9463
9320	Youngstown-Warren, OH	0.9406	0.9589
10	Rural Florida	0.8553	0.8985

TABLE 4C₁.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY MSA—Continued

MSA code	Area	Wage index	GAF
14	Rural Illinois	0.8348	0.8837
24	Rural Minnesota	0.9339	0.9542
26	Rural Missouri	0.8041	0.8613
28	Rural Nebraska	0.9040	0.9332
29	Rural Nevada	0.9286	0.9505
30	Rural New Hampshire	0.9931	0.9953
45	Rural Texas	0.7942	0.8540
50	Rural Washington	1.0063	1.0043
53	Rural Wyoming	0.9172	0.9425

23. On pages 49531 through 49536, in Hospitals that are Reclassified by CBSA,
Table 4C₂—Wage Index and Capital the table is corrected to read as follows:
Geographic Adjustment Factor (GAF) for

TABLE 4C₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA

CBSA code	Area	Wage index	GAF
10180	Abilene, TX	0.7997	0.8581
10420	Akron, OH	0.9042	0.9334
10740	Albuquerque, NM	1.0211	1.0144
10780	Alexandria, LA	0.8178	0.8713
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9519	0.9668
11020	Altoona, PA	0.8452	0.8912
11100	Amarillo, TX	0.9177	0.9429
11180	Ames, IA	0.9480	0.9641
11260	Anchorage, AK	1.2164	1.1436
11460	Ann Arbor, MI	1.0756	1.0512
11500	Anniston-Oxford, AL	0.7949	0.8545
11700	Asheville, NC	0.9208	0.9451
12020	Athens-Clarke County, GA	0.9974	0.9982
12060	Atlanta-Sandy Springs-Marietta, GA	0.9846	0.9894
12220	Auburn-Opelika, AL	0.8070	0.8634
12260	Augusta-Richmond County, GA-SC	0.9035	0.9329
12420	Austin-Round Rock, TX	0.9597	0.9722
12620	Bangor, ME	0.9937	0.9957
12700	Barnstable Town, MA	1.2158	1.1432
12940	Baton Rouge, LA	0.8322	0.8818
13020	Bay City, MI	0.9579	0.9710
13780	Binghamton, NY	0.8464	0.8921
13820	Birmingham-Hoover, AL	0.9157	0.9415
14060	Bloomington-Normal, IL	0.9110	0.9382
14484	Boston-Quincy, MA	1.1574	1.1053
14540	Bowling Green, KY	0.8141	0.8686
15380	Buffalo-Niagara Falls, NY	0.9332	0.9538
15540	Burlington-South Burlington, VT	0.9104	0.9377
15764	Cambridge-Newton-Framingham, MA	1.1184	1.0796
16180	Carson City, NV	0.9899	0.9931
16220	Casper, WY	0.9327	0.9534
16580	Champaign-Urbana, IL	0.9301	0.9516
16620	Charleston, WV (OH Hospitals)	0.8692	0.9085
16620	Charleston, WV (WV Hospitals)	0.8572	0.8999
16700	Charleston-North Charleston, SC	0.9415	0.9596
16740	Charlotte-Gastonia-Concord, NC-SC	0.9585	0.9714
16820	Charlottesville, VA	0.9931	0.9953
16860	Chattanooga, TN-GA	0.9208	0.9451
16974	Chicago-Naperville-Joliet, IL	1.0709	1.0480
17140	Cincinnati-Middletown, OH-KY-IN	0.9497	0.9653
17300	Clarksville, TN-KY	0.8109	0.8663
17460	Cleveland-Elyria-Mentor, OH	0.9644	0.9755
17780	College Station-Bryan, TX	0.9246	0.9477
17860	Columbia, MO	0.8388	0.8866
17900	Columbia, SC	0.9298	0.9514
17980	Columbus, GA-AL	0.8357	0.8843
18140	Columbus, OH	0.9604	0.9727
18700	Corvallis, OR	1.0333	1.0227
19124	Dallas-Plano-Irving, TX	1.0068	1.0047
19340	Davenport-Moline-Rock Island, IA-IL	0.8758	0.9132

TABLE 4C₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index	GAF
19460	Decatur, AL	0.8893	0.9228
19740	Denver-Aurora, CO	1.0679	1.0460
19780	Des Moines, IA	0.9101	0.9375
20260	Duluth, MN-WI	1.0329	1.0224
20500	Durham, NC	1.0213	1.0145
21140	Elkhart-Goshen, IN	0.9134	0.9399
21500	Erie, PA	0.8502	0.8948
21660	Eugene-Springfield, OR	1.0528	1.0359
21780	Evansville, IN-KY	0.8209	0.8736
22020	Fargo, ND-MN (MN Hospitals)	0.9330	0.9536
22020	Fargo, ND-MN (ND Hospitals)	0.9189	0.9437
22180	Fayetteville, NC	0.9003	0.9306
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8670	0.9069
22380	Flagstaff, AZ	1.0564	1.0383
22540	Fond du Lac, WI	0.9507	0.9660
22660	Fort Collins-Loveland, CO	1.0230	1.0157
22744	Ft Lauderdale-Pompano Beach-Deerfield	1.0382	1.0260
22900	Fort Smith, AR-OK	0.8067	0.8632
23020	Fort Walton Beach-Crestview-Destin, FL	0.8598	0.9017
23104	Fort Worth-Arlington, TX	0.9476	0.9638
23540	Gainesville, FL	0.9446	0.9617
24340	Grand Rapids-Wyoming, MI	0.9418	0.9598
24500	Great Falls, MT	0.8831	0.9184
24540	Greeley, CO	0.9732	0.9816
24580	Green Bay, WI	0.9578	0.9709
24780	Greenville, NC	0.9179	0.9430
24860	Greenville, SC	0.9532	0.9677
25060	Gulfport-Biloxi, MS	0.8764	0.9136
25420	Harrisburg-Carlisle, PA	0.9201	0.9446
25540	Hartford-West Hartford-East Hartford, CT (CT Hospitals)	1.1583	1.1059
25540	Hartford-West Hartford-East Hartford, CT (MA, NY Hospitals)	1.1070	1.0721
25860	Hickory-Lenoir-Morganton, NC	0.9344	0.9546
26100	Holland-Grand Haven, MI	0.9424	0.9602
26180	Honolulu, HI	1.1033	1.0696
26420	Houston-Baytown-Sugar Land, TX	0.9975	0.9983
26580	Huntington-Ashland, WV-KY-OH	0.9009	0.9310
26620	Huntsville, AL	0.8838	0.9189
26820	Idaho Falls, ID	0.8525	0.8965
26900	Indianapolis, IN	1.0104	1.0071
26980	Iowa City, IA	0.9486	0.9645
27060	Ithaca, NY	0.9291	0.9509
27140	Jackson, MS	0.8285	0.8791
27180	Jackson, TN	0.8707	0.9095
27260	Jacksonville, FL	0.9565	0.9700
27860	Jonesboro, AR	0.8229	0.8750
27900	Joplin, MO	0.8573	0.8999
28020	Kalamazoo-Portage, MI	1.0689	1.0467
28100	Kankakee-Bradley, IL	1.0618	1.0419
28140	Kansas City, MO-KS	0.9617	0.9736
28420	Kennewick-Richland-Pasco, WA	1.0280	1.0191
28700	Kingsport-Bristol-Bristol, TN-VA	0.8235	0.8755
28940	Knoxville, TN	0.8564	0.8993
29140	Lafayette, IN	0.9051	0.9340
29180	Lafayette, LA	0.8299	0.8801
29460	Lakeland, FL	0.8943	0.9264
29620	Lansing-East Lansing, MI	0.9653	0.9761
29820	Las Vegas-Paradise, NV	1.1193	1.0802
30460	Lexington-Fayette, KY	0.8931	0.9255
30620	Lima, OH	0.9324	0.9532
30700	Lincoln, NE	0.9720	0.9807
30780	Little Rock-North Little Rock, AR	0.8840	0.9190
30980	Longview, TX	0.8570	0.8997
31084	Los Angeles-Long Beach-Santa Ana, CA	1.1742	1.1162
31140	Louisville, KY-IN	0.9126	0.9393
31180	Lubbock, TX	0.8774	0.9143
31340	Lynchburg, VA	0.8883	0.9221
31420	Macon, GA	0.9814	0.9872
31540	Madison, WI	1.0194	1.0132
31700	Manchester-Nashua, NH	1.0528	1.0359
32780	Medford, OR	1.0248	1.0169
32820	Memphis, TN-MS-AR	0.8884	0.9222

TABLE 4C₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index	GAF
33124	Miami-Miami Beach-Kendall, FL	0.9870	0.9911
33260	Midland, TX	0.9199	0.9444
33340	Milwaukee-Waukesha-West Allis, WI	0.9954	0.9968
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1044	1.0704
33540	Missoula, MT	0.9630	0.9745
33660	Mobile, AL	0.7997	0.8581
33700	Modesto, CA	1.1993	1.1325
33860	Montgomery, AL	0.8311	0.8810
34740	Muskegon-Norton Shores, MI a	0.9743	0.9823
34900	Napa, CA	1.3508	1.2287
34980	Nashville-Davidson--Murfreesboro, TN	0.9758	0.9834
35084	Newark-Union, NJ-PA	1.1569	1.1050
35380	New Orleans-Metairie-Kenner, LA	0.9100	0.9375
35644	New York-Wayne-White Plains, NY-NJ	1.3318	1.2168
36084	Oakland-Fremont-Hayward, CA	1.5338	1.3403
36100	Ocala, FL	0.9174	0.9427
36140	Ocean City, NJ	1.0028	1.0019
36220	Odessa, TX	0.9495	0.9651
36260	Ogden-Clearfield, UT	0.9228	0.9465
36420	Oklahoma City, OK	0.8985	0.9293
36500	Olympia, WA	1.1005	1.0678
36540	Omaha-Council Bluffs, NE-IA	0.9740	0.9821
36740	Orlando, FL	0.9731	0.9815
37900	Peoria, IL	0.8862	0.9206
38060	Phoenix-Mesa-Scottsdale, AZ	0.9985	0.9990
38220	Pine Bluff, AR	0.8381	0.8861
38300	Pittsburgh, PA	0.8723	0.9107
38340	Pittsfield, MA	0.9998	0.9999
38540	Pocatello, ID	0.9337	0.9541
38860	Portland-South Portland-Biddeford, ME	0.9807	0.9867
38900	Portland-Vancouver-Beaverton, OR-WA	1.1371	1.0920
38940	Port St. Lucie-Fort Pierce, FL	1.0093	1.0064
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1034	1.0697
39340	Provo-Orem, UT	0.9572	0.9705
39580	Raleigh-Cary, NC	0.9616	0.9735
39740	Reading, PA	0.9074	0.9356
39820	Redding, CA	1.1709	1.1141
39900	Reno-Sparks, NV	1.0450	1.0306
40220	Roanoke, VA	0.8455	0.8914
40340	Rochester, MN	1.1490	1.0998
40380	Rochester, NY	0.9283	0.9503
40420	Rockford, IL	0.9484	0.9644
40484	Rockingham County, NH	1.0300	1.0204
40660	Rome, GA	0.8909	0.9239
40900	Sacramento—Arden-Arcade—Roseville, CA	1.1683	1.1124
40980	Saginaw-Saginaw Township North, MI	0.9405	0.9589
41060	St. Cloud, MN	1.0095	1.0065
41180	St. Louis, MO-IL	0.8973	0.9285
41700	San Antonio, TX	0.9000	0.9304
42044	Santa Ana-Anaheim-Irvine, CA	1.1701	1.1136
42140	Santa Fe, NM	1.0066	1.0045
42220	Santa Rosa-Petaluma, CA	1.2938	1.1929
42340	Savannah, GA	0.9464	0.9630
42644	Seattle-Bellevue-Everett, WA	1.1476	1.0989
43300	Sherman-Denison, TX	0.9106	0.9379
43340	Shreveport-Bossier City, LA	0.8955	0.9272
43580	Sioux City, IA-NE-SD	0.9040	0.9332
43620	Sioux Falls, SD	0.9414	0.9595
43780	South Bend-Mishawaka, IN-MI	0.9434	0.9609
43900	Spartanburg, SC	0.9378	0.9570
44060	Spokane, WA	1.0458	1.0311
44100	Springfield, IL	0.8732	0.9113
44180	Springfield, MO	0.8267	0.8778
44220	Springfield, OH	0.8741	0.9120
44300	State College, PA	0.8309	0.8809
44940	Sumter, SC	0.8705	0.9094
45060	Syracuse, NY	0.9246	0.9477
45500	Texarkana, TX-Texarkana, AR	0.8440	0.8903
45780	Toledo, OH	0.9514	0.9665
45820	Topeka, KS	0.8896	0.9230
46140	Tulsa, OK	0.8717	0.9103

TABLE 4C₂.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index	GAF
46220	Tuscaloosa, AL	0.8339	0.8830
46340	Tyler, TX	0.9335	0.9540
47260	Virginia Beach-Norfolk-Newport News, VA	0.8928	0.9253
47380	Waco, TX	0.8151	0.8694
47644	Warren-Farmington-Hills-Troy, MI	1.0109	1.0075
47894	Washington-Arlington-Alexandria DC-VA	1.0895	1.0605
47940	Waterloo-Cedar Falls, IA	0.8629	0.9040
48140	Wausau, WI	1.0101	1.0069
48424	West Palm Beach-Boca Raton-Boynton FL	1.0348	1.0237
48620	Wichita, KS	0.9179	0.9430
48700	Williamsport, PA	0.8476	0.8929
48864	Wilmington, DE-MD-NJ (DE, MD Hospitals)	1.0853	1.0577
48864	Wilmington, DE-MD-NJ (NJ Hospitals)	1.1277	1.0858
48900	Wilmington, NC	0.9225	0.9463
49020	Winchester, VA-WV	1.0008	1.0005
49180	Winston-Salem, NC	0.9252	0.9482
49660	Youngstown-Warren-Boardman, OH-PA	0.9067	0.9351
10	Rural Florida	0.8418	0.8888
14	Rural Illinois	0.8346	0.8835
24	Rural Minnesota	0.9330	0.9536
26	Rural Missouri	0.8011	0.8591
28	Rural Nebraska	0.9040	0.9332
29	Rural Nevada	0.8778	0.9146
30	Rural New Hampshire	0.9931	0.9953
45	Rural Texas	0.7997	0.8581
50	Rural Washington	0.9837	0.9888
53	Rural Wyoming	0.9172	0.9425

24. On pages 49538 through 49578, in Table 4G—Pre-Reclassified Wage Index for Urban Areas, the table is corrected to read as follows:

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

CBSA code	Urban area (constituent counties)	Wage index
10180	*Abilene, TX	0.7997
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	
10380	Aguadilla-Isabela-San Sebastián, PR	0.4274
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	
10420	Akron, OH	0.9042
	Portage County, OH	
	Summit County, OH	
10500	Albany, GA	1.1277
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	
10580	Albany-Schenectady-Troy, NY	0.8668
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	
10740	Albuquerque, NM	1.0486
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
10780	Alexandria, LA	0.8178
	Grant Parish, LA	
	Rapides Parish, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ	1.1277
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.8452
	Blair County, PA	
11100	Amarillo, TX	0.9177
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	0.9480
	Story County, IA	
11260	Anchorage, AK	1.2164
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.8753
	Madison County, IN	
11340	Anderson, SC	0.8705
	Anderson County, SC	
11460	Ann Arbor, MI	1.1037
	Washtenaw County, MI	
11500	*Anniston-Oxford, AL	0.7898
	Calhoun County, AL	
11540	*Appleton, WI	0.9489
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9208
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	1.0173
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	0.9960
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City, NJ	1.1277

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
12220	Atlantic County, NJ	0.8221
	Auburn-Opelika, AL	
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	0.9156
	Burke County, GA	0.9597
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	
12420	Austin-Round Rock, TX	
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	*Bakersfield, CA	1.0450
	Kern County, CA	0.9892
12580	Baltimore-Towson, MD	
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	
12620	Bangor, ME	0.9937
	Penobscot County, ME	1.2327
12700	Barnstable Town, MA	
	Barnstable County, MA	0.8322
12940	Baton Rouge, LA	
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	
12980	Battle Creek, MI	0.9345
	Calhoun County, MI	0.9579
13020	Bay City, MI	
	Bay County, MI	0.8617
13140	Beaumont-Port Arthur, TX	
	Hardin County, TX	1.1605
	Jefferson County, TX	
	Orange County, TX	
13380	Bellingham, WA	
	Whatcom County, WA	1.0560
13460	Bend, OR	
	Deschutes County, OR	1.0935
13644	Bethesda-Frederick-Gaithersburg, MD	
	Frederick County, MD	
	Montgomery County, MD	0.8973
13740	Billings, MT	
	Carbon County, MT	
	Yellowstone County, MT	0.8464
13780	Binghamton, NY	
	Broome County, NY	
	Tioga County, NY	0.9157
13820	Birmingham-Hoover, AL	
	Bibb County, AL	
	Blount County, AL	
	Chilton County, AL	
	Jefferson County, AL	
	St. Clair County, AL	
	Shelby County, AL	
	Walker County, AL	
13900	*Bismarck, ND	
	Burleigh County, ND	0.7750

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
13980	Morton County, ND *Blacksburg-Christiansburg-Radford, VA	0.8062
	Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	
14020	*Bloomington, IN	0.8657
	Greene County, IN Monroe County, IN Owen County, IN	
14060	Bloomington-Normal, IL	0.9110
	McLean County, IL	
14260	Boise City-Nampa, ID	0.9338
	Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	
14484	Boston-Quincy, MA	1.1766
	Norfolk County, MA Plymouth County, MA Suffolk County, MA	
14500	Boulder, CO	1.0044
	Boulder County, CO	
14540	Bowling Green, KY	0.8141
	Edmonson County, KY Warren County, KY	
14740	Bremerton-Silverdale, WA	1.0608
	Kitsap County, WA	
14860	Bridgeport-Stamford-Norwalk, CT	1.2846
	Fairfield County, CT	
15180	Brownsville-Harlingen, TX	1.0158
	Cameron County, TX	
15260	Brunswick, GA	1.1958
	Brantley County, GA Glynn County, GA McIntosh County, GA	
15380	Buffalo-Niagara Falls, NY	0.9332
	Erie County, NY Niagara County, NY	
15500	Burlington, NC	0.8954
	Alamance County, NC	
15540	*Burlington-South Burlington, VT	0.9356
	Chittenden County, VT Franklin County, VT Grand Isle County, VT	
15764	Cambridge-Newton-Framingham, MA	1.1184
	Middlesex County, MA	
15804	Camden, NJ	1.1277
	Burlington County, NJ Camden County, NJ Gloucester County, NJ	
15940	Canton-Massillon, OH	0.8908
	Carroll County, OH Stark County, OH	
15980	Cape Coral-Fort Myers, FL	0.9338
	Lee County, FL	
16180	Carson City, NV	1.0336
	Carson City, NV	
16220	Casper, WY	0.9235
	Natrona County, WY	
16300	Cedar Rapids, IA	0.8963
	Benton County, IA Jones County, IA Linn County, IA	
16580	Champaign-Urbana, IL	0.9515
	Champaign County, IL Ford County, IL Piatt County, IL	
16620	Charleston, WV	0.8877
	Boone County, WV	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
16700	Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV Charleston-North Charleston, SC	0.9415
16740	Berkeley County, SC Charleston County, SC Dorchester County, SC Charlotte-Gastonia-Concord, NC-SC	0.9698
16820	Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Stanly, NC Union County, NC York County, SC Charlottesville, VA	1.0292
16860	Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA Chattanooga, TN-GA	0.9208
16940	Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN *Cheyenne, WY	0.9172
16974	Laramie County, WY Chicago-Naperville-Joliet, IL	1.0864
17020	Cook County, IL DeKalb County, IL DuPage County, IL Grundey County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL Chico, CA	1.0546
17140	Butte County, CA Cincinnati-Middletown, OH-KY-IN	0.9497
17300	Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH Clarks ville, TN-KY	0.8004
17420	Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN *Cleveland, TN	0.7896
17460	Bradley County, TN Polk County, TN Cleveland-Elyria-Mentor, OH	0.9644
	Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
17660	Medina County, OH	0.9325
	Coeur d'Alene, ID	
	Kootenai County, ID	
17780	College Station-Bryan, TX	0.9246
	Brazos County, TX	
	Burleson County, TX	
17820	Robertson County, TX	0.9771
	Colorado Springs, CO	
	El Paso County, CO	
17860	Teller County, CO	0.8388
	Columbia, MO	
	Boone County, MO	
17900	Howard County, MO	0.9402
	Columbia, SC	
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	
	Russell County, AL	0.8691
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	
18020	Columbus, IN	
	Bartholomew County, IN	0.9387
18140	Columbus, OH	
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
18580	Union County, OH	0.8645
	Corpus Christi, TX	
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	
18700	Corvallis, OR	
	Benton County, OR	1.0517
19060	*Cumberland, MD-WV (MD Hospitals)	
	Allegany County, MD	
	Mineral County, WV	0.9225
19060	Cumberland, MD-WV (WV Hospitals)	
	Allegany County, MD	
	Mineral County, WV	
19124	Dallas-Plano-Irving, TX	
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	
	Murray County, GA	
	Whitfield County, GA	0.9546
19180	Danville, IL	
	Vermilion County, IL	
19260	Danville, VA	0.8404
	Pittsylvania County, VA	
	Danville City, VA	
19340	Davenport-Moline-Rock Island, IA-IL	0.8660
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	0.8758
	Scott County, IA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
19380	Dayton, OH	0.9299
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	
19460	Decatur, AL	0.8893
	Lawrence County, AL	
	Morgan County, AL	
19500	*Decatur, IL	0.8346
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.8899
	Volusia County, FL	
19740	Denver-Aurora, CO	1.0879
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines, IA	0.9266
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI	1.0362
	Wayne County, MI	
20020	*Dothan, AL	0.7646
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	
20100	*Dover, DE	0.9866
	Kent County, DE	
20220	Dubuque, IA	0.8730
	Dubuque County, IA	
20260	Duluth, MN-WI	1.0329
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	
20500	Durham, NC	1.0322
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	
20740	*Eau Claire, WI	0.9489
	Chippewa County, WI	
	Eau Claire County, WI	
20764	Edison, NJ	1.1277
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	
20940	*El Centro, CA	1.0450
	Imperial County, CA	
21060	Elizabethtown, KY	0.8690
	Hardin County, KY	
	Larue County, KY	
21140	Elkhart-Goshen, IN	0.9257
	Elkhart County, IN	
21300	Elmira, NY	0.8464
	Chemung County, NY	
21340	El Paso, TX	0.9213
	El Paso County, TX	
21500	Erie, PA	0.8700
	Erie County, PA	
21604	Essex County, MA	1.0654
	Essex County, MA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
21660	Eugene-Springfield, OR	1.0921
	Lane County, OR	
21780	*Evansville, IN-KY (IN Hospitals)	0.8657
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	
21780	Evansville, IN-KY (KY Hospitals)	0.8386
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	
21820	*Fairbanks, AK	1.1733
	Fairbanks North Star Borough, AK	
21940	Fajardo, PR	0.3942
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	
22020	*Fargo, ND-MN (MN Hospitals)	0.9330
	Cass County, ND	
	Clay County, MN	
22020	*Fargo, ND-MN (ND Hospitals)	0.9106
	Cass County, ND	
	Clay County, MN	
22140	*Farmington, NM	0.8684
	San Juan County, NM	
22180	Fayetteville, NC	0.9363
	Cumberland County, NC	
	Hoke County, NC	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8656
	Benton County, AR	
	Madison County, AR	
	Washington County, AR	
	McDonald County, MO	
22380	Flagstaff, AZ	1.0777
	Coconino County, AZ	
22420	Flint, MI	1.1165
	Genesee County, MI	
22500	Florence, SC	0.8857
	Darlington County, SC	
	Florence County, SC	
22520	Florence-Muscle Shoals, AL	0.7906
	Colbert County, AL	
	Lauderdale County, AL	
22540	Fond du Lac, WI	0.9896
	Fond du Lac County, WI	
22660	Fort Collins-Loveland, CO	1.0187
	Larimer County, CO	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0153
	Broward County, FL	
22900	Fort Smith, AR-OK	0.8300
	Crawford County, AR	
	Franklin County, AR	
	Sebastian County, AR	
	Le Flore County, OK	
	Sequoyah County, OK	
23020	Fort Walton Beach-Crestview-Destin, FL	0.8781
	Okaloosa County, FL	
23060	Fort Wayne, IN	0.9802
	Allen County, IN	
	Wells County, IN	
	Whitley County, IN	
23104	Fort Worth-Arlington, TX	0.9476
	Johnson County, TX	
	Parker County, TX	
	Tarrant County, TX	
	Wise County, TX	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
23420	Fresno, CA	1.0648
	Fresno County, CA	
23460	Gadsden, AL	0.8077
	Etowah County, AL	
23540	*Gainesville, FL	0.9446
	Alachua County, FL	
	Gilchrist County, FL	
23580	Gainesville, GA	0.9572
	Hall County, GA	
23844	Gary, IN	0.9306
	Jasper County, IN	
	Lake County, IN	
	Newton County, IN	
	Porter County, IN	
24020	Glens Falls, NY	0.8486
	Warren County, NY	
	Washington County, NY	
24140	Goldsboro, NC	0.8776
	Wayne County, NC	
24220	*Grand Forks, ND-MN (MN Hospitals)	0.9330
	Polk County, MN	
	Grand Forks County, ND	
24220	Grand Forks, ND-MN (ND Hospitals)	0.9147
	Polk County, MN	
	Grand Forks County, ND	
24300	Grand Junction, CO	0.9932
	Mesa County, CO	
24340	Grand Rapids-Wyoming, MI	0.9418
	Barry County, MI	
	Ionia County, MI	
	Kent County, MI	
	Newaygo County, MI	
24500	Great Falls, MT	0.8789
	Cascade County, MT	
24540	Greeley, CO	0.9461
	Weld County, CO	
24580	Green Bay, WI	0.9578
	Brown County, WI	
	Kewaunee County, WI	
	Oconto County, WI	
24660	Greensboro-High Point, NC	0.9209
	Guilford County, NC	
	Randolph County, NC	
	Rockingham County, NC	
24780	Greenville, NC	0.9162
	Greene County, NC	
	Pitt County, NC	
24860	Greenville, SC	0.9532
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	
25020	Guayama, PR	0.4008
	Arroyo Municipio, PR	
	Guayama Municipio, PR	
	Patillas Municipio, PR	
25060	Gulfport-Biloxi, MS	0.8934
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	
25180	Hagerstown-Martinsburg, MD-WV	0.9744
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	
25260	*Hanford-Corcoran, CA	1.0450
	Kings County, CA	
25420	Harrisburg-Carlisle, PA	0.9354
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	
25500	Harrisonburg, VA	0.9278
	Rockingham County, VA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
25540	Harrisonburg City, VA *Hartford-West Hartford-East Hartford, CT	1.1583
	Hartford County, CT Litchfield County, CT Middlesex County, CT Tolland County, CT	
25620	*Hattiesburg, MS	0.7649
	Forrest County, MS Lamar County, MS Perry County, MS	
25860	Hickory-Lenoir-Morganton, NC	0.9510
	Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	
25980	*Hinesville-Fort Stewart, GA	0.7752
	Liberty County, GA Long County, GA	
26100	Holland-Grand Haven, MI	0.9424
	Ottawa County, MI	
26180	Honolulu, HI	1.1012
	Honolulu County, HI	
26300	Hot Springs, AR	0.9268
	Garland County, AR	
26380	Houma-Bayou Cane-Thibodaux, LA	0.7761
	Lafourche Parish, LA Terrebonne Parish, LA	
26420	Houston-Baytown-Sugar Land, TX	0.9975
	Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	
26580	Huntington-Ashland, WV-KY-OH	0.9560
	Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	
26620	Huntsville, AL	0.8826
	Limestone County, AL Madison County, AL	
26820	Idaho Falls, ID	0.8525
	Bonneville County, ID Jefferson County, ID	
26900	Indianapolis, IN	1.0104
	Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	
26980	Iowa City, IA	0.9649
	Johnson County, IA Washington County, IA	
27060	Ithaca, NY	0.9640
	Tompkins County, NY	
27100	Jackson, MI	0.9133
	Jackson County, MI	
27140	Jackson, MS	0.8285
	Copiah County, MS Hinds County, MS	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
27180	Madison County, MS Rankin County, MS Simpson County, MS Jackson, TN	0.8891
27260	Chester County, TN Madison County, TN Jacksonville, FL	0.9553
27340	Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL *Jacksonville, NC	0.8570
27500	Onslow County, NC Janesville, WI	0.9597
27620	Rock County, WI Jefferson City, MO	0.8332
27740	Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO Johnson City, TN	0.8162
27780	Carter County, TN Unicoi County, TN Washington County, TN Johnstown, PA	0.8365
27860	Cambria County, PA Jonesboro, AR	0.8195
27900	Craighead County, AR Poinsett County, AR Joplin, MO	0.8725
28020	Jasper County, MO Newton County, MO Kalamazoo-Portage, MI	1.0689
28100	Kalamazoo County, MI Van Buren County, MI Kankakee-Bradley, IL	1.0618
28140	Kankakee County, IL Kansas City, MO-KS	0.9617
28420	Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO Kennewick-Richland-Pasco, WA	1.0508
28660	Benton County, WA Franklin County, WA Killeen-Temple-Fort Hood, TX	0.9276
28700	Bell County, TX Coryell County, TX Lampasas County, TX Kingsport-Bristol-Bristol, TN-VA	0.8235
28740	Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA Kingston, NY	0.9002
28940	Ulster County, NY Knoxville, TN	0.8564
	Anderson County, TN	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
29020	Blount County, TN Knox County, TN Loudon County, TN Union County, TN Kokomo, IN	0.9023
29100	Howard County, IN Tipton County, IN *La Crosse, WI-MN (MN Hospitals)	0.9330
29100	Houston County, MN La Crosse County, WI *La Crosse, WI-MN (WI Hospitals)	0.9489
29140	Houston County, MN La Crosse County, WI Lafayette, IN	0.9051
29180	Benton County, IN Carroll County, IN Tippecanoe County, IN Lafayette, LA	0.8299
29340	Lafayette Parish, LA St. Martin Parish, LA Lake Charles, LA	0.7940
29404	Calcasieu Parish, LA Cameron Parish, LA Lake County-Kenosha County, IL-WI	1.0348
29460	Lake County, IL Kenosha County, WI Lakeland, FL	0.8943
29540	Polk County, FL Lancaster, PA	0.9896
29620	Lancaster County, PA Lansing-East Lansing, MI	0.9653
29700	Clinton County, MI Eaton County, MI Ingham County, MI Laredo, TX	0.8775
29740	Webb County, TX Las Cruces, NM	0.8759
29820	Dona Ana County, NM Las Vegas-Paradise, NV	1.1345
29940	Clark County, NV *Lawrence, KS	0.8123
30020	Douglas County, KS Lawton, OK	0.8249
30140	Comanche County, OK Lebanon, PA	0.8758
30300	Lebanon County, PA *Lewiston, ID-WA (ID Hospitals)	0.9300
30300	Nez Perce County, ID Asotin County, WA Lewiston, ID-WA (WA Hospitals)	0.9837
30340	Nez Perce County, ID Asotin County, WA Lewiston-Auburn, ME	0.9552
30460	Androscoggin County, ME Lexington-Fayette, KY	0.9336
30620	Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	
30700	Lima, OH	0.9310
30780	Allen County, OH Lincoln, NE	1.0180
	Lancaster County, NE Seward County, NE Little Rock-North Little Rock, AR	0.8840
	Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
30860	Pulaski County, AR Saline County, AR Logan, UT-ID	0.9105
30980	Franklin County, ID Cache County, UT Longview, TX	0.8802
31020	Gregg County, TX Rusk County, TX Upshur County, TX *Longview, WA	1.0208
31084	Cowlitz County, WA Los Angeles-Long Beach-Glendale, CA	1.1742
31140	Los Angeles County, CA Louisville, KY-IN	0.9126
31180	Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY Lubbock, TX	0.8774
31340	Crosby County, TX Lubbock County, TX Lynchburg, VA	0.9026
31420	Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA Macon, GA	0.9922
31460	Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA *Madera, CA	1.0450
31540	Madera County, CA Madison, WI	1.0301
31700	Columbia County, WI Dane County, WI Iowa County, WI Manchester-Nashua, NH	1.0633
31900	Hillsborough County, NH Merrimack County, NH Mansfield, OH	0.9200
32420	Richland County, OH Mayagüez, PR	0.4492
32580	Hormigueros Municipio, PR Mayagüez Municipio, PR McAllen-Edinburg-Pharr, TX	0.8603
32780	Hidalgo County, TX Medford, OR	1.0533
32820	Jackson County, OR Memphis, TN-MS-AR	0.9223
32900	Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN *Merced, CA	1.0526

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
33124	Merced County, CA	
33124	Miami-Miami Beach-Kendall, FL	0.9868
33140	Miami-Dade County, FL	
33140	Michigan City-La Porte, IN	0.9332
33260	LaPorte County, IN	
33260	Midland, TX	0.9383
33340	Midland County, TX	
33340	Milwaukee-Waukesha-West Allis, WI	1.0081
33460	Milwaukee County, WI	
33460	Ozaukee County, WI	
33460	Washington County, WI	
33460	Waukesha County, WI	
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1044
33540	Anoka County, MN	
33540	Carver County, MN	
33540	Chisago County, MN	
33540	Dakota County, MN	
33540	Hennepin County, MN	
33540	Isanti County, MN	
33540	Ramsey County, MN	
33540	Scott County, MN	
33540	Sherburne County, MN	
33540	Washington County, MN	
33540	Wright County, MN	
33540	Pierce County, WI	
33540	St. Croix County, WI	
33540	Missoula, MT	0.9580
33660	Missoula County, MT	
33700	Mobile, AL	0.7997
33700	Mobile County, AL	
33740	Modesto, CA	1.1993
33740	Stanislaus County, CA	
33780	Monroe, LA	0.7908
33780	Ouachita Parish, LA	
33780	Union Parish, LA	
33860	Monroe, MI	0.9498
33860	Monroe County, MI	
34060	Montgomery, AL	0.8311
34060	Autauga County, AL	
34060	Elmore County, AL	
34060	Lowndes County, AL	
34060	Montgomery County, AL	
34100	Morgantown, WV	0.8741
34100	Monongalia County, WV	
34100	Preston County, WV	
34580	*Morristown, TN	0.7896
34580	Grainger County, TN	
34580	Hamblen County, TN	
34580	Jefferson County, TN	
34620	Mount Vernon-Anacortes, WA	1.0554
34620	Skagit County, WA	
34740	*Muncie, IN	0.8657
34740	Delaware County, IN	
34820	Muskegon-Norton Shores, MI	0.9743
34820	Muskegon County, MI	
34900	Myrtle Beach-Conway-North Myrtle Beach, SC	0.9017
34900	Horry County, SC	
34940	Napa, CA	1.2517
34940	Napa County, CA	
34980	Naples-Marco Island, FL	1.0531
34980	Collier County, FL	
34980	Nashville-Davidson--Murfreesboro, TN	1.0074
34980	Cannon County, TN	
34980	Cheatham County, TN	
34980	Davidson County, TN	
34980	Dickson County, TN	
34980	Hickman County, TN	
34980	Macon County, TN	
34980	Robertson County, TN	
34980	Rutherford County, TN	
34980	Smith County, TN	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
35004	Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2928
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1680
35300	New Haven-Milford, CT New Haven County, CT	1.1830
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9100
35644	New York-Wayne-White Plains, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3318
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8901
35980	Norwich-New London, CT New London County, CT	1.1627
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.5205
36100	Ocala, FL Marion County, FL	0.9174
36140	Ocean City, NJ Cape May County, NJ	1.1277
36220	Odessa, TX Ector County, TX	0.9797
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9214
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8985
36500	Olympia, WA Thurston County, WA	1.1005
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE	0.9740

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
36740	Washington County, NE Orlando, FL	0.9731
	Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	
36780	*Oshkosh-Neenah, WI	0.9489
36980	Winnebago County, WI Owensboro, KY	0.8450
	Daviess County, KY Hancock County, KY McLean County, KY	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1099
37340	Ventura County, CA Palm Bay-Melbourne-Titusville, FL	0.9625
37460	Brevard County, FL *Panama City-Lynn Haven, FL	0.8545
37620	Bay County, FL *Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8692
	Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	
37620	Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8315
	Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	
37700	Pascagoula, MS	0.7974
	George County, MS Jackson County, MS	
37860	*Pensacola-Ferry Pass-Brent, FL	0.8545
	Escambia County, FL Santa Rosa County, FL	
37900	Peoria, IL	0.8862
	Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	
37964	Philadelphia, PA	1.0855
	Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	0.9985
	Maricopa County, AZ Pinal County, AZ	
38220	Pine Bluff, AR	0.8700
	Cleveland County, AR Jefferson County, AR Lincoln County, AR	
38300	Pittsburgh, PA	0.8723
	Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	
38340	Pittsfield, MA	1.0439
38540	Berkshire County, MA Pocatello, ID	0.9589
	Bannock County, ID Power County, ID	
38660	Ponce, PR	0.5006
	Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	
38860	Portland-South Portland-Biddeford, ME	1.0102

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
38900	Cumberland County, ME Sagadahoc County, ME York County, ME Portland-Vancouver-Beaverton, OR-WA	1.1371
	Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	
38940	Port St. Lucie-Fort Pierce, FL	1.0053
	Martin County, FL St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1364
	Dutchess County, NY Orange County, NY	
39140	Prescott, AZ	0.9681
39300	Yavapai County, AZ Providence-New Bedford-Fall River, RI-MA	1.0916
	Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	
39340	Provo-Orem, UT	0.9572
	Juab County, UT Utah County, UT	
39380	*Pueblo, CO	0.9356
	Pueblo County, CO	
39460	Punta Gorda, FL	0.9451
	Charlotte County, FL	
39540	*Racine, WI	0.9489
	Racine County, WI	
39580	Raleigh-Cary, NC	1.0034
	Franklin County, NC Johnston County, NC Wake County, NC	
39660	Rapid City, SD	0.8919
	Meade County, SD Pennington County, SD	
39740	Reading, PA	0.9218
	Berks County, PA	
39820	Redding, CA	1.1830
	Shasta County, CA	
39900	Reno-Sparks, NV	1.0446
	Storey County, NV Washoe County, NV	
40060	Richmond, VA	0.9379
	Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	
40140	Riverside-San Bernardino-Ontario, CA	1.0979

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
40220	Riverside County, CA San Bernardino County, CA Roanoke, VA	0.8429
	Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	
40340	Rochester, MN	1.1490
	Dodge County, MN Olmsted County, MN Wabasha County, MN	
40380	Rochester, NY	0.9283
	Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	
40420	Rockford, IL	0.9607
	Boone County, IL Winnebago County, IL	
40484	Rockingham County-Strafford County, NH	1.0205
	Rockingham County, NH Strafford County, NH	
40580	Rocky Mount, NC	0.8997
	Edgecombe County, NC Nash County, NC	
40660	Rome, GA	0.8870
	Floyd County, GA	
40900	Sacramento—Arden-Arcade—Roseville, CA	1.1681
	El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	
40980	Saginaw-Saginaw Township North, MI	0.9868
	Saginaw County, MI	
41060	St. Cloud, MN	1.0271
	Benton County, MN Stearns County, MN	
41100	St. George, UT	0.9473
	Washington County, UT	
41140	*St. Joseph, MO-KS (KS Hospitals)	0.8123
	Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	
41140	*St. Joseph, MO-KS (MO Hospitals)	0.8009
	Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	
41180	St. Louis, MO-IL	0.9080
	Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	
41420	Salem, OR	1.0549

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
41500	Marion County, OR Polk County, OR Salinas, CA	1.3820
41540	Monterey County, CA *Salisbury, MD	0.9225
41620	Somerset County, MD Wicomico County, MD Salt Lake City, UT	0.9564
41660	Salt Lake County, UT Summit County, UT Tooele County, UT San Angelo, TX	0.8174
41700	Irion County, TX Tom Green County, TX San Antonio, TX	0.9000
41740	Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX San Diego-Carlsbad-San Marcos, CA	1.1260
41780	San Diego County, CA Sandusky, OH	0.9023
41884	Erie County, OH San Francisco-San Mateo-Redwood City, CA	1.4694
41900	Marin County, CA San Francisco County, CA San Mateo County, CA San Germán-Cabo Rojo, PR	0.5230
41940	Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR San Jose-Sunnyvale-Santa Clara, CA	1.4712
41980	San Benito County, CA Santa Clara County, CA San Juan-Caguas-Guaynabo, PR	0.4644
	Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerio Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA	1.1115
	San Luis Obispo County, CA	
42044	Santa Ana-Anaheim-Irvine, CA	1.1601
	Orange County, CA	
42060	Santa Barbara-Santa Maria-Goleta, CA	1.0757
	Santa Barbara County, CA	
42100	Santa Cruz-Watsonville, CA	1.4759
	Santa Cruz County, CA	
42140	Santa Fe, NM	1.0885
	Santa Fe County, NM	
42220	Santa Rosa-Petaluma, CA	1.2938
	Sonoma County, CA	
42260	Sarasota-Bradenton-Venice, FL	0.9610
	Manatee County, FL	
	Sarasota County, FL	
42340	Savannah, GA	0.9464
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	
42540	Scranton-Wilkes-Barre, PA	0.8525
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	
42644	Seattle-Bellevue-Everett, WA	1.1476
	King County, WA	
	Snohomish County, WA	
43100	*Sheboygan, WI	0.9489
	Sheboygan County, WI	
43300	Sherman-Denison, TX	0.9619
	Grayson County, TX	
43340	Shreveport-Bossier City, LA	0.9130
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	
43580	Sioux City, IA-NE-SD	0.9054
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	
43620	Sioux Falls, SD	0.9414
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	
43780	South Bend-Mishawaka, IN-MI	0.9434
	St. Joseph County, IN	
	Cass County, MI	
43900	Spartanburg, SC	0.9521
	Spartanburg County, SC	
44060	Spokane, WA	1.0643
	Spokane County, WA	
44100	Springfield, IL	0.8732
	Menard County, IL	
	Sangamon County, IL	
44140	*Springfield, MA	1.0439
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	
44180	Springfield, MO	0.8562
	Christian County, MO	
	Dallas County, MO	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
44220	Greene County, MO Polk County, MO Webster County, MO Springfield, OH	0.8741
44300	Clark County, OH State College, PA	0.8465
44700	Centre County, PA Stockton, CA	1.0583
44940	San Joaquin County, CA *Sumter, SC	0.8705
45060	Sumter County, SC Syracuse, NY	0.9482
45104	Madison County, NY Onondaga County, NY Oswego County, NY Tacoma, WA	1.1074
45220	Pierce County, WA Tallahassee, FL	0.8671
45300	Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL Tampa-St. Petersburg-Clearwater, FL	0.9074
45460	Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL *Terre Haute, IN	0.8657
45500	Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN Texarkana, TX-Texarkana, AR	0.8415
45780	Miller County, AR Bowie County, TX Toledo, OH	0.9514
45820	Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH Topeka, KS	0.8896
45940	Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS Trenton-Ewing, NJ	1.1277
46060	Mercer County, NJ Tucson, AZ	0.9102
46140	Pima County, AZ Tulsa, OK	0.8717
46220	Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK Tuscaloosa, AL	0.8339
46340	Greene County, AL Hale County, AL Tuscaloosa County, AL Tyler, TX	0.9516
46540	Smith County, TX Utica-Rome, NY	0.8316
46660	Herkimer County, NY Oneida County, NY Valdosta, GA	0.8334
	Brooks County, GA Echols County, GA Lanier County, GA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
46700	Lowndes County, GA	1.4269
	Vallejo-Fairfield, CA	
	Solano County, CA	
46940	Vero Beach, FL	0.9492
47020	Indian River County, FL	0.8456
	Victoria, TX	
	Calhoun County, TX	
	Goliad County, TX	
47220	Victoria County, TX	1.1277
	Vineland-Millville-Bridgeton, NJ	
47260	Cumberland County, NJ	0.8928
	Virginia Beach-Norfolk-Newport News, VA-NC	
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	*Visalia-Porterville, CA	1.0450
	Tulare County, CA	0.8151
47380	Waco, TX	
47580	McLennan County, TX	0.8496
	Warner Robins, GA	
47644	Houston County, GA	1.0109
	Warren-Farmington Hills-Troy, MI	
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
47894	St. Clair County, MI	1.1026
	Washington-Arlington-Alexandria, DC-VA-MD-WV	
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Fauquier County, VA	
	Loudoun County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA	
	Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg City, VA	
	Manassas City, VA	
	Manassas Park City, VA	
47940	Jefferson County, WV	0.8629
	Waterloo-Cedar Falls, IA	
	Black Hawk County, IA	
	Bremer County, IA	
48140	Grundy County, IA	0.9628
	Wausau, WI	
48260	Marathon County, WI	0.8692
	*Weirton-Steubenville, WV-OH (OH Hospitals)	
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
48260	Weirton-Steubenville, WV-OH (WV Hospitals)	0.8274
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	
48300	*Wenatchee, WA	1.0949
	Chelan County, WA	
	Douglas County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0348
	Palm Beach County, FL	
48540	*Wheeling, WV-OH (OH Hospitals)	0.8692
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48540	*Wheeling, WV-OH (WV Hospitals)	0.7882
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9472
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	
48660	Wichita Falls, TX	0.8365
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	
48700	Williamsport, PA	0.8476
	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ (DE and MD Hospitals)	1.1095
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	
48864	*Wilmington, DE-MD-NJ (NJ Hospitals)	1.1277
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	
48900	Wilmington, NC	0.9225
	Brunswick County, NC	
	New Hanover County, NC	
	Pender County, NC	
49020	Winchester, VA-WV	1.0486
	Frederick County, VA	
	Winchester City, VA	
	Hampshire County, WV	
49180	Winston-Salem, NC	0.9410
	Davie County, NC	
	Forsyth County, NC	
	Stokes County, NC	
	Yadkin County, NC	
49340	Worcester, MA	1.1001
	Worcester County, MA	
49420	Yakima, WA	1.0317
	Yakima County, WA	
49500	Yauco, PR	0.4493
	Guánica Municipio, PR	
	Guayanilla Municipio, PR	
	Peñuelas Municipio, PR	
	Yauco Municipio, PR	
49620	York-Hanover, PA	0.9152
	York County, PA	
49660	Youngstown-Warren-Boardman, OH-PA	0.9234
	Mahoning County, OH	
	Trumbull County, OH	
	Mercer County, PA	
49700	*Yuba City, CA	1.0450
	Sutter County, CA	
	Yuba County, CA	
49740	*Yuma, AZ	0.9102
	Yuma County, AZ	

*Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2005.

25. On pages 49579 through 49580, in Table 4H—Pre-Reclassified Wage Index for Rural Areas, the table is corrected to read as follows:

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS

CBSA code	Nonurban area	Wage index
01	Alabama	0.7646
02	Alaska	1.1733
03	Arizona	0.9102
04	Arkansas	0.7433
05	California	1.0450
06	Colorado	0.9356
07	Connecticut	1.1583
08	Delaware	0.9504
10	Florida	0.8545
11	Georgia	0.7752
12	Hawaii	1.0558
13	Idaho	0.8525
14	Illinois	0.8346
15	Indiana	0.8657
16	Iowa	0.8478
17	Kansas	0.8123
18	Kentucky	0.7769
19	Louisiana	0.7370
20	Maine	0.9027
21	Maryland	0.9225
22	Massachusetts ¹	1.0439
23	Michigan	0.8783
24	Minnesota	0.9330
25	Mississippi	0.7649
26	Missouri	0.8009
27	Montana	0.8693
28	Nebraska	0.9040
29	Nevada	0.9286
30	New Hampshire	0.9931
31	New Jersey ¹	1.1277
32	New Mexico	0.8684
33	New York	0.8166
34	North Carolina	0.8570
35	North Dakota	0.7750
36	Ohio	0.8692
37	Oklahoma	0.7711
38	Oregon	0.9931
39	Pennsylvania	0.8309
40	Puerto Rico ¹ .....	.....
41	Rhode Island ¹	0.9244
42	South Carolina	0.8705
43	South Dakota	0.8390
44	Tennessee	0.7896
45	Texas	0.7997
46	Utah	0.8297
47	Vermont	0.9356
49	Virginia	0.8062
50	Washington	0.9837
51	West Virginia	0.7882
52	Wisconsin	0.9489
53	Wyoming	0.9172

¹ All counties within the State are classified as urban.

26. On pages 49580 through 49591, in Table 4J—Out Migration Adjustment, the table is corrected to read as follows:

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are

reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act are designated with an asterisk. Hospitals have the opportunity to use the new additional 30-day period to review their individual situation to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. We will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Hospitals are not required to provide CMS with any type of formal notification that they wish to remain reclassified/redesignated.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT

Provider No.	Out-migration adjustment	Qualifying county name
010005*	0.0259	Marshall
010008*	0.0212	Crenshaw
010010	0.0259	Marshall
010012	0.0205	De Kalb
010022*	0.0714	Cherokee
010029*	0.0107	Lee
010035*	0.0375	Cullman
010038	0.0062	Calhoun
010045*	0.0160	Fayette
010047	0.0155	Butler
010061	0.0506	Jackson
010072*	0.0310	Talladega
010078	0.0062	Calhoun
010083	0.0121	Baldwin
010100	0.0121	Baldwin
010101*	0.0310	Talladega
010115	0.0093	Franklin
010129	0.0121	Baldwin
010143*	0.0375	Cullman
010146	0.0062	Calhoun
010150*	0.0155	Butler
010158*	0.0093	Franklin
040014*	0.0159	White
040019*	0.0697	St. Francis
040047*	0.0090	Randolph
040066*	0.0382	Clark
040069*	0.0140	Mississippi
040070*	0.0140	Mississippi
040071	0.0026	Jefferson
040076	0.1075	Hot Spring
040100	0.0159	White
040143	0.0026	Jefferson
050009	0.0478	Napa
050013	0.0478	Napa
050014*	0.0131	Amador
050042*	0.0219	Tehama
050046*	0.0156	Ventura
050065	0.0029	Orange
050069	0.0029	Orange

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
050073*	0.0269	Solano
050082*	0.0156	Ventura
050084	0.0555	San Joaquin
050089	0.0152	San Bernardino
050090	0.0308	Sonoma
050099	0.0152	San Bernardino
050101	0.0269	Solano
050117	0.0463	Merced
050118	0.0555	San Joaquin
050122	0.0555	San Joaquin
050129	0.0152	San Bernardino
050133	0.0170	Yuba
050136	0.0308	Sonoma
050140	0.0152	San Bernardino
050150*	0.0316	Nevada
050159*	0.0156	Ventura
050167	0.0555	San Joaquin
050168	0.0029	Orange
050173	0.0029	Orange
050174*	0.0308	Sonoma
050177*	0.0156	Ventura
050193	0.0029	Orange
050224	0.0029	Orange
050226	0.0029	Orange
050230	0.0029	Orange
050236*	0.0156	Ventura
050245	0.0152	San Bernardino
050253	0.0029	Orange
050272	0.0152	San Bernardino
050279	0.0152	San Bernardino
050291	0.0308	Sonoma
050298	0.0152	San Bernardino
050300	0.0152	San Bernardino
050313	0.0555	San Joaquin
050325*	0.0176	Tuolumne
050327	0.0152	San Bernardino
050331	0.0308	Sonoma
050335	0.0176	Tuolumne
050336	0.0555	San Joaquin
050348	0.0029	Orange
050367	0.0269	Solano
050385	0.0308	Sonoma
050394*	0.0156	Ventura
050426	0.0029	Orange
050444	0.0463	Merced
050469*	0.0152	San Bernardino
050476	0.0257	Lake
050491	0.0029	Orange
050494*	0.0316	Nevada
050517	0.0152	San Bernardino
050526	0.0029	Orange
050528*	0.0463	Merced
050535	0.0029	Orange
050539	0.0257	Lake
050543	0.0029	Orange
050547	0.0308	Sonoma
050548	0.0029	Orange
050549*	0.0156	Ventura
050550	0.0029	Orange
050551	0.0029	Orange
050567	0.0029	Orange
050568	0.0062	Madera
050570	0.0029	Orange
050580	0.0029	Orange
050584	0.0152	San Bernardino
050585	0.0029	Orange
050586	0.0152	San Bernardino
050589	0.0029	Orange
050592	0.0029	Orange

TABLE 4J.—OUT-MIGRATION
ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
050594	0.0029	Orange
050603	0.0029	Orange
050609*	0.0029	Orange
050616*	0.0156	Ventura
050618*	0.0152	San Bernardino
050667	0.0478	Napa
050678	0.0029	Orange
050680	0.0269	Solano
050690*	0.0308	Sonoma
050693	0.0029	Orange
050695	0.0555	San Joaquin
050720	0.0029	Orange
050728	0.0308	Sonoma
060001*	0.0294	Weld
060003*	0.0203	Boulder
060027*	0.0203	Boulder
060103*	0.0203	Boulder
070003*	0.0009	Windham
070006*	0.0047	Fairfield
070010*	0.0047	Fairfield
070018*	0.0047	Fairfield
070020	0.0073	Middlesex
070021*	0.0009	Windham
070028*	0.0047	Fairfield
070033*	0.0047	Fairfield
070034*	0.0047	Fairfield
100014	0.0118	Volusia
100017	0.0118	Volusia
100045*	0.0118	Volusia
100047	0.0021	Charlotte
100062	0.0060	Marion
100068	0.0118	Volusia
100072	0.0118	Volusia
100077	0.0021	Charlotte
100118	0.0398	Flagler
100175	0.0231	De Soto
100212	0.0060	Marion
100232	0.0347	Putnam
100236	0.0021	Charlotte
100252	0.0233	Okeechobee
110023*	0.0500	Gordon
110027	0.0387	Franklin
110029*	0.0063	Hall
110041*	0.0777	Habersham
110063	0.0290	Liberty
110069	0.0474	Houston
110120*	0.0873	Polk
110124	0.0428	Wayne
110136	0.0261	Baldwin
110150*	0.0261	Baldwin
110153	0.0474	Houston
110187*	0.1172	Lumpkin
110189*	0.0031	Fannin
110190	0.0182	Macon
110205*	0.0779	Gilmer
130003*	0.0095	Nez Perce
130011	0.0218	Latah
130024	0.0275	Bonner
130049*	0.0349	Kootenai
140012*	0.0220	Lee
140026	0.0346	La Salle
140033	0.0147	Lake
140043*	0.0046	Whiteside
140058*	0.0081	Morgan
140084	0.0147	Lake
140100	0.0147	Lake
140110*	0.0346	La Salle
140129*	0.0096	Wabash
140130	0.0147	Lake

TABLE 4J.—OUT-MIGRATION
ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
140155*	0.0027	Kankakee
140160*	0.0286	Stephenson
140161*	0.0138	Livingston
140173*	0.0046	Whiteside
140186*	0.0027	Kankakee
140202	0.0147	Lake
140205	0.0163	Boone
140234*	0.0346	La Salle
140291	0.0147	Lake
150022	0.0249	Montgomery
150030*	0.0201	Henry
150035	0.0083	Porter
150045	0.0416	De Kalb
150062	0.0153	Decatur
150065*	0.0139	Jackson
150076*	0.0189	Marshall
150088	0.0196	Madison
150091	0.0573	Huntington
150102*	0.0160	Starke
150113	0.0196	Madison
150122	0.0199	Ripley
160013	0.0218	Muscatine
160026*	0.0496	Boone
160032	0.0272	Jasper
160080*	0.0049	Clinton
160140	0.0364	Plymouth
180012*	0.0083	Hardin
180066*	0.0567	Logan
180127*	0.0352	Franklin
180128	0.0282	Lawrence
190001*	0.0645	Washington
190003*	0.0107	Iberia
190010	0.0401	Tangipahoa
190015*	0.0401	Tangipahoa
190017	0.0235	St. Landry
190049	0.0645	Washington
190054*	0.0107	Iberia
190078	0.0235	St. Landry
190088	0.0705	Webster
190099*	0.0390	Avoyelles
190106*	0.0238	Allen
190133	0.0238	Allen
190144	0.0705	Webster
190147*	0.0401	Tangipahoa
190148*	0.0390	Avoyelles
190191	0.0235	St. Landry
200002*	0.0129	Lincoln
200013	0.0186	Waldo
200024*	0.0071	Androscoggin
200034*	0.0071	Androscoggin
200050*	0.0140	Hancock
210001	0.0129	Washington
210004	0.0040	Montgomery
210016	0.0040	Montgomery
210018	0.0040	Montgomery
210022	0.0040	Montgomery
210023	0.0209	Anne Arundel
210043	0.0209	Anne Arundel
210048	0.0287	Howard
210057	0.0040	Montgomery
220001	0.0056	Worcester
220002	0.0249	Middlesex
220003	0.0056	Worcester
220006	0.0306	Essex
220010	0.0306	Essex
220011	0.0249	Middlesex
220019	0.0056	Worcester
220025	0.0056	Worcester
220028	0.0056	Worcester

TABLE 4J.—OUT-MIGRATION
ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
220029	0.0306	Essex
220033	0.0306	Essex
220035	0.0306	Essex
220049	0.0249	Middlesex
220058	0.0056	Worcester
220062	0.0056	Worcester
220063	0.0249	Middlesex
220070	0.0249	Middlesex
220076	0.0249	Middlesex
220080	0.0306	Essex
220082	0.0249	Middlesex
220084	0.0249	Middlesex
220089	0.0249	Middlesex
220090	0.0056	Worcester
220095	0.0056	Worcester
220098	0.0249	Middlesex
220101	0.0249	Middlesex
220105	0.0249	Middlesex
220163	0.0056	Worcester
220171	0.0249	Middlesex
220174	0.0306	Essex
230003*	0.0035	Ottawa
230013*	0.0091	Oakland
230015	0.0359	St. Joseph
230019*	0.0091	Oakland
230021	0.0136	Berrien
230022*	0.0113	Branch
230029*	0.0091	Oakland
230037*	0.0178	Hillsdale
230041	0.0099	Bay
230042*	0.0685	Allegan
230047	0.0082	Macomb
230069	0.0487	Livingston
230071*	0.0091	Oakland
230072*	0.0035	Ottawa
230075	0.0145	Calhoun
230078*	0.0136	Berrien
230092	0.0389	Jackson
230093*	0.0079	Mecosta
230096*	0.0359	St. Joseph
230099	0.0339	Monroe
230106*	0.0030	Newaygo
230121*	0.0691	Shiawassee
230130*	0.0091	Oakland
230151*	0.0091	Oakland
230174*	0.0035	Ottawa
230184	0.0389	Jackson
230195	0.0082	Macomb
230204	0.0082	Macomb
230207*	0.0091	Oakland
230217	0.0145	Calhoun
230222	0.0228	Midland
230223*	0.0091	Oakland
230227	0.0082	Macomb
230254*	0.0091	Oakland
230257	0.0082	Macomb
230264	0.0082	Macomb
230269*	0.0091	Oakland
230277*	0.0091	Oakland
230279	0.0487	Livingston
230295	0.0685	Allegan
240011*	0.0506	Mc Leod
240013*	0.0226	Morrison
240014	0.0454	Rice
240018*	0.1196	Goodhue
240044	0.0868	Winona
240064*	0.0138	Itasca
240069*	0.0419	Steele
240071*	0.0454	Rice

TABLE 4J.—OUT-MIGRATION
ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
240089*	0.1196	Goodhue
240133	0.0319	Meeker
240152*	0.0735	Kanabec
240154	0.0138	Itasca
240187*	0.0506	Mc Leod
240205	0.0138	Itasca
240211*	0.0705	Pine
250030*	0.0318	Leake
250040	0.0294	Jackson
250045	0.0042	Hancock
250088*	0.0122	Wilkinson
250154*	0.0318	Leake
260011*	0.0007	Cole
260047*	0.0007	Cole
260074	0.0158	Randolph
260097	0.0425	Johnson
260127	0.0158	Pike
280054*	0.0137	Gage
280077*	0.0089	Dodge
280123	0.0137	Gage
290019*	0.0026	Carson City
300017	0.0361	Rockingham
300023	0.0361	Rockingham
300029	0.0361	Rockingham
310002*	0.0351	Essex
310009	0.0351	Essex
310013	0.0351	Essex
310018	0.0351	Essex
310038*	0.0350	Middlesex
310039	0.0350	Middlesex
310054	0.0351	Essex
310070*	0.0350	Middlesex
310076*	0.0351	Essex
310078	0.0351	Essex
310083	0.0351	Essex
310093	0.0351	Essex
310096	0.0351	Essex
310108	0.0350	Middlesex
310119*	0.0351	Essex
320018	0.0063	Dona Ana
320085	0.0063	Dona Ana
330001	0.0560	Orange
330004*	0.0959	Ulster
330008*	0.0470	Wyoming
330027*	0.0137	Nassau
330094**	0.0778	Columbia
330106*	0.0137	Nassau
330126*	0.0560	Orange
330135*	0.0560	Orange
330167	0.0137	Nassau
330181*	0.0137	Nassau
330182*	0.0137	Nassau
330191	0.0026	Warren
330198	0.0137	Nassau
330205*	0.0560	Orange
330209	0.0560	Orange
330224*	0.0959	Ulster
330225	0.0137	Nassau
330235*	0.0270	Cayuga
330259	0.0137	Nassau
330264*	0.0560	Orange
330276	0.0063	Fulton
330331	0.0137	Nassau
330332	0.0137	Nassau
330333	0.0137	Nassau
330372	0.0137	Nassau
330386*	0.1139	Sullivan
330402	0.0959	Ulster
340015	0.0267	Rowan

TABLE 4J.—OUT-MIGRATION
ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
340020	0.0207	Lee
340021*	0.0216	Cleveland
340037	0.0216	Cleveland
340039*	0.0144	Iredell
340069	0.0053	Wake
340070	0.0448	Alamance
340073	0.0053	Wake
340085	0.0377	Davidson
340088*	0.0115	Transylvania
340096	0.0377	Davidson
340104	0.0216	Cleveland
340114	0.0053	Wake
340126*	0.0161	Wilson
340127*	0.0961	Granville
340129*	0.0144	Iredell
340138	0.0053	Wake
340144*	0.0144	Iredell
340145*	0.0563	Lincoln
340173	0.0053	Wake
360013	0.0166	Shelby
360025*	0.0087	Erie
360034	0.0263	Wayne
360036*	0.0263	Wayne
360065*	0.0141	Huron
360070	0.0028	Stark
360078*	0.0159	Portage
360084	0.0028	Stark
360086	0.0168	Clark
360093	0.0120	Defiance
360095*	0.0087	Hancock
360099*	0.0087	Hancock
360100	0.0028	Stark
360107*	0.0213	Sandusky
360131	0.0028	Stark
360151	0.0028	Stark
360156	0.0213	Sandusky
360175*	0.0159	Clinton
360187	0.0168	Clark
360197*	0.0092	Logan
370004*	0.0193	Ottawa
370014*	0.0831	Bryan
370015*	0.0463	Mayes
370023	0.0084	Stephens
370043*	0.0294	Marshall
370065	0.0121	Craig
370113*	0.0205	Delaware
370149	0.0356	Pottawatomie
370179	0.0314	Okfuskee
380002	0.0130	Josephine
380008*	0.0201	Linn
380022*	0.0201	Linn
390011	0.0012	Cambria
390044	0.0200	Berks
390046	0.0098	York
390056	0.0042	Huntingdon
390065*	0.0501	Adams
390066	0.0259	Lebanon
390096	0.0200	Berks
390101	0.0098	York
390110*	0.0012	Cambria
390130	0.0012	Cambria
390138*	0.0325	Franklin
390146	0.0053	Warren
390150*	0.0206	Greene
390151*	0.0325	Franklin
390201*	0.1127	Monroe
390233	0.0098	York
420007	0.0001	Spartanburg
420020*	0.0035	Georgetown

TABLE 4J.—OUT-MIGRATION
ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
420027	0.0210	Anderson
420030*	0.0103	Colleton
420043	0.0177	Cherokee
420068*	0.0097	Orangeburg
420070*	0.0101	Sumter
420083	0.0001	Spartanburg
420093	0.0001	Spartanburg
420098	0.0035	Georgetown
440008*	0.0663	Henderson
440024	0.0387	Bradley
440035	0.0441	Montgomery
440047	0.0499	Gibson
440056	0.0321	Jefferson
440060*	0.0499	Gibson
440063	0.0011	Washington
440073*	0.0513	Maury
440105	0.0011	Washington
440114	0.0523	Lauderdale
440115	0.0499	Gibson
440143	0.0448	Marshall
440148*	0.0568	De Kalb
440174	0.0372	Haywood
440181	0.0407	Hardeman
440184	0.0011	Washington
440185*	0.0387	Bradley
450032*	0.0416	Harrison
450039	0.0097	Tarrant
450050	0.0750	Ward
450059	0.0073	Comal
450064	0.0097	Tarrant
450087	0.0097	Tarrant
450099*	0.0180	Gray
450113	0.0195	Anderson
450121	0.0097	Tarrant
450135	0.0097	Tarrant
450137	0.0097	Tarrant
450144*	0.0573	Andrews
450163	0.0134	Kleberg
450187*	0.0264	Washington
450194*	0.0328	Cherokee
450214*	0.0368	Wharton
450224*	0.0411	Wood
450347*	0.0427	Walker
450362	0.0486	Burnet
450370	0.0258	Colorado
450389*	0.0881	Henderson
450395	0.0484	Polk
450419	0.0097	Tarrant
450438	0.0258	Colorado
450447*	0.0358	Navarro
450451*	0.0551	Somervell
450465	0.0435	Matagorda
450547*	0.0411	Wood
450563*	0.0097	Tarrant
450596	0.0808	Hood
450597	0.0077	De Witt
450623*	0.0492	Fannin
450626	0.0294	Jackson
450639	0.0097	Tarrant
450672	0.0097	Tarrant
450675	0.0097	Tarrant
450677	0.0097	Tarrant
450694*	0.0368	Wharton
450747*	0.0195	Anderson
450755*	0.0484	Hockley
450763	0.0236	Hutchinson
450779	0.0097	Tarrant
450813	0.0195	Anderson
450858	0.0097	Tarrant

TABLE 4J.—OUT-MIGRATION
ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
460017	0.0392	Box Elder
460036*	0.0700	Wasatch
460039*	0.0392	Box Elder
470018	0.0287	Windsor
470023	0.0118	Caledonia
490019	0.1240	Culpeper
490038	0.0022	Smyth
490047*	0.0198	Page
490084	0.0167	Essex
490105	0.0022	Smyth
490110	0.0082	Montgomery
500003*	0.0208	Skagit
500007	0.0208	Skagit
500019	0.0213	Lewis
500021	0.0055	Pierce
500024	0.0023	Thurston
500039*	0.0174	Kitsap
500041*	0.0118	Cowlitz
500079	0.0055	Pierce
500108	0.0055	Pierce
500118*	0.0548	Mason
500122*	0.0459	Island
500129	0.0055	Pierce
500139	0.0023	Thurston
500143	0.0023	Thurston
510018*	0.0209	Jackson
510028*	0.0141	Fayette
510039	0.0112	Ohio
510047*	0.0275	Marion
510050	0.0112	Ohio
510088	0.0141	Fayette
520028*	0.0157	Green
520035	0.0077	Sheboygan
520042	0.0118	Sauk
520044	0.0077	Sheboygan
520057	0.0118	Sauk
520059*	0.0200	Racine
520071*	0.0239	Jefferson
520094*	0.0200	Racine
520095	0.0118	Sauk
520096*	0.0200	Racine
520102*	0.0298	Walworth
520116*	0.0239	Jefferson
520132	0.0077	Sheboygan

*Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8) of the Act. These hospitals will retain their reclassification/redesignation status, and will not receive this out-migration adjustment unless they inform CMS that they would like to waive their reclassification/redesignation status.

** This hospital was redesignated under section 1886(d)(8) of the Act, however, the hospital informed CMS that it wished to withdraw redesignation, and receive the out-migration adjustment instead. This hospital will thus receive the out-migration adjustment listed in the table.

27. On pages 49690 through 49704, in Table 9A₁—Hospital Reclassifications and Resdesignations by Individual Hospital and by MSA, the table is corrected to read as follows:

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
010005	01	1000	
010008	01	5240	
010010	01	3440	Lugar
010029	0580	1800	
010035	01	1000	
010043	01	1000	Lugar
010045	01	8600	
010065	01	0580	
010072	01	0450	Lugar
010101	01	0450	Lugar
010118	01	5240	
010120	01	5160	
010126	01	5240	
010143	01	1000	
010158	01	2030	
020005	02	0380	
020006	02	0380	
030007	03	2620	
030012	03	6200	
030033	03	2620	
040014	04	4400	
040017	04	7920	
040019	04	4920	
040020	3700	4920	
040027	04	7920	
040041	04	4400	
040047	04	26	
040066	04	4400	
040069	04	4920	
040072	04	4400	
040080	04	3700	
040088	04	7680	
040091	04	8360	
040119	04	4400	
050014	05	6920	
050042	05	6690	
050046	8735	4480	
050071	7400	5775	
050073	8720	5775	
050076	7360	5775	
050082	8735	4480	
050150	05	6920	
050159	8735	4480	
050174	7500	8720	
050177	8735	4480	
050228	7360	5775	
050236	8735	4480	
050251	05	6720	
050296	05	7400	
050325	05	5170	
050394	8735	4480	
050419	05	6690	
050430	05	6720	
050510	7360	5775	
050541	7360	5775	
050569	05	7500	
050609	5945	4480	
050616	8735	4480	
050668	7360	5775	
050686	6780	5945	
050690	7500	8720	
060001	3060	2080	
060003	1125	2080	
060027	1125	2080	
060044	06	2080	
060049	06	2670	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
060096	06	2080	
060103	1125	2080	
070015	3283	5600	
070033	5483	5600	
080004	2190	9160	
080007	08	0560	
100022	5000	2680	
100023	10	5960	
100024	10	5000	
100045	2020	5960	
100049	10	3980	
100098	10	8960	Lugar
100103	10	3600	Lugar
100105	10	2710	
100109	10	5960	
100150	10	5000	
100176	8960	2710	
100217	10	2710	
100249	10	5790	
110001	11	0520	
110002	11	0520	
110003	11	3600	
110016	11	1800	
110023	11	0520	
110025	11	3600	
110029	11	0520	
110038	11	10	
110040	11	0500	Lugar
110041	11	0500	
110054	11	0520	
110075	11	7520	
110122	11	10	
110128	11	7520	
110150	11	4680	
110168	11	0520	
110187	11	0520	
110189	11	0520	
110205	11	0520	
120028	12	3320	
130002	13	29	
130003	13	50	
130018	13	6340	
130026	13	6340	
130049	13	7840	
140012	14	1600	
140015	14	7040	
140027	14	1960	
140032	14	7040	
140034	14	7040	
140040	14	1960	
140043	14	6880	
140046	14	7040	
140058	14	7880	
140064	14	1960	
140086	14	7040	Lugar
140093	14	1400	
140102	14	7880	Lugar
140110	14	6120	
140137	14	7040	
140141	14	7040	Lugar
140143	14	6120	
140160	14	6880	
140161	14	1600	
140164	14	7040	
140189	14	1400	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
140230	14	1400	Lugar
140234	14	6120	
140271	14	7880	Lugar
150002	2960	1600	
150004	2960	1600	
150006	15	7800	
150008	2960	1600	
150011	15	3480	
150015	15	1600	
150030	15	3480	Lugar
150048	15	3200	
150065	15	3480	
150069	15	1640	
150076	15	7800	
150090	2960	1600	
150112	15	3480	
150125	2960	1600	
150126	2960	1600	
150132	2960	1600	
150133	15	2330	
150146	15	2330	
150147	2960	1600	
160001	16	2120	
160016	16	2120	
160037	16	24	
160057	16	3500	
160080	16	6880	
160089	16	2120	
160147	16	2120	
170006	17	3710	
170010	17	8560	
170012	17	9040	
170013	17	9040	
170014	17	3760	
170020	17	9040	
170022	17	3760	
170023	17	9040	
170033	17	9040	
170045	17	8440	
170058	17	3710	
170060	17	28	
170094	17	8440	
170120	17	3710	
170131	17	8440	Lugar
170145	17	8560	
170175	17	9040	
180005	18	3400	
180011	18	4280	
180012	18	4520	
180013	18	5360	
180016	18	4520	
180018	18	4280	
180027	18	1660	
180028	18	3400	
180029	18	3660	
180044	18	3400	
180066	18	5360	
180069	18	3400	
180078	18	3400	
180080	18	4280	
180093	18	2440	
180102	18	1660	
180104	18	1660	
180116	18	1660	
180124	18	5360	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
180127	18	4520	
180132	18	4280	
180139	18	4280	
190001	19	5560	
190003	19	3880	
190015	19	5560	
190054	19	3880	
190086	19	7680	
190099	19	3880	
190106	19	3880	
190131	19	5560	
190164	19	0220	
200002	20	6403	
200020	6403	1123	
200024	4243	6403	
200034	4243	6403	
200039	20	6403	
200050	20	0733	
200063	20	6403	
220060	1123	0743	
220077	8003	3283	
230022	23	0440	
230027	23	3000	Lugar
230030	23	6960	
230037	23	0440	
230040	23	3720	Lugar
230054	23	3080	
230080	23	6960	
230093	23	3000	
230096	23	3720	
230105	23	6960	
230121	23	2640	Lugar
230188	23	6960	Lugar
230199	23	0870	Lugar
230235	23	6960	Lugar
230253	23	2160	
240011	24	5120	
240013	24	5120	
240016	24	2520	
240018	24	5120	
240030	24	6980	
240045	24	2240	
240052	24	2520	
240064	24	2240	
240069	24	6820	
240071	24	5120	
240075	24	6980	
240088	24	6980	
240093	24	5120	
240121	24	2240	
240152	24	5120	
240187	24	5120	
240211	24	5120	
250004	25	4920	
250009	25	3580	
250030	25	3560	
250031	25	3560	
250034	25	4920	
250042	25	4920	
250069	25	3560	
250081	25	3560	
250082	25	6240	
250094	3285	0920	
250097	25	0760	
250099	25	3560	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
250100	25	8600	
250104	25	3560	
250126	25	4920	
260009	26	3760	
260011	26	1740	
260015	26	3700	
260017	26	7040	
260022	26	1740	
260025	26	7040	
260034	26	3760	
260047	26	1740	
260064	26	1740	
260078	26	7920	
260094	26	7920	
260110	26	7040	
260113	26	14	
260116	26	14	
260183	26	7040	
260186	26	1740	
260195	26	7920	
270003	27	3040	
270011	27	3040	
270017	27	5140	
270051	27	5140	
270082	27	3040	
280009	28	4360	
280023	28	4360	
280032	28	4360	
280054	28	4360	
280057	28	4360	
280061	28	53	
280065	28	3060	
280077	28	5920	
280125	28	7720	
290008	29	4120	
290019	29	6720	
300003	30	1123	
300005	30	1123	
310002	5640	5600	
310003	3640	5600	
310005	5015	5640	
310015	5640	0875	
310032	8760	6160	
310034	5190	5015	
310038	5015	5600	
310045	0875	5600	
310048	5015	5640	
310070	5015	5600	
310073	5190	5015	
310075	5190	5015	
310076	5640	5600	
310111	5190	5015	
310112	5190	5015	
310119	5640	5600	
320005	32	0200	
320006	32	7490	
320013	32	7490	
320063	32	5800	
320065	32	5800	
330004	33	5660	
330023	2281	5660	
330027	5380	5600	
330084	33	1303	
330085	33	8160	
330136	33	8160	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
330157	33	8160	
330181	5380	5600	
330182	5380	5600	
330224	33	3283	
330239	3610	2360	
330250	33	1303	
330386	33	5660	
340008	34	2560	
340010	2980	6640	
340013	34	1520	
340017	34	0480	
340021	34	1520	
340023	34	0480	
340027	34	3150	
340039	34	1520	
340050	34	2560	
340051	34	3290	
340068	34	9200	
340071	34	6640	Lugar
340088	34	0480	
340109	34	5720	
340115	34	6640	
340124	34	6640	Lugar
340126	34	6640	Lugar
340127	34	6640	
340129	34	1520	
340131	34	3150	
340144	34	1520	
340147	6895	6640	
350009	35	2520	
360008	36	3400	
360010	36	0080	
360011	36	1840	
360014	36	1840	
360025	36	1680	
360036	36	1680	
360039	36	1840	
360046	3200	1640	
360054	36	1480	
360056	3200	1640	
360065	36	1680	
360071	36	4320	Lugar
360076	3200	1640	
360078	0080	1680	
360095	36	4320	
360107	36	8400	
360112	8400	0440	
360121	36	0440	
360132	3200	1640	
360159	36	1840	
360175	36	1840	
360197	36	1840	
370004	37	3710	
370014	37	7640	
370015	37	8560	
370018	37	8560	
370025	37	8560	
370034	37	2720	
370043	37	7640	
370047	37	7640	
370049	37	5880	
370054	37	5880	
370060	37	8560	
370099	37	8560	
370103	37	45	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
370113	37	2580	
370200	37	5880	
380001	38	6440	
380022	38	1890	
380027	38	2400	
380040	38	2400	
380050	38	4890	
380070	38	6440	
390006	39	3240	
390013	39	3240	
390030	39	0240	
390048	39	3240	
390052	39	0280	
390065	39	8840	
390086	39	8050	
390091	39	6280	
390093	39	6280	
390110	3680	6280	
390113	39	9320	
390138	39	8840	
390151	39	8840	
390163	39	6280	
390201	39	5660	
400120	1310	7440	
410001	6483	1123	
410004	6483	1123	
410005	6483	1123	
410006	6483	1123	
410007	6483	1123	
410008	6483	1123	
410009	6483	1123	
410011	6483	1123	
410012	6483	1123	
410013	6483	1123	
420020	42	1440	
420030	42	1440	
420036	42	1520	
420068	42	0600	
420070	8140	1760	
420071	42	0600	
420080	42	7520	
420085	5330	9200	
430012	43	7760	
430014	43	2520	
430094	43	53	
440008	44	3580	
440020	44	3440	
440050	44	0480	
440058	44	1560	
440059	44	5360	
440060	44	3580	
440067	44	3840	
440068	44	1560	
440072	44	4920	
440073	44	5360	
440148	44	5360	
440151	44	5360	
440175	44	3440	
440180	44	3840	
440185	44	1560	
440186	44	5360	
440192	44	5360	
440200	44	5360	
450007	45	7240	
450014	45	8750	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
450073	45	0040	
450080	45	4420	
450098	45	4420	
450099	45	0320	
450144	45	5800	
450187	45	3360	
450192	45	1920	
450194	45	1920	
450196	45	1920	
450211	45	3360	
450214	45	3360	
450224	45	8640	
450347	45	3360	
450351	45	2800	
450400	45	8800	
450447	45	1920	
450451	45	2800	
450484	45	3360	
450508	45	8640	
450534	45	0320	
450547	45	1920	
450563	2800	1920	
450623	45	1920	
450653	45	5800	
450656	45	8640	
450694	45	3360	
450747	45	1920	
450755	45	4600	
450770	45	0640	
450830	45	5800	
460021	46	4120	
460029	46	6520	
460036	46	6520	
460039	46	7160	
470001	47	30	
470011	47	1123	
470012	47	6323	
490004	49	1540	
490005	49	8840	
490013	49	4640	
490018	49	1540	
490047	49	8840	
490079	49	3120	
490092	49	5720	
490126	49	6800	
500002	50	6740	
500003	50	7600	
500016	50	7600	
500031	50	5910	
500039	1150	7600	
500041	50	6440	
500059	50	7600	
500072	50	7600	
510001	51	6280	
510002	51	6800	
510006	51	6280	
510024	51	6280	
510028	51	1480	
510046	51	1480	
510047	51	6280	
510048	51	3400	
510070	51	1480	
510071	51	1480	
520002	52	8940	
520021	3800	1600	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
520028	52	4720	Lugar
520032	52	4720	
520037	52	8940	
520059	6600	5080	
520066	3620	4720	
520071	52	5080	
520076	52	4720	
520084	52	4720	
520088	52	5080	
520094	6600	5080	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
520096	6600	5080	Lugar
520102	52	1600	
520107	52	3080	
520113	52	3080	
520116	52	5080	
520152	52	3080	
520173	52	2240	
520189	3800	1600	
530002	53	1350	
530009	53	1350	

TABLE 9A₁.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY MSA—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Lugar
530016	53	6340	
530025	53	2670	

28. On pages 49704 through 49720, in Table 9A₂—Hospital Reclassifications and Redesignations by Individual Hospital and by CBSA, is corrected to read as follows:

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA

Provider No.	Actual CBSA or rural area	Wage index CBSA reclassification	Lugar	Nearest county
010005	01	13820	Lugar.	Baldwin
010008	01	33860		
010022	01	40660		
010029	12220	17980		
010035	01	13820		
010045	01	46220		
010065	01	12220		
010072	01	11500		
010101	01	11500		
010118	01	33860		
010120	01	33660	Lugar.	Baldwin
010126	01	33860		
010143	01	13820		
010158	01	19460		
020005	02	11260		
030007	03	22380		
030012	39140	38060		
030033	03	22380		
040014	04	30780		
040017	04	44180		
040019	04	32820	Lugar.	Bossier
040020	27860	32820		
040027	04	44180		
040041	04	30780		
040047	04	26		
040066	04	30780		
040069	04	32820		
040072	04	30780		
040080	04	27860		
040088	04	43340		
040091	04	45500	Lugar.	Napa
040119	04	30780		
050014	05	40900		
050042	05	39820		
050046	37100	31084		
050071	41940	36084		
050073	46700	36084		
050076	41884	36084		
050082	37100	31084		
050150	05	40900		
050159	37100	31084	Lugar.	Napa
050174	42220	34900		
050177	37100	31084		
050228	41884	36084		
050236	37100	31084		
050251	05	39900		
050325	05	33700		
050394	37100	31084		

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA—Continued

Provider No.	Actual CBSA or rural area	Wage index CBSA reclas- sification	Lugar	Nearest county
050419	05	39820		Napa
050430	05	39900		
050510	41884	36084		
050541	41884	36084		
050569	05	42220		
050609	42044	31084		
050616	37100	31084		
050668	41884	36084		
050686	40140	42044		
050690	42220	34900	.....	
060001	24540	19740		
060003	14500	19740		
060027	14500	19740		
060044	06	19740		
060049	06	22660		
060096	06	19740		
060103	14500	19740		
070003	07	25540	Lugar.	Cape May
070015	25540	35644		
070021	07	25540	Lugar.	
070033	14860	35644		
080004	20100	48864		
080007	08	36140	.....	
100022	33124	22744		
100023	10	36740		
100024	10	33124		
100045	19660	36740		
100049	10	29460		
100081	10	23020	Lugar.	
100098	10	48424	Lugar.	
100103	10	23540	Lugar.	
100105	46940	38940		
100109	10	36740		
100139	10	23540	Lugar.	
100150	10	33124		
100176	48424	38940		
100217	46940	38940		
100249	10	36100		
110001	19140	12060		
110002	11	12060		
110003	11	27260		
110009	11	31420	Lugar.	
110016	11	17980		
110023	11	12060		
110025	15260	27260		
110029	23580	12060		
110038	11	10		Jones
110040	11	12060	Lugar.	
110041	11	12020		
110052	11	16860	Lugar.	
110054	40660	12060		
110075	11	42340		
110088	11	12060	Lugar.	
110117	11	12060	Lugar.	
110120	11	12060	Lugar.	
110122	46660	10		
110128	11	42340		
110150	11	31420	.....	
110168	40660	12060		
110187	11	12060		
110189	11	12060		
110205	11	12060		
120028	12	26180		
130002	13	29		
130003	30300	50		
130018	13	38540		
130022	13	26820	Lugar.	
130026	13	38540		
130049	17660	44060		
140004	14	44100	Lugar.	

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA—Continued

Provider No.	Actual CBSA or rural area	Wage index CBSA reclas- sification	Lugar	Nearest county
140012	14	16974	.....	Dekalb
140015	14	41180	.....	
140027	14	19340	.....	
140032	14	41180	.....	
140034	14	41180	.....	
140038	14	40420	Lugar.	
140040	14	37900	.....	
140043	14	40420	.....	Winnebago
140046	14	41180	.....	
140058	14	44100	.....	
140064	14	19340	.....	
140093	19180	16580	.....	
140102	14	44100	Lugar.	
140110	14	37900	.....	
140112	14	37900	Lugar.	
140143	14	37900	.....	
140146	14	14060	Lugar.	
140160	14	40420	.....	Winnebago
140161	14	16974	.....	Grundy
140164	14	41180	.....	
140189	14	16580	.....	
140234	14	37900	.....	
140236	14	28100	Lugar.	
140271	14	44100	Lugar.	
150002	23844	16974	.....	Cook
150004	23844	16974	.....	Cook
150006	33140	43780	.....	
150008	23844	16974	.....	Cook
150011	15	26900	.....	
150015	33140	16974	.....	
150030	15	26900	Lugar.	
150043	15	29140	Lugar.	
150048	15	17140	.....	
150065	15	26900	.....	
150069	15	17140	.....	
150076	15	43780	.....	
150090	23844	16974	.....	Cook
150102	15	16974	Lugar.	
150103	15	29140	Lugar.	
150112	18020	26900	.....	Brown
150125	23844	16974	.....	Cook
150126	23844	16974	.....	Will
150132	23844	16974	.....	Cook
150133	15	21140	.....	
150146	15	21140	.....	
150147	23844	16974	.....	Cook
160001	16	19780	.....	
160016	16	19780	.....	
160026	16	11180	Lugar.	
160037	16	24	.....	
160057	16	26980	.....	
160080	16	40420	.....	Winnebago
160086	16	47940	Lugar.	
160089	16	19780	.....	
160147	16	19780	.....	
170006	17	27900	.....	
170010	17	46140	.....	
170012	17	48620	.....	
170013	17	48620	.....	
170020	17	48620	.....	
170022	17	28140	.....	
170023	17	48620	.....	
170033	17	48620	.....	
170045	17	45820	.....	
170058	17	27900	.....	
170060	17	28	.....	
170094	17	45820	.....	
170120	17	27900	.....	
170145	17	46140	.....	
170175	17	48620	.....	

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA—Continued

Provider No.	Actual CBSA or rural area	Wage index CBSA reclas- sification	Lugar	Nearest county
180005	18	26580	.....	Wayne
180011	18	30460	.....	Clark
180012	21060	31140	.....	
180013	14540	34980	.....	
180018	18	30460	.....	Bourbon
180027	18	17300	.....	
180028	18	26580	.....	Wayne
180029	18	28700	.....	Scott
180044	18	26580	.....	Wayne
180066	18	34980	.....	
180069	18	26580	.....	Wayne
180075	18	14540	Lugar.	
180078	18	26580	.....	Wayne
180080	18	30460	.....	Clark
180093	18	21780	.....	
180102	18	17300	.....	
180104	18	17300	.....	
180116	18	17300	.....	
180124	14540	34980	.....	
180127	18	31140	.....	Jefferson
180132	18	30460	.....	Jessamine
180139	18	30460	.....	Clark
190001	19	35380	.....	St. Tammany
190003	19	29180	.....	St. Martin
190015	19	35380	.....	St. John the Baptist
190029	19	12940	Lugar.	
190054	19	29180	.....	St. Martin
190086	19	43340	.....	Bossier
190099	19	29180	.....	St. Landry
190106	19	29180	.....	Acadia
190131	12940	35380	.....	St. John the Baptist
190155	19	12940	Lugar.	
190164	19	10780	.....	
190223	19	12940	Lugar.	
200002	20	38860	.....	
200020	38860	40484	.....	Strafford
200024	30340	38860	.....	
200034	30340	38860	.....	
200039	20	38860	.....	
200050	20	12620	.....	
200063	20	38860	.....	
220060	14484	12700	.....	
220077	44140	25540	.....	Hartford
230022	23	11460	.....	
230030	23	40980	.....	Saginaw
230035	23	24340	Lugar.	
230037	23	11460	.....	Washtenaw
230042	23	26100	Lugar.	
230054	23	24580	.....	
230080	23	40980	.....	Saginaw
230093	23	24340	.....	
230096	23	28020	.....	Kalamazoo
230105	23	13020	.....	Bay
230121	23	29620	Lugar.	
230134	23	26100	Lugar.	
230155	23	24340	Lugar.	
230171	23	34740	Lugar.	
230178	23	24340	Lugar.	
230188	23	40980	Lugar.	
230208	23	24340	Lugar.	
230235	23	40980	Lugar.	
230253	23	47644	.....	Lapeer
240011	24	33460	.....	
240013	24	33460	.....	
240016	24	22020	.....	
240018	24	33460	.....	
240030	24	41060	.....	
240052	24	22020	.....	
240064	24	20260	.....	
240069	24	40340	.....	

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA—Continued

Provider No.	Actual CBSA or rural area	Wage index CBSA reclas- sification	Lugar	Nearest county
240071	24	33460		
240075	24	41060		
240088	24	41060		
240093	24	33460		
240105	24	40340	Lugar.	
240150	24	40340	Lugar.	
240152	24	33460		
240187	24	33460		
240211	24	33460		
250004	25	32820		
250009	25	27180		
250023	25	25060	Lugar.	
250030	25	27140		
250031	25	27140		
250034	25	32820		
250042	25	32820		
250069	25	27140		
250081	25	27140		
250082	25	38220		
250094	25620	25060		Hancock
250097	25	12940		
250099	25	27140		
250100	25	46220		
250104	25	27140		
250117	25	25060	Lugar.	
260009	26	28140		
260011	27620	17860		
260015	26	27860		
260017	26	41180		
260022	26	17860		
260025	26	41180		
260047	27620	17860		
260049	26	44180	Lugar.	
260064	26	17860		
260078	26	44180		
260094	26	44180		
260110	26	41180		
260113	26	14		
260116	26	14		
260183	26	41180		
260186	26	17860		
270003	27	24500		
270011	27	24500		
270017	27	33540		
270051	27	33540		
270082	27	24500		
280009	28	30700		
280023	28	30700		
280032	28	30700		
280054	28	30700		
280057	28	30700		
280061	28	53		
280065	28	24540		
280077	28	36540		
280125	28	43580		
290002	29	16180	Lugar.	
290008	29	29820		Nye
290019	16180	39900		
300003	30	31700		Hillsborough
300005	30	31700		
310002	35084	35644		
310015	35084	35644		
310032	47220	48864		Salem, NJ
310038	20764	35644		
310048	20764	35084		Hunterdon
310070	20764	35644		
310076	35084	35644		
310119	35084	35644		
320005	22140	10740		
320006	32	42140		Santa Fe

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA—Continued

Provider No.	Actual CBSA or rural area	Wage index CBSA reclas- sification	Lugar	Nearest county
320013	32	42140	.....	Santa Fe
320033	32	42140	Lugar.	
320063	32	36220	.....	Ector
320065	32	36220	.....	Ector
330004	28740	39100	.....	Orange
330008	33	15380	Lugar.	
330027	35004	35644		
330038	33	40380	Lugar.	
330062	33	27060	Lugar.	
330073	33	40380	Lugar.	
330084	33	15540		
330085	33	45060	.....	Madison
330136	33	45060	.....	Madison
330157	33	45060	.....	Oswego
330181	35004	35644		
330182	35004	35644		
330224	28740	25540	.....	Hartford
330235	33	45060	Lugar.	
330239	33	21500		
330250	33	15540		
330359	33	39100	Lugar.	
330386	33	39100	.....	Orange
340008	34	22180		
340010	24140	39580	.....	Johnston
340013	34	16740		
340018	34	43900	Lugar.	
340021	34	16740		
340027	34	24780		
340039	34	16740		
340050	34	22180		
340051	34	25860		
340068	34	48900		
340071	34	39580	Lugar.	
340088	34	11700		
340109	34	47260		
340115	34	20500	.....	Chatham
340124	34	39580	Lugar.	
340126	34	39580	.....	Johnston
340127	34	20500	.....	Person
340129	34	16740		
340131	34	24780		
340136	34	20500	Lugar.	
340144	34	16740		
340145	34	16740	Lugar.	
340147	40580	39580	.....	Franklin
350009	35	22020		
360008	36	26580	.....	Greenup
360010	36	10420		
360011	36	18140		
360014	36	18140		
360025	41780	17460		
360036	36	17460		
360039	36	18140		
360042	36	17460	Lugar.	
360054	36	16620		
360056	17140	17140		
360065	36	17460		
360078	10420	17460		
360088	36	44220	Lugar.	
360095	36	30620	.....	Allen
360096	36	49660	Lugar.	
360107	36	45780		
360112	45780	11460	.....	Washtenaw
360121	36	11460	.....	Washtenaw
360125	36	17460	Lugar.	
360127	36	17460	Lugar.	
360159	36	18140		
360175	36	18140		
360185	36	49660	Lugar.	
360197	36	18140		

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA—Continued

Provider No.	Actual CBSA or rural area	Wage index CBSA reclas- sification	Lugar	Nearest county
360238	36	49660	Lugar.	
360245	36	17460	Lugar.	
370004	37	27900		
370014	37	43300		
370015	37	46140		
370018	37	46140		
370025	37	46140		
370034	37	22900		
370043	37	43300		
370047	37	43300		
370049	37	36420	.....	Lincoln
370099	37	46140		
370103	37	45		
370113	37	22220		
370200	37	36420	.....	Lincoln
380001	38	38900		
380008	38	18700	Lugar.	
380022	38	18700		
380027	38	21660		
380040	38	21660		
380050	38	32780		
380070	38	38900		
390006	39	25420	.....	Dauphin
390013	39	25420	.....	Dauphin
390030	39	10900		
390031	39	39740	Lugar.	
390048	39	25420	.....	Perry
390052	39	11020		
390065	39	47894	Lugar	Frederick
390071	39	48700	Lugar.	
390086	39	44300		
390091	39	38300		
390093	39	38300		
390110	27780	38300		
390113	39	49660	.....	Mercer
390138	39	47894		
390150	39	38300	Lugar.	
390151	39	47894	.....	Frederick
390201	39	35084	.....	Pike
390224	39	13780	Lugar.	
390244	39	48700	Lugar.	
390249	39	13780	Lugar.	
410001	39300	14484	.....	Bristol, MA
410004	39300	14484	.....	Bristol, MA
410005	39300	14484	.....	Bristol, MA
410006	39300	14484	.....	Bristol, MA
410007	39300	14484	.....	Bristol, MA
410008	39300	14484	.....	Bristol, MA
410009	39300	14484	.....	Bristol, MA
410011	39300	14484	.....	Bristol, MA
410012	39300	14484	.....	Bristol, MA
410013	39300	14484	.....	Bristol, MA
420009	42	24860	Lugar.	
420020	42	16700		
420028	42	44940	Lugar.	
420030	42	16700		
420036	42	16740		
420039	42	43900	Lugar.	
420068	42	12260		
420069	42	44940	Lugar.	
420070	44940	17900		
420071	42	12260		
420080	42	42340		
420085	34820	48900		
430012	43	43620		
430014	43	22020		
430094	43	53		
440008	44	27180		
440020	44	26620		
440050	44	11700		

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA—Continued

Provider No.	Actual CBSA or rural area	Wage index CBSA reclas- sification	Lugar	Nearest county
440058	44	16860		
440059	44	34980		
440060	44	27180		
440067	34100	28940	.....	Knox
440068	44	16860		
440072	44	32820		
440073	44	34980		
440148	44	34980		
440151	44	34980		
440175	44	26620		
440180	44	28940	.....	Union
440185	17420	16860		
440192	44	34980		
450007	45	41700		
450032	45	30980	Lugar.	
450052	45	47380	Lugar.	
450073	45	10180		
450080	45	30980	.....	Usphur
450098	45	30980	.....	Usphur
450099	45	11100		
450144	45	36220	.....	Ector
450187	45	26420		
450192	45	19124		
450194	45	19124		
450196	45	19124		
450211	45	26420		
450214	45	26420		
450224	45	46340		
450283	45	19124	Lugar.	
450286	45	17780	Lugar.	
450347	45	26420		
450348	45	47380	Lugar.	
450351	45	23104		
450389	45	19124	Lugar.	
450400	45	47380		
450447	45	19124		
450451	45	23104		
450484	45	26420		
450508	45	46340		
450534	45	11100		
450547	45	19124		
450563	23104	19124		
450623	45	19124		
450648	45	12420	Lugar.	
450653	45	33260	.....	Midland
450656	45	46340		
450694	45	26420		
450747	45	19124		
450755	45	31180		
450770	45	12420	Lugar.	
450830	45	36220	.....	Ector
460021	41100	29820	.....	Mohave
460029	46	39340		
460036	46	39340		
460039	46	36260	.....	Weber
470001	47	30		
470011	47	15764		
470012	47	38340		
490004	25500	16820		
490005	49020	47894	.....	Clarke
490006	49	49020	Lugar.	
490013	49	31340		
490018	49	16820		
490047	49	47894	.....	Warren
490079	49	49180	.....	Stokes
490092	49	47260		
490126	49	40220		
500002	50	28420		
500003	34580	42644	.....	Snohomish
500016	48300	42644	.....	King

TABLE 9A₂.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND BY CBSA—Continued

Provider No.	Actual CBSA or rural area	Wage index CBSA reclassification	Lugar	Nearest county
500031	50	36500		
500039	14740	42644	.....	King
500041	31020	38900		
500059	50	42644	.....	King
500072	50	42644	.....	Snohomish
500118	50	36500	Lugar.	
500122	50	42644	Lugar.	
510001	34060	38300		
510002	51	40220		
510006	51	38300		
510018	51	16620	Lugar.	
510024	34060	38300		
510028	51	16620		
510046	51	16620		
510047	51	38300		
510048	51	26580	.....	Wayne
510070	51	16620		
510071	51	16620		
510081	51	16620	Lugar.	
520002	52	48140		
520021	29404	16974		
520028	52	31540	Lugar.	
520037	52	48140		
520059	39540	33340		
520060	52	22540	Lugar.	
520066	27500	31540		
520071	52	33340	Lugar.	
520076	52	31540		
520088	22540	33340		
520094	39540	33340		
520096	39540	33340		
520102	52	16974	Lugar.	
520107	52	24580		
520113	52	24580		
520116	52	33340	Lugar.	
520152	52	24580		
520173	52	20260		
520189	52	16974		
530002	53	16220		
530009	53	16220		
530025	53	22660		

29. On pages 49720 through 49724, in Hospital under Section 508 Pub. L. 108– Assignments—FY 2005, the table is
Table 9B—Hospital Reclassifications 173 and Special Exceptions Wage Index corrected to read as follows:
and Resdesignations by Individual

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 PUB. L. 108–173 AND SPECIAL EXCEPTIONS WAGE INDEX ASSIGNMENTS—FY 2005

Provider No.	Old MSA or rural area	Wage index old MSA 508 reclassification	New MSA or rural area	Wage index new MSA 508 reclassification	Nearest county	Own wage index
010150	01	1800	01	17980	.....	
020008	02	.....	02	.....	.....	1.3119
050494	05	7500	05	42220	.....	
050549	8735	7500	37100	42220	.....	
060057	06	2080	06	19740	.....	
060075	06	.....	06	.....	.....	1.1677
070001	5483	5380	35300	35004	.....	
070005	5483	5380	35300	35004	.....	
070006*	5483	.....	14860	.....	.....	
070010	5483	5600	14860	35644	.....	
070016	5483	5380	35300	35004	.....	
070017	5483	5380	35300	35004	.....	
070018*	5483	.....	14860	.....	.....	
070019	5483	5380	35300	35004	.....	
070022	5483	5380	35300	35004	.....	

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 PUB. L. 108–173 AND SPECIAL EXCEPTIONS WAGE INDEX ASSIGNMENTS—FY 2005—Continued

Provider No.	Old MSA or rural area	Wage index old MSA 508 reclassification	New MSA or rural area	Wage index new MSA 508 reclassification	Nearest county	Own wage index
070028	5483	5600	14860	35644	.....	.....
070031	5483	5380	35300	35004	.....	.....
070034*	5483	.....	14860	.....	.....	.....
070036	3283	.....	25540	.....	.....	1.2918
070039	5483	5380	35300	35004	.....	.....
120025	12	3320	12	26180	.....	.....
140155*	3740	.....	28100	.....	.....	.....
140186*	3740	.....	28100	.....	.....	.....
150034	2960	1600	23844	16974	Cook .....	.....
160040	8920	1360	47940	16300	.....	.....
160064	16	.....	16	.....	.....	1.0481
160067	8920	1360	47940	16300	.....	.....
160110	8920	1360	47940	16300	.....	.....
190218	19	7680	19	43340	Caddo .....	.....
220046	6323	1123	38340	14484	.....	.....
230003	3000	3720	26100	28020	Van Buren .....	.....
230004	3000	3720	34740	28020	Van Buren .....	.....
230013	2160	2640	47644	22420	.....	.....
230019	2160	2640	47644	22420	.....	.....
230020	2160	0440	19804	11460	Washtenaw .....	.....
230024	2160	0440	19804	11460	Washtenaw .....	.....
230029	2160	2640	47644	22420	.....	.....
230036	23	2640	23	22420	.....	.....
230038	3000	3720	24340	28020	Kalamazoo .....	.....
230053	2160	0440	19804	11460	Washtenaw .....	.....
230059	3000	3720	24340	28020	Saginaw .....	.....
230066	3000	3720	34740	28020	Van Buren .....	.....
230071	2160	2640	47644	22420	.....	.....
230072	3000	3720	26100	28020	Van Buren .....	.....
230089	2160	0440	19804	11460	Washtenaw .....	.....
230097	23	3720	23	28020	Kalamazoo .....	.....
230104	2160	0440	19804	11460	Washtenaw .....	.....
230106	23	3720	24340	28020	Van Buren .....	.....
230119	2160	0440	19804	11460	Washtenaw .....	.....
230130	2160	2640	47644	22420	.....	.....
230135	2160	0440	19804	11460	Washtenaw .....	.....
230146	2160	0440	19804	11460	Washtenaw .....	.....
230151	2160	2640	47644	22420	.....	.....
230165	2160	0440	19804	11460	Washtenaw .....	.....
230174	3000	3720	26100	28020	Van Buren .....	.....
230176	2160	0440	19804	11460	Washtenaw .....	.....
230207	2160	2640	47644	22420	.....	.....
230223	2160	2640	47644	22420	.....	.....
230236	3000	3720	24340	28020	Kalamazoo .....	.....
230254	2160	2640	47644	22420	.....	.....
230269	2160	2640	47644	22420	.....	.....
230270	2160	0440	19804	11460	Washtenaw .....	.....
230273	2160	0440	19804	11460	Washtenaw .....	.....
230277	2160	2640	47644	22420	.....	.....
250002	25	0920	25	25060	.....	.....
250078*	3285	.....	25620	.....	.....	.....
250122	25	0920	25	25060	Hancock .....	.....
270002*	27	.....	27	.....	.....	.....
270012*	3040	.....	24500	.....	.....	.....
270021	27	0880	27	13740	.....	.....
270032	27	0880	27	13740	.....	.....
270050	27	0880	27	13740	.....	.....
270057	27	0880	27	13740	.....	.....
270084*	27	.....	27	.....	.....	.....
310021	8480	0875	45940	35644	.....	.....
310028	5640	5600	35084	35644	.....	.....
310050	5640	5600	35084	35644	.....	.....
310051	5640	5600	35084	35644	.....	.....
310060	5640	5600	10900	35644	.....	.....
310115	5640	5600	10900	35644	.....	.....
310120	5640	5600	35084	35644	.....	.....
330023*	2281	.....	39100	.....	.....	.....
330049	2281	5600	39100	35644	.....	.....
330067*	2281	.....	39100	.....	.....	.....

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND RESDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 PUB. L. 108–173 AND SPECIAL EXCEPTIONS WAGE INDEX ASSIGNMENTS—FY 2005—Continued

Provider No.	Old MSA or rural area	Wage index old MSA 508 reclassification	New MSA or rural area	Wage index new MSA 508 reclassification	Nearest county	Own wage index
330106	5380 .....	.....	35004 .....	.....	.....	1.5118
330126	5660	5600	39100	35644 .....	.....	.....
330135	5660	5600	39100	35644 .....	.....	.....
330205	5660	5600	39100	35644 .....	.....	.....
330264	5660	5380	39100	35004 .....	.....	.....
340002	0480	1520	11700	16740	Gaston .....	.....
350002	1010	2520	13900	22020 .....	.....	.....
350003	35	2520	35	22020 .....	.....	.....
350006	35	2520	35	22020 .....	.....	.....
350010	35	2520	35	22020 .....	.....	.....
350014	35	2520	35	22020 .....	.....	.....
350015	1010	2520	13900	22020 .....	.....	.....
350017	35	2520	35	22020 .....	.....	.....
350019*	2985 .....	.....	24220 .....	.....	.....	.....
350030	35	2520	35	22020 .....	.....	.....
350061	35	2520	35	22020 .....	.....	.....
380090	38 .....	.....	38 .....	.....	.....	1.2777
390001	7560	0240	42540	10900 .....	.....	.....
390003	7560	0240	39	10900 .....	.....	.....
390054	7560	4000	42540	29540 .....	.....	.....
390072	7560	0240	39	10900 .....	.....	.....
390095	7560	0240	42540	10900 .....	.....	.....
390109	7560	0240	42540	10900 .....	.....	.....
390119	7560	0240	42540	10900 .....	.....	.....
390137	7560	0240	42540	10900 .....	.....	.....
390169	7560	0240	42540	10900 .....	.....	.....
390185	7560	4000	42540	29540 .....	.....	.....
390192	7560	0240	42540	10900 .....	.....	.....
390237	7560	0240	42540	10900 .....	.....	.....
390270	7560	4000	42540	29540 .....	.....	.....
410010	6483 .....	.....	39300 .....	.....	.....	1.1677
430005	43	6660	43	39660 .....	.....	.....
430008*	43 .....	.....	43 .....	.....	.....	.....
430013*	43 .....	.....	43 .....	.....	.....	.....
430015	43	7760	43	43620 .....	.....	.....
430031*	43 .....	.....	43 .....	.....	.....	.....
430048	43	7760	43	43620 .....	.....	.....
430060	43	7760	43	43620 .....	.....	.....
430064	43	7760	43	43620 .....	.....	.....
430077	6660	7760	39660	43620 .....	.....	.....
430091	6660	7760	39660	43620 .....	.....	.....
450010	9080	4880	48660	32580 .....	.....	.....
450072	1145	3360	26420	26420 .....	.....	.....
450591	1145	3360	26420	26420 .....	.....	.....
470003	1303	1123	15540	14484 .....	.....	.....
490001	49	4640	49	31340 .....	.....	.....
490024	6800	1950	40220	19260 .....	.....	.....
530008*	53 .....	.....	53 .....	.....	.....	.....
530010*	53 .....	.....	53 .....	.....	.....	.....
530015	53 .....	.....	53 .....	.....	.....	0.9980

*Special exception wage index as specified in section 1886(d)(5)(l)(i) of the Act. (For more information see sections IV.N.2. and N.4. of the preamble to this final rule.)

D. Correction of Appendix A (Regulatory Impact Analysis) Errors

1. On page 49755, first column,

Line 28, the figure “5.8” is corrected to read “5.7”;

Line 32, the figure “5.05” is corrected to read “4.96”.

2. On page 49756,

Second column,

Line 28, the figure “5.8” is corrected to read “5.7”;

Line 32, the figure “5.05” is corrected to read “4.96”.

Third column, after line 61, add the following:

“• The total change in payments based on final FY 2005 policies and MMA-imposed revisions relative to payment based on FY 2004 policies.”

3. On page 49757,

a. First column

(1) Line 18, the phrase “that most” is corrected to read “that almost all”;

(2) Lines 20 through 25, the sentence “Hospitals were not required to submit these data in order to qualify for a full update until July 2004, and we therefore unable to determine for the proposed rule the rate of compliance with this requirement for receiving the full update” is corrected to read “Because very few hospitals have failed to qualify for the full update, we modeled payments as if every hospital received the full update.”.

b. Second column,

(1) Line 54, the figure “2,661” is corrected to read “2,612”;

(2) Line 56, the figure “1,448” is corrected to read “1,438”;

(3) Line 58, the figure “1,213 is corrected to read “1,174”;

(4) Line 60, the figure “1,236” is corrected to read “1,285”;

(5) Line 75, the figures “2,639” and “1,455” are corrected to read “2,688” and “1,454”; and

(6) Line 76, the figures “1,238” and “1,204” are corrected to read “1,234” and “1,209”.

c. Third column,

(1) Line 45 the figures “126” and “430” are corrected to read “127” and “433”;

(2) Line 46, the figure “73” is corrected to read “74”;

4. On pages 49758 through 49761, Table I.—Impact Analysis of Final Changes for FY 2005 is corrected to read as follows:

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TABLE I.--IMPACT ANALYSIS OF FINAL CHANGES FOR FY 2005
OPERATING PROSPECTIVE PAYMENT SYSTEM
(PERCENT CHANGES IN PAYMENTS PER CASE)

	NO. OF HOSPS. ¹ (1)	DRG RECAL ² (2)	LABOR SHARE SPLIT ³ (3)	CORE BASED STAT. AREAS ⁴ (4)	NEW WAGE DATA ⁵ (5)	OCCUPA- TIONAL MIX ⁶ (6)	DRG & WAGE INDEX CHANGES ⁷ (7)	TRANSITION BLENDED NEW WAGE TO NO TRANSITION * ⁸ (8)	MGCRB RECLASSIF- ICATION ⁹ (9)	OUT- MIGRATION DATA ¹⁰ (10)	ALL FY 2005 CHANGES ¹¹ (11)
By Geographic Location:											
All hospitals.....	3,897	-0.1	0.5	0.0	-0.1	0.0	0.0	0.0	0.0	0.1	5.7
Urban hospitals.....	2,612	-0.1	0.4	0.1	-0.1	0.0	0.0	-0.1	-0.3	0.1	5.6
Large urban areas (populations over 1 million).....	1,438	-0.1	0.2	0.2	-0.1	0.0	-0.1	-0.1	-0.3	0.1	5.3
Other urban areas (populations of 1 million of fewer).....	1,174	0.0	0.7	0.1	0.0	0.1	0.2	0.0	-0.2	0.2	5.9
Rural hospitals.....	1,285	0.2	1.1	-0.5	0.0	0.0	0.1	0.3	1.9	0.1	6.2
Bed Size (Urban):											
0-99 beds.....	658	0.1	0.5	0.4	0.0	0.0	0.4	-0.1	-0.4	0.1	6.8
100-199 beds.....	920	-0.1	0.5	0.0	0.0	0.0	0.1	0.0	-0.2	0.1	5.4
200-299 beds.....	489	-0.1	0.4	0.2	-0.2	0.0	-0.1	-0.1	-0.2	0.1	5.2
300-499 beds.....	410	-0.1	0.5	0.2	0.0	0.1	0.1	-0.1	-0.3	0.1	5.7
500 or more beds.....	135	-0.1	0.4	0.1	0.0	0.0	-0.1	0.0	-0.5	0.0	5.7
Bed Size (Rural):											
0-49 beds.....	551	0.2	1.0	-0.2	0.1	0.0	0.3	0.1	0.6	0.1	6.5
50-99 beds.....	423	0.2	0.9	-0.5	0.0	0.0	0.2	0.3	1.0	0.1	6.2
100-149 beds.....	198	0.1	1.3	-0.9	0.0	0.0	0.1	0.6	2.5	0.1	6.2
150-199 beds.....	62	0.1	1.2	-0.7	-0.2	0.1	-0.1	0.5	2.9	0.1	6.4
200 or more beds.....	51	0.0	1.1	-0.3	-0.2	0.0	-0.2	0.1	2.9	0.0	5.9
Urban by Region:											
New England.....	131	0.1	0.0	-0.1	-0.2	0.0	0.2	0.2	-0.1	0.3	5.2
Middle Atlantic.....	374	-0.3	0.3	0.4	-0.9	0.0	-0.7	0.0	0.0	0.2	4.8
South Atlantic.....	395	-0.1	0.5	0.2	0.2	0.0	0.2	-0.1	-0.4	0.0	5.7

	NO. OF HOSPS. ¹ (1)	DRG RECAL ² (2)	LABOR SHARE SPLIT ³ (3)	CORE BASED STAT. AREAS ⁴ (4)	NEW WAGE DATA ⁵ (5)	OCCUPA- TIONAL MIX ⁶ (6)	DRG & WAGE INDEX CHANGES ⁷ (7)	TRANSITION BLENDED NEW WAGE TO NO TRANSITION ° (8)	MGCRB RECLASSIF- ICATION ⁹ (9)	OUT- MIGRATION DATA ¹⁰ (10)	ALL FY 2005 CHANGES ¹¹ (11)
East North Central	421	0.0	0.3	0.0	0.1	0.0	0.1	-0.1	-0.3	0.1	5.5
East South Central	168	0.0	1.1	0.1	-0.2	0.4	0.2	-0.1	-0.4	0.2	6.3
West North Central	162	0.0	0.6	0.1	0.1	0.0	0.1	-0.2	-0.5	0.0	5.7
West South Central	357	0.0	0.9	0.0	0.5	0.1	0.5	-0.1	-0.5	0.0	6.4
Mountain	136	0.0	0.2	0.2	-0.4	0.0	-0.2	-0.1	-0.2	0.0	4.6
Pacific	416	-0.1	0.0	0.0	0.2	0.0	0.2	-0.1	-0.3	0.1	5.5
Puerto Rico	52	-0.5	6.2	0.0	-0.3	0.0	-0.9	0.3	-0.3	0.0	15.8
Rural by Region:											
New England	36	0.1	0.2	0.0	0.1	0.0	0.2	-0.1	1.6	0.0	4.4
Middle Atlantic	77	0.2	1.0	-0.7	-0.3	0.0	-0.2	0.3	1.7	0.1	4.7
South Atlantic	197	0.2	1.1	-1.0	-0.1	0.1	0.1	0.5	1.9	0.1	6.6
East North Central	178	0.2	0.7	-0.4	0.0	0.0	0.1	0.2	1.5	0.1	4.8
East South Central	204	0.1	2.0	-0.2	-0.5	0.1	-0.3	0.1	2.7	0.1	9.5
West North Central	197	0.2	0.8	-0.1	0.3	0.0	0.5	-0.1	1.3	0.1	6.0
West South Central	236	0.1	1.6	-0.7	0.0	0.2	0.3	0.7	2.8	0.2	7.2
Mountain	95	0.2	0.3	-1.6	0.0	0.0	0.2	1.4	0.5	0.1	4.0
Pacific	65	0.1	0.0	0.0	0.3	-0.3	0.1	0.1	1.1	0.1	4.7
By Payment Classification:											
Urban hospitals	2,688	-0.1	0.5	0.1	-0.1	0.0	0.0	0.0	-0.3	0.1	5.6
Large urban areas (populations over 1 million)	1,454	-0.1	0.2	0.1	-0.1	0.0	-0.1	-0.1	-0.3	0.1	5.3
Other urban areas (populations of 1 million of fewer)	1,234	0.0	0.7	0.1	0.0	0.1	0.2	0.0	-0.2	0.2	5.9
Rural areas	1,209	0.1	1.1	-0.5	0.0	0.0	0.1	0.3	1.8	0.1	6.3
Teaching Status:											
Non-teaching	2,785	0.0	0.7	0.0	-0.1	0.0	0.1	0.0	0.3	0.1	5.9
Fewer than 100 Residents	912	-0.1	0.5	0.1	0.1	0.0	0.1	0.0	-0.2	0.1	5.5
100 or more Residents	200	-0.1	0.2	0.0	-0.3	0.0	-0.2	0.0	-0.3	0.0	5.4
Urban DSH:											
Non-DSH	1,146	0.0	0.4	0.1	0.0	0.0	0.1	0.0	-0.1	0.1	5.5

	NO. OF HOSPS. ¹ (1)	DRG RECAL ² (2)	LABOR SHARE SPLIT ³ (3)	CORE BASED STAT. AREAS ⁴ (4)	NEW WAGE DATA ⁵ (5)	OCCUPA- TIONAL MIX ⁶ (6)	DRG & WAGE INDEX CHANGES ⁷ (7)	TRANSITION BLENDED NEW WAGE TO NO TRANSITION * ⁸ (8)	MGCRB RECLASSIF- ICATION ⁹ (9)	OUT- MIGRATION DATA ¹⁰ (10)	ALL FY 2005 CHANGES ¹¹ (11)
100 or more beds.....	1,466	-0.1	0.5	0.1	-0.1	0.0	0.0	0.0	-0.3	0.1	5.5
Less than 100 beds	367	0.1	0.7	0.9	0.0	0.0	0.3	-0.1	0.0	0.1	7.6
Rural DSH:											
Sole Community (SCH).....	450	0.1	0.6	-0.3	0.1	0.0	0.2	0.1	0.3	0.1	4.9
Referral Center (RRC)	158	0.0	1.3	-0.3	-0.2	0.0	-0.1	0.1	3.6	0.0	6.4
Other Rural: 100 or more beds	74	0.3	1.7	-1.7	-0.2	0.1	0.1	1.7	1.2	0.3	9.2
Less than 100 beds	236	0.3	1.8	-1.1	-0.2	0.1	0.2	0.9	0.9	0.3	10.6
Urban teaching and DSH: Both teaching and DSH	814	-0.1	0.4	0.1	-0.1	0.0	0.0	0.0	-0.3	0.0	5.4
Teaching and no DSH	235	-0.1	0.3	0.2	0.0	0.0	0.1	-0.1	-0.2	0.1	5.6
No teaching and DSH	1,019	-0.1	0.6	0.2	0.0	0.0	0.1	0.0	-0.2	0.2	5.9
No teaching and no DSH	620	0.0	0.4	0.2	-0.1	0.0	0.1	-0.1	-0.2	0.1	5.6
Rural Hospital Types:											
Non special status hospitals	393	0.3	1.7	-1.2	-0.1	0.1	0.2	1.1	1.0	0.3	9.2
RRC.....	127	0.1	1.7	-0.3	-0.2	0.1	-0.1	0.1	4.8	0.1	7.2
SCH	433	0.1	0.4	-0.3	0.1	0.0	0.2	0.2	0.2	0.1	4.1
Medicare-dependent hospitals (MDH)	178	0.3	1.6	-0.2	0.2	0.1	0.5	0.0	0.8	0.1	8.3
SCH and RRC.....	74	0.0	0.5	-0.2	0.0	0.0	0.0	0.1	1.4	0.0	4.6
Type of Ownership:											
Voluntary	2,300	-0.1	0.5	0.1	-0.1	0.0	0.0	0.0	0.0	0.1	5.5
Proprietary.....	716	-0.1	0.7	-0.2	0.1	0.1	0.1	0.0	0.0	0.0	6.0
Government	741	0.0	0.7	0.1	-0.1	0.0	0.0	0.0	0.2	0.1	5.9
Unknown.....	140	-0.3	0.7	0.1	0.0	0.0	-0.1	-0.1	-0.5	0.1	7.1
Medicare Utilization as a Percent of Inpatient Days:											
0-25	224	-0.2	0.2	0.1	-0.1	0.0	-0.2	0.0	-0.2	0.1	5.2
25-50	1,102	-0.1	0.4	0.0	0.0	0.0	0.1	-0.1	-0.3	0.1	5.5

	NO. OF HOSPS. ¹ (1)	DRG RECAL ² (2)	LABOR SHARE SPLIT ³ (3)	CORE BASED STAT. AREAS ⁴ (4)	NEW WAGE DATA ⁵ (5)	OCCUPA- TIONAL MIX ⁶ (6)	DRG & WAGE INDEX CHANGES ⁷ (7)	TRANSITION BLENDED NEW WAGE TO NO TRANSITION ⁸ (8)	MGCRB RECLASSIF- ICATION ⁹ (9)	OUT- MIGRATION DATA ¹⁰ (10)	ALL FY 2005 CHANGES ¹¹ (11)
50-65.....	1,413	0.0	0.7	0.1	0.0	0.1	0.1	0.0	0.2	0.1	5.9
Over 65.....	912	0.0	0.7	-0.1	-0.2	0.1	0.1	0.1	0.3	0.1	5.6
Unknown.....	246	-0.1	0.4	0.2	-0.1	0.0	-0.1	0.0	-0.2	0.1	5.8
Rural Converted to Urban	160	-0.3	1.1	3.4	-0.2	0.0	0.0	-0.1	1.3	0.0	6.5
Urban Converted to Rural	58	0.6	0.8	-6.6	-0.3	0.1	0.0	6.0	0.1	0.7	5.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:											
All Reclassified Hospitals	461	0.0	0.9	0.4	-0.1	0.0	0.0	0.0	3.9	0.0	5.9
Nonreclassified Hospitals	3,359	-0.1	0.5	0.0	0.0	0.0	0.0	0.0	-0.5	0.1	5.6
All Reclassified Urban Hospitals	117	-0.2	0.5	1.3	-0.1	0.0	0.1	-0.1	3.9	0.0	5.3
Urban Nonreclassified Hospitals	2,493	-0.1	0.4	0.1	-0.1	0.0	0.0	-0.1	-0.5	0.1	5.6
All Reclassified Rural Hospitals	344	0.1	1.2	-0.2	-0.1	0.0	0.0	0.0	3.9	0.0	6.3
Rural Nonreclassified Hospitals	866	0.2	1.0	-0.8	0.0	0.1	0.2	0.6	-0.4	0.2	6.2
Other Reclassified Hospitals (Section 1886(D)(9)(B))	77	0.3	0.8	-1.6	-0.1	0.0	0.2	0.6	3.2	0.1	5.7

¹ Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2003, and hospital cost report data are from reporting periods beginning in FY 2001 and FY 2000.

² This column displays the payment impact of the recalibration of the DRG weights based on FY 2003 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

³ This column displays the payment impact of applying a lower labor-related share for hospitals with wage indexes less than or equal to 1.0, as required under section 403 of Pub. L. 108-173.

⁴ This column displays the impact of the adoption of the new MSAs as announced by OMB in June 2003. It does not take into account the effects of the transitional blended wage indexes for certain hospitals. This effect is accounted for in column 8.

⁵ This column displays the impact of updating the wage index with wage data from hospitals' FY 2001 cost reports.

⁶ This column displays the effects of adjusting hospitals' wage data to reflect the occupational mix based on our survey of hospitals.

⁷ This column shows the payment impact of the budget neutrality adjustment factor for DRG and wage index changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4 and 5, and the proposed FY 2005 budget neutrality factor of 0.999876 (the change to the labor-related share shown in column 3 is not included in the budget neutrality calculation). The effects of adopting an imputed floor for all-urban States are included in this column.

⁸ Shown here are the effects of providing special blended wage indexes in FY 2005 for hospitals whose FY 2005 wage indexes would decrease solely due to the effects of adopting the new labor market definitions. This column shows the effects of using these blended wage indexes compared to full implementation of the wage indexes computed on the basis of the new labor market definitions. The effects reflected here are budget neutral; this column therefore includes the effect of the 0.998162 adjustment that we have applied to the rates to ensure budget neutrality.

⁹ Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRRB). The effects demonstrate the FY 2005 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2005. Reclassification for prior years has no bearing on the payment impacts shown here.

¹⁰ This column displays the impact of the proposed implementation of section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

¹¹ This column shows changes in payments from FY 2004 to FY 2005. It incorporates all of the changes displayed in columns 3, 7, 8, 9 and 10 (the changes displayed in columns 2, 4, 5 and 6 are included in column 7). It also reflects the impact of the FY 2005 update, changes in hospitals' reclassification status in FY 2005 compared to FY 2004, and the changes in payments as a result of implementing Section 508 of the MMA. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

5. On page 49762,
 a. First column, line 62 the figure “0.1” is corrected to read “0.2”.
 b. Second column,
 (1) Line 64, the figure “0.3” is corrected to read “0.5”;
 (2) Lines 69 and 70, the phrase “the South Atlantic, which will experience the next largest impact, with a 0.8 percent decrease” is corrected to read “the Mountain region, which will experience a 1.6 percent decrease”.
 c. Third column,
 (1) Lines 42 through 46, the sentence “The largest declines from updating the wage data are seen in the urban Middle

Atlantic and Mountain regions (a 0.9 and 0.4 percent decreases, respectively).” is corrected to read “The largest decline from updating the wage data is seen in the urban Middle Atlantic region (a 0.9 percent decrease)”;
 (2) Line 47, the phrase “rural Mountain region experiences a 0.2 percent increase” is corrected to read “East South Central region experiences a 0.5 percent decrease”;
 (3) Line 64, the figure “104” is corrected to read “56”;
 (4) Line 65, the figure “103” is corrected to read “14”;

(5) Line 67, the figure “25” is corrected to read “24”;
 (6) Line 70, the figure “30” is corrected to read “31”;
 (7) Lines 73 through 75, the sentence “One urban hospital would experience decreases in their wage index values greater than 10 percent.” is corrected to read “On rural hospital will experience a decrease in their wage index value of at least 5 percent, but less than 10 percent.”
 6. On page 49763,
 a. Top of the page, the chart is corrected to read as follows:

Percentage Change in Area Wage Index Values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	14	0
Increase more than 5 percent and less than 10 percent	56	24
Increase or decrease less than 5 percent	2562	1295
Decrease more than 5 percent and less than 10 percent	31	1
Decrease more than 10 percent	0	0

b. First column, lines 22 through 26, the sentence “The biggest change is in the rural hospital in the South Atlantic, East South Central, and West South Central regions, which are projected to experience a 0.1 percent increase for FY 2005.” is corrected to read “The biggest change is in the urban hospitals of the East South Central region, which are projected to experience a 0.4 percent increase for FY 2005.”

c. Second column, line 3, the figure “0.54” is corrected to read “0.5”.

d. Third column,

(1) Line 16, the figure “8” is corrected to read “9”; and

(2) Line 50, the phrase “1.8 percent in column 8” is corrected to read “1.9 percent in column 9”.

7. On page 49764,

a. First column,

(1) Line 1, the figure “0.9” is corrected to read “1.1”;

(2) Line 4, the figure “2.5” is corrected to read “2.7”;

(3) Line 6, the figure “3.0” is corrected to read “2.8”;

(4) Line 12, the figure “3.8” is corrected to read “3.9”;

(5) Line 17, the figure “3.8” is corrected to read “3.9”;

(6) Line 22, the figure “0.3” is corrected to read “0.4”;

(7) Line 45, the figure “230” is corrected to read “275”;

(8) Line 46, the figure “415” is corrected to read “555”;

(9) Line 54, the phrase “East South Central region” is corrected to read “New England region”;

(10) Line 55, the figure “0.2” is corrected to read “0.3”;

b. Second column,

(1) Line 3, the figure “5.8” is corrected to read “5.7”;

(2) Line 20, the figure “0.5” is corrected to read “0.4”.

c. Third column

(1) Line 39, the figure “5.8” is corrected to read “5.7”;

(2) Line 40, the figure “5.7” is corrected to read “5.6”;

(3) Line 45, the figure “5.4” is corrected to read “5.3”;

(4) Line 47, the figure “6.1” is corrected to read “5.9”; and

(5) Line 76, the figures “9.2” and “7.1” are corrected to read “9.5” and “7.2”.

8. On page 49765,

a. First column,

(1) Line 2, the figure “4.4” is corrected to read “4.0”; and

(2) Line 9, the figure “4.5” is corrected to read “4.6”.

b. Second column, line 7, the figure “5.8” is corrected to read “5.9”.

c. Third column,

(1) Line 2, the figure “6.2” is corrected to read “6.3”; and

(2) Line 7, the figure “5.3” is corrected to read “5.7”.

9. On pages 49765 through 49767, Table II.—Impact Analysis of Final Changes for FY 2005 Operating Prospective Payment System is corrected to read as follows:

**TABLE II.—IMPACT ANALYSIS OF FINAL CHANGES FOR FY 2005
OPERATING PROSPECTIVE PAYMENT SYSTEM
(PAYMENTS PER CASE)**

	Number of Hospitals (1)	Average FY 2004 Payment Per Case¹ (2)	Average FY 2005 Payment Per Case¹ (3)	All FY 2005 Changes (4)
By Geographic Location:				
All hospitals.....	3,897	7,757	8,196	5.7
Urban hospitals.....	2,612	8,102	8,553	5.6
Large urban areas (populations over 1 million).....	1,438	8,492	8,942	5.3
Other urban areas (populations of 1 million or fewer).....	1,174	7,630	8,083	5.9
Rural hospitals.....	1,285	6,059	6,438	6.2
Bed Size (Urban):				
0-99 beds.....	658	5,890	6,290	6.8
100-199 beds.....	920	6,907	7,280	5.4
200-299 beds.....	489	7,928	8,343	5.2
300-499 beds.....	410	8,707	9,202	5.7
500 or more beds.....	135	10,112	10,691	5.7
Bed Size (Rural):				
0-49 beds.....	551	5,212	5,553	6.5
50-99 beds.....	423	5,810	6,173	6.2
100-149 beds.....	198	5,905	6,274	6.2
150-199 beds.....	62	6,788	7,223	6.4
200 or more beds.....	51	7,422	7,857	5.9
Urban by Region:				
New England.....	131	8,682	9,136	5.2
Middle Atlantic.....	374	8,857	9,280	4.8
South Atlantic.....	395	7,717	8,156	5.7
East North Central.....	421	7,839	8,267	5.5
East South Central.....	168	7,470	7,941	6.3
West North Central.....	162	7,961	8,413	5.7
West South Central.....	357	7,585	8,070	6.4
Mountain.....	136	8,019	8,388	4.6
Pacific.....	416	9,530	10,058	5.5
Puerto Rico.....	52	3,499	4,051	15.8
Rural by Region:				
New England.....	36	8,300	8,664	4.4
Middle Atlantic.....	77	5,914	6,189	4.7
South Atlantic.....	197	5,950	6,343	6.6
East North Central.....	178	5,993	6,278	4.8
East South Central.....	204	5,210	5,706	9.5
West North Central.....	197	6,551	6,943	6.0
West South Central.....	236	5,465	5,858	7.2
Mountain.....	95	7,056	7,342	4.0
Pacific.....	65	8,683	9,094	4.7
By Payment Classification:				
Urban hospitals.....	2,688	8,073	8,523	5.6
Large urban areas (populations over 1 million).....	1,454	8,485	8,934	5.3
Other urban areas (populations of 1 million or fewer).....	1,234	7,585	8,035	5.9
Rural areas.....	1,209	6,083	6,464	6.3
Teaching Status:				
Non-teaching.....	2,785	6,509	6,894	5.9
Fewer than 100 Residents.....	912	8,094	8,539	5.5
100 or more Residents.....	200	11,995	12,640	5.4

	Number of Hospitals (1)	Average FY 2004 Payment Per Case ¹ (2)	Average FY 2005 Payment Per Case ¹ (3)	All FY 2005 Changes (4)
Urban DSH:				
Non-DSH.....	1,146	6,982	7,367	5.5
100 or more beds.....	1,466	8,607	9,080	5.5
Less than 100 beds.....	367	5,487	5,904	7.6
Rural DSH:				
Sole Community (SCH).....	450	6,578	6,900	4.9
Referral Center (RRC).....	158	6,708	7,140	6.4
Other Rural:				
100 or more beds.....	74	5,157	5,631	9.2
Less than 100 beds.....	236	4,477	4,953	10.6
Urban teaching and DSH:				
Both teaching and DSH.....	814	9,435	9,948	5.4
Teaching and no DSH.....	235	7,952	8,395	5.6
No teaching and DSH.....	1,019	6,895	7,299	5.9
No teaching and no DSH.....	620	6,485	6,850	5.6
Rural Hospital Types:				
Non special status hospitals.....	393	4,764	5,203	9.2
RRC.....	127	6,153	6,594	7.2
SCH.....	433	7,171	7,466	4.1
Medicare-dependent hospitals (MDH).....	178	4,418	4,783	8.3
SCH and RRC.....	74	7,508	7,851	4.6
Type of Ownership:				
Voluntary.....	2,300	7,880	8,315	5.5
Proprietary.....	716	7,050	7,476	6.0
Government.....	741	7,870	8,338	5.9
Unknown.....	140	7,851	8,410	7.1
Medicare Utilization as a Percent of Inpatient Days:				
0-25.....	224	10,267	10,799	5.2
25-50.....	1,102	8,503	8,969	5.5
50-65.....	1,413	6,896	7,302	5.9
Over 65.....	912	6,876	7,258	5.6
Unknown.....	246	9,763	10,327	5.8
Rural Converted to Urban	160	6,886	7,332	6.5
Urban Converted to Rural	58	5,686	6,011	5.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:				
All Reclassified Hospitals.....	461	7,226	7,651	5.9
All Nonreclassified Hospitals.....	3,359	7,850	8,292	5.6
All Urban Reclassified Hospitals.....	117	8,379	8,820	5.3
Urban Nonreclassified Hospitals.....	2,493	8,088	8,539	5.6
All Reclassified Rural Hospitals.....	344	6,597	7,012	6.3
Rural Nonreclassified Hospitals.....	866	5,619	5,969	6.2
Other Reclassified Hospitals (Section 1886(d)(8)(B)).....	77	5,762	6,092	5.7

¹ These payment amounts per case do not reflect any estimates of annual case-mix increase.

10. On page 49774, third column, lines 56 and 57, the section heading "VIII. Impact of Proposed Changes in the Capital PPS" is corrected to read "VIII. Impact of Changes in the Capital PPS".

11. On pages 49778 through 49781, the text beginning with the section heading "VIII. Impact of Proposed Changes in the Capital PPS" and ending with the table entitled "Table III.—Comparison of Total Payments Per Case" is deleted.

III. Waiver of Proposed Rulemaking and Retroactive Application of Changes

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive the notice and comment procedures if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

The policies and payment methodology expressed in the FY 2005 final rule have previously been subjected to notice and comment procedures. This correcting amendment makes changes to conform the regulation text to the policies described in the preamble of the FY 2005 final rule and effective since October 1, 2004. This correcting amendment also revises the preamble of the FY 2005 final rule to clarify our policy regarding add-on payments for new technologies. We also have corrected errors in wage index tables. Therefore, we find it unnecessary to undertake further notice and comment procedures with respect to this correcting amendment. This

correcting amendment is intended to ensure that the FY 2005 final rule accurately reflects the policies expressed in the final rule.

We are also waiving the 30-day delay in effective date for this correcting amendment. We believe that it is in the public interest to ensure that the FY 2005 final rule accurately represents our prospective payment methodology, payment rates, and that the correct wage index values are used to calculate hospital payments. We believe that a delay in the effective date of these corrections would be contrary to the public interest.

We also find that it is in the public interest to apply certain changes in this correcting amendment retroactively to October 1, 2004, the effective date of the FY 2005 final rule. Section 1871(e)(1)(A) of the Social Security Act, as amended by section 903(a) of Pub. L. 108–173, provides that a substantive change in regulations shall not be applied retroactively to items and services furnished before the effective date of the change, unless the Secretary finds that such retroactive application is necessary to comply with statutory requirements or failure to apply the change retroactively would be contrary to the public interest. In sections II.A., II.B., II.C. items 1 through 11 and 13, and II.D. of this correcting amendment, we have made substantive corrections to errors in the preamble, regulation text, operating standardized amounts and Federal capital rates, and the regulatory impact analysis that were published in the August 11, 2004 **Federal Register** and in the October 7, 2004 **Federal Register** to ensure that the final rule accurately reflects our policies and payment methodologies. Although the FY 2005 final rule and the correction of the final rule contained errors (that are described in this correcting amendment), we implemented the

correct policies and payment methodologies as of October 1, 2004. Accordingly, hospitals have been paid under the appropriate policies and payment methodologies since that date. Therefore, not applying these changes retroactively to October 1, 2004 would have a disruptive effect on the hospital inpatient and long-term care hospital prospective payment systems. As a result, we are applying most changes in this correcting amendment retroactively to October 1, 2004 because we believe that to do otherwise would be contrary to the public interest.

Since October 1, 2004, hospitals have been paid using the wage index values posted on the CMS Website on September 29, 2004 and referenced in October 7, 2004 correction of the final rule that appeared in the October 7, 2004 **Federal Register** (69 FR 60243). Subsequent to this posting and publication, we identified additional errors in the hospital wage index, geographic reclassification, and out-migration data. Therefore, consistent with both 42 CFR 412.64(k)(2) and our longstanding policy of making midyear corrections to the wage index on a prospective basis, we are applying the corrections in section II.C. items 12 and 14 through 29 of this correcting amendment as of January 1, 2005. (For a more detailed explanation of our midyear wage index correction policy, see the January 3, 1984 **Federal Register** (49 FR 258)).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 20, 2004.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 04–28128 Filed 12–22–04; 8:45 am]

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Federal Register

**Thursday,
December 30, 2004**

Part III

Department of the Treasury

**Internal Revenue Service
26 CFR Parts 54 and 602**

Department of Labor

**Employee Benefits Security
Administration**

29 CFR Part 2590

Department of Health and Human Services

**Centers for Medicare & Medicaid Services
45 CFR Parts 144 and 146**

**Final Regulations for Health Coverage
Portability; Final Rule**

**Notice of Proposed Rulemaking for
Health Coverage Portability and Request
for Information on Benefit-Specific
Waiting Periods Under HIPAA Titles I &
IV; Proposed Rules**

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Parts 54 and 602**

[TD 9166]

RIN 1545–AX84

DEPARTMENT OF LABOR**Employee Benefits Security Administration****29 CFR Part 2590**

RIN 1210–AA54

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****45 CFR Parts 144 and 146**

RIN 0938–AL43

Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final regulation.

SUMMARY: This document contains final regulations governing portability requirements for group health plans and issuers of health insurance coverage offered in connection with a group health plan. The rules contained in this document implement changes made to the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act enacted as part of the Health Insurance Portability and Accountability Act of 1996.

DATES: *Effective date.* These final regulations are effective February 28, 2005.

Applicability date. These final regulations apply for plan years beginning on or after July 1, 2005.

FOR FURTHER INFORMATION CONTACT:

Dave Mlawsky, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, at 1–877–267–2323 ext. 61565; Amy Turner, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; or Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622–6080.

SUPPLEMENTARY INFORMATION:**Customer Service Information**

To assist consumers and the regulated community, the Departments have issued questions and answers concerning HIPAA. Individuals interested in obtaining copies of Department of Labor publications concerning changes in health care law may call a toll free number, 1–866–444–EBSA (3272), or access the publications on-line at www.dol.gov/ebsa, the Department of Labor's Web site. These regulations as well as other information on the new health care laws are also available on the Department of Labor's interactive web pages, *Health Elaws*. In addition, CMS's publication entitled "Protecting Your Health Insurance Coverage" is available by calling 1–800–633–4227 or on the Department of Health and Human Services' Web site (www.cms.hhs.gov/hipaa1), which includes the interactive webpages, HIPAA Online. Copies of the HIPAA regulations, as well as notices and press releases related to HIPAA and other health care laws, are also available at the above-referenced Web sites.

A. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, was enacted on August 21, 1996. HIPAA amended the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) to provide for, among other things, improved portability and continuity of health coverage. Interim final regulations implementing the HIPAA provisions were first made available to the public on April 1, 1997 (published in the **Federal Register** on April 8, 1997, 62 FR 16894) (April 1997 interim rules). On December 29, 1997, the Departments published in the **Federal Register** (62 FR 67688) a clarification of the April 1997 interim rules as they relate to excepted benefits. On October 25, 1999, the Departments published a notice in the **Federal Register** (64 FR 57520) soliciting additional comments on the portability requirements based on the experience of plans and issuers operating under the April 1997 interim rules.

After consideration of all the comments received on the portability provisions, the Departments are publishing these final regulations. These final regulations do not significantly modify the framework established in the April 1997 interim rules. Instead, these final regulations implement changes to improve the portability of health

coverage while seeking to minimize burdens on group health plans and group health insurance issuers. These final regulations become applicable to plans and issuers on the first day of the plan year beginning on or after July 1, 2005. Each plan or issuer must continue to comply with the April 1997 interim rules until these final regulations become applicable to that plan or issuer. In addition, the Departments are publishing proposed regulations elsewhere in this issue of the **Federal Register** to address additional and discrete issues.

B. Overview of the Final Regulations**1. Definitions—26 CFR 54.9801–2, 29 CFR 2590–701–2, 45 CFR 144.103**

This section of the final regulations provides most of the definitions used in the regulations implementing HIPAA. In addition to some minor restructuring of the April 1997 interim rules (*i.e.*, some definitions have been moved into other sections of the regulations), some additional terms have been added. Among the new terms is the definition of the term *dependent*. *Dependent* is defined as any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant. This is intended to clarify that for purposes of HIPAA the terms of the group health plan determine which individuals are eligible for coverage as a dependent under the plan. Thus, for example, the plan terms control the age (if any) at which and conditions under which a child of a participant ceases to be eligible for coverage as a dependent. Moreover, whether an individual is eligible for special enrollment as a dependent is determined in part based on the plan's definition of dependent.

2. Limitations on Preexisting Condition Exclusions—26 CFR 54.9801–3, 29 CFR 2590.701–3, 45 CFR 146.111

This section of the final regulations addresses HIPAA's limitations on a plan's or issuer's ability to impose a preexisting condition exclusion. Comments addressing this topic generally approved of the approach taken in the Departments' April 1997 interim rules. Accordingly, these final regulations do not modify significantly the April 1997 interim rules but instead add several clarifications to the general framework already established. Also, some comments reflect a misunderstanding of the notice requirements for plans and issuers that impose a preexisting condition exclusion. Thus, these final regulations are restructured to clarify these notice

obligations. In addition, an example in the regulations contains language that plans and issuers can use to satisfy the notice requirements.

Definition of a Preexisting Condition Exclusion

In these final regulations, a preexisting condition exclusion continues to be defined broadly. A preexisting condition exclusion is any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. This definition has been moved to this section on limitations on preexisting condition exclusions to emphasize the difference between the broadness of the definition and the narrowness of permissible preexisting condition exclusions. The definition has also been modified slightly from the previous definition and clarifications of its application have been added.

If a plan exclusion satisfies the definition of a preexisting condition exclusion, it is subject to the rules of this section for preexisting condition exclusions. Under the April 1997 interim rules, whether an exclusion is a preexisting condition exclusion is determined by whether the plan provision restricts benefits for a condition because it was present before the "first day of coverage." These final regulations have replaced the term *first day of coverage* with *effective date of coverage under a group health plan or health insurance coverage*. In the case of a plan that changes health insurance issuers, "first day of coverage" can be read to mean only the first day of coverage under the plan and not the first day of coverage under the new issuer's policy or contract (because "first day of coverage" is thus defined for purposes of determining the enrollment date). This reading would mean that an exclusion of benefits based on the fact that a condition existed before the effective date of coverage in the health insurance of the succeeding issuer would not be a preexisting condition (because it would not apply based on the fact that a condition existed before the first day of coverage under the plan). The phrase "effective date of coverage under a group health plan or health insurance coverage" under the final regulations thus applies to coverage either under a plan or health insurance coverage. Therefore, a provision used by a succeeding issuer to deny benefits for a condition because it arose before the effective date of coverage under the new

policy would also fit the definition of a preexisting condition exclusion.

Since the April 1997 interim rules were published, several situations have repeatedly arisen in which a plan exclusion is not designated as a preexisting condition exclusion but nevertheless satisfies the definition of a preexisting condition exclusion. Examples have been added to illustrate some of these common plan provisions. These situations include a plan provision that provides coverage for accidental injury only if the injury occurred while covered under the plan, a plan provision that counts against a lifetime limit benefits received under prior health coverage, and a plan provision that denies benefits for pregnancy until 12 months after an individual generally becomes eligible for benefits under the plan.¹ The regulations also include a series of examples relating to exclusions for congenital conditions. These examples illustrate that a plan that generally provides benefits for a condition cannot exclude benefits for the condition in instances where it arises congenitally without complying with these limitations on preexisting condition exclusions. However, these limitations would not apply if a plan excludes benefits for all instances of a condition, even if all instances are likely to be congenital. Plans and policies that contain these types of preexisting condition exclusions that are not designated as such should be modified to comply with HIPAA's requirements for preexisting condition exclusions, or the exclusions should be deleted. In addition, because a preexisting condition exclusion discriminates against individuals based on one or more health factors, unless a preexisting condition exclusion complies with HIPAA's limitations on preexisting condition exclusions, the plan provision will also violate the HIPAA nondiscrimination provisions.²

General Rules Governing Preexisting Condition Exclusions

In addition to modifying the definition of a preexisting condition exclusion, these final regulations set

forth HIPAA's limitations on preexisting condition exclusions, as follows:

Six-Month Look-Back Rule

The final regulations retain the 6-month look-back rule set forth in the April 1997 interim rules. In addition, these regulations clarify that a plan or issuer can use a period shorter than 6 months for purposes of applying the 6-month look-back rule. Examples in these final regulations also clarify that if a doctor's recommendation for treatment occurs before the 6-month look-back period, an individual can be subject to a preexisting condition exclusion only if the individual receives the recommended treatment within the 6-month look-back period.

Maximum Length of Preexisting Condition Exclusion

The final regulations retain the rule set forth in the April 1997 interim rules that a preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date.

Reducing a Preexisting Condition Exclusion Period by Creditable Coverage

The final regulations retain the rule set forth in the April 1997 interim rules. Accordingly, under these final regulations, the period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage³ the individual has as of the enrollment date (not including any days before a significant break in coverage). Some comments asked how this rule applies to individuals who currently have coverage under another plan (that is, the coverage has not yet ended). An example clarifies that a plan or issuer must count all days of creditable coverage prior to an individual's enrollment date, even if that coverage is still in effect.

Other Standards

The final regulations retain the statement that other legal standards may apply to group health coverage preexisting condition exclusions. In this connection, the Department of Labor's Veterans' Employment and Training Service (VETS) has commented that the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides reemployment rights for persons who leave civilian employment to perform service in the uniformed

¹ Several comments (including those of several State insurance commissioner's offices) have asked the Departments to clarify that a preexisting condition exclusion would also include any waiting period or other temporary benefit exclusion (other than a waiting period on all benefits). The Departments are publishing separately in this issue of the **Federal Register** a Request for Information, which invites further comments on this issue of benefit-specific waiting periods.

² See 26 CFR 54.9802-1T(b)(3), 29 CFR 2590.702(b)(3), and 45 CFR 146.121(b)(3), published on January 8, 2001 at 66 FR 1378.

³ For purposes of these regulations, the phrase "days of creditable coverage" has the same meaning as the phrase "aggregate of the periods of creditable coverage" as such phrase is used in the statute.

services and prohibits employer discrimination against any person on the basis of the person's military service, obligations, intent to join or certain other protected activities. In general, USERRA reemployment rights apply to persons who leave civilian employment to serve a single enlistment period in the active military or to employees who are members of the National Guard or Reserve and are required to perform intermittent military service or training. USERRA provides rights regarding both continuation of group health plan coverage by an employee who is absent to perform service in the uniformed services and reinstatement of group health plan coverage upon reemployment if the coverage was interrupted by the service. In response to this comment, the final regulations include a statement that USERRA can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service. For more information, a VETS directory and additional USERRA information is available at www.dol.gov/vets.

Enrollment Definitions

Both the 6-month look-back period and the maximum length of preexisting condition exclusion are measured with respect to an individual's enrollment date. The final regulations generally retain the enrollment definitions that were set forth in the April 1997 interim rules (including definitions of enrollment date, waiting period, and late enrollee). Under HIPAA, the April 1997 interim rules, and these final regulations, the enrollment date is the first day of coverage under the plan or, if there is a waiting period, the first day of the waiting period. These final regulations clarify that if an individual receiving benefits under a group health plan changes benefit package options, or if the plan changes group health insurance issuers, the individual's enrollment date remains the same.

The Departments received several comments reflecting confusion about the relationship between the preexisting condition exclusion rules and the definitions of enrollment date and waiting period. Accordingly, guidance concerning waiting periods previously located in the definitions section has been moved to this section of the regulations and expanded. In addition, the definition of waiting period has been modified with respect to individuals seeking individual market coverage. Specifically, these final rules clarify that if an individual seeks

coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on either the date coverage begins (if the application results in coverage), or the date on which the application is denied by the issuer or the date on which the offer of coverage lapses (if the application does not result in coverage). Under the statute, the April 1997 interim rules, and these final regulations, the effect of considering this period a waiting period is that the period is not counted when determining the length of any break in coverage. This rule modifies the rule contained in the April 1997 interim rules (which provided a waiting period only if the individual actually obtained coverage). The modification addresses situations where some individuals have been denied individual market policies or individuals declined coverage because, for example, the policies had an exorbitant premium.

Additional examples illustrate the interaction between a waiting period and the 6-month look-back period, the application of the 6-month look-back and maximum preexisting condition exclusion period rules to plans with more than one benefit package option at open season, and the interaction between these rules and other eligibility criteria under the plan.

Individuals and Conditions That Cannot Be Subject to a Preexisting Condition Exclusion

Under HIPAA, the April 1997 interim rules, and these final rules, a preexisting condition exclusion cannot be applied to pregnancy. Nor can a preexisting condition exclusion be applied to a newborn, adopted child, or child placed for adoption if the child is covered under a group health plan (or other creditable coverage) within 30 days after birth, adoption, or placement for adoption.

One comment noted that the rule for newborns in the April 1997 interim rules is expressed inconsistently. Some of those expressions are inconsistent with the rule for adopted children. Specifically, the rule for adopted children and one expression of the rule for newborns refers to eligibility being conditioned on being covered under any creditable coverage as of the last day of the 30-day period after birth, adoption, or placement for adoption. However, in other expressions of the rule for newborns, a reference is made to being covered under creditable coverage within 30 days after birth. These final regulations use one term consistently, referring to coverage within 30 days

after birth, adoption, or placement for adoption. This accords with the conference report. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 184–185 (1996). Consequently, if, for example, a child is covered within 30 days of birth, the child cannot be subject to a preexisting condition exclusion even if the child is no longer covered under the plan on the 30th day after birth (unless the child has a significant break in coverage).

Several comments noted that State laws applicable to health insurance issuers sometimes require that a mother's health coverage must provide benefits for health care expenses incurred for the child for a specified period following birth and cannot be recouped even if the child never enrolls in the plan under which the mother is covered. A new example clarifies that, in this situation, the child has creditable coverage within 30 days after birth and, therefore, no preexisting condition exclusion may be imposed on the child unless the child has a subsequent significant break in coverage.

Finally, HIPAA, the April 1997 interim rules, and these final regulations provide that a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. Comments expressed concern that the definition of genetic information in the April 1997 interim rules was too broad and would prevent the application of a preexisting condition exclusion to conditions that would be otherwise permitted independent of any genetic information. Although these regulations have not changed the definition of genetic information, the regulations clarify that if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section. This rule was located in the definition of medical condition in the April 1997 interim rules. Some comments indicated this rule was difficult to locate. Thus, it has been moved to this section, and an example illustrating the rule has been added.

First Notice of Preexisting Condition Exclusion—General Notice

Under these final regulations, as with the April 1997 interim rules, a group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance coverage under a plan imposing a preexisting condition

exclusion, must provide a written general notice of preexisting condition exclusion before it can impose a preexisting condition exclusion.

After publication of the April 1997 interim rules, the Departments received questions about the operation of this requirement. The April 1997 interim rules provided that a plan or issuer could not impose a preexisting condition exclusion with respect to a participant or dependent before providing the general notice to the participant. Several comments asked whether plans and issuers could delay providing the general notice until a large claim was filed and then pend the claim until the general notice was sent. Other comments expressed concern that if plans do not notify individuals upon enrollment about the benefit exclusions that apply to their coverage, individuals will not be able to make informed decisions about their health care choices.

The Departments had contemplated under the April 1997 interim rules that individuals should be provided the information required in the general notice before they incurred claims that could be denied under a preexisting condition exclusion. These final regulations clarify the procedural requirements for the general notice of preexisting condition exclusion. Specifically, under the final regulations, the general notice of preexisting condition exclusion must be provided as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice. Moreover, regarding the content of this general notice, the final regulations clarify precisely what is required when disclosing the existence and terms of the plan's preexisting condition exclusion. In addition, these final regulations require the notice to include the person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion. An example in these final regulations sets forth sample language that plans and issuers can use when developing the general notice for their coverages.

Issuers that sell different policies to different plans should also be aware that when describing the existence and terms of the maximum preexisting condition exclusion period, the issuer must describe to individuals the actual

maximum exclusion period under their policy. Therefore, if an issuer sells two policies, one with a 6-month and one with a 12-month maximum preexisting condition exclusion, the issuer could not send one notice to individuals under both policies indicating that the maximum preexisting condition exclusion is 12 months. Instead, the issuer is required to send one notice to participants under the policy with the 6-month preexisting condition exclusion (indicating that the maximum exclusion period is 6 months) and a different notice to participants under the policy with the 12-month preexisting condition exclusion (indicating that the maximum exclusion period is 12 months).

Determination of Creditable Coverage

These final regulations require a plan or issuer that imposes a preexisting condition exclusion to make a determination of creditable coverage within a reasonable time after receiving information regarding prior health coverage. This rule was included in the section of the April 1997 interim rules addressing certification and disclosure of previous coverage, and it has been moved to this section on preexisting condition exclusions unchanged. These final regulations clarify that a plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.⁴

Second Notice of Preexisting Condition Exclusion—Individual Notice

These final regulations retain the requirement to provide an individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. These final regulations clarify that this individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. Also, a plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. These final regulations add a new example that illustrates how the notice works and includes sample language that may be helpful to plans and issuers in developing this type of notice with respect to their coverage.

⁴ Of course, after a claim has been denied under a preexisting condition exclusion, other laws, such as section 503 of ERISA, may set forth timing rules for an individual to appeal a denied claim.

Reconsideration

Consistent with the April 1997 interim rules, these final regulations do not prevent a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage and if certain procedural requirements are met. The final regulations have been slightly reorganized and modified to make clearer that a plan or issuer is permitted to modify its initial determination if a notice of the new determination (that meets the requirements of the second, individual notice of preexisting condition exclusion, described above) is provided and, until the notice of the new determination is provided, the plan or issuer acts in a manner consistent with the initial determination for purposes of approving access to medical services (such as pre-surgery authorization).

3. Rules Relating to Creditable Coverage—26 CFR 54.9801–4, 29 CFR 2590.701–4, 45 CFR 146.113

This section of the final regulations describes the varieties of health coverage that constitute creditable coverage and sets forth rules for how to count creditable coverage for purposes of the rule requiring plans and issuers to offset the maximum length of a preexisting condition exclusion by prior creditable coverage.

Creditable Coverage

The rules in the final regulations describing the varieties of health coverage that constitute creditable coverage generally follow the April 1997 interim rules, with two modifications. The April 1997 interim rules contain ten categories of creditable coverage. After publication of the April 1997 interim rules, Congress created the State Children's Health Insurance Program (S-CHIP), which allows states to provide health coverage to eligible children through Medicaid expansion or private market mechanisms. This coverage meets the definition of creditable coverage as either Medicaid coverage, group health plan coverage, or health insurance coverage. In addition, Congress specifically provides⁵ that S-CHIP coverage is creditable coverage under HIPAA. Therefore, these final regulations have added coverage under S-CHIP as an eleventh category of creditable coverage.

The second modification is to the definition of public health plan. This

⁵ Section 2109 of the Social Security Act, enacted by section 4901 of the Balanced Budget Act of 1997, Pub. L. 105–33, 111 Stat. 567.

definition has been changed in two ways. The first change relates to the type of health coverage provided by a public health plan. The statute does not define the term. The April 1997 interim rules limit the definition of public health plans to certain plans provided through health *insurance* coverage. Some comments suggested it was unnecessary to restrict the definition to insured coverage and argued that the term public health plan should be expanded. These final regulations delete the word “insurance” from that requirement so that any health coverage provided by a governmental entity, regardless of whether it has the risk-shifting or risk-distributing effects of insurance, is a public health plan.

The second change to the definition of public health plan relates to the type of governmental entity that can establish or maintain a public health plan. Under the April 1997 interim rules, only health coverage provided under a plan established or maintained by a State, a county, or another political subdivision of a State can be a public health plan. This definition does not include a plan established or maintained by a foreign government or the U.S. government. The preamble to the April 1997 interim rules specifically solicited comments on whether public health systems of foreign countries should be considered public health plans.

Many comments addressed this issue, arguing both for and against including public health systems of foreign governments in the definition of public health plan. The comments in favor of inclusion argued that generally the health coverage provided through public health systems in foreign countries is more comprehensive than that received in this country. Some comments argued that the exclusion of foreign public health systems from the definition of public health plan arbitrarily penalizes individuals who maintain continuous health coverage through a foreign public health system. The comments against inclusion focused on the difficulty for a plan or issuer to verify whether someone had the coverage they claimed under a foreign public health system.

Under these final regulations, the definition of a public health plan includes health coverage provided under a plan established or maintained by a foreign country or a political subdivision. While this result can inconvenience plans and issuers, verifying this type of coverage may be no more inconvenient than verifying certain other types of coverage, such as group health coverage provided through foreign employers. In addition, this

result is much less inequitable than denying an individual coverage for a preexisting condition in a case in which the individual can provide reliable evidence of having coverage under the public health system of a foreign government. Under the rules for establishing creditable coverage in the absence of a certificate of creditable coverage, an individual is required to present at a minimum some corroborating evidence of the claimed creditable coverage and is required to cooperate with a plan’s or issuer’s efforts to verify coverage. Thus, in the case of an individual claiming coverage under the public health system of a foreign country, a plan or issuer could require some evidence of residency in the foreign country (or evidence that some other eligibility standard had been met) and the individual would have to cooperate with the plan’s or issuer’s efforts to verify that the individual had coverage under that country’s health system.

Under the revised definition in these final regulations, health coverage provided under a plan established or maintained by the U.S. Government is also a public health plan.

Counting Creditable Coverage

The rules in the final regulations for how to count creditable coverage are adopted with stylistic and conforming changes from the April 1997 interim rules. In addition, a technical modification was added, as required by a statutory change made by the Trade Act of 2002 (“the Trade Act”, Public Law 107–210, enacted on August 6, 2002). Under the Trade Act, workers whose employment is adversely affected by international trade may become entitled to receive trade adjustment assistance (TAA) and a 65% health coverage tax credit (HCTC). The Trade Act also amended COBRA continuation coverage provisions in ERISA, the Public Health Service Act, and the Internal Revenue Code, to provide a second opportunity to elect COBRA for individuals who are eventually determined to qualify for TAA, but who did not elect COBRA after their original loss of health coverage. Because this could result in a “significant break in coverage” for purposes of HIPAA, the Trade Act specifies that the period beginning with the loss of coverage, and ending on the first day of the second election period, for individuals who elect COBRA during this second election period, should be disregarded for purposes of the HIPAA pre-existing condition provisions. Accordingly, as required by the Trade Act, under these final rules the days between the date an

individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred. For more information on TAA, contact the Department of Labor’s Employment and Training Administration at 877-US2-JOBS or at www.doleta.gov/tradeact. For more information on the HCTC, contact the IRS toll-free at 866-628-4282.

The existing examples relating to the tolling of the period for determining a significant break in coverage in the case of individuals seeking coverage in the individual market have also been modified to conform to the change in the definition of waiting period, which under these final regulations includes the period beginning when an individual submits a substantially complete application for coverage in the individual market and ends when the application is denied or when the offer of coverage lapses. In addition, here, as throughout these final regulations, references in the April 1997 interim rules to “plan or policy” have been revised so that the reference includes health insurance coverage not offered through a policy of insurance, such as health insurance coverage offered through a contract of a health maintenance organization.

Published elsewhere in this issue of the **Federal Register** is a proposed rule that provides that the period that determines whether a significant break in coverage has occurred (generally 63 days) is tolled in cases in which a certificate of creditable coverage is not provided on or before the day coverage ceases. In those cases, the significant-break-in-coverage period would be tolled until a certificate is provided or, if earlier, until 44 days after the coverage ceases.

These final regulations retain the methods in the April 1997 interim rules for counting creditable coverage, that is, the standard method and the alternative method. Comments requested that the alternative method be expanded so that a plan or issuer could elect to have it apply to categories in addition to the five categories prescribed in the April 1997 interim rules (mental health; substance abuse treatment; prescription drugs; dental care; and vision care). The types of categories described in the comments were significant differences in deductibles, cost-sharing, or out-of-pocket maximums between plans. One comment suggested that any comparison between plans on the basis of difference in deductibles or cost sharing was unworkable.

It is the view of the Departments that a comparison between plans, and allowing one plan not to count creditable coverage (in whole or in part) under another plan, based solely on differences in deductibles or in some other cost-sharing mechanism or in all cost-sharing mechanisms, is an insufficient basis for determining the comparative value of benefits under the plans. A plan with a low deductible or low co-payments might also have an annual or per-incident limit on benefits so low as to make the plan with the higher deductible or higher cost sharing actually more valuable. Similarly, a plan with a higher deductible or coinsurance might also have a higher table of usual, customary, and reasonable costs, might be much more liberal in covering treatments considered experimental, and might provide a much broader base of benefits than the plan with the lower deductible or coinsurance. Because of the numerous ways that plans or issuers can limit the amount of benefits available under the plan, it is very complicated to compare the value of one plan or coverage with another. Singling out one or several of these features is insufficient for making a true comparison of the value of the benefits.

4. Evidence of Creditable Coverage—26 CFR 54.9801–5, 29 CFR 2590.701–5, 45 CFR 146.115

This section of the final regulations sets forth guidance regarding the certification requirements and other requirements for disclosure of information relating to prior creditable coverage. The provision of a certificate and certain other disclosures of information provided for in the statute, the April 1997 interim rules, and these final regulations are intended to enable an individual to establish prior creditable coverage for purposes of reducing or eliminating any preexisting condition exclusion imposed on the individual by any subsequent group health plan coverage. The Departments received generally favorable comments on the April 1997 interim rules from interested parties who submitted comments with regard to the certification requirements. For example, several comments praised the Departments' promulgation of a model certificate in the April 1997 interim

rules as a vehicle that helped reduce compliance burdens associated with the statutory requirements under HIPAA.

Form of Certificate

These final regulations retain the requirement that the certificate must generally be provided in writing. The April 1997 interim rules clarified that for this purpose a writing included any form approved by the Secretaries as a writing. These final regulations modify that standard to include any other medium approved by the Secretary. As with the April 1997 interim rules, these final regulations provide that where an individual requests that the certificate be sent to another plan or issuer instead of the individual, and the other plan or issuer agrees, the certification information may be provided by other means, such as by telephone.

Information in Certificate

The information required to be provided in a certificate under these final regulations is the same as required under the April 1997 interim rules with one addition. In response to recommendations made by the U.S. General Accounting Office (GAO)⁶ and several comments, the Departments have modified the April 1997 interim rules to require that an educational statement be provided as part of a certificate of creditable coverage in order to inform consumers of their HIPAA rights. Some comments stated that such educational language was not necessary, but indicated that if the Departments adopted such an approach

⁶ In the report entitled "PRIVATE HEALTH INSURANCE: Progress and Challenges in Implementing 1996 Federal Standards" (GAO/HEHS-99-100, May 12, 1999) the GAO recommended that the Departments revise the model certificate of creditable health plan coverage to more explicitly inform consumers of their new rights under HIPAA. At a minimum, the GAO recommended that the certificate of creditable coverage should inform consumers about appropriate contacts for additional information about HIPAA and highlight key provisions and restrictions, including (1) the limits on preexisting condition exclusion periods and the guaranteed renewability of all health coverage; (2) the reduction or elimination of preexisting condition exclusion periods for employees changing jobs; (3) the prohibition against excluding an individual from an employer health plan on the basis of health status; and (4) the guarantee of access to insurance products for certain individuals losing group health coverage and the restrictions placed on that guarantee.

they should provide language for compliance purposes. In response to the GAO recommendation, the Departments have amended the requirements for the certificate of creditable coverage in the final regulations to include the provision of an educational statement regarding certain HIPAA protections. Model educational language is provided in the model certificate (set forth below). This eliminates the burden on plans and issuers of developing language to satisfy this requirement.

Model Certificate

The first model certificate below has been authorized by the Secretary of each of the Departments. The model educational statement is set forth under the heading "Statement of HIPAA Portability Rights." Use of the model certificate by group health plans and group health insurance issuers will satisfy the requirements of paragraph (a)(3)(ii) of the regulations. The second model certificate below has been authorized by the Secretary of Health and Human Services. State Medicaid programs may use this version. Once these final regulations are applicable, use of the previously-published model certificate (published in the preamble to the April 1997 interim rules) will no longer satisfy paragraph (a)(3)(ii) of the regulations.

In addition to these model certificates, the Departments are publishing a different model certificate for group health plans and group health insurance issuers in the preamble to the proposed rules published elsewhere in this issue of the **Federal Register**. That model certificate includes in its educational statement an additional paragraph regarding coordination with rules under the Family and Medical Leave Act (FMLA). The Secretaries of the Departments authorize plans and issuers to use either model certificate in fulfillment of their obligations under paragraph (a)(3)(ii) of this section in the final regulations. State Medicaid programs may use either the model certificate below that is designated for Medicaid programs, or the model certificate in the proposed rules that is so designated and includes an additional paragraph on FMLA.

BILLING CODE 4830-01-P

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of this certificate: _____ 2. Name of group health plan: _____ _____ 3. Name of participant: _____ 4. Identification number of participant: _____ 5. Name of individuals to whom this certificate applies: _____ _____ 6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____ _____	7. For further information, call: _____ 8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10: ☐ _____ 9. Date waiting period or affiliation period (if any) began: _____ 10. Date coverage began: _____ 11. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.]

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive web pages - Health Laws, or <http://www.cms.hhs.gov/hipaa1>.

CERTIFICATE OF MEDICAID COVERAGE

1. Date of this certificate: _____ 2. Name of state Medicaid program: _____ 3. Name of recipient: _____ 4. Identification number of recipient: _____ 5. Name of individuals to whom this certificate applies: _____ _____ 6. Name, address, and telephone number of state Medicaid agency responsible for providing this certificate: _____ _____	7. For further information call: _____ 8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip line 9. ☐ 9. Date coverage began: _____ 10. Date coverage ended (or if coverage has not ended, enter "continuing"): _____ <i>[Note: separate certificates will be furnished if information is not identical for the recipient and each dependent.]</i>

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this state Medicaid program. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under a group health plan, to help you get special enrollment in a group health plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in a group health plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage in a group health plan ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa> or <http://www.cms.hhs.gov/hipaa1>.

Procedure for Requesting Certificates

The April 1997 interim rules require plans and health insurance issuers to establish a procedure for individuals to request and receive certificates of creditable coverage. The Departments have received requests to clarify whether such procedures need to be in writing. These final regulations clarify that the procedures need to be in writing, helping to ensure that individuals are aware of their right to request a certificate and how to make the request.

In addition, the Departments have become aware that some plans and issuers believe they are not required to provide a certificate to individuals who request one while their coverage is still in effect. This requirement exists under the April 1997 interim rules. However, due to these questions being raised, the final regulations more explicitly state this requirement.

Dependent Coverage Information

Under HIPAA, plans and health insurance issuers are required to issue certificates of creditable coverage (automatically, and upon request) to dependents who are or were covered under a group health plan. In response to comments, and in order to allow entities responsible for issuing certificates adequate time to modify their data collection systems, the Departments established a transitional rule in the April 1997 interim rules for providing dependent coverage information. Under this transitional rule, a group health plan or health insurance issuer that, after having made reasonable efforts, could not provide a certificate of creditable coverage for a dependent could satisfy the requirements for providing a certificate to the dependent by providing the name of the participant covered by the group health plan or health insurance issuer and specifying that the type of coverage described in the certificate was for dependent coverage (for example, family coverage or employee-plus-spouse coverage). This transitional rule was effective through June 30, 1998.

Under these final regulations, the transitional rule is no longer in effect and dependents are entitled to receive individualized certificates of creditable coverage under the same circumstances as other individuals. As with the April 1997 interim rules, these final regulations permit a single certificate of creditable coverage to be provided with respect to both a participant and the participant's dependents if the information is identical for each individual. In addition, these final

regulations retain the provisions of the April 1997 interim rules permitting the combining of information for families. As a result, in situations where coverage information is not identical for a participant and the participant's dependents, these final regulations allow certificates for all individuals to be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

Special Rules for Certain Entities

Section 2791(a)(3) of the PHS Act provides that certain entities not otherwise subject to HIPAA's requirements are to comply with the statutory certification of coverage requirements that apply to group health plans, with respect to providing certificates of creditable coverage for Medicare, Medicaid, TRICARE, and medical care programs provided through the Indian Health Service or a tribal organization. These rules further establish that such entities are required to comply with the general statutory requirement to provide certificates. However, the Departments recognize that these programs operate in a different manner than do private employment-based group health plans, nonfederal governmental group health plans, and health insurance issuers. In addition, the populations served by these programs are unique. Therefore, it may be appropriate to allow these programs to implement the certification process in a manner that addresses these unique characteristics and better serves the individuals covered by these programs, including requiring different information elements (for example, see the above model certificate of creditable coverage for use by State Medicaid programs). HHS will coordinate with the appropriate entities responsible for issuing these certificates and will issue separate guidance to these entities on how they must comply with the certification requirements.

5. Special Enrollment Periods—26 CFR 54.9801-6, 29 CFR 2590.701-6, 45 CFR 146.117

Under HIPAA, the April 1997 interim rules, and these final regulations, a group health plan and a health insurance issuer offering group health insurance coverage are required to provide for special enrollment periods during which certain individuals are allowed to enroll (without having to wait until a late enrollment opportunity and regardless of whether the plan offers late enrollment). A special enrollment right can arise if a person with other health coverage loses

eligibility for that coverage or employer contributions toward the other coverage cease, or if a person becomes a dependent through marriage, birth, adoption, or placement for adoption.

In order to qualify for special enrollment, an individual must be otherwise eligible for coverage under the plan. Being otherwise eligible for coverage means having met the plan's substantive eligibility requirements (such as satisfying any waiting period, being in an eligible job classification, or working full time), regardless of whether the individual previously satisfied the plan's procedural requirements for becoming enrolled (such as completing written application materials or providing them to the plan within a specified time frame) during any enrollment opportunity prior to special enrollment.

The special enrollment rules have been reorganized and clarified. As discussed below, the special enrollment rules have also been modified in response to comments.

Loss of Eligibility for Other Coverage

A special enrollment right resulting from loss of eligibility for other coverage is available to employees and their dependents who meet certain requirements. As under the April 1997 interim rules, the employee or dependent must otherwise be eligible for coverage under the terms of the plan. When coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage. The plan can require that, when coverage in the plan was previously declined, the employee must have declared in writing that the reason was other coverage, in which case the plan must at that time have provided notice of this requirement and the consequences of the employee's failure to provide the statement.

These regulations include an example that clarifies that the initial opportunity for enrollment (generally provided when employment begins) is not the only time when an individual with other health coverage may decline coverage for purposes of satisfying the prerequisites to special enrollment upon loss of other coverage. (Other examples discussed below also illustrate this principle.) An individual who initially did not enroll for coverage without having other health coverage might later be eligible for special enrollment. This could occur if, after subsequently enrolling in other coverage, the individual had an opportunity for late

enrollment or special enrollment under the plan, but again chose not to enroll.

These final regulations, like the April 1997 interim rules, contain a list of situations when an individual loses eligibility for other coverage. While the list is not exhaustive, it has nonetheless been expanded in these final regulations to address situations that have prompted frequent questions. Thus, these regulations clarify that a loss of eligibility for coverage occurs, in the case of individual coverage provided through an HMO, when an individual no longer resides, lives, or works in the service area of the HMO (whether or not within the choice of the individual) and the HMO does not provide coverage for that reason. In the case of group coverage provided through an HMO, the same rule applies, provided that there is no other coverage under the plan available to the individual. For purposes of this rule, the HMO service area is typically defined by State law. In addition, the regulations clarify that a loss of eligibility for coverage occurs due to the cessation of dependent status. For example, a child who "ages out" of dependent coverage—who attains an age in excess of the maximum age for coverage of a dependent child—incur a loss of eligibility for coverage for purposes of special enrollment.

The regulations also clarify that a loss of eligibility for coverage occurs when a plan no longer offers any benefits to a class of similarly situated individuals. Thus, if a plan terminated health coverage for all part-time workers, the part-time workers incur a loss of eligibility for coverage, even if the plan continues to provide coverage to other employees. An example in the final regulations also illustrates how the loss of eligibility rule applies to a plan that terminates a benefit package option. Similarly, if an issuer providing one of the options ceases to operate in the group market, thus terminating one of the options offered by the plan, the individuals formerly in the terminated option would incur a loss of eligibility for coverage for purposes of special enrollment, unless the plan otherwise provided a current right to enroll in alternative health coverage. In addition, the final regulations clarify that an employee who is already enrolled in a benefit package may enroll in another benefit package under the plan if a dependent of that employee has a special enrollment right in the plan because the dependent lost eligibility for other coverage.

These regulations clarify that a loss of eligibility for coverage is still considered to exist even if there are subsequent coverage opportunities. As

under the April 1997 interim rules, an individual does not have to elect COBRA continuation coverage or exercise similar continuation rights in order to preserve the right to special enrollment. Moreover, a special enrollment right exists even if an individual who lost coverage elects COBRA continuation coverage. In that case, if an individual declines special enrollment, and instead elects and exhausts COBRA continuation coverage, the individual has a second special enrollment right upon exhausting the COBRA continuation coverage.

In addition, as under the statute and the April 1997 interim rules, even if there is no loss of eligibility for coverage, a special enrollment right can result when employer contributions towards other coverage terminate. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer.

Lifetime Benefit Limits

Comments asked how the special enrollment rules apply when an individual reaches a lifetime limit on all benefits under a plan. The regulations clarify that where an individual has a claim denied due to the operation of a lifetime limit on all benefits, there is a loss of eligibility for coverage for special enrollment purposes. In this regard, an individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until 30 days after the earliest date that a claim is denied due to the operation of the lifetime limit. Accordingly, because individuals who are keeping track of claims in relation to a lifetime limit can request enrollment immediately (after the claim is incurred, but before it is denied by the plan), the period for requesting special enrollment can be longer than 30 days. (Timeframes for providing certificates of creditable coverage and determining when COBRA is exhausted for individuals who have reached a lifetime limit on all benefits are set forth elsewhere in these final regulations, under the certificate and the definition provisions, respectively.)

Tolling of the Special Enrollment Period

Proposed rules, published elsewhere in this issue of the **Federal Register**, would toll the beginning of the 30-day period for requesting special enrollment until a certificate of creditable coverage is provided to the person losing coverage, up to a maximum of 44 days of tolling. This tolling rule would be in the paragraph reserved for special

enrollment procedures in these final regulations.

Dependent Special Enrollment

Comments asked for clarification of the interaction of coverage for children under a State Children's Health Insurance Program (S-CHIP) and special enrollment. In particular, it was asked whether a child would have a right to special enrollment in a group health plan if the child becomes eligible for benefits under S-CHIP and the child is otherwise eligible for dependent coverage under the plan. This situation would arise if a State creates a children's health program that provides payments to a parent to cover the increased cost of enrolling a dependent child in the parent's employer's group health. However, without a special enrollment right, the parent might not be able to take advantage of the program until the next late enrollment opportunity, if the plan allows late enrollment at all. The statutory language of HIPAA, however, only provides special enrollment if there is loss of eligibility for other coverage, loss of employer contributions, or addition of a new dependent to the employee's family. Becoming eligible under a health program such as S-CHIP does not fall under any of these categories.⁷

Under these final regulations, as under the April 1997 interim rules, the special enrollment of dependents is subject to the plan's general eligibility requirements. For example, a plan may require an employee to remain enrolled, or to special enroll, in order to special enroll the employee's dependent. However, a plan's general eligibility requirements cannot prevent the application of a special enrollment right. For example, a plan may not deny special enrollment to an otherwise eligible dependent merely because the individual became a dependent of the participant after the participant's first day of coverage under the plan.

Modification of Special Enrollment Procedures

Under proposed rules, published elsewhere in this issue of the **Federal Register**, more detailed procedures are described for how plans and issuers would have to enroll individuals requesting special enrollment.

⁷Nonetheless, in addition to the dependent special enrollment rights under HIPAA, for plans subject to ERISA, section 609 of ERISA imposes additional requirements on group health plans to provide benefits to certain children, including in cases where a qualified medical child support order applies, as well as in cases of adoption. HIPAA does not prevent States from imposing similar requirements on nonfederal governmental plans.

When Coverage Begins Under Special Enrollment

Where the special enrollment right results from marriage or a loss of eligibility, coverage generally begins no later than the first day of the first calendar month after the date the plan or issuer receives the request for special enrollment. Where the special enrollment right results from a birth, coverage must begin on the date of birth. In the case of adoption or placement for adoption, coverage must begin no later than the date of such adoption or placement for adoption.

Clarification of Special Enrollment During a Late Enrollment Opportunity

The April 1997 interim rules provided a definition of the term *special enrollment date*. The purpose of the definition and accompanying examples was to illustrate that if an individual who qualified for special enrollment enrolled during a coinciding late enrollment opportunity, the individual could not be treated as a late enrollee. The final regulations eliminate the term *special enrollment date* and clarify this issue by providing that if an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request coincides with a late enrollment opportunity under the plan. Thus, the individual cannot be treated as a late enrollee.

Notice of Special Enrollment

The preamble to the April 1997 interim rules stated that a plan must provide a description of the special enrollment rights to anyone who declines coverage. However, the text of the April 1997 interim rules required the notice to be provided to all eligible employees. Even employees who enroll may need to avail themselves of their special enrollment rights in the future, either for a spouse or other dependent, or if they lose the present coverage. Thus, these regulations reiterate the requirement in the April 1997 interim rules that a plan must provide all employees (those who enroll as well as those who decline enrollment) with a notice of special enrollment at or before the time the employee is initially offered the opportunity to enroll in the plan. The regulation also provides model language that plans can use to satisfy this requirement.

Treatment of Special Enrollees

HIPAA provides that a late enrollee does not include an individual who enrolls when first eligible or who enrolls during a special enrollment period. These regulations further clarify

that individuals who enroll during a special enrollment period must generally be treated the same as individuals who enroll when first eligible. That is, relative to similarly situated individuals who enroll when first eligible, special enrollees must be offered all the same benefit packages, cannot be required to pay more for coverage, and cannot be subject to a longer preexisting condition exclusion.

6. HMO Affiliation Period as an Alternative to a Preexisting Condition Exclusion—29 CFR 2590.701–7, 45 CFR 146.119

Under HIPAA, the April 1997 interim rules, and these final regulations, a group health plan that offers health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period under certain conditions. An affiliation period is a period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which time the HMO is not required to provide benefits. Under these final regulations an affiliation period can be imposed if each of the following requirements is satisfied:

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of the HIPAA nondiscrimination provisions.

(4) The affiliation period does not exceed 2 months (or 3 months for a late enrollee).

(5) The affiliation period begins on the enrollment date (or, in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage, but for the affiliation period).

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

The requirements related to HMO affiliation periods contained in these final regulations clarify that a group health plan offering health insurance through an HMO or an HMO that offers health insurance coverage in connection with a group health plan may impose different affiliation periods, so long as the affiliation period complies with the requirements of the HIPAA nondiscrimination provisions. To illustrate this clarification, these final

regulations contain an example where a group health plan that provides benefits through an HMO imposes an affiliation period with respect to salaried employees but does not impose an affiliation period with respect to hourly employees. This example illustrates that it is permissible to impose an affiliation period on salaried employees but not hourly employees, so long as treating these two groups differently complies with the requirements of the HIPAA nondiscrimination provisions.

The April 1997 interim rules and these final regulations specify that the affiliation period begins on the enrollment date (which is the first day of coverage under the plan, or if there is a waiting period for coverage under the plan, the first day of the waiting period), not when coverage under a particular benefit package option begins. Accordingly, an example in these final regulations illustrates that if a group health plan offers multiple benefit package options simultaneously, the HMO cannot impose an affiliation period on a plan participant who later switches to the HMO benefit package option, assuming the period of time that has elapsed since the enrollment date (during which the participant was covered under the first benefit package option) exceeds the duration of the HMO affiliation period. Moreover, these regulations clarify that, in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage, but for the affiliation period.

The April 1997 interim rules and these final regulations allow an HMO to use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Because an affiliation period may be imposed only if no preexisting condition exclusion is imposed, an alternative to an affiliation period may not encompass an arrangement that is in the nature of a preexisting condition exclusion.

7. Interaction With the Family and Medical Leave Act—26 CFR 54.9801–7, 29 CFR 701–8, 45 CFR 146.120

This section has been reserved. For proposed rules on the interaction with the Family and Medical Leave Act, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

8. Special Rules; Excepted Plans and Excepted Benefits—26 CFR 54.9831–1, 29 CFR 2590.732, 45 CFR 146.145

This section of the final regulations contains special rules that apply for

Chapter 100 of the Code, Part 7 of Subtitle B of Title I of ERISA (Part 7 of ERISA), and Title XXVII of the PHS Act. For ease in applying these rules, the definition of *group health plan* has been moved from the definitions section to this section (and the reference to employees in that definition has been modified to clarify that the term includes both current and former employees). New rules have been added for defining limited scope dental and vision benefits and for determining the extent to which benefits provided under a health flexible spending arrangement are excepted benefits. Special rules for partnerships have also been clarified.

Determination of the Number of Plans

A paragraph has been reserved in the final regulation for determining the number of plans an employer or employee organization maintains. For proposed rules on this topic, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

Coverage Provided by an Employer Through Two or More Individual Policies

If an employer provides coverage to its employees through two or more individual policies, the coverage may be considered coverage offered in connection with a group health plan and, therefore, subject to the group market provisions under HIPAA. A determination of whether there is a group health plan depends on the particular facts and circumstances surrounding the extent of the employer's involvement. For example, one significant factor in establishing whether there is a group health plan is the extent to which the employer makes contributions to health insurance premiums. The fact that health insurance coverage is provided through a contract regulated under State law as individual health insurance coverage does not necessarily prevent the coverage from being treated for HIPAA purposes as coverage sold in the group market. Similarly, the policy that provides the coverage does not have to be considered a "group" policy under State law in order for the group market requirements to apply. Further, the mere fact that an employer forwards employee payroll deductions to a health insurance issuer will not, alone, cause the coverage to become group health plan coverage. However, the employer need not be a party to the insurance policy, or arrange or pay for it directly, in order for its coverage to be considered group health plan coverage. For example, if an employer's actions

appear to endorse one or more policies offered by a health insurance issuer (or issuers), the coverage might be considered group health plan coverage.

General Exception for Certain Small Group Health Plans

Under HIPAA, the April 1997 interim rules, and these final regulations, the group market requirements do not apply to a group health plan or to group health insurance coverage offered in connection with a group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees. As noted in the preamble to the April 1997 interim rules, a State may apply some or all of the group market provisions in the PHS Act to health insurance issuers in connection with group health plans with fewer than two participants who are current employees on the first day of the plan year. In this case, to the extent the State applies its group market provisions to such insurance, the insurance would not be subject to the individual market requirements.

In the event a group health plan has two or more participants who are current employees on the first day of the plan year but the number of participants who are current employees drops below two during the plan year, under these final regulations the group market requirements continue to apply to the group health plan for the duration of the plan year.

To the extent a health insurance issuer offers group health insurance that is subject to HIPAA's group health insurance requirements, HIPAA generally prohibits the issuer from terminating or failing to offer to renew the insurance (*see* 45 CFR 146.152). With respect to very small employers, whether group health insurance is subject to the requirements of 45 CFR 146.152 is generally determined by whether the group health plan has two or more participants who are current employees on the first day of the plan year. If so, the issuer generally must provide such coverage throughout the plan year, and is prohibited from terminating coverage in the midst of that plan year merely because the number of current-employee participants drops below two.⁸ However, an issuer is permitted to terminate an employer's coverage in the midst of a plan year if the employer fails to satisfy any valid plan participation requirements in the midst of that plan year (*see* 45 CFR

146.152(a)(3)), including instances where such failure causes the number of current-employee participants to drop below two.

Excepted Benefits

Under HIPAA, the April 1997 interim rules, and these final regulations, certain benefits are excepted from HIPAA in all circumstances, including coverage only for accident (including accidental death and dismemberment); disability income coverage; liability insurance, including general liability insurance and automotive liability insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar coverage; automobile medical payment insurance; credit-only insurance (for example, mortgage insurance); and coverage for on-site medical clinics.

Limited Excepted Benefits

Under HIPAA, the April 1997 interim rules, and these final regulations, limited scope dental benefits, limited scope vision benefits, and long-term care benefits⁹ are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan that is subject to these regulations. Benefits are not an integral part of such a plan if participants have the right not to elect coverage for the benefits, and if participants who elect such coverage must pay an additional premium or contribution for it. These regulations clarify that whether limited scope dental benefits, limited scope vision benefits, or long-term care benefits are provided through a plan that is subject to these regulations, or through a separate plan, is irrelevant to determining whether such benefits are an integral part of a plan that is subject to these regulations. Thus, if participants can decline coverage for the limited-scope benefits, and those electing such coverage must pay an additional premium or contribution, the limited scope benefits could be considered not to be an integral part of a plan that is subject to these regulations, even if such benefits are not provided through that plan.

Limited Scope Vision and Dental Benefits

These regulations define *limited scope dental benefits* as benefits

⁹ Long term care benefits are defined as benefits that are either subject to State long-term care insurance laws; that meet the qualifications of section 7702B(c)(1) or 7702B(b) of the Internal Revenue Code; or are based on cognitive impairment or loss of functional capacity that is expected to be chronic.

⁸ See CMS Program Memorandum No. 99-03, *Group Size Issues Under Title XXVII of the Public Health Service Act*, September 1999.

substantially all of which are for treatment of the mouth (including any organ or structure within the mouth). These regulations also define *limited scope vision benefits* as benefits substantially all of which are for treatment of the eye. Thus, if benefits meet the definition of limited scope dental benefits or limited scope vision benefits, they will be excepted benefits if they satisfy the requirements set forth in these regulations.

These definitions were added in response to questions raised in comments about the prior guidance. The April 1997 interim rules did not define these terms. The preamble to the April 1997 interim rules suggested that the term *limited scope dental benefits* typically does not include medical services, such as those procedures associated with oral cancer or with a mouth injury that results in broken, displaced, or lost teeth. Similarly, the preamble to the April 1997 interim rules suggested that the term *limited scope vision benefits* does not include benefits for such ophthalmological services as treatment of an eye disease (such as glaucoma or a bacterial eye infection) or an eye injury. Comments indicated that typically most independent dental and vision coverages include benefits for these types of medical services. Accordingly, these regulations include definitions of limited scope dental benefits and limited scope vision benefits that reflect this market reality.

Health FSAs

Some comments asked about the extent to which health flexible spending arrangements (FSAs) are subject to these regulations. A health FSA generally is a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for the participant's coverage. Coverage and reimbursements provided to an individual under a group health plan that is a health FSA and that conforms to the generally applicable rules for accident or health plans qualify for the same tax-favored treatment that generally is extended to coverage and reimbursements under employer-provided accident or health plans. Health FSA reimbursements typically provide coverage for medical care expenses not otherwise covered by the

employer's primary group health plan. A health FSA is permitted to operate under a cafeteria plan described in section 125 of the Code. Pursuant to the rules of section 125, an employee can elect to reduce the employee's salary in order to pay for health FSA coverage without the employee having to include that portion of the salary in gross income. Commonly, the maximum benefit payable under a health FSA for any year is equal to the amount of the employee's salary reduction election for the year, plus any additional employer contribution for the year.

The April 1997 interim rules did not address the extent to which health FSAs qualify as excepted benefits. On December 29, 1997, a clarification to the April 1997 interim rules was published that specified the circumstances under which a health FSA qualifies as excepted benefits. (62 FR 67688) That clarification stated that benefits under a health FSA are treated as excepted benefits if the FSA meets certain requirements. Specifically, FSA benefits are treated as excepted benefits if the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year (or, if greater, the amount of the employee's salary reduction election under the FSA for the year, plus \$500). In addition, the employee must have other coverage available under a group health plan of the employer for the year, and that other coverage cannot be limited to benefits that are excepted benefits.

Based on section 9832(c)(2)(C) of the Code, section 733(c)(2)(C) of ERISA, and section 2791(c)(2)(C) of the PHS Act, these regulations adopt the December 29, 1997 guidance with some additional clarifications. Specifically, these regulations clarify that to be considered excepted benefits, a health FSA must meet the definition of a health FSA in section 106(c)(2) of the Code. Also, these regulations clarify that other group health plan coverage not limited to excepted benefits must be made available for the year to the class of participants by reason of their employment. Similarly, the maximum amount payable to any participant in the class for the year is the amount to consider when determining whether the maximum amount payable under the FSA for the year complies with the limit specified in the previous paragraph. Additionally, these regulations clarify that an employer credit under a health FSA that an employee can elect to receive as taxable income is considered an employee salary reduction election. However, if the employee cannot

receive the employer credit as taxable income (that is, the credit is lost unless the employee uses the amount for nontaxable benefits under a cafeteria plan), then the amount is not considered an employee salary reduction election.

Application to HSAs and HDHPs

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, added section 223 to the Internal Revenue Code to permit individuals to establish Health Savings Accounts (HSAs). HSAs are established to receive tax-favored contributions and amounts in an HSA may be used to pay or reimburse qualified medical expenses. Questions have arisen concerning the application of HIPAA to HSAs.

In order to establish and contribute to an HSA, an individual must be covered by a High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. An HDHP may be a group health plan sponsored by an employer or individual health insurance coverage purchased in the individual market. There is no provision in the HIPAA rules that excludes an HDHP, by virtue of qualifying as an HDHP, from the respective HIPAA requirements for group health plans or individual health insurance coverage. Generally, employer-sponsored HDHPs are employee welfare benefit plans. See Department of Labor Field Assistance Bulletin 2004-01 (FAB 2004-01), issued on April 7, 2004. Because an employer-sponsored HDHP provides medical care, it is generally subject to the portability requirements of HIPAA and the applicable regulations.

FAB 2004-01 concluded that HSAs, in contrast to HDHPs, generally will not constitute employee welfare benefit plans. See Department of Labor Field Assistance Bulletin 2004-01 (FAB 2004-01), issued on April 7, 2004. Because HSAs are generally not employee welfare benefit plans, the HIPAA portability requirements under ERISA or the PHS Act generally will not apply.

Moreover, the HIPAA portability requirements generally are not relevant for purposes of HSAs. Due to the rules imposed by the Internal Revenue Code with respect to HSAs, employers or HSA trustees do not have discretion with respect to the coverage provided by an HSA, both with respect to what expenses qualify for reimbursement as well as which individuals' expenses are eligible. For example, expenses reimbursable by an HSA cannot

generally be restricted by the employer or HSA trustee. Under the statute and administrative guidance, any expense incurred after an HSA is established is eligible for reimbursement, without restriction by an employer contributing to the HSA or trustee of the HSA. Thus, as a practical matter, whether or not an expense relates to a preexisting condition cannot determine the reimbursement. As such HSAs by design cannot impose a preexisting condition exclusion. Similarly, due to comparability rules requiring uniform contributions to HSAs by employers, employers and trustees generally cannot use differing amounts of contributions to impose a preexisting condition exclusion.

The eligibility for tax-free reimbursement from an HSA is also determined by statute; namely, the qualified medical expenses of the HSA owner and the HSA owner's dependents incurred after the HSA is established may be reimbursed on a tax-free basis by the HSA. Special enrollment rules for dependent children or spouses are not relevant because once an HSA is established they are eligible for tax-free reimbursements immediately. With respect to special enrollment upon loss of coverage, the rules for employer contributions generally require that all employees who are eligible for HSA contributions and participating in the employer's HDHP receive comparable HSA contributions. Thus, the combination of the comparability rules and the application of the special enrollment rules to the HDHP will generally ensure compliance with respect to employer HSA contributions because once an employee is enrolled in an employer-provided HDHP due to the special enrollment rules, the employer must make comparable contributions to the employee's HSA.

Indemnity Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, hospital indemnity and other fixed-dollar indemnity insurance are excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; if there is no coordination of benefits between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and if the benefits are paid with respect to an event regardless of whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. These regulations clarify that, for hospital indemnity or other fixed-dollar indemnity insurance to

qualify as excepted benefits, such insurance must pay a fixed dollar amount per day (or other period), regardless of the amount of expenses incurred. An example clarifies that if a policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum amount per day, the benefits are not excepted benefits. This is the result even if, in practice, the policy pays the maximum for every day of hospitalization.

Supplemental Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act); coverage supplemental to TRICARE; and similar coverage that is supplemental to a group health plan are excepted benefits if they are provided under a separate policy, certificate, or contract of insurance. These regulations clarify that, for coverage supplemental to a group health plan to qualify as excepted benefits, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Coverage that becomes secondary or supplemental only under a coordination-of-benefits provision in the insurance contract or plan documents does not qualify as excepted supplemental benefits.

Treatment of Partnerships

Any plan, fund, or program that is established or maintained by a partnership and that provides medical care to present or former partners or their dependents, and that otherwise would not be an employee welfare benefit plan, is considered an employee welfare benefit plan that is a group health plan under Part 7 of ERISA and Title XXVII of the PHS Act.¹⁰ As such, the partnership is considered the employer with respect to any partner. Participants in the plan include individuals who are partners of the partnership. Additionally, with respect to group health plans maintained by self-employed individuals (under which one or more employees are participants), the self-employed individual is considered a participant if this individual is or may become eligible to receive a benefit under the plan or if the individual's beneficiaries may be so eligible. These regulations clarify that, for purposes of Part 7 of ERISA and Title XXVII of PHS Act, a

¹⁰ Such a plan, fund, or program is also considered a group health plan under section 5000(b)(1) and Chapter 100 of the Code.

partner must be a bona fide partner in order to be considered an employee, and the partnership is considered the employer of a partner only if the partner is a bona fide partner. These final regulations also clarify that whether an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

Counting the Average Number of Employees

A paragraph has been reserved in the final rules for determining the average number of employees employed by an employer for a year. For proposed rules on this topic, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

C. Economic Impact and Paperwork Burden

Summary—Department of Labor and Department of Health and Human Services

HIPAA's group market portability provisions, which include limitations on the scope and application of preexisting condition exclusions, and special enrollment rights, provide a minimum standard of protection designed to increase access to health coverage. The Departments crafted these final regulations to secure these protections, consistent with the intent of Congress, and to do so in a manner that is economically efficient.

The primary economic effects of HIPAA's portability provisions ensue directly from the statute. These regulations, by clarifying and securing HIPAA's statutory protections, will delineate and possibly expand HIPAA's effects at the margin.

Effects of the Statute

HIPAA's statutory group market portability provisions extend coverage to certain individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits. In some instances these individuals will gain coverage for services they otherwise would have purchased out-of-pocket. In other instances the extension of coverage will induce individuals to consume more (or different) health care services, which in some cases may improve health outcomes. The dollar value of the extended coverage is estimated to be \$515 million annually. Potential additional benefits from improved health outcomes are difficult

to quantify (and the Departments have not attempted to do so), but may be large in aggregate, and will be large for at least some individuals whose health outcomes may be substantially improved. Another indirect benefit of HIPAA's portability provisions is a reduction in so-called "job lock"—a phenomenon in which individuals keep jobs they would prefer to leave to avoid losing coverage for preexisting conditions. If workers move into more productive jobs, the overall economy will benefit.

It should be noted that the benefits of HIPAA's portability provisions in any given year will be concentrated in a relatively small population that gains coverage under HIPAA for needed care that would otherwise not be covered. The number that might so benefit has been estimated at 100,000 individuals.

The direct costs of HIPAA's portability provisions generally include the cost of extending coverage to additional services, as well as certain attendant administrative costs. The cost of extended coverage is estimated at \$515 million annually. The major administrative costs include the cost of providing certificates of creditable coverage, and possibly the cost of carrying out special enrollments and offsets of preexisting condition exclusion periods. The Departments did not attempt to fully estimate the administrative costs of the HIPAA statute but in crafting this regulation did attempt to constrain these costs.

The Departments believe that the cost of HIPAA is borne by covered workers. Cost can be shifted to workers through increases in employee premium shares or reductions (or smaller increases) in pay or other components of compensation, or by increases in deductibles or other cost sharing or other reductions in the richness of health benefits. Whereas the benefits of HIPAA are concentrated in a relatively small population, the costs are distributed broadly across plans and enrollees.

The Departments have considered whether the costs imposed by HIPAA's statutory portability provisions have had any major indirect negative effects, and concluded that such effects are possible but probably small.

Any mandate to increase the richness or availability of health insurance adds to the cost of insurance. It is possible that some small number of employers and employees already at the brink of affordability would drop coverage in response to the implementation of HIPAA. The Departments also note that the estimated \$515 million cost associated with extensions of coverage

under HIPAA amounts to a small fraction of one percent of total expenditures by private group health plans. This suggests that the cost of HIPAA is a small, possibly negligible, factor in most employers' decisions to offer health coverage and workers' decisions to enroll. The Departments believe that the benefits of HIPAA's statutory group market portability provisions justify their cost. The Departments' full assessment of the costs and benefits of HIPAA's statutory provisions and their basis for that assessment is detailed later in the preamble.

Effects of the Final Regulations

By clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a small increase at the margin in the direct and indirect economic effects of HIPAA's statutory portability provisions. The Departments believe that the regulation's benefits will justify its costs.

Additional economic benefits derive from the regulations' clarifications of HIPAA's portability requirements. By clarifying employees' rights and plan sponsors' obligations under HIPAA's portability provisions, the regulations will reduce uncertainty over health benefits, thereby fostering labor market efficiency and the establishment and continuation of group health plans by employers.

Many provisions of the final regulations closely resemble provisions included in the interim final regulations that the final regulations supplant. This regulatory action, however, adds or amends both certain provisions directed at the scope of HIPAA's portability protections and certain provisions establishing administrative requirements intended to safeguard those protections.

Scope of Protections

These final regulations are intended to secure and implement HIPAA's group market portability provisions under certain special circumstances. The final regulations therefore contain a number of provisions intended to clearly delimit the scope of HIPAA's portability protections. Most of these provisions closely resemble and will have the same effect as provisions of the interim final regulations. Others, however, clarify or expand at the margin the range of situations to which HIPAA's portability protections apply or in which a loss of eligibility may trigger special enrollment rights. These include the requirement that health coverage under

foreign government programs be treated as creditable coverage for purposes of limiting the application of preexisting condition exclusions; the extension of special enrollment rights to individuals who lose eligibility for coverage in connection with the application of lifetime benefit limits, movement out of an HMO's service area, or the termination of a health coverage option previously offered under a group health plan; and the establishment of a special enrollment right for a participant to change among available coverage options under a group health plan when adding one or more dependents in connection with marriage, adoption, or placement for adoption. Each of these provisions is expected to result in a small increase in the economic effects of HIPAA's statutory portability protections. The Departments have no basis to quantify these small increases. The potential size of affected sub populations is explored later in the preamble.

Administrative Requirements

In order to secure and implement HIPAA's group market special enrollment and portability provisions, both the HIPAA statute and these final regulations establish certain administrative requirements.

As noted above, the HIPAA statute generally requires plans and issuers to provide certifications of prior coverage to individuals leaving coverage. These regulations additionally require plans and issuers to notify individuals of their special enrollment rights, any preexisting condition exclusion provisions, and the applicability of such exclusions where individuals provide evidence of prior coverage that is of insufficient duration to fully offset exclusion periods. Plans will incur cost to comply with these administrative requirements. The Departments estimate the administrative cost to prepare and distribute certifications and notices to be \$97 million per year. Nearly all of this, or \$96 million, is attributable to the preparation and distribution of certifications as required under HIPAA's statutory provisions. These final regulations include numerous special provisions that serve to reduce plans' cost of providing certifications. A more strict interpretation of the statute would require plans to send an individual certificate to each affected enrollee. Such strict interpretation would result in plans sending 80.1 million certificates annually at cost of \$157.6 million, which is \$61.6 million more than the burden imposed by the final regulations.

Generally all of the major administrative requirements included in the final regulations were also included in the interim final regulations. The final regulations make minor additions to two requirements, however. They require plans to include educational statements in certificates of creditable coverage and to maintain in writing their procedures for requesting certificates. The cost of these additional requirements is expected to be small, and was not estimated separately from the overall cost of providing certificates.

Other changes included in these final regulations are likely to slightly reduce plans' cost to provide certain HIPAA-required notices. Included with the final regulation is new sample language for general and specific notices of preexisting condition exclusions, which may serve to reduce some plans' costs of providing these notices, and revised sample language for special enrollment rights notices. The final regulations also clarify the narrow scope of the requirement to notify certain affected participants of the specific application of preexisting condition exclusions. The Departments did not estimate the impact of these provisions separately from the overall cost of providing general and specific notices of preexisting condition exclusions and notices of special enrollment rights.

The Departments' full assessment of the costs and benefits of this regulation and their basis for that assessment is detailed later in this preamble.

Executive Order 12866—Department of Labor and Department of Health and Human Services

Under Executive Order 12866 (58 FR 551735, Oct. 4, 1993), the Departments must determine whether a regulatory action is "significant" and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a "significant regulatory action" as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4)

raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, this action is "economically significant" and subject to OMB review under Section 3(f) of the Executive Order. Consistent with the Executive Order, the Departments have assessed the costs and benefits of this action. The Departments' assessment, and the analysis underlying that assessment, is detailed below. The Departments performed a comprehensive, unified analysis to estimate the costs and benefits attributable to the regulations for purposes of compliance with Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act.

Statement of Need for Action

These final regulations are needed to clarify and interpret the HIPAA portability provisions (increased portability through limitation on preexisting condition exclusions) under Section 701 of the Employee Retirement Income Security Act of 1974 (ERISA), Section 2701 of the Public Health Service Act, and Section 9801 of the Internal Revenue Code of 1986. The provisions are needed to improve the availability and portability of health coverage by limiting preexisting condition exclusions and their use, and requiring that group health plans and group health insurance issuers allow individuals to enroll under certain circumstances (special enrollment). Additional guidance was required to clarify certain definitions, such as the definition of creditable coverage; to clarify the method of determining the proper length of a preexisting condition exclusion period for an individual; to describe the circumstances under which an individual must be allowed a special enrollment opportunity; and to describe notices that group health plans and group health insurance issuers must provide to individuals.

Economic Effects

The Departments believe that this regulation's benefits will justify its costs. This belief is grounded in the assessment of costs and benefit that is summarized earlier in the preamble and detailed below.

Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the

notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a rule will not have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires the agency to present a final regulatory flexibility analysis at the time of the publication of the notice of final rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

Because these final rules are being issued without prior notices of proposed rulemaking, the RFA does not apply, and the Departments are not required to either certify that the rule will not have a significant impact on a substantial number of small entities or conduct a regulatory flexibility analysis. The Departments nonetheless crafted these regulations in careful consideration of their effects on small entities.

For purposes of this discussion, the Departments consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for simplified annual reporting and disclosure if the statutory requirements of part 1 of Title I of ERISA would otherwise be inappropriate for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department of Labor has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10, certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and which satisfy certain other requirements.

Further, while some small plans are maintained by large employers, most are maintained by small employers. Both small and large plans may enlist small third party service providers to perform administrative functions, but it is generally understood that third party service providers transfer their costs to their plan clients in the form of fees. Thus, the Departments believe that assessing the impact of this rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity

considered appropriate for this purpose differs, however, from a definition of small business based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (5 U.S.C. 631 *et seq.*). The Department of Labor solicited comments on the use of this standard for evaluating the effects of the interim final on small entities. No comments were received with respect to the standard.

The Departments believe that the benefits of this regulation will justify its costs. This belief is grounded in the assessment of costs and benefit that is summarized earlier in the preamble and detailed below in the "Basis for Assessment of Economic Impact" section. The direct financial value of coverage extensions pursuant to HIPAA's portability provisions are estimated to be approximately \$180 million for small plans, or a small fraction of one percent of total small plan expenditures.¹¹

In order to secure and implement HIPAA's portability provisions, the HIPAA statute and interim final regulations established certain administrative requirements, including requirements to provide certifications of creditable coverage and notices of special enrollment rights and preexisting condition exclusions. The Departments estimate the cost for small plans to prepare and distribute certifications and notices to be \$13 million per year.¹² These costs will initially be borne by issuers who supply small group insurance products and by third-party administrators who provide services to small insured plans. These two types of entities will spread the costs across a much larger pool of small

plans who will in turn transfer cost broadly to plan enrollees.

Special Analyses—Department of the Treasury

Notwithstanding the determinations of the Departments of Labor and of Health and Human Services, for purposes of the Department of the Treasury it has been determined that this Treasury decision is not a significant regulatory action. Pursuant to sections 603(a) and 605(b) of the Regulatory Flexibility Act, it is hereby certified that the collections of information referenced in this Treasury decision (*see* §§ 54.9801–3, 54.9801–4, 54.9801–5, and 54.9801–6) will not have a significant economic impact on a substantial number of small entities. Although a substantial number of small entities will be subject to the collection of information requirements in these regulations, the requirements will not have a significant economic impact on these entities. The average time required to complete a certification required under these regulations is estimated to be 4 to 5 minutes for all employers. This average is based on the assumption that most employers will automate the certification process. The paperwork requirements other than certifications that are contained in the regulations are estimated to impose less than 2% of the burden imposed by the certifications. Many small employers that maintain group health plans have their plans administered by an insurance company or third party administrators (TPAs). Most insurers and TPAs are expected to automate the certification process and therefore their average time to produce a certificate should be similar to the 4 to 5 minute average estimated for all employers. However, even for small employers that do not automate the certification process, the collection of information requirements in the regulation will not have a significant impact. Even if it is conservatively assumed that their average time to produce a certificate is 3 times as long as the highest estimate for all employers (*i.e.*, 15 minutes per certificate) and that all of their employees are covered by their group health plan and that half of the employees receive a certificate each year, the average burden per employee is less than 8 minutes per year. This can be rounded up to 8 minutes to more than account for the additional burden imposed by the other paperwork requirements of the final regulations. Thus, for example, for an employer with 10 employees, the annual burden would be not more than 1 hour and 20 minutes per year. At an estimated cost of \$18 per hour, this would result in a cost of not

more than \$24 per year for the employer, which is not a significant economic impact. Because the collection of information requirements of this Treasury decision will not have a significant economic impact on a substantial number of small entities, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these regulations was submitted to the Small Business Administration for comment on its impact on small business.

Paperwork Reduction Act

Department of Labor

These final regulations include three separate collections of information as that term is defined in the Paperwork Reduction Act of 1995 (PRA 95), 44 U.S.C. 3502(3): the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by the Office of Management and Budget (OMB) through October 31, 2006 in accordance with PRA 95 under control numbers 1210–0101, 1210–0102, and 1210–0103.

Department of the Treasury

These final regulations include a collection of information as that term is defined in PRA 95: the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by OMB under control number 1545–1537.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Department of Health and Human Services

These final regulations include three separate collections of information as that term is defined in PRA 95: the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by OMB through June 30, 2006 in accordance with PRA 95 under control number 0938–0702.

¹¹ Computer runs using Medical Expenditure Survey Household Component (MEPS-HC) and the Robert Wood Johnson Employer Healthy Benefits Survey determined that the share of covered private-sector job leavers at small firms average 35 percent of all covered private sector job leavers. From this, we inferred that the financial burden borne by small plans is approximately 35 percent of the total expenditures by private-sector group health plans.

¹² As noted above, the total cost for certificates and notices is estimated to be \$97 million. We estimate that 13 percent of individuals receiving certificates and notices receive them from small group health plans, and on that basis estimates that 13% of the total cost falls on such plans. As noted below, we estimate that out of a total of 54 million individuals who leave coverage under group health plans, individual health insurance policies or public programs, 20 million, or 44 percent, are leaving private-sector group plans. Assuming that the proportion of these that are leaving small plans is equal to the proportion of covered, private-sector job leavers who leave small firms (estimated to be 35 percent, as noted above), 13 percent of those leaving any type of coverage are leaving coverage under small group plans.

Small Business Regulatory Enforcement Fairness Act

This final rule is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and is being transmitted to Congress and the Comptroller General for review. The final rule, is a "major rule," as that term is defined in 5 U.S.C. 804, because it may result in (1) an annual effect on the economy of \$100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or federal, State or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million. These final regulations have no such mandated consequential effect on State, local, or tribal governments, or on the private sector.

Federalism Statement Under Executive Order 13132—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by federal agencies in formulating and implementing policies that have "substantial direct effects" on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these final regulations have federalism implications because they may have substantial direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various

levels of government. However, in the Departments' view, the federalism implications of these final regulations are substantially mitigated because, with respect to health insurance issuers, the vast majority of States have enacted laws which meet or exceed the federal HIPAA portability standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, HIPAA added a new section to ERISA (as well as to the PHS Act) narrowly preempting State requirements for issuers of group health insurance coverage. Specifically, with respect to seven provisions of the HIPAA portability rules, States may impose stricter obligations on health insurance issuers.¹³ Moreover, with respect to other requirements for health insurance issuers, States may continue to apply State law requirements except to the extent that such requirements prevent the application of HIPAA's portability, access, and renewability provisions.

In enacting these new preemption provisions, Congress intended to preempt State insurance requirements only to the extent that they prevent the application of the basic protections set forth in HIPAA. HIPAA's conference report States that the conferees intended the narrowest preemption of State laws with regard to health insurance issuers. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 205 (1996). State insurance laws that are more stringent than the federal requirements are unlikely to "prevent the application of" the HIPAA portability provisions, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance insurers that are more restrictive than the federal law.

Guidance conveying this interpretation of HIPAA's preemption provisions was published in the **Federal Register** on April 8, 1997. 62 FR 16904.

¹³ States may shorten the six-month look-back period prior to the enrollment date; shorten the 12-month and 18-month maximum preexisting condition exclusion periods; increase the 63-day significant break in coverage period; increase the 30-day period for newborns, adopted children, and children placed for adoption to enroll in the plan with no preexisting condition exclusion; further limit the circumstances in which a preexisting condition exclusion may be applied (beyond the federal exceptions for certain newborns, adopted children, children placed for adoption, pregnancy, and genetic information in the absence of a diagnosis; require additional special enrollment periods; and reduced the HMO affiliation period to less than 2 months (3 months for late enrollees).

These final regulations clarify and implement the statute's minimum standards and do not significantly reduce the discretion given the States by the statute. Moreover, the Departments understand that the vast majority of States have requirements that meet or exceed the minimum requirements of the HIPAA portability provisions.

HIPAA provides that the States may enforce the provisions of HIPAA as they pertain to issuers, but that the Secretary of Health and Human Services must enforce any provisions that a State fails to substantially enforce. Currently, HHS enforces the HIPAA portability provisions in only one State in accordance with that State's specific request to do so. When exercising its responsibility to enforce the provisions of HIPAA, HHS works cooperatively with the State for the purpose of addressing the State's concerns and avoiding conflicts with the exercise of State authority. HHS has developed procedures to implement its enforcement responsibilities, and to afford the States the maximum opportunity to enforce HIPAA's requirements in the first instance. HHS's procedures address the handling of reports that States may not be substantially enforcing HIPAA's requirements, and the mechanism for allocating responsibility between the States and HHS. In compliance with Executive Order 13132's requirement that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of the States, DOL and HHS have engaged in numerous efforts to consult and work cooperatively with affected State and local officials.

For example, the Departments sought and received input from State insurance regulators and the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit corporation established by the insurance commissioners of the 50 States, the District of Columbia, and the four U.S. territories. In most States the Insurance Commissioner is appointed by the Governor, in approximately 14 States, the insurance commissioner is an elected official. Among other activities, it provides a forum for the development of uniform policy when uniformity is appropriate. Its members meet, discuss and offer solutions to mutual problems. The NAIC sponsors quarterly meetings to provide a forum for the exchange of ideas and in-depth consideration of insurance issues by regulators, industry representatives and consumers. CMS and the Department of Labor staff have consistently attended these quarterly meetings to listen to the concerns of the

State Insurance Departments regarding HIPAA portability issues. In addition to the general discussions, committee meetings, and task groups, the NAIC sponsors the standing CMS/DOL meeting on HIPAA issues for members during the quarterly conferences. This meeting provides CMS and the Department of Labor with the opportunity to provide updates on regulations, bulletins, enforcement actions, and outreach efforts regarding HIPAA.

The Departments received written comments on the interim regulation from the NAIC and from ten States. In general, these comments raised technical issues that the Departments considered in conjunction with similar issues raised by other commenters. In a letter sent before issuance of the interim regulation, the NAIC expressed concerns that the Departments interpret the new preemption provisions of HIPAA narrowly so as to give the States flexibility to impose more stringent requirements. As discussed above, the Departments address this concern in the preamble to the interim regulation.

In addition, the Departments specifically consulted with the NAIC in developing these final regulations. Through the NAIC, the Departments sought and received the input of State insurance departments regarding certain insurance industry definitions, enrollment procedures and standard coverage terms. This input is generally reflected in the discussion of comments received and changes made in Section B—Overview of the Regulations of the preamble to these regulations.

The Departments have also cooperated with the States in several ongoing outreach initiatives, through which information on HIPAA is shared among federal regulators, State regulators and the regulated community. In particular, the Department of Labor has established a Health Benefits Education Campaign with more than 70 partners, including CMS, NAIC and many business and consumer groups. CMS has sponsored conferences with the States—the Consumer Outreach and Advocacy conferences in March 1999 and June 2000, and the Implementation and Enforcement of HIPAA National State-Federal Conferences in August 1999, 2000, 2001, 2002, and 2003. Furthermore, both the Department of Labor and CMS Web sites offer links to important State Web sites and other resources, facilitating coordination between the State and federal regulators and the regulated community.

Throughout the process of developing these regulations, to the extent feasible within the specific preemption

provisions of HIPAA, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and the Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in Section 8(a) of Executive Order 13132, and by the signatures affixed to these final regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached final regulation, Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers (RIN 1210-AA54 and RIN 0938-AL43), in a meaningful and timely manner.

Basis for Assessment of Economic Impact—Department of Labor and Department of Health and Human Services

As noted above, the primary economic effects of HIPAA's portability provisions ensue directly from the statute. These regulations, by clarifying and securing HIPAA's statutory protections, will delineate and possibly expand HIPAA's effects at the margin.

Effects of the Statute

In order to determine how many workers could benefit from crediting prior coverage against a new health plan's preexisting condition exclusion period, we examined the 18 million individuals who changed jobs in 2002. Of these, approximately 1 in 3 had health care coverage at those jobs and an additional 8 million dependents also received employer-sponsored health care coverage through these job changers. By allowing prior creditable coverage, 4 million job changers, who had at least 12 months of prior creditable coverage, were able to change jobs without the risk of a preexisting condition exclusions for them or their 5 million dependents. An additional 2 million workers who changed jobs and had some smaller amount of prior coverage, faced reduced waiting periods before receiving full coverage for them and their 3 million dependents.¹⁴

¹⁴ We calculated these estimates using internal runs off the MEPS-HC. These runs gave the number of total job changers, total job changers that had employer-sponsored insurance (ESI), and whether this coverage had been for less than 12 months or not. Estimates for dependents were based off the ratio of policy-holders to total dependents from the March 2003 Current Population Survey (March

The most direct effect of HIPAA's statutory group market portability provisions is the extension of coverage to individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits. In some instances these individuals will gain coverage for services they otherwise would have purchased out-of-pocket, thereby reaping a simple and direct financial benefit. In other instances the extension of coverage will induce individuals to consume more (or different) health care services, reaping a benefit which has financial value, and which in some cases will produce additional indirect benefits both to the individual (improved health) and possibly to the economy at large (increased productivity).¹⁵ The simple financial value of the direct benefits (essentially the dollar value of the extended coverage) is estimated to be \$515 million.¹⁶ The indirect benefits are

CPS). This approach to the question of how many people are impacted by increased portability parallels that of the September 1995 U.S. General Accounting Office (GAO), Report HEHS-95-257, "Health Insurance Portability: Reform Could Ensure Continued Coverage for up to 25 Million Americans," September 1995.

¹⁵ For more detailed information, see Ellen O'Brien's article "Employer Benefits from Workers' Health Insurance" Milbank Quarterly, Vol. 1, No. 1, 2003. She provides an extensive analysis of the literature on benefits accruing to employers from offering health benefits. She reports that researchers are beginning to calculate the costs to employers of unhealthy employees. Her work provides information on studies that have demonstrated that poor health may be related to lower productivity. For example, she discusses studies that have examined the effects on workplace productivity of specific health conditions and show that poor health reduces workers' productivity at work, and that effective health care treatments can reduce productivity losses and may even pay for themselves in terms of increased productivity.

¹⁶ The estimate of \$515 million is the 1999 projection published in the August 1, 1996 Congressional Budget Office (CBO) report, "Estimate of Costs of Private Sector Mandates," Bill Number H.R. 3103, indexed. The index is derived from the average annual percent change from 1999 to 2004 in aggregate private health insurance expenditures, as reported in Table 3 of the "National Health Care Projections Tables" by the Centers for Medicare & Medicaid Services, Office of the Actuary. CBO estimated the direct cost to the private sector would total about \$300 million in 1999. The specific items included in the estimate are: (1) Limiting the length of time employer-sponsored and group insurance plans could withhold coverage for pre-existing conditions, and (2) requiring that periods of continuous prior health plan coverage be credited against pre-existing condition exclusions of a new plan.

According to CBO, two-thirds of the cost reflects the provision to limit exclusions for pre-existing conditions. The key components of this estimate are: (1) The number of people who would have more of their medical expenses covered by insurance if exclusions were limited to one year or less, and (2) the average cost to insurers of that newly insured medical care. The provision

difficult to quantify (and the Departments have not attempted to do so), but may be large in aggregate, and will be large for at least some individuals whose health outcomes may be substantially improved.

Another indirect (though intended) benefit of HIPAA's portability provisions is a reduction in so-called "job lock." Job lock occurs when an individual stays in a job with health insurance that he or she would prefer to leave out of concern that he or she would lose coverage for care of his or her own or a covered dependent's preexisting condition¹⁷.

No attempt is made here to quantify increases in labor force mobility attributable to reduced job lock under HIPAA. However, it is noted that at least two indirect economic effects are likely to follow such increased mobility. First, the cost of coverage for some preexisting conditions will be transferred from one plan or issuer to another.¹⁸ Second, if,

crediting prior coverage against current exclusions will account for a third of the cost. This estimate is based on two components: (1) The number of people who would receive some added coverage, and (2) the additional full-year cost of coverage, adjusted to reflect the estimated number of months of that coverage.

¹⁷ Findings on the effect of health insurance coverage on job mobility have been mixed. A thorough assessment of the job lock literature in the past 10 years concluded that the most convincing evidence suggests that health insurance plays an important role in job mobility decisions, but is unclear as to its implications (see Gruber, Jonathan and Brigitte C. Madrian, 2002, Health Insurance, Labor Supply and Job Mobility: A Critical Review of the Literature, NBER Working Paper Series, No. 8817). A major concern in this literature has been to find an identification strategy able to overcome the potential correlation between the holding of employer-sponsored health insurance and other factors affecting job mobility independent from health insurance (see Anna Sanz de Galdeano, 2004, Health Insurance and Job Mobility: Evidence from Clinton's Second Mandate, Center for Studies in Economics and Finance Working Paper, No. 122). This is illustrated by the 2004 Health Confidence Survey which finds that 27 percent of the non-aged population reported that they or an immediate family member had experienced some form of job lock, but only 15 percent of those attributed the job lock to a preexisting condition (see Ruth Helman & Paul Frostin, "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey," Employee Benefits Research Institute, Issue Brief no. 275 (EBRI, November 2004)).

¹⁸ This transfer generally implies offsetting costs and benefits. It is possible, however, that in some instances individuals' mobility will allow them to exploit opportunities for adverse selection by moving into a richer health plan (see Cutler, D. and Reber, S., 1998, Paying for health insurance: the tradeoff between competition and adverse selection. Quarterly Journal of Economics 113, 433–466, and Cutler, D. and Zeckhauser, R. 2000. The anatomy of health insurance, in Culyer, A., Newhouse, J.P. (Eds.), Handbook of Health Economics, Vol. 1A. Elsevier, Amsterdam, pp. 564–629. For a contrasting study see, Pauly, M.V., Mitchell, O. and Zeng, Y. 2004 "Death Spiral Or Euthanasia? The Demise Of Generous Group Health Insurance Coverage" NBER Working Paper No. 10464, for a discussion). Such movements would constitute

as is likely, a result is movement of workers into more productive jobs, the overall economy will benefit.

It should be noted that the benefits of HIPAA's portability provisions in any given year will be concentrated in a relatively small population—generally, individuals who because of some combination of family health status and use of health services, job mobility, and plan provisions related to preexisting condition exclusions or enrollment opportunities, gain coverage under HIPAA for needed care that would otherwise not be covered.

According to CBO, any point in time, about 100,000 individuals would have a preexisting condition exclusion reduced for prior creditable coverage. An additional 45,000 would gain added coverage in the individual market.¹⁹

The direct costs of HIPAA's portability provisions generally include the cost of extending coverage to additional services, as well as certain attendant administrative costs. The cost of extended coverage is estimated at \$515 million annually. The major administrative costs include the cost of providing certificates of creditable coverage, and possibly the cost of carrying out special enrollments and offsets of preexisting condition exclusion periods. The Departments did not attempt to fully estimate the administrative costs of the HIPAA statute but did, in crafting this regulation, attempt to constrain these costs, where possible, without compromising HIPAA's intent, as discussed below.

The Departments considered the probable incidence of these costs. The Departments believe that by and large the cost of HIPAA, like all of the cost of group health benefits, are borne by covered workers.²⁰ The most direct

extensions of coverage with costs and benefits resembling those of direct extensions of coverage under HIPAA.

¹⁹ Congressional Budget Office, "Estimate of Costs of Private Sector Mandates; Bill Number H.R. 3103, August 1, 1996.

²⁰ The voluntary nature of the employment-based health benefit system in conjunction with the open and dynamic character of labor markets make explicit as well as implicit negotiations on compensation a key determinant of the prevalence of employee benefits coverage. It is likely that 80% to 100% of the cost of employee benefits is borne by workers through reduced wages (see for example Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," *Tax Policy and Economy* (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, Vol. 84 (June 1994), pp. 622–641; Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review*, Vol. 79, No. 2 (May 1989); Louise Sheiner, "Health Care Costs, Wages, and Aging," Federal Reserve Board of

ways this cost can be shifted to workers is through increases in employee premium shares or reductions (or smaller increases) in pay or other components of compensation. Other paths for shifting of HIPAA's cost to workers might include increases in deductibles or other cost sharing, or other reductions in the richness of health benefits.

Whereas the benefits of HIPAA are concentrated in a relatively small population, the costs are distributed broadly across plans and enrollees. The cost for affected large, self-insured or experience rated group plans is spread across all enrollees in the plan. The cost for small insured plans typically is spread across large populations of small plans and their enrollees, partly as a result of State laws that compress small group premium rates.

The Departments have considered whether the costs imposed by HIPAA's statutory portability provisions have had any major indirect negative effects, and concluded that such effects are possible but probably small.

Any mandate to increase the richness or availability of health insurance adds to the cost of insurance. It is possible that some small number of employers already at the brink of affordability would drop coverage in response to the implementation of HIPAA. The number of employers so affected is probably limited in part because as noted above, employers can shift HIPAA's cost to workers in various ways, including through increases in employee premium shares or cost sharing—though such increases might prompt some workers at the margin to decline coverage. Economic literature provides some estimates of the responsiveness of employers and workers to increases in the price of insurance.²¹

Governors working paper, April 1999; and Edward Montgomery, Kathryn Shaw, and Mary Ellen Benedict, "Pensions and Wages: An Hedonic Price Theory Approach," *International Economic Review*, Vol. 33 No. 1, Feb. 1992). The prevalence of benefits is therefore largely dependent on the efficacy of this exchange. If workers perceive that there is the potential for inappropriate denial of benefits they will discount their value to adjust for this risk. This discount drives a wedge in the compensation negotiation, limiting its efficiency. With workers unwilling to bear the full cost of the benefit, fewer benefits will be provided. To the extent which workers perceive a federal regulation supported by enforcement authority to improve the security and quality of benefits, the differential between the employers' costs and workers' willingness to accept wage offsets is minimized.

²¹ Research shows that while the share of employers offering insurance is generally stable and eligibility rates have only declined slightly over time, the overall increase in uninsured workers is due to the decline in worker take-up rates, which workers primarily attribute to cost. Research on

Continued

The Departments note, however, that cost increases attributable to HIPAA are not price increases per se but reflect the cost to enrich benefits, implying that negative responses should be smaller than would be expected in connection with pure price increases. The Departments also note that the estimated \$515 million cost associated with extensions of coverage under HIPAA amounts to a small fraction of one percent of total expenditures by private group health plans.²² This compares with average annual group premium growth of 9.4 percent for family coverage between 1996 and 2002.²³ To the extent that such increases are small, they are likely to have a negligible effect on employers' decisions to provide health insurance and in workers' decisions to enroll.

Various other studies to date suggest that any negative indirect effects of HIPAA are relatively minor. In one study,²⁴ large employers and health benefit consultants reported few ongoing problems in adopting HIPAA's portability provisions. Many issuers interviewed for the report said that their plans tended to require few changes to comply with HIPAA. This is probably because many large employer plans had already incorporated portability protections, similar to those of HIPAA. A second study indicates that while the share of small firms (those with fewer than 200 workers) offering health insurance has increased slightly from 1996 to 2004, the share has drifted downward from its high of 68 percent

in the economic boom year of 2000.²⁵ In addition, in aggregate, employers covered a larger proportion of health care costs for family plans in 2002 than in 1996, with a slight decrease in the share of single plans over the same time period.²⁶

The data above suggest that the HIPAA changes may have been less significant in the decision about health insurance coverage than overall economic conditions and labor market forces. In fact, there is no evidence that any indirect economic effect, positive or negative, can be readily attributed to the statute. Therefore, it appears that HIPAA has not placed an unreasonable burden on health plans.

There has been a significant decrease in the prevalence of preexisting condition exclusion clauses among large plans. A major employee benefits survey²⁷ reported that in 1996, 59 percent of the employees in small firms (less than 200 employees) were subject to pre-existing condition limitations. In 2002, the figure had dropped to 33 percent. If preexisting condition limitation exists for new employees, the average number of months to wait before coverage declined from 10.7 months in 1996 to 10.0 months in 2002. A discussion of results from a 1998 version of the same survey noted that, overall, 42 percent of employers reported making changes to their plans' preexisting condition clauses due to HIPAA. The Departments are not aware of any surveys that have consistently tracked the prevalence of preexisting condition exclusions in smaller plans (less than 200 employees) since 1996.

Another significant trend involves the use of waiting periods. According to a survey of employers with 200 or more employees, the average number of days that new enrollees must wait before health coverage takes effect increased from 40 days in 1996 to 58 days in 1998. Some attribute this increase indirectly to HIPAA, suggesting that some plans may be replacing the preexisting condition exclusion period with a longer waiting period.

Effects of the Final Regulations

By clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a small increase at the

margin in the direct and indirect economic effects of HIPAA's statutory portability provisions.

Additional economic benefits derive from the regulations' clarifications of HIPAA's portability requirements. The regulations provide clarity through both their provisions and their examples of how those provisions apply in various circumstances. By clarifying employees' rights and plan sponsors' obligations under HIPAA's portability provisions, the regulations will reduce uncertainty and costly disputes over these rights and obligations. They will promote employers' and employees' common understanding of the value of group health plan benefits and confidence in the security and predictability of those benefits, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans by employers.

Many provisions of the final regulations closely resemble provisions included in the interim final regulations that the final regulations supplant. The economic impact of this regulatory action therefore generally will be limited to the impact of provisions that were not so included. These include both provisions directed at the scope of HIPAA's portability protections and provisions establishing administrative requirements intended to safeguard those protections.

Scope of Protections

These final regulations are intended to secure and implement HIPAA's group market portability provisions under certain special circumstances. The final regulations therefore contain a number of provisions intended to clearly delimit the scope of HIPAA's portability protections. Most of these provisions closely resemble and will have the same effect as provisions of the interim final regulations. Others, however, clarify or expand at the margin the range of situations to which HIPAA's portability protections explicitly apply. These include the requirement that health coverage under foreign government programs be treated as creditable coverage for purposes of limiting the application of preexisting condition exclusions; the extension of special enrollment rights to individuals who lose eligibility for coverage in connection with the application of lifetime benefit limits, movement out of an HMO's service area, or the termination of a health coverage option previously offered under a group health plan; and the establishment of a special enrollment right for a participant to change among available coverage options under a group health plan when

elasticity of coverage, however, has focused on getting uninsured workers to adopt coverage (which appears to require large subsidies) rather than covered workers opting out of coverage. This makes it difficult to ascertain the loss in coverage that would result from a marginal increase in costs. (See, for example, David M. Cutler "Employee Costs and the Decline in Health Insurance Coverage" NBER Working Paper #9036, July 2002; Gruber, Jonathon and Ebonya Washington. "Subsidies to Employee Health Insurance Premiums and the Health Insurance Market" NBER Working Paper #9567, March 2003; and Cooper, PF and J. Vistnes. "Workers' Decisions to Take-up Offered Insurance Coverage: Assessing the Importance of Out-of-Pocket Costs" Med Care 2003, 41(7 Suppl): III35-43.) Finally, economic discussions on elasticity of insurance tend to view coverage as a discrete concept and does not consider that the value of coverage may have also changed.

²² While these costs are expected in aggregate to be less than one percent of total expenditures by group health plans, the statute may disproportionately affect particular plans.

²³ This is the average annual rate of increase in total family premiums as reported in the Medical Expenditure Panel Survey, Insurance Component (MEPS-IC) public tables, 1996-2002.

²⁴ U.S. General Accounting Office, Report HEH-99-100, "Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards," pp. 6-7, May 1999.

²⁵ Gabel, Jon R. *et al.* "Health Benefits in 2004: Four Years of Double Digit Premium Increases Take Their Toll on Coverage" Health Affairs, Volume 23, Number 5, September/October 2004.

²⁶ As reported in the MEPS-IC 1996-2002 public tables.

²⁷ Employee Health Benefits 2002 Study, Kaiser Family Foundation.

adding one or more dependents in connection with marriage, adoption, or placement for adoption. Each of these provisions is expected to result in a small increase in the economic effects of HIPAA's statutory portability protections.

The Departments lack any firm basis for quantifying the number of individuals likely to be affected by these provisions, and therefore were unable to quantify the resultant increase in transfers. However, given the special and narrow circumstances to which these provisions apply, the number of affected individuals, and therefore the increase in transfers under these regulations, is expected to be small. In reaching this conclusion, the Departments considered the following.

In 2002, an estimated 359,000 employer sponsored insurance enrollees had moved from abroad in the previous year.²⁸ It is not known what fraction of these had been covered under foreign government programs, or of those, what fraction joined group health plans that included preexisting condition exclusions while suffering from and requiring additional care for preexisting conditions. Comparing GAO's estimate of the number of individuals who could potentially benefit from HIPAA's portability protections (20 million or more individuals with prior creditable coverage who join new health plans in a given year) with CBO estimates of the number who might actually have added coverage for needed care (145,000) produces a ratio of about 1 percent. If this proportion holds for group health plan enrollees who moved to the U.S. from abroad, and if all such enrollees were previously covered under a foreign government program (an upper bound), then about 4,000 individuals annually might gain coverage for needed care under the final regulation's provision treating coverage under such programs as creditable coverage.²⁹

The provision that clarifies the special enrollment rights of individuals who lose eligibility for coverage in connection with the movement out of an HMO's service area is expected mainly to benefit certain individuals with COBRA continuation coverage. The number of individuals affected in any given year is expected to be small. It is estimated that in 2002, fewer than 10,000 COBRA enrollees were covered by HMOs, moved across State or county lines, and were potentially eligible for

coverage under another family member's group plan.³⁰

Lifetime benefit limits (LBL) are fairly common in-group health plans and are typically set at \$1 million or more.³¹ Based on tabulations made by an actuarial consulting firm,³² in plans with LBLs of \$1 million, annually about 27 per one million enrollees will exceed the benefit limits. In plans with a \$500,000 LBL, the comparable figure is 181 per million enrollees; and in plans with a \$2 million LBL, 5 per million enrollees. Combining these proportions with a distribution of LBLs by plan enrollment reported by a national employer survey, yields about 8,700 plan enrollees who will annually reach their plan's LBL. The Departments recognize that those individuals who do encounter such limits by definition have very high expenses, a large portion of which would be transferred to the group health plans into which they special enroll. It is possible, however, that a large share of such transfers would have occurred even without the provisions of these final regulations establishing a right to special enroll upon encountering lifetime limits. For example, the same individuals might have enrolled in these plans during open enrollment opportunities, either before or after encountering the limits. Alternatively, participants who have met their LBL might have left their jobs in order to create a special enrollment opportunity.

The Departments estimate that annually about 1 million families will be eligible for special enrollments due to marriage, 2 million due to births. About one-half of employees offered coverage at work have a choice of plan options.³³ Taken together, this suggests that the number of individuals gaining special enrollment rights to switch among options within group health plans when adding dependents may be large. However, it is unclear how many will elect to switch, or how many who do would have been so permitted even absent the applicable requirement of

these final regulations. More important, it is unclear whether merely switching among options will increase or decrease the transfer from the affected health plans to the affected individuals. In any event, individuals exercising this special enrollment right to switch options are not gaining coverage under any particular group health plan but are merely modifying that coverage.

Administrative Requirements

In order to secure and implement HIPAA's group market special enrollment and portability provisions, both the HIPAA statute and these final regulations establish certain administrative requirements. As noted above, the HIPAA statute generally requires plans and issuers to provide certifications of prior coverage to individuals leaving coverage. These regulations additionally require plans and issuers to notify individuals of their special enrollments rights, any preexisting condition exclusion provisions, and the applicability of such exclusions where individuals provide evidence of prior coverage that is of insufficient duration to fully offset exclusion periods. Plans will incur cost to comply with these administrative requirements. The Departments estimate the administrative cost to prepare and distribute certifications and notices to be \$97 million per year.³⁴

Nearly all of this, or \$96 million, is attributable to the preparation and distribution of certifications as required under HIPAA's statutory provisions. These final regulations include numerous special provisions that serve to reduce plans' cost of providing certifications. These provisions serve to streamline and standardize certifications' content and format, minimize the number of duplicative certifications issued, and encourage the use of telephone calls and other modes of communication when they will suffice in lieu of written certifications. The provisions are designed to minimize certifications' cost while ensuring that individuals and plans (respectively) can efficiently and effectively demonstrate and verify prior coverage. Demonstration and verification of prior coverage enable individuals to secure and plans to

²⁸ Estimates using the March 2003 CPS. It should be noted that CPS is a weighted survey and that the number of actual observations of individuals that were COBRA enrollees with HMO coverage, moved across counties and/or States and were eligible for coverage under another family member's group plan was extremely small. As a result, this estimate is extremely noisy.

³¹ See, for example, U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Establishments, 2000* (Washington, DC: U.S. Government Printing Office, 2003).

³² Milliman USA memorandum dated December 6, 2001.

³³ Sally Trude, "Who Has A Choice of Health Plans?" Center for Studying Health Systems Change, *Issue Brief: Findings from HSC*, No. 27, Feb. 2000.

³⁴ The Departments assumed that a clerical-level employee at a total labor cost (wages, fringe benefits, and overhead) of \$17.24 per-hour would generate the certificates. The Departments further assumed that the average time required to complete a certification is 4 to 5 minutes for all employers. This average is based on the assumption that most employers will automate the certification process. The cost of printing/copying, an envelope and postage is assumed to be \$0.53 per employee.

²⁸ Calculation from the 2003 March CPS.

²⁹ This number is 1 percent of the number of ESI holders in 2002 who moved from abroad the previous year.

appropriately honor individuals' portability rights under HIPAA.

First, an intermediate issuer will not have to issue a certificate of creditable coverage when an individual changes options under the same health plan. In lieu of the certificate, the issuer could simply transmit to the plan information regarding individuals' effective date of coverage and the last date of coverage. An individual would retain the right to get a certificate automatically and upon request if he/she leaves the plan.

Second, telephonic certification will fulfill the requirement to send a certificate if the receiving plan, prior plan, and the participant mutually agree to that arrangement. The individual can get a written certificate upon request.

Third, in situations where the issuer and the plan contract for the issuer to complete the certificates, the plan would not remain liable even if the issuer failed to send the certificates.

Fourth, the period of coverage listed on automatic certificates will be only the last continuous period of coverage without any break. This is the most efficient and simplest method of record keeping for plans and issuers.

Fifth, the period of coverage contained in the on-request certification will be all periods of coverage ending within 24 months before the date of the request. Essentially, a plan may simply look back two years and send copies of any automatic certificates issued during that period.

Sixth, a single certificate of creditable coverage can be provided with respect to both a participant and the participant's dependent if the information is identical for each individual. In addition, certificates may contain combined information for families.

Seventh, plans and issuers are not required to furnish an individual an automatic certificate with respect to a dependent until they know or should know of the dependent's cessation of coverage under the plan.

The above reductions in burdens on plans and issuers may cause more frequent circumstances in which participants are required to demonstrate creditable coverage. In order to help offset some of the additional burdens that will be shifted to the participants, the regulations provide the following protections:

First, if an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of dependent status, and the

individual cooperates with the plan's or issuer's efforts to verify the dependent status.

Second, if the accuracy of a certificate is contested or a certificate is unavailable when needed, individuals have the right to demonstrate creditable coverage through the presentation of relevant corroborating evidence of creditable coverage during the relevant time period and by cooperating with the plan's efforts to verify the individual's coverage.

Third, plans and issuers that impose preexisting condition exclusion periods must notify participants of this fact. They must also explain that prior creditable coverage can reduce the length of a preexisting condition exclusion period, and that the plan or issuer will assist in obtaining a certificate of creditable coverage from any prior plan or issuer, if necessary. An exclusion may not be imposed until this notice is given. This is beneficial to participants insofar as it forewarns them of potential claim denials and enables them to more easily exercise their right to protection from such denials under HIPAA's portability provisions.

Fourth, after an individual has presented evidence of creditable coverage, the plan or issuer must give the individual a written notice of the length of any preexisting condition exclusion that remains after offsetting for creditable coverage.

Fifth, certificates of creditable coverage now contain educational language that more explicitly informs consumers of their HIPAA rights.

As noted earlier in this preamble, GAO and others recommended that educational statements be added to certifications. The Departments have provided a suitable statement for use by plans, thereby eliminating any need for plans to develop their own. The cost of providing such statements is therefore expected to be minimal.

The administrative cost associated with provision of certifications under the HIPAA statute and these final regulations was estimated as follows.

The ongoing burden associated with the issuance of automatic certifications by group plans is estimated as a function of (1) the number of events that trigger such issuances; (2) the statutory and regulatory specifications for the content of the certificates; and (3) the assumed burden associated with the preparation and distribution of each certificate.

Certifications must be issued when an event, defined as the loss of health coverage by a participant or by a dependent, occurs. Survey tabulations indicate that there were 54.3 million

events in 2002.³⁵ Additionally, results from the March 1999 CPS indicate that about 3 percent of the events involve a dependent who lives at a different address than the participant. In such cases the plan is required to send out at least 2 separate certificates.

The model certificate illustrates how plans may incur a lesser burden when it is certified that prior periods of coverage were of at least 18 months duration; that is, in lieu of a specific date that coverage began and waiting/affiliation period information, such certifications may simply indicate that the prior period of coverage lasted at least 18 months. In contrast, certifications of shorter periods of prior coverage must contain the specific dates when coverage—and waiting/affiliation periods, if applicable—began.

Combining the options for the addresses with the time periods results in four categories of certifications: (1) One address and less than 18 months of prior creditable coverage (12 million annual events); (2) one address and 18 months or more of prior creditable coverage (42.3 million); (3) more than one address and prior creditable coverage of less than 18 months (.4 million); and (4) more than one address and 18 months or more of prior creditable coverage (1.3 million).

Consistent with the interim regulations, we assume that the per-certificate preparation effort requires 5 minutes for prior creditable coverage of less than 18 months and 4 minutes for creditable coverage that is greater than or equal to 18 months. The additional cost involved in sending certificates to multiple addresses for a given participant is assumed to be 50 percent of the cost of sending a certificate to one address.

The Departments assumed that the certificates would be generated by a clerical-level employee who costs the plans \$17.24 per-hour in wages, benefits, and overhead³⁶. The cost of printing/copying, envelope and postage is assumed to be \$0.53 per envelope.

³⁵ This total is based on internal estimates. The ESI total (24.0 million or 20.4 private-sector and 3.6 public sector) was the sum of policy-holders who left jobs, according to the 2002 MEPS-HC, and their dependents, which were derived by multiplying this number by the CPS ratio of dependents to policy holders. Based on counts of the number of people with partial year coverage off the March 2003 CPS, we estimated the SCHIP and Medicaid total to be 14.9 million and the private individual market to be 15.4 million.

³⁶ The total labor cost is derived from wage and compensation data from the Bureau of Labor Statistics and includes an overhead component, which is a multiple of compensation based on the Government Cost Estimate.

The resulting annual burden is \$96 million.

A more strict interpretation of the statute would require plans to send an individual certificate to each affected enrollee. Obviously, this requirement would significantly increase the administrative burden. Such strict interpretation would result in plans sending 80.1 million certificates annually at cost of \$157.6 million, which is \$61.6 million more than the burden imposed by the final regulations.

The final regulations require that plans, in response to requests made by or on behalf of individuals, provide certificates at any time while the individual is covered under the plan and for up to 24 months after coverage ceases. Such requests are most likely to be made by an individual who is unable to locate the certificate of creditable coverage from his/her prior health plan and is seeking to enroll in a group health plan that imposes preexisting condition exclusions or is seeking to reduce or eliminate any preexisting condition exclusions that may otherwise be applied by a source of individual coverage.

The Departments believe that the requested certificate burden is negligible for several reasons. First, as reported by a major health benefits survey³⁷ the proportion of enrollees that are in plans with preexisting condition exclusion has not changed from the 2000 share of 30 percent, which is down from the pre-HIPAA level of 60 percent. In addition, the educational statement contained within the certificate serves to highlight the importance of the document, thus encouraging its retention. Furthermore, the final rules permit individuals to establish and verify creditable coverage through other means. Finally, evidence of creditable coverage may be transmitted through means other than documentation, such as by a telephone call from the plan to a third party.

Apart from the provision of certifications of prior creditable coverage, the remaining \$1 million in administrative expenses is attributable to notices of special enrollment rights and of the existence and application of preexisting condition exclusions, which are required under these final regulations. The Departments believe that these notices are necessary to ensure that individuals understand and can effectively exercise their special enrollment and portability rights under HIPAA, and that the benefits of ensuring

this outweigh the associated administrative cost.

The regulations provide that a plan must provide all employees with a notice describing special enrollment rights at or before the time the employee is initially offered the opportunity to enroll in the plan. The final regulations provide model language that can be used to satisfy the special enrollment notice requirement.

The Departments believe that the vast majority of plans have incorporated special enrollment language into their plan enrollment materials. Thus, the cost of the special enrollment notice is assumed to be a minor component of the overall cost of providing plan enrollment materials.

The number of employees who are hired annually by firms that offer health coverage and who are eligible for such coverage was developed by using the proportion of workers with less than one year of tenure as reported by the 2002 MEPS-HC. We find that 10.8 million employees will be newly hired and eligible for health coverage on an annual basis. We assume that the special enrollment notice is a component of plan enrollment materials and requires one-third of a sheet of paper. Using a printing/copying cost of \$0.05 per page, we assume that the per-notice cost is \$0.0167. The resulting burden is estimated to be \$180,687.

The final regulations provide that every plan with a preexisting condition exclusion must provide in writing a general notice of such provisions to individuals eligible for enrollment under the plan. The regulations specify what is required of the plan when it discusses the amount and terms of its preexisting condition exclusion, including the person to contact for further information regarding the exclusions. In addition, the regulations clarify that issuers must describe the actual maximum exclusion period that is applicable to a specific plan. A regulatory example provides sample language that the plans can use to develop the general notice.

Based on results from the 2000 Kaiser/HRET Employer survey, we assume that 35 percent of plans with fewer than 100 participants, and 28 percent of plans with 100 or more participants, apply preexisting condition exclusions to new enrollees. If we apply these proportions to the number of new employees hired each year by employers that offer health coverage, we find that 3.1 million employees will annually receive the general notice.

As with the special enrollment notice, we assume that the general notice of

preexisting condition exclusions is a component of standard plan enrollment materials and also requires one-third of a sheet of paper. Assuming a printing/copying cost of \$0.05 per page, the per-notice cost is \$0.0167. The annual cost to distribute the notices is therefore estimated to be \$51,852.

The regulations provide sample notice language, thus relieving the plans of the burden of developing their own forms.

Plans that impose preexisting condition exclusions must, in writing, notify participants who have failed to demonstrate sufficient prior coverage that the exclusions will affect them and indicate what the length of the preexisting condition exclusion period is, with respect to each individual. This notice is required only in situations in which the individual presents evidence of prior creditable coverage and its duration is less than the maximum length of the preexisting condition exclusion period. These final regulations clarify that the notice does not have to identify any medical conditions that are specific to the individual and subject to the exclusion.

Tabulations from the 2002 MEPS-HC indicate that, of those individuals in the private sector who changed jobs and hold insurance, 16 percent have prior creditable coverage of between 1 day and 12 months, which is the statutory preexisting condition exclusion maximum for individuals who enroll when first eligible. The comparable proportion for State and local governmental plans is 18 percent. Applying these proportion to the number of general preexisting exclusion notices required, yields 478,569 notices that will be prepared annually.

Because the notice must be customized to reflect each individual's applicable preexisting condition exclusion period, the per-notice time burden will be greater than that for the general notice of preexisting condition exclusions. Consistent with the interim final regulations, the Departments assume that the preparation of each notice will take two minutes of a clerical-level employee's time, plus \$0.47 for printing, envelope, and postage, yielding a per-notice cost of \$1.05. The resulting annual burden is estimated to be \$582,497.

The estimated burden represents only the cost of producing and distributing the notices and does not include the expense involved in determining the adequacy of a participant's prior coverage, since such expense is considered to be part of the regular business practices necessary to comply with HIPAA's statutory portability protections.

³⁷ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2002 Annual Survey*.

Generally all of the major administrative requirements included in the final regulations were also included in the interim final regulations. The final regulations make minor additions to two requirements, however. They require plans to include educational statements in certificates of creditable coverage and to maintain in writing their procedures for requesting certificates. The cost of these additional requirements is expected to be small, and was not estimated separately from the overall cost of providing certificates.

The requirement that certification request procedures be in writing is essentially a clarification of the interim final regulations' requirement that plans have such procedures. The Departments believe it is likely that most plans already maintain written procedures, and therefore expect the cost of this requirement to be small. The Departments did not estimate the cost of this requirement separately from the cost of providing certifications on request.

Other changes included in these final regulations are likely to slightly reduce plans' cost to provide certain HIPAA-required notices. Included with the final regulation is new sample language for general and specific notices of preexisting condition exclusions, which may serve to reduce some plans' costs of providing these notices, and revised sample language for special enrollment rights notices. The final regulations also clarify the narrow scope of the requirement to notify certain affected participants of the specific application of preexisting condition exclusions, thereby potentially relieving some plans of the burden associated with a more expansive interpretation of that requirement. The Departments did not estimate the impact of these provisions separately from the overall cost of providing general and specific notices of preexisting condition exclusions and notices of special enrollment rights.

Statutory Authority

The Department of the Treasury final rule is adopted pursuant to the authority contained in sections 7805 and 9833 of the Code (26 U.S.C. 7805, 9833).

The Department of Labor final rule is adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c, sec. 101(g), Public Law 104–191, 101 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); Secretary of Labor's Order 1–2003, 68 FR 5374 (Feb. 3, 2003).

The Department of HHS final rule is adopted pursuant to the authority

contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as added by HIPAA (Public Law 104–191, 110 Stat. 1936), and amended by MHPA and NMHPA (Public Law 104–204, 110 Stat. 2935), and WHCRA (Public Law 105–277, 112 Stat. 2681–436).

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Parts 144 and 146

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

Adoption of Amendments to the Regulations

Internal Revenue Service

26 CFR Chapter I

■ Accordingly, 26 CFR parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 is amended by:

■ 1. Removing the citations for 54.9801–1T, 54.9801–2T, 54.9801–3T, 54.9801–4T, 54.9801–5T, 54.9801–6T, 54.9831–1T, and 54.9833–1T.

■ 2. Adding entries in numerical order for 54.9801–1, 54.9801–2, 54.9801–3, 54.9801–4, 54.9801–5, 54.9801–6, 54.9802–1, 54.9831–1, and 54.9833–1.

The additions read as follows:

Authority: 26 U.S.C. 7805. * * *

Section 54.9801–1 also issued under 26 U.S.C. 9833.

Section 54.9801–2 also issued under 26 U.S.C. 9833.

Section 54.9801–3 also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801–4 also issued under 26 U.S.C. 9801(c)(1)(I) and 9833.

Section 54.9801–5 also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801–6 also issued under 26 U.S.C. 9833.

Section 54.9802–1 also issued under 26 U.S.C. 9833. * * *

Section 54.9831–1 also issued under 26 U.S.C. 9833.

Section 54.9833–1 also issued under 26 U.S.C. 9833.

■ **Par. 2.** Sections 54.9801–1T, 54.9801–2T, 54.9801–3T, 54.9801–4T, 54.9801–5T, 54.9801–6T, 54.9831–1T, and 54.9833–1T are removed.

■ **Par. 3.** Sections 54.9801–1, 54.9801–2, 54.9801–3, 54.9801–4, 54.9801–5, 54.9801–6, 54.9831–1, and 54.9833–1 are added to read as follows:

§ 54.9801–1 Basis and scope.

(a) *Statutory basis.* Sections 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, 54.9831–1, and 54.9833–1 (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope.* A group health plan may provide greater rights to participants and beneficiaries than those set forth in these portability sections. These portability sections set forth minimum requirements for group health plans concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to creditable coverage.

(4) Special enrollment periods.

(5) Prohibition against discrimination on the basis of health factors.

(c) *Similar requirements under the Employee Retirement Income Security Act and the Public Health Service Act.* Sections 701, 702, 703, 711, 712, 732, and 733 of the Employee Retirement Income Security Act of 1974 and sections 2701, 2702, 2704, 2705, 2721, and 2791 of the Public Health Service Act impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. See 29 CFR part 2590 and 45 CFR parts 144, 146, and 148. See also part B of Title XXVII of the Public Health Service Act and 45 CFR part 148 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801–2).

§ 54.9801–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, 54.9831–1, and 54.9833–1.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means section 4980B (other than paragraph (f)(1) of section 4980B insofar as it relates to pediatric vaccines), sections 601–608 of ERISA, or Title XXII of the PHS Act.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

Condition means a *medical condition*.

Creditable coverage means *creditable coverage* within the meaning of § 54.9801–4(a).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Employee Retirement Income Security Act of 1974 (ERISA) means the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an

election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date*, *first day of coverage*, and *waiting period*) are set forth in § 54.9801–3(a)(3)(i), (ii), and (iii).

Excepted benefits means the benefits described as excepted in § 54.9831(c).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan or *plan* means a *group health plan* within the meaning of § 54.9831(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the *individual market*, rather than the group market; see the definition of individual market in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Issuer means a *health insurance issuer*.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in § 54.9801–3(a)(3)(v) and (vi).

Medical care has the meaning given such term by section 213(d), determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means *participant* within the meaning of section 3(7) of ERISA.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means *preexisting condition exclusion* within the meaning of § 54.9801–3(a)(1).

Public health plan means *public health plan* within the meaning of § 54.9801–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan under the rights described in § 54.9801–6 or in group health insurance coverage under the rights described in 29 CFR 2590.701–6 or 45 CFR 146.117.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4(a)(1)(vii).

Waiting period means *waiting period* within the meaning of § 54.9801–3(a)(3)(iii).

§ 54.9801–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined*—(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(ii) *Examples*. The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan provides benefits solely through an insurance policy offered by Issuer S. At the expiration of the policy, the plan switches coverage to

a policy offered by Issuer T. Issuer T's policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion*. In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. (Therefore, the exclusion of benefits is required to comply with the limitations on preexisting condition exclusions in this section. For an example illustrating the application of these limitations to a succeeding insurance policy, see *Example 3* of paragraph (a)(3)(iv) of this section.)

Example 2. (i) *Facts*. A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion*. In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 3. (i) *Facts*. A group health plan provides coverage for the treatment of diabetes, generally not subject to any lifetime dollar limit. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a lifetime limit of \$10,000.

(ii) *Conclusion*. In this *Example 3*, the \$10,000 lifetime limit is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 4. (i) *Facts*. A group health plan provides coverage for the treatment of acne, subject to a lifetime limit of \$2,000. The plan counts against this \$2,000 lifetime limit on acne treatment benefits provided under prior health coverage.

(ii) *Conclusion*. In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a lifetime limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 5. (i) *Facts*. When an individual's coverage begins under a group health plan, the individual generally becomes eligible for all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion*. In this *Example 5*, the requirement to be covered under the plan for

12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. Because a plan is prohibited under paragraph (b)(5) of this section from imposing any preexisting condition exclusion on pregnancy, the plan provision is prohibited. However, if the plan provision included an exception for women who were pregnant before the effective date of coverage under the plan (so that the provision applied only to women who became pregnant on or after the effective date of coverage) the plan provision would not be a preexisting condition exclusion (and would not be prohibited by paragraph (b)(5) of this section).

Example 6. (i) *Facts*. A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion*. In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) *Facts*. A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion*. In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) *Facts*. A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion*. In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules*. Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied. (See section 701 of ERISA

and section 2701 of the PHS Act, under which these requirements are also imposed on a health insurance issuer offering group health insurance coverage.)

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A is diagnosed with a medical condition 8 months before A's enrollment date in Employer R's group health plan. A's doctor recommends that A take a prescription drug for 3 months, and A follows the recommendation.

(ii) *Conclusion.* In this *Example 1*, Employer R's plan may impose a preexisting condition exclusion with respect to A's condition because A received treatment during the 6-month period ending on A's enrollment date in Employer R's plan by taking the prescription medication during that period. However, if A did not take the prescription drug during the 6-month period, Employer R's plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) *Facts.* Individual B is treated for a medical condition 7 months before the enrollment date in Employer S's group health plan. As part of such treatment, B's physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, B does not receive a follow-up examination, and no other medical advice, diagnosis, care, or treatment for that

condition is recommended to B or received by B during the 6-month period ending on B's enrollment date in Employer S's plan.

(ii) *Conclusion.* In this *Example 2*, Employer S's plan may not impose a preexisting condition exclusion with respect to the condition for which B received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as *Example 2*, except that Employer S's plan learns of the condition and attaches a rider to B's certificate of coverage excluding coverage for the condition. Three months after enrollment, B's condition recurs, and Employer S's plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3*, the rider is a preexisting condition exclusion and Employer S's plan may not impose a preexisting condition exclusion with respect to the condition for which B received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 54.9802-1, even if B had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual C has asthma and is treated for that condition several times during the 6-month period before C's enrollment date in Employer T's plan. Three months after the enrollment date, C begins coverage under Employer T's plan. Two months later, C is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4*, Employer T's plan may impose a preexisting condition exclusion with respect to C's asthma because care relating to C's asthma was received during the 6-month period ending on C's enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual D, who is subject to a preexisting condition exclusion imposed by Employer U's plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). D receives treatment for these conditions during the 6-month period ending on D's enrollment date in Employer U's plan. After enrolling in the plan, D stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5*, the leg fracture is not a condition related to D's diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of D's preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer U's plan.

(ii) *Maximum length of preexisting condition exclusion.* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee)

after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the 18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage.*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 54.9801-4. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 54.9801-5(a)), or through other means in accordance with the rules of § 54.9801-5(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual D works for Employer X and has been covered continuously under X's group health plan. D's spouse works for Employer Y. Y maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. D enrolls in Y's plan, but also stays covered under X's plan. D presents Y's plan with evidence of creditable coverage under X's plan.

(ii) *Conclusion.* In this *Example*, Y's plan must reduce the preexisting condition exclusion period that applies to D by the number of days of coverage that D had under X's plan as of D's enrollment date in Y's plan (even though D's coverage under X's plan was continuing as of that date).

(iv) *Other standards.* See § 54.9802-1 for other standards that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions.*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

(ii) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on —

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) Facts. Employer V's group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer V's plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee E is hired by Employer V on October 13, 1998, and on October 14, 1998 E completes and files all the forms necessary to enroll in the plan. E's coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after E's date of hire).

(ii) *Conclusion.* In this *Example 1*, E's enrollment date is October 13, 1998 (which is the first day of the waiting period for E's enrollment and is also E's date of hire). Accordingly, with respect to E, the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer V's plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by E's days of creditable coverage as of October 13, 1998.

Example 2. (i) Facts. A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month preexisting condition exclusion is imposed. Individual B is enrolled in Option 1 on the

first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2*, B cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on B's enrollment date, which is B's first day of coverage, rather than the date that B enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before B switched to Option 2.

Example 3. (i) Facts. On May 13, 1997, Individual E is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer S. On December 27, 1998, E's leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer T. Issuer T's policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3*, E's enrollment date is May 13, 1997, E's first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer T's policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998.

Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by E for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of E's coverage under Issuer T's policy), the plan may not impose any preexisting condition exclusion with respect to E. Moreover, even if E had received treatment during the 6-month look-back period, the plan still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of E's coverage under Issuer T's policy). See 29 CFR 2590.701-3(a)(3)(iv) *Example 3* and 45 CFR 146.111(a)(3)(iv) *Example 3* for a conclusion that Issuer T is similarly prohibited from imposing a preexisting condition exclusion with respect to E.

Example 4. (i) Facts. A group health plan limits eligibility for coverage to full-time employees of Employer Y. Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee C begins working full-time for Employer Y on April 11. Prior to this date, C worked part-time for Y. C enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4*, C's enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while C was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) Facts. To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan

requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee D begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). D works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5*, D's enrollment date is the first day of the quarter during which D satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(1) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(2) Through special enrollment. (For rules relating to special enrollment, see § 54.9801-6.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) Facts. Employee F first becomes eligible to be covered by Employer W's group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. F has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1*, F is a late enrollee with respect to F's coverage that became effective under the plan on January 1, 2001.

Example 2. (i) Facts. Same facts as *Example 1*, except that F terminates employment with Employer W on July 1, 1999 without having had any health insurance coverage under the plan. F is rehired by Employer W on January 1, 2000 and is eligible for and elects coverage under Employer W's plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2*, F would not be a late enrollee with respect to F's coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general*. Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 54.9801–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

(ii) *Examples*. The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. Individual *E*, who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion*. In this *Example 1*, because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts*. Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion*. In this *Example 2*, the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be

imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children*. Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 54.9801–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage*. Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (See § 54.9801–4(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment*. For special enrollment rules relating to new dependents, see § 54.9801–6(b).

(5) *Pregnancy*. A group health plan may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information*—(i) A group health plan may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts*. Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion*. In this *Example*, the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion*. A group health plan imposing a preexisting condition

exclusion must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided. (See 29 CFR 2590.701–3(c) and 45 CFR 146.111(c), which also impose this requirement on a health insurance issuer offering group health insurance coverage subject to a preexisting condition exclusion.)

(1) *Manner and timing*. A plan must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan for enrollment. If the plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content*. The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18 months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 54.9801–5(a)) or through other means (as described in § 54.9801–5(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required*. If a notice satisfying the requirements of this paragraph (c) is provided to an individual by another party, the plan's obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied. (See 29 CFR 2590.701–3(c)(3) and 45 CFR 146.111(c)(3), which provide that

the issuer's obligation is similarly satisfied.)

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) Facts. A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual B at Address M or Telephone Number N.

(ii) *Conclusion.* In this *Example*, the plan satisfies the general notice requirement of this paragraph (c).

(d) *Determination of creditable coverage—(1) Determination within reasonable time.* If a group health plan receives creditable coverage information under § 54.9801–5, the plan is required, within a reasonable time following

receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care. (See 29 CFR 2590.701–3(d) and 45 CFR 146.111(d), which also impose this requirement on a health insurance issuer offering group health insurance coverage.)

(2) *No time limit on presenting evidence of creditable coverage.* A plan may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(3) *Example.* The rules of this paragraph (d) are illustrated by the following example:

Example. (i) Facts. A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual H develops an urgent health condition before receiving a certificate of creditable coverage from H's prior group health plan. H attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on H's behalf in accordance with the rules of § 54.9801–5.

(ii) *Conclusion.* In this *Example*, the plan must review the evidence presented by H and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of H's health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan has made a determination of creditable coverage under paragraph (d) of this section, the plan must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan is not required to provide this notice if the plan does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. (See 29 CFR 2590.701–3(e) and 45 CFR 146.111(e), which also impose this requirement on

a health insurance issuer offering group health insurance coverage.)

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual by another party, the plan's obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied. (See 29 CFR 2590.701–3(e)(3) and 45 CFR 146.111(e)(3), which provide that the issuer's obligation is similarly satisfied.)

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) Facts. A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual G presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that G is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies G that, based on the certificate G submitted, G is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of G's medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1*, the plan satisfies the requirements of this paragraph (e).

Example 2. (i) Facts. Same facts as in *Example 1*, except that the plan determines that G has 430 days of creditable coverage based on G's certificate indicating 430 days of creditable coverage under G's prior plan.

(ii) *Conclusion.* In this *Example 2*, the plan is not required to notify G that G will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan from modifying

an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

§ 54.9801–4 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage*. For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 54.9831–1(a).

(ii) Health insurance coverage as defined in § 54.9801–2 (whether or not the entity offering the coverage is subject to Chapter 100 of Subtitle K, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26);

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such

State and who, by reason of the existence or history of a medical condition —

(1) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(2) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage*. Creditable coverage does not include coverage of solely excepted benefits (described in § 54.9831–1).

(3) *Methods of counting creditable coverage*. For purposes of reducing any preexisting condition exclusion period, as provided under § 54.9801–3(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section or may provide that a health insurance issuer offering health insurance coverage under the plan may use the alternative method of counting creditable coverage.

(b) *Standard method*—(1) *Specific benefits not considered*. Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days*. For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage*. Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (See section 731(b)(2)(iii) of ERISA and section 2723(b)(2)(iii) of the PHS Act, which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Periods that toll a significant break*. Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(v) *Examples*. The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 1. (i) *Facts*. Individual A has creditable coverage under Employer P's plan for 18 months before coverage ceases. A is provided a certificate of creditable coverage on A's last day of coverage. Sixty-four days after the last date of coverage under P's plan, A is hired by Employer Q and enrolls in Q's group health plan. Q's plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion*. In this *Example 1*, A has a break in coverage of 63 days. Because A's break in coverage is a significant break in coverage, Q's plan may disregard A's prior coverage and A may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts*. Same facts as *Example 1*, except that A is hired by Q and enrolls in Q's plan on the 63rd day after the last date of coverage under P's plan.

(ii) *Conclusion*. In this *Example 2*, A has a break in coverage of 62 days. Because A's break in coverage is not a significant break in coverage, Q's plan must count A's prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to A.

Example 3. (i) *Facts*. Same facts as *Example 1*, except that Q's plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion*. In this *Example 3*, under State law, the issuer that provides group health insurance coverage to Q's plan must count A's period of creditable coverage prior

to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. [Reserved]

Example 5. (i) *Facts.* Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T*. *T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T*, *C* begins working for Employer *U*. *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5*, *C* does not have a significant break in coverage because, after disregarding the waiting period under *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days), accordingly, *C* has 200 days of creditable coverage, and *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C*.

Example 6. [Reserved]

Example 7. (i) *Facts.* Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.*

In this *Example 7*, because *E* applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7*, except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8*, even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods—(a) Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 54.9801–5), a group health plan may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in

this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method—(1) Specific benefits considered.* Under the alternative method, a group health plan determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan may use the alternative method for any or all of the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan. A plan that provides benefits (in part or in whole) through one or more policies or contracts of insurance will not fail the uniform application requirement of this paragraph (c)(2) if the alternative method is used (or not used) separately with respect to participants and beneficiaries under any policy or contract, provided that the alternative method is applied uniformly with respect to all coverage under that policy or contract. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

- (i) Mental health;
- (ii) Substance abuse treatment;
- (iii) Prescription drugs;
- (iv) Dental care; or
- (v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and State this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 54.9801–5(b) for special rules concerning disclosure of coverage to a plan (or issuer) using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage—(i) In general.* Under the alternative method, the group health plan counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2)), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) *Conclusion.* In this *Example*, Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

§ 54.9801-5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage—*
(1) *Entities required to provide certificate—*(i) *In general.* A group health plan is required to furnish certificates of creditable coverage in accordance with this paragraph (a). (See section 701(e) of ERISA and section 2701(e) of the PHS Act, under which this obligation is also imposed on each health insurance issuer offering group health insurance coverage under the plan.)

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, a group health plan is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if any other entity actually provides a certificate that includes the information required under paragraph (a)(3) of this section with respect to the participant or beneficiary.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan satisfies the certification requirements under this paragraph (a) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and an employer sponsoring a plan under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to

an individual when the plan would have been required to provide one under this paragraph (a), then the plan does not violate the certification requirements of this paragraph (a) (though the issuer would have violated the certification requirements pursuant to section 701(e) of ERISA and section 2701(e) of the PHS Act).

(iv) *Special rules relating to issuers providing coverage under a plan—*(A)(1) *Responsibility of issuer for coverage period.* See 29 CFR 2590.701-5 and 45 CFR 146.115, under which an issuer is not required to provide information regarding coverage provided to an individual by another party.

(2) *Example.* The rule referenced by this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) *Facts.* A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example*, if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(1) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy or contract ceases before the individual's coverage under the plan ceases, the issuer is required (under section 701(e) of ERISA and section 2701(e) of the PHS Act) to provide sufficient information to the plan (or to another party designated by the plan) to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate that reflects the period of coverage under the policy or contract. By providing that information to the plan, the issuer satisfies its obligation to provide an automatic certificate for that period of creditable coverage with respect to the individual under paragraph (a)(2)(ii) of this section. The issuer, however, must still provide a certificate upon request as required under paragraph (a)(2)(iii) of this section. In addition, the issuer is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). Moreover, if the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy or contract ceases, the issuer must still provide an automatic certificate under

paragraph (a)(2)(ii) of this section. If an individual's coverage under an issuer's policy or contract ceases on the effective date for changing enrollment options under the plan, the issuer may presume (absent information to the contrary) that the individual's coverage under the plan continues. Therefore, the issuer is required to provide information to the plan in accordance with this paragraph (a)(1)(iv)(B)(1) (and is not required to provide an automatic certificate under paragraph (a)(2)(ii) of this section).

(2) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) *Facts.* A group health plan provides coverage under an HMO option and an indemnity option through different issuers, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example*, if an employee switches from the indemnity option to the HMO option on January 1, the indemnity issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance—*

(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 4980B(g)(3)) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 4980B(f)(6) (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who

is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate must be provided at the time the individual ceases to be covered under the plan. A plan satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

(1) The cessation of temporary continuation coverage (TCC) under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefit Program) is a cessation of coverage upon which an automatic certificate must be provided.

(2) In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time after coverage ceases under the plan.

(3) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease for purposes of this paragraph (a)(2)(ii)(B) on the earliest date that a claim is denied due to the operation of the lifetime limit.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* A certificate must be provided in response to a request made by, or on behalf of, an individual at any time while the individual is covered under a plan and up to 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly

enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A terminates employment with Employer Q. A is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer Q's group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) *Conclusion.* In this *Example 1*, the automatic certificate may be provided at the same time that A is provided the COBRA notice.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the automatic certificate for A is not completed by the time the COBRA notice is furnished to A.

(ii) *Conclusion.* In this *Example 2*, the automatic certificate may be provided after the COBRA notice but must be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) *Facts.* Employer R maintains an insured group health plan. R has never had 20 employees and thus R's plan is not subject to the COBRA continuation provisions. However, R is in a State that has a State program similar to COBRA. B terminates employment with R and loses coverage under R's plan.

(ii) *Conclusion.* In this *Example 3*, the automatic certificate must be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) *Facts.* Individual C terminates employment with Employer S and receives both a notice of C's rights under COBRA and an automatic certificate. C elects COBRA continuation coverage under Employer S's group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, S's group health plan determines that C's COBRA continuation coverage has ceased due to a failure to make a timely payment for continuation coverage.

(ii) *Conclusion.* In this *Example 4*, the plan must provide an updated automatic certificate to C within a reasonable time after the end of the grace period.

Example 5. (i) *Facts.* Individual D is currently covered under the group health plan of Employer T. D requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for T's plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) *Conclusion.* In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate—*
(i) *Written certificate—*(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (including any form approved by the Secretary as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2)(ii) or (iii) of this section, if —

(1) An individual who is entitled to receive the certificate requests that the certificate be sent to another plan or issuer instead of to the individual;

(2) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (such as by telephone); and

(3) The receiving plan or issuer receives the information from the sending plan or issuer through such means within the time required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(1) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(2) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(H) An educational statement regarding HIPAA, which explains:

(1) The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage);

(2) Special enrollment rights;

(3) The prohibitions against discrimination based on any health factor;

(4) The right to individual health coverage;

(5) The fact that State law may require issuers to provide additional protections to individuals in that State; and

(6) Where to get more information.

(iii) *Periods of coverage under the certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, the certificate provided must include each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 54.9831-1(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 54.9801-4(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures—(i) Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a written procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address).

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated individual or entity. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated individual or entity.

(5) *Special rules concerning dependent coverage—(i)(A) Reasonable efforts.* A plan is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5)(i) are illustrated by the following example:

Example. (i) *Facts.* A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) *Conclusion.* In this *Example*, the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent covered by the certificate, the procedures described in paragraph (c)(5) of this section may be used to demonstrate dependent status. In addition, these procedures may be used to demonstrate that a child was covered under any creditable coverage within 30 days after birth, adoption, or placement for adoption. See also § 54.9801-3(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules for entities not subject to Chapter 100 of Subtitle K—(i) Issuers.* For rules requiring that issuers in the group and individual markets provide certificates consistent with the rules in this section, see section 701(e) of ERISA and sections 2701(e), 2721(b)(1)(B), and 2743 of the PHS Act.

(ii) *Other entities.* For special rules requiring that certain other entities not subject to Chapter 100 of Subtitle K provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHS Act applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, TRICARE, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to nonfederal governmental plans generally, and section 2721(b)(2)(C)(ii) of the PHS Act applicable to nonfederal governmental plans that elect to be excluded from the requirements of Subparts 1 through 3 of Part A of Title XXVII of the PHS Act.

(b) *Disclosure of coverage to a plan or issuer using the alternative method of counting creditable coverage—(1) In general.* After an individual provides a certificate of creditable coverage to a plan (or issuer) using the alternative method under § 54.9801-4(c), that plan (or issuer) (requesting entity) must request that the entity that issued the certificate (prior entity) disclose the

information set forth in paragraph (b)(2) of this section. The prior entity is required to disclose this information promptly.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category.

(3) *Charge for providing information.* The prior entity may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information—*(1) *Purpose.* The rules in this paragraph (c) implement section 9801(c)(4), which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 9801(e)(3), which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual.

(2) *In general.* If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time;

(ii) The individual has creditable coverage provided by an entity that is not required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(iv) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(3) *Evidence of creditable coverage—*

(i) *Consideration of evidence—*(A) A plan is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage. A plan shall treat the

individual as having furnished a certificate under paragraph (a) of this section if—

(1) The individual attests to the period of creditable coverage;

(2) The individual also presents relevant corroborating evidence of some creditable coverage during the period; and

(3) The individual cooperates with the plan's efforts to verify the individual's coverage.

(B) For purposes of this paragraph (c)(3)(i), cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that corroborate creditable coverage (and waiting or affiliation periods) include explanations of benefits (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting or affiliation periods) may also be corroborated through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(3) are illustrated by the following example:

Example. (i) *Facts.* Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, *W*, and requests a certificate. However, *F* (and *X*'s plan, on *F*'s behalf and with *F*'s cooperation) is unable to obtain a certificate from *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under *W*'s plan, and that the coverage ended no earlier than *F*'s

termination of employment from *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) *Conclusion.* In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(4) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine the duration of an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(5) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

§ 54.9801–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage—*(1) *In general.* A group health plan is required to permit current employees and dependents (as defined in § 54.9801–2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (See section 701(f)(1) of ERISA and section 2701(f)(1) of the PHS Act, under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment—*(i) *When employee loses coverage.* A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage—* (A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(1) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(2) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(3) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. Individual A works for Employer X. A, A's spouse, and A's dependent children are eligible but not enrolled for coverage under X's group health plan. A's spouse works for Employer Y and at the time coverage was offered under X's plan, A was enrolled in coverage under Y's plan. Then, A loses eligibility for coverage under Y's plan.

(ii) *Conclusion.* In this *Example 1*, because A satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, A, A's spouse, and A's dependent children are eligible for special enrollment under X's plan.

Example 2. (i) Facts. Individual A and A's spouse are eligible but not enrolled for coverage under Group Health Plan P maintained by A's employer. When A was first presented with an opportunity to enroll A and A's spouse, they did not have other coverage. Later, A and A's spouse enroll in Group Health Plan Q maintained by the employer of A's spouse. During a subsequent open enrollment period in P, A and A's spouse did not enroll because of their coverage under Q. They then lose eligibility for coverage under Q.

(ii) *Conclusion.* In this *Example 2*, because A and A's spouse were covered under Q when they did not enroll in P during open enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, A and A's spouse are eligible for special enrollment under P.

Example 3. (i) Facts. Individual B works for Employer X. B and B's spouse are eligible but not enrolled for coverage under X's group

health plan. B's spouse works for Employer Y and at the time coverage was offered under X's plan, B's spouse was enrolled in self-only coverage under Y's group health plan. Then, B's spouse loses eligibility for coverage under Y's plan.

(ii) *Conclusion.* In this *Example 3*, because B's spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both B and B's spouse are eligible for special enrollment under X's plan.

Example 4. (i) Facts. Individual A works for Employer X. X maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. A enrolls for self-only coverage in the HMO option. A's spouse works for Employer Y and was enrolled for self-only coverage under Y's plan at the time coverage was offered under X's plan. Then, A's spouse loses coverage under Y's plan. A requests special enrollment for A and A's spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4*, because A's spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both A and A's spouse can enroll in either benefit package under X's plan. Therefore, if A requests enrollment in accordance with the requirements of this section, the plan must allow A and A's spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment—*(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an

individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 54.9801-2.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to State in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the

employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) Facts. Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1*, employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) Facts. A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2*, *A* has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) Facts. Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer *Z*, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3*, *C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other

conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage*—(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) In general. A group health plan that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (See 29 CFR 2590.701–6(b) and 45 CFR 146.117(b), under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either—

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 54.9801–2) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan (or any issuer offering health insurance

coverage under the plan) receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) Facts. An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee A is hired on September 3. A is married to B, and they have no children. On March 15 in the following year a child C is born to A and B. Before that date, A and B have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1*, the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If A satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows A to enroll either with employee-only coverage, with employee-plus-spouse coverage (for A and B), or with family coverage (for A, B, and C). The plan must allow whatever coverage is chosen to begin on March 15, the date of C's birth.

Example 2. (i) Facts. Individual D works for Employer X. X maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. D enrolls for self-only coverage in the HMO option. Then, a child, E, is placed for adoption with D. Within 30 days of the placement of E for adoption, D requests enrollment for D and E under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2*, D and E satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow D and E to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment

must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees—(1)* If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules

prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 54.9801–3(b).

(3) The rules of this section are illustrated by the following example:

Example 2. (i) Facts. Employer Y maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual B loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. B submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example*, B is a special enrollee. Therefore, even though B's request for enrollment coincides with an open enrollment period, B's coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

§ 54.9831–1 Special rules relating to group health plans.

(a) *Group health plan—(1) Defined.* A group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits—(1) In general.* The requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1), or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2)) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of

participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed \$500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of \$100 a day.

(ii) *Conclusion.* In this *Example*, even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of \$100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example*, the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* (See 29 CFR 2590.732(d)(1) and 45 CFR 146.145(d)(1), under which a plan providing medical care, maintained by a partnership, and usually not treated as an employee welfare benefit plan under ERISA is treated as a group health plan for purposes of Part 7 of Subtitle B of Title I of ERISA and Title XXVII of the PHS Act.)

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

§ 54.9833-1 Effective dates.

Sections 54.9801-1 through 54.9801-6, 54.9831-1, and this section are applicable for plan years beginning on or after July 1, 2005.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

■ **Par. 4.** The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

■ **Par. 5.** In § 602.101, paragraph (b) is amended by:

■ a. Removing the entries in the table for §§ 54.9801-3T, 54.9801-4T, 54.9801-5T, and 54.9801-6T.

■ b. Adding the following entries in numerical order to the table:

§ 602.101 OMB Control numbers.

* * * *

(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * *	* * *
54.9801-3	1545-1537
54.9801-4	1545-1537
54.9801-5	1545-1537
54.9801-6	1545-1537
* * *	* * *

Mark E. Matthews,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: July 14, 2004.

Gregory F. Jenner,

Acting Assistant Secretary of the Treasury.

Employee Benefits Security Administration

29 CFR Chapter XXV

■ For the reasons set forth above, Chapter XXV of Title 29 of the Code of

Federal Regulations is amended as set forth below:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The authority citation for Part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c, sec. 101(g), Public Law 104-191, 101 Stat. 1936; sec. 401(b), Public Law 105-200, 112 Stat. 645 (42 U.S.C. 651 note); Secretary of Labor's Order 1-2003, 68 FR 5374 (Feb. 3, 2003).

■ 2. The heading for Subpart B is revised to read as follows:

Subpart B—Health Coverage Portability, Nondiscrimination, and Renewability

■ 3. Sections 2590.701-1, 2590.701-2, 2590.701-3, 2590.701-4, 2590.701-5, 2590.701-6, and 2590.701-7 are revised to read as follows:

§ 2590.701-1 Basis and scope.

(a) *Statutory basis.* This Subpart B implements Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (hereinafter ERISA or the Act).

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this Subpart B. This Subpart B sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to counting creditable coverage.

(4) Special enrollment periods.

(5) Prohibition against discrimination on the basis of health factors.

(6) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.

§ 2590.701-2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 2590.701 through 2590.734.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601-608 of the Act, section 4980B of the Internal Revenue Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), or Title XXII of the PHS Act.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

Condition means a *medical condition*. *Creditable coverage* means *creditable coverage* within the meaning of § 2590.701-4(a).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date*, *first day of coverage*,

and *waiting period*) are set forth in § 2590.701–3(a)(3)(i), (ii), and (iii).

Excepted benefits means the benefits described as excepted in § 2590.732(c).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan or *plan* means a *group health plan* within the meaning of § 2590.732(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of *individual market* in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Act). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual

health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Internal Revenue Code means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a *health insurance issuer*.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in § 2590.701–3(a)(3)(v) and (vi).

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means *participant* within the meaning of section 3(7) of the Act.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an

annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means *preexisting condition exclusion* within the meaning of § 2590.701–3(a)(1).

Public health plan means *public health plan* within the meaning of § 2590.701–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.

Significant break in coverage means a *significant break in coverage* within the meaning of § 2590.701–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan or group health insurance coverage under the rights described in § 2590.701–6.

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 2590.701–4(a)(1)(vii).

Waiting period means *waiting period* within the meaning of § 2590.701–3(a)(3)(iii).

§ 2590.701–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion—*

(1) *Defined—*(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(ii) *Examples.* The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) Facts. A group health plan provides benefits solely through an insurance policy offered by Issuer S. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer T. Issuer T's policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. (Therefore, the exclusion of benefits is required to comply with the limitations on preexisting condition exclusions in this section. For an example illustrating the application of these limitations to a succeeding insurance policy, see *Example 3* of paragraph (a)(3)(iv) of this section.)

Example 2. (i) Facts. A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion.* In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 3. (i) Facts. A group health plan provides coverage for the treatment of diabetes, generally not subject to any lifetime dollar limit. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a lifetime limit of \$10,000.

(ii) *Conclusion.* In this *Example 3*, the \$10,000 lifetime limit is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 4. (i) Facts. A group health plan provides coverage for the treatment of acne, subject to a lifetime limit of \$2,000. The plan counts against this \$2,000 lifetime limit acne treatment benefits provided under prior health coverage.

(ii) *Conclusion.* In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a lifetime limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 5. (i) Facts. When an individual's coverage begins under a group health plan, the individual generally becomes eligible for

all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion.* In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. Because a plan is prohibited under paragraph (b)(5) of this section from imposing any preexisting condition exclusion on pregnancy, the plan provision is prohibited. However, if the plan provision included an exception for women who were pregnant before the effective date of coverage under the plan (so that the provision applied only to women who became pregnant on or after the effective date of coverage) the plan provision would not be a preexisting condition exclusion (and would not be prohibited by paragraph (b)(5) of this section).

Example 6. (i) Facts. A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) Facts. A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) Facts. A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion.* In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules.* Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group

health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied.

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) Facts. Individual A is diagnosed with a medical condition 8 months before A's enrollment date in Employer R's group health plan. A's doctor recommends that A take a prescription drug for 3 months, and A follows the recommendation.

(ii) *Conclusion.* In this *Example 1*, Employer R's plan may impose a preexisting condition exclusion with respect to A's condition because A received treatment during the 6-month period ending on A's enrollment date in Employer R's plan by taking the prescription medication during that period. However, if A did not take the prescription drug during the 6-month period, Employer R's plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) Facts. Individual B is treated for a medical condition 7 months before the enrollment date in Employer S's group health plan. As part of such treatment, B's physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, B does not receive a

follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) *Conclusion.* In this *Example 2*, Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as *Example 2*, except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3*, the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 2590.702, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer *T*'s plan. Two months later, *C* is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4*, Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual *D*, who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5*, the leg fracture is not a condition related to *D*'s diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion.* A preexisting condition exclusion is not permitted to

extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the 18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage.*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 2590.701–4. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 2590.701–5(a)), or through other means in accordance with the rules of § 2590.701–5(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y*. *Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example*, *Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 2590.702 for other standards in this Subpart B that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions.*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance

issuers, the individual's enrollment date does not change.

(ii) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on—

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and on October 14, 1998 *E* completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) *Conclusion.* In this *Example 1*, *E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) *Facts.* A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month

preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2*, *B* cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before *B* switched to Option 2.

Example 3. (i) *Facts.* On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S*. On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3*, *E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998. Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), Issuer *T* may not impose any preexisting condition exclusion with respect to *E*. Moreover, even if *E* had received treatment during the 6-month look-back period, Issuer *T* still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy).

Example 4. (i) *Facts.* A group health plan limits eligibility for coverage to full-time employees of Employer *Y*. Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y*. *C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4*, *C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) *Facts.* To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is

satisfied, coverage becomes effective on the first day of the current calendar quarter.

Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5*, *D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(1) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(2) Through special enrollment. (For rules relating to special enrollment, see § 2590.701–6.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1*, *F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that *F* terminates employment with Employer *W* on July 1, 1999 without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2*, *F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions—(1)*

Newborns—(i) In general. Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 2590.701–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *E*, who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion.* In this *Example 1*, because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts.* Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion.* In this *Example 2*, the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 2590.701–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (See § 2590.701–4(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment.* For special enrollment rules relating to new dependents, see § 2590.701–6(b).

(5) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information.*—(i) A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) Facts. Individual A enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before A's enrollment, A's doctor told A that, based on genetic information, A has a predisposition towards breast cancer. A was not diagnosed with breast cancer at any time prior to A's enrollment date in the plan. Nine months after A's enrollment date in the plan, A is diagnosed with breast cancer.

(ii) *Conclusion.* In this *Example*, the plan may not impose a preexisting condition exclusion with respect to A's breast cancer because, prior to A's enrollment date, A was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance coverage subject to a preexisting condition exclusion, must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided.

(1) *Manner and timing.* A plan or issuer must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18-months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 2590.701–5(a)) or through other means (as described in § 2590.701–5(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual, the obligation to provide a general notice of preexisting condition exclusion with respect to that

individual is satisfied for both the plan and the issuer.

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans and issuers can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) Facts. A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual B at Address M or Telephone Number N.

(ii) *Conclusion.* In this *Example*, the plan satisfies the general notice requirement of this paragraph (c), and thus also satisfies this requirement for any issuer providing the coverage.

(d) *Determination of creditable coverage.*—(1) *Determination within reasonable time.* If a group health plan or health insurance issuer offering group health insurance coverage receives

creditable coverage information under § 2590.701–5, the plan or issuer is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care.

(2) *No time limit on presenting evidence of creditable coverage.* A plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(3) *Example.* The rules of this paragraph (d) are illustrated by the following example:

Example. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *H* develops an urgent health condition before receiving a certificate of creditable coverage from *H*'s prior group health plan. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf in accordance with the rules of § 2590.701–5.

(ii) *Conclusion.* In this *Example*, the plan must review the evidence presented by *H* and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan or issuer has made a determination of creditable coverage under paragraph (d) of this section, the plan or issuer must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a

determination that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan or issuer must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan or issuer relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan or issuer.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual, the obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1*, the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1*, except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion.* In this *Example 2*, the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

§ 2590.701–4 Rules relating to creditable coverage.

(a) *General rules—*(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 2590.732(a).

(ii) Health insurance coverage as defined in § 2590.701–2 (whether or not the entity offering the coverage is subject to Part 7 of Subtitle B of Title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(1) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(2) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a *public health plan* means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in § 2590.732).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 2590.701–3(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan or issuer may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does

not have any creditable coverage. (See also § 2590.731(c)(2)(iii) regarding the applicability to issuers of State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(v) *Examples.* The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A has creditable coverage under Employer P's plan for 18 months before coverage ceases. A is provided a certificate of creditable coverage on A's last day of coverage. Sixty-four days after the last date of coverage under P's plan, A is hired by Employer Q and enrolls in Q's group health plan. Q's plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1*, A has a break in coverage of 63 days. Because A's break in coverage is a significant break in coverage, Q's plan may disregard A's prior coverage and A may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that A is hired by Q and enrolls in Q's plan on the 63rd day after the last date of coverage under P's plan.

(ii) *Conclusion.* In this *Example 2*, A has a break in coverage of 62 days. Because A's break in coverage is not a significant break in coverage, Q's plan must count A's prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to A.

Example 3. (i) *Facts.* Same facts as *Example 1*, except that Q's plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3*, under State law, the issuer that provides group health insurance coverage to Q's plan must count A's period of creditable coverage prior to the 63-day break. (However, if Q's plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and A's previous health coverage could be disregarded.)

Example 4. —[Reserved]

Example 5. (i) *Facts.* Individual C has creditable coverage under Employer S's plan for 200 days before coverage ceases. C is provided a certificate of creditable coverage

on C's last day of coverage. C then does not have any creditable coverage for 51 days before being hired by Employer T. T's plan has a 3-month waiting period. C works for T for 2 months and then terminates employment. Eleven days after terminating employment with T, C begins working for Employer U. U's plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5*, C does not have a significant break in coverage because, after disregarding the waiting period under T's plan, C had only a 62-day break in coverage (51 days plus 11 days). Accordingly, C has 200 days of creditable coverage, and U's plan may not apply its 6-month preexisting condition exclusion with respect to C.

Example 6. —[Reserved]

Example 7. (i) *Facts.* Individual E has creditable coverage under Employer X's plan. E is provided a certificate of creditable coverage on E's last day of coverage. On the 63rd day without coverage, E submits a substantially complete application for a health insurance policy in the individual market. E's application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.* In this *Example 7*, because E applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7*, except that E's application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8*, even though E did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied E would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods*—(A) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 2590.701–5), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual F has coverage under Group Health Plan Y from January 3, 1997 through March 25, 1997. F

then becomes covered by Group Health Plan Z. *F*'s enrollment date in Plan Z is May 1, 1997. Plan Z has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example*, Plan Z may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan Z may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan or issuer may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or health insurance coverage. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

- (i) Mental health;
- (ii) Substance abuse treatment;
- (iii) Prescription drugs;
- (iv) Dental care; or
- (v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure

statements concerning the plan, and State this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 2590.701–5(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage*—(i) *In general.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) *Conclusion.* In this *Example*, Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

§ 2590.701–5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In general.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, in the case of a group health plan funded through an insurance policy, the issuer satisfies the certification requirement with respect to an individual if the plan actually provides a certificate that includes all the information required under paragraph (a)(3) of this section with respect to the individual.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan satisfies the certification requirements under this paragraph (a) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and a plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers*—(A)(1) *Responsibility of issuer for coverage period.* An issuer is not required to provide information regarding coverage provided to an individual by another party.

(2) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) *Facts.* A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with

the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example*, if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(1) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy or contract ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate that reflects the period of coverage under the policy or contract. By providing that information to the plan, the issuer satisfies its obligation to provide an automatic certificate for that period of creditable coverage with respect to the individual under paragraph (a)(2)(ii) of this section. The issuer, however, must still provide a certificate upon request as required under paragraph (a)(2)(iii) of this section. In addition, the issuer is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). Moreover, if the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy or contract ceases, the issuer must still provide an automatic certificate under paragraph (a)(2)(ii) of this section. If an individual's coverage under an issuer's policy or contract ceases on the effective date for changing enrollment options under the plan, the issuer may presume (absent information to the contrary) that the individual's coverage under the plan continues. Therefore, the issuer is required to provide information to the plan in accordance with this paragraph (a)(1)(iv)(B)(1) (and is not required to provide an automatic certificate under paragraph (a)(2)(ii) of this section).

(2) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) *Facts.* A group health plan provides coverage under an HMO option and an indemnity option through different issuers, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example*, if an employee switches from the indemnity

option to the HMO option on January 1, the indemnity issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance—*

(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of the Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 606 of the Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate must be provided at the time the individual ceases to be covered under the plan. A plan or issuer satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

(1) The cessation of temporary continuation coverage (TCC) under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefit Program) is a cessation of coverage upon which an automatic certificate must be provided.

(2) In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is

deemed to be provided within a reasonable time after coverage ceases under the plan.

(3) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease for purposes of this paragraph (a)(2)(ii)(B) on the earliest date that a claim is denied due to the operation of the lifetime limit.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* A certificate must be provided in response to a request made by, or on behalf of, an individual at any time while the individual is covered under a plan and up to 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A terminates employment with Employer Q. A is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer Q's group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) *Conclusion.* In this *Example 1*, the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) *Conclusion.* In this *Example 2*, the automatic certificate may be provided after the COBRA notice but must be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) *Facts.* Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) *Conclusion.* In this *Example 3*, the automatic certificate must be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) *Facts.* Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to a failure to make a timely payment for continuation coverage.

(ii) *Conclusion.* In this *Example 4*, the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5. (i) *Facts.* Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) *Conclusion.* In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate—*

(i) *Written certificate—*(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (or any other medium approved by the Secretary).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2)(ii) or (iii) of this section, if—

(1) An individual who is entitled to receive the certificate requests that the certificate be sent to another plan or issuer instead of to the individual;

(2) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this

paragraph (a)(3) through means other than a written certificate (such as by telephone); and

(3) The receiving plan or issuer receives the information from the sending plan or issuer through such means within the time required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—
(A) The date the certificate is issued;
(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(1) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(2) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(H) An educational statement regarding HIPAA, which explains:

(1) The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage);

(2) Special enrollment rights;

(3) The prohibitions against discrimination based on any health factor;

(4) The right to individual health coverage;

(5) The fact that state law may require issuers to provide additional protections to individuals in that State; and

(6) Where to get more information.

(iii) *Periods of coverage under the certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last

period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, the certificate provided must include each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately States the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 2590.732(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 2590.701–4(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures—*(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. (See also § 2520.104b–1, which permits plans to make disclosures under the Act—including the furnishing of certificates—through electronic means if certain standards are met.) If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the

dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a written procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address).

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated individual or entity. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated individual or entity.

(5) *Special rules concerning dependent coverage—(i)(A) Reasonable efforts.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5)(i) are illustrated by the following example:

Example. (i) *Facts.* A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) *Conclusion.* In this *Example*, the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a

plan or issuer does not provide the name of any dependent covered by the certificate, the procedures described in paragraph (c)(5) of this section may be used to demonstrate dependent status. In addition, these procedures may be used to demonstrate that a child was covered under any creditable coverage within 30 days after birth, adoption, or placement for adoption. *See also* § 2590.701–3(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules for entities not subject to Part 7 of Subtitle B of Title I of the Act—(i) Issuers.* For special rules requiring that issuers not subject to Part 7 of Subtitle B of Title I of the Act provide certificates consistent with the rules in this section, including issuers offering coverage with respect to creditable coverage described in sections 701(c)(1)(G), (I), and (J) of the Act (coverage under a State health benefits risk pool, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act), see sections 2743 and 2721(b)(1)(B) of the PHS Act (requiring certificates by issuers in the individual market, and issuers offering health insurance coverage in connection with a group health plan, including a church plan or a governmental plan (such as the Federal Employees Health Benefits Program (FEHBP))). (However, this section does not require a certificate to be provided with respect to short-term, limited-duration insurance, as described in the definition of *individual health insurance coverage* in § 2590.701–2, that is not provided by a group health plan or issuer offering health insurance coverage in connection with a group health plan.)

(ii) *Other entities.* For special rules requiring that certain other entities not subject to Part 7 of Subtitle B of Title I of the Act provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHS Act applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, TRICARE, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to nonfederal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHS Act applicable to nonfederal governmental plans that elect to be excluded from the requirements of Subparts 1 through 3 of Part A of Title XXVII of the PHS Act, and section 9832(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan or issuer using the alternative method of*

counting creditable coverage—(1) In general. After an individual provides a certificate of creditable coverage to a plan or issuer using the alternative method under § 2590.701–4(c), that plan or issuer (requesting entity) must request that the entity that issued the certificate (prior entity) disclose the information set forth in paragraph (b)(2) of this section. The prior entity is required to disclose this information promptly.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category.

(3) *Charge for providing information.* The prior entity may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information—(1) Purpose.* The rules in this paragraph (c) implement section 701(c)(4) of the Act, which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 701(e)(3) of the Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual.

(2) *In general.* If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time;

(ii) The individual has creditable coverage provided by an entity that is not required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(iv) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(3) *Evidence of creditable coverage*—(i) *Consideration of evidence*—(A) A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if—

(1) The individual attests to the period of creditable coverage;

(2) The individual also presents relevant corroborating evidence of some creditable coverage during the period; and

(3) The individual cooperates with the plan's or issuer's efforts to verify the individual's coverage.

(B) For purposes of this paragraph (c)(3)(i), cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents*. Documents that corroborate creditable coverage (and waiting or affiliation periods) include explanations of benefits (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence*. Creditable coverage (and waiting or affiliation periods) may also be corroborated through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example*. The rules of this paragraph (c)(3) are illustrated by the following example:

Example. (i) Facts. Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to

receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, *W*, and requests a certificate. However, *F* (and *X*'s plan, on *F*'s behalf and with *F*'s cooperation) is unable to obtain a certificate from *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) *Conclusion*. In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(4) *Demonstrating categories of creditable coverage*. Procedures similar to those described in this paragraph (c) apply in order to determine the duration of an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(5) *Demonstrating dependent status*. If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

§ 2590.701–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general*. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 2590.701–2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment*—(i) *When employee loses coverage*. A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage*—(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(1) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(2) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(3) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan or issuer is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

(iii) *Examples*. The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. Individual *A* works for Employer *X*. *A*, *A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under *X*'s group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion*. In this *Example 1*, because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A*, *A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) Facts. Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P*, *A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion*. In this *Example 2*, because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open

enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, A and A's spouse are eligible for special enrollment under P.

Example 3. (i) *Facts.* Individual B works for Employer X. B and B's spouse are eligible but not enrolled for coverage under X's group health plan. B's spouse works for Employer Y and at the time coverage was offered under X's plan, B's spouse was enrolled in self-only coverage under Y's group health plan. Then, B's spouse loses eligibility for coverage under Y's plan.

(ii) *Conclusion.* In this *Example 3*, because B's spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both B and B's spouse are eligible for special enrollment under X's plan.

Example 4. (i) *Facts.* Individual A works for Employer X. X maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. A enrolls for self-only coverage in the HMO option. A's spouse works for Employer Y and was enrolled for self-only coverage under Y's plan at the time coverage was offered under X's plan. Then, A's spouse loses coverage under Y's plan. A requests special enrollment for A and A's spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4*, because A's spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both A and A's spouse can enroll in either benefit package under X's plan. Therefore, if A requests enrollment in accordance with the requirements of this section, the plan must allow A and A's spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period

that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 2590.702(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 2590.701–2.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to State in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with

notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual D enrolls in a group health plan maintained by Employer Y. At the time D enrolls, Y pays 70 percent of the cost of employee coverage and D pays the rest. Y announces that beginning January 1, Y will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1*, employer contributions towards D's coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether D elects to pay the total cost and continue coverage under Y's plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee A is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2*, A has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if A satisfies the other conditions of this paragraph (a), the plan must permit A to enroll in Option 2 as a special enrollee. (A may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of A's spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to A.

Example 3. (i) *Facts.* Individual C is covered under a group health plan maintained by Employer X. While covered under X's plan, C was eligible for but did not enroll in a plan maintained by Employer Z, the employer of C's spouse. C terminates employment with X and loses eligibility for coverage under X's plan. C has a special

enrollment right to enroll in Z's plan, but C instead elects COBRA continuation coverage under X's plan. C exhausts COBRA continuation coverage under X's plan and requests special enrollment in Z's plan.

(ii) *Conclusion.* In this Example 3, C has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that C had into Z's plan immediately after the loss of eligibility for coverage under X's plan was an offer of coverage under Z's plan. When C later exhausts COBRA coverage under X's plan, C has a second special enrollment right in Z's plan.

(4) *Applying for special enrollment and effective date of coverage—*(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries—*(1) *In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph

(b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either —

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 2590.701–2) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage—*(i) *Request.* A plan or issuer must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin—*(A) *Marriage.* In the case of marriage, coverage must begin no later than the

first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee A is hired on September 3. A is married to B, and they have no children. On March 15 in the following year a child C is born to A and B. Before that date, A and B have not been enrolled in the plan.

(ii) *Conclusion.* In this Example 1, the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If A satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows A to enroll either with employee-only coverage, with employee-plus-spouse coverage (for A and B), or with family coverage (for A, B, and C). The plan must allow whatever coverage is chosen to begin on March 15, the date of C's birth.

Example 2. (i) *Facts.* Individual D works for Employer X. X maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. D enrolls for self-only coverage in the HMO option. Then, a child, E, is placed for adoption with D. Within 30 days of the placement of E for adoption, D requests enrollment for D and E under the plan's indemnity option.

(ii) *Conclusion.* In this Example 2, D and E satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow D and E to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is

applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 2590.701–3(b).

(3) The rules of this section are illustrated by the following example:

Example. (i) *Facts.* Employer Y maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual B loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. B submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example*, B is a special enrollee. Therefore, even though B's request for enrollment coincides with an open enrollment period, B's coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

§ 2590.701–7 HMO affiliation period as an alternative to a preexisting condition exclusion.

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the following requirements is satisfied—

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of § 2590.702 (prohibiting discrimination based on a health factor).

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date, or in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage but for the affiliation period.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(b) *Examples.* The rules of paragraph (a) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan. Benefits under the plan are provided through an HMO, which imposes a two-month affiliation period. In order to be eligible under the plan, employees must have worked for the

employer for six months. Individual A begins working for the employer on February 1.

(ii) *Conclusion.* In this *Example 1*, Individual A's enrollment date is February 1 (see § 2590.701–3(a)(2)), and both the waiting period and the affiliation period begin on this date and run concurrently. Therefore, the affiliation period ends on March 31, the waiting period ends on July 31, and A is eligible to have coverage begin on August 1.

Example 2. (i) *Facts.* A group health plan has two benefit package options, a fee-for-service option and an HMO option. The HMO imposes a 1-month affiliation period. Individual B is enrolled in the fee-for-service option for more than one month and then decides to switch to the HMO option at open season.

(ii) *Conclusion.* In this *Example 2*, the HMO may not impose the affiliation period with respect to B because any affiliation period would have to begin on B's enrollment date in the plan rather than the date that B enrolled in the HMO option. Therefore, the affiliation period would have expired before B switched to the HMO option.

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides benefits through an HMO. The plan imposes a two-month affiliation period with respect to salaried employees, but it does not impose an affiliation period with respect to hourly employees.

(ii) *Conclusion.* In this *Example 3*, the plan may impose the affiliation period with respect to salaried employees without imposing any affiliation period with respect to hourly employees (unless, under the circumstances, treating salaried and hourly employees differently does not comply with the requirements of § 2590.702).

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. However, an arrangement that is in the nature of a preexisting condition exclusion cannot be an alternative to an affiliation period. Nothing in this part requires a State to receive proposals for or approve alternatives to affiliation periods.

■ 4. Section 2590.701–8 is added and reserved to read as follows:

§ 2590.701–8 Interaction with the Family and Medical Leave Act. [Reserved]

■ 5. Revise the heading of subpart D to read as follows:

Subpart D—General Provisions Related to Subparts B and C

■ 6. Sections 2590.731, 2590.732 and 2590.736 are revised to read as follows:

§ 2590.731 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this

section and except as provided in paragraph (c) of this section, part 7 of subtitle B of Title I of the Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part 7 of subtitle B of Title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules—(1) In general.* Subject to paragraph (c)(2) of this section, the provisions of part 7 of subtitle B of Title I of the Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the “6-month period” described in section 701(a)(1) of the Act and § 2590.701–3(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the “12 months” and “18 months” described in section 701(a)(2) of the Act and § 2590.701–3(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the “63-day period” described in sections 701(c)(2)(A) and (d)(4)(A) of the Act and §§ 2590.701–3(a)(1)(iii) and 2590.701–4 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the “30-day period” described in sections 701(b)(2) and (d)(1) of the Act and § 2590.701–3(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) of the Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 701(f) of the Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B) of the Act.

(d) *Definitions—(1) State law.* For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State (as defined in § 2590.701–2), any political subdivisions of a State, or any agency or instrumentality of either.

§ 2590.732 Special rules relating to group health plans.

(a) *Group health plan—(1) Defined.* A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of this part, other than § 2590.711, do not apply to any group health plan (and group health insurance coverage) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits—(1) In general.* The requirements of this Part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers’ compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits—(i) In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope—(A) Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year

cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed \$500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of \$100 a day.

(ii) *Conclusion.* In this *Example*, even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of \$100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example*, the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* Any plan, fund, or program that would not be (but for this paragraph (d)) an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, is treated (subject to paragraph (d)(2)) as an employee welfare benefit plan that is a group health plan.

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual

performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term participant also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

§ 2590.736 Applicability dates.

Sections 2590.701–1 through 2590.701–8 and 2590.731 through 2590.736 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2004.

Signed at Washington, DC, this 1st day of December, 2004.

Ann L. Combs,

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

Department of Health and Human Services

45 CFR Subtitle A

■ For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR Part 144 and Part 146 as follows:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ A. Part 144 is amended as set forth below:

■ 1. The authority citation for Part 144 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, 30gg-92 as amended by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA (Public Law 104–204, 110 Stat. 2944, as amended by Public Law 107–116, 115 Stat. 2177), NMHPA (Public Law 104–204, 110 Stat. 2935), WHCRA (Public Law 105–277, 112 Stat. 2681–436), and section 103(c)(4) of HIPAA.

■ 2. Section 144.103 is revised to read as follows:

§ 144.103 Definitions.

For purposes of parts 146 (group market), 148 (individual market), and 150 (enforcement) of this subchapter, the following definitions apply unless otherwise provided:

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

Applicable State authority means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of 45 CFR parts 146 and 148 for the State involved with respect to the issuer.

Beneficiary has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which States, “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit” under the plan.

Bona fide association means, with respect to health insurance coverage offered in a State, an association that meets the following conditions:

(1) Has been actively in existence for at least 5 years.

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance.

(3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee).

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(6) Meets any additional requirements that may be imposed under State law.

Church plan means a Church plan within the meaning of section 3(33) of ERISA.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of the

Employee Retirement Income Security Act, section 4980B of the Internal Revenue Code of 1986 (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), or Title XXII of the PHS Act.

(4) *Continuation coverage* means coverage under a COBRA continuation provision or a similar State program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar State program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

(5) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

(6) *Exhaustion of continuation coverage* means that an individual's continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted continuation coverage if—

(i) Coverage ceases due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other continuation coverage available to the individual.

Condition means a *medical condition*.

Creditable coverage has the meaning given the term in 45 CFR 146.113(a).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Eligible individual, for purposes of—

(1) The group market provisions in 45 CFR part 146, subpart E, is defined in 45 CFR 146.150(b); and

(2) The individual market provisions in 45 CFR part 148, is defined in 45 CFR 148.103.

Employee has the meaning given the term under section 3(6) of ERISA, which States, “any individual employed by an employer.”

Employer has the meaning given the term under section 3(5) of ERISA, which States, “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.”

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date*, *first day of coverage*, and *waiting period*) are set forth in 45 CFR 146.111(a)(3)(i) through (iii).

ERISA stands for the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Excepted benefits, consistent for purposes of the—

(1) Group market provisions in 45 CFR part 146 subpart D, is defined in 45 CFR 146.145(c); and

(2) Individual market provisions in 45 CFR part 148, is defined in 45 CFR 148.220.

Federal governmental plan means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Governmental plan means a governmental plan within the meaning of section 3(32) of ERISA.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan or *plan* means a group health plan within the meaning of 45 CFR 146.145(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of *individual market* in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). This term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A Federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Health status-related factor is any factor identified as a health factor in 45 CFR 146.121(a).

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Internal Revenue Code means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a *health insurance issuer*.

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Large group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer, unless otherwise provided under State law.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in 45 CFR 146.111(a)(3)(v) and (vi).

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is

accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Network plan means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

Non-Federal governmental plan means a governmental plan that is not a Federal governmental plan.

Participant has the meaning given the term under section 3(7) of ERISA, which States, “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.”

PHS Act stands for the Public Health Service Act (42 U.S.C. 201 *et seq.*).

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child’s adoption. The child’s placement for adoption with such person ends upon the termination of such legal obligation.

Plan sponsor has the meaning given the term under section 3(16)(B) of ERISA, which states, “(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.”

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the

insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion has the meaning given the term in 45 CFR 146.111(a)(1), with respect to group health plans and group health insurance coverage. With respect to individual market health insurance issuers or other entities providing coverage to federally eligible individuals pursuant to 45 CFR part 148, preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan has the meaning given the term in 45 CFR 146.113(a)(1)(ix).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.

Significant break in coverage has the meaning given the term in 45 CFR 146.113(b)(2)(iii).

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Small group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

Special enrollment means enrollment in a group health plan or group health

insurance coverage under the rights described in 45 CFR 146.117.

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool has the meaning given the term in 45 CFR § 146.113(a)(1)(vii).

Waiting period has the meaning given the term in 45 CFR 146.111(a)(3)(iii).

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ B. Part 146 is amended as set forth below:

■ 1. The authority citation for Part 146 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, 30gg-92 as amended by HIPAA (Public Law 104-191, 110 Stat. 1936), MHPA (Public Law 104-204, 110 Stat. 2944, as amended by Public Law 107-116, 115 Stat. 2177), NMHPA (Public Law 104-204, 110 Stat. 2935), WHCRA (Public Law 105-277, 112 Stat. 2681-436), and section 103(c)(4) of HIPAA.

■ 2. Revise § 146.111 to read as follows:

§ 146.111 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined.*—(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(ii) *Examples.* The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer S. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer T. Issuer T's policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. (Therefore, the exclusion of benefits is required to comply with the limitations on preexisting condition exclusions in this section. For an example illustrating the application of these limitations to a succeeding insurance policy, see *Example 3* of paragraph (a)(3)(iv) of this section.)

Example 2. (i) *Facts.* A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion.* In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 3. (i) *Facts.* A group health plan provides coverage for the treatment of diabetes, generally not subject to any lifetime dollar limit. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a lifetime limit of \$10,000.

(ii) *Conclusion.* In this *Example 3*, the \$10,000 lifetime limit is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 4. (i) *Facts.* A group health plan provides coverage for the treatment of acne, subject to a lifetime limit of \$2,000. The plan counts against this \$2,000 lifetime limit acne treatment benefits provided under prior health coverage.

(ii) *Conclusion.* In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a lifetime limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 5. (i) *Facts.* When an individual's coverage begins under a group health plan, the individual generally becomes eligible for all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion.* In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to

exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. Because a plan is prohibited under paragraph (b)(5) of this section from imposing any preexisting condition exclusion on pregnancy, the plan provision is prohibited. However, if the plan provision included an exception for women who were pregnant before the effective date of coverage under the plan (so that the provision applied only to women who became pregnant on or after the effective date of coverage) the plan provision would not be a preexisting condition exclusion (and would not be prohibited by paragraph (b)(5) of this section).

Example 6. (i) Facts. A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) **Conclusion.** In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) Facts. A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) **Conclusion.** In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) Facts. A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) **Conclusion.** In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) **General rules.** Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied.

(i) **6-month look-back rule.** A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) Facts. Individual *A* is diagnosed with a medical condition 8 months before *A*'s enrollment date in Employer *R*'s group health plan. *A*'s doctor recommends that *A* take a prescription drug for 3 months, and *A* follows the recommendation.

(ii) **Conclusion.** In this *Example 1*, Employer *R*'s plan may impose a preexisting condition exclusion with respect to *A*'s condition because *A* received treatment during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan by taking the prescription medication during that period. However, if *A* did not take the prescription drug during the 6-month period, Employer *R*'s plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) Facts. Individual *B* is treated for a medical condition 7 months before the enrollment date in Employer *S*'s group health plan. As part of such treatment, *B*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *B* does not receive a follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) **Conclusion.** In this *Example 2*, Employer *S*'s plan may not impose a preexisting condition exclusion with respect

to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) Facts. Same facts as *Example 2*, except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) **Conclusion.** In this *Example 3*, the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 146.121, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) Facts. Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer *T*'s plan. Two months later, *C* is hospitalized for asthma.

(ii) **Conclusion.** In this *Example 4*, Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) Facts. Individual *D*, who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) **Conclusion.** In this *Example 5*, the leg fracture is not a condition related to *D*'s diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) **Maximum length of preexisting condition exclusion.** A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the

18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 146.113. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 146.115(a)), or through other means in accordance with the rules of § 146.115(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) Facts. Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y*. *Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example*, *Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 146.121 for other standards in this Subpart A that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

(ii) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the

individual market, the first day of coverage under the policy or contract.

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on—

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) Facts. Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and on October 14, 1998 *E* completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) *Conclusion.* In this *Example 1*, *E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) Facts. A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2*, *B* cannot be subject to any preexisting condition exclusion under Option 2 because

any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before *B* switched to Option 2.

Example 3. (i) Facts. On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S*. On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3*, *E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998.

Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), Issuer *T* may not impose any preexisting condition exclusion with respect to *E*. Moreover, even if *E* had received treatment during the 6-month look-back period, Issuer *T* still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy).

Example 4. (i) Facts. A group health plan limits eligibility for coverage to full-time employees of Employer *Y*. Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y*. *C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4*, *C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) Facts. To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5*, *D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(1) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(2) Through special enrollment. (For rules relating to special enrollment, see § 146.117.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1*, *F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that *F* terminates employment with Employer *W* on July 1, 1999 without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2*, *F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions—*(1) *Newborns—*(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage.

Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 146.113(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *E*, who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion.* In this *Example 1*, because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts.* Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion.* In this *Example 2*, the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a

child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 146.113(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (See § 146.113(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment.* For special enrollment rules relating to new dependents, see § 146.117(b).

(5) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information—*(i) A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion.* In this *Example*, the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance

coverage subject to a preexisting condition exclusion, must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided.

(1) *Manner and timing.* A plan or issuer must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18-months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 146.115(a)) or through other means (as described in § 146.115(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual, the obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example,

which includes sample language that plans and issuers can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) *Facts.* A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual B at Address M or Telephone Number N.

(ii) *Conclusion.* In this *Example*, the plan satisfies the general notice requirement of this paragraph (c), and thus also satisfies this requirement for any issuer providing the coverage.

(d) *Determination of creditable coverage—(1) Determination within reasonable time.* If a group health plan or health insurance issuer offering group health insurance coverage receives creditable coverage information under § 146.115, the plan or issuer is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of

the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care.

(2) *No time limit on presenting evidence of creditable coverage.* A plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(3) *Example.* The rules of this paragraph (d) are illustrated by the following example:

Example. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual H develops an urgent health condition before receiving a certificate of creditable coverage from H's prior group health plan. H attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on H's behalf in accordance with the rules of § 146.115.

(ii) *Conclusion.* In this *Example*, the plan must review the evidence presented by H and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of H's health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan or issuer has made a determination of creditable coverage under paragraph (d) of this section, the plan or issuer must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan or issuer must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan or issuer relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan or issuer.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual, the obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual G presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that G is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies G that, based on the certificate G submitted, G is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of G's medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1*, the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1*, except that the plan determines that G has 430 days of creditable coverage based on G's certificate indicating 430 days of creditable coverage under G's prior plan.

(ii) *Conclusion.* In this *Example 2*, the plan is not required to notify G that G will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that —

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan or issuer, for purposes of approving access to medical services (such as a pre-

surgery authorization), acts in a manner consistent with the initial determination.

■ 3. Revise § 146.113 to read as follows:

§ 146.113 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 146.145(a).

(ii) Health insurance coverage as defined in § 144.103 of this chapter (whether or not the entity offering the coverage is subject to the requirements of this part and 45 CFR part 148 and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(1) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(2) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a *public health plan* means any plan established or maintained by a State, the U.S.

government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in § 146.145).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 146.111(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan or issuer may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage.

Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (See also § 146.143(c)(2)(iii) regarding the applicability to issuers of State insurance laws that require a break of more than 63 days before an individual

has a significant break in coverage for purposes of State insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(v) *Examples.* The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A has creditable coverage under Employer P's plan for 18 months before coverage ceases. A is provided a certificate of creditable coverage on A's last day of coverage. Sixty-four days after the last date of coverage under P's plan, A is hired by Employer Q and enrolls in Q's group health plan. Q's plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1*, A has a break in coverage of 63 days. Because A's break in coverage is a significant break in coverage, Q's plan may disregard A's prior coverage and A may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that A is hired by Q and enrolls in Q's plan on the 63rd day after the last date of coverage under P's plan.

(ii) *Conclusion.* In this *Example 2*, A has a break in coverage of 62 days. Because A's break in coverage is not a significant break in coverage, Q's plan must count A's prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to A.

Example 3. (i) *Facts.* Same facts as *Example 1*, except that Q's plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3*, under State law, the issuer that provides group health insurance coverage to Q's plan must count A's period of creditable coverage prior to the 63-day break. (However, if Q's plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and A's previous health coverage could be disregarded.)

Example 4. —[Reserved]

Example 5. (i) *Facts.* Individual C has creditable coverage under Employer S's plan for 200 days before coverage ceases. C is provided a certificate of creditable coverage on C's last day of coverage. C then does not have any creditable coverage for 51 days before being hired by Employer T. T's plan has a 3-month waiting period. C works for T for 2 months and then terminates

employment. Eleven days after terminating employment with T, C begins working for Employer U. U's plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5*, C does not have a significant break in coverage because, after disregarding the waiting period under T's plan, C had only a 62-day break in coverage (51 days plus 11 days). Accordingly, C has 200 days of creditable coverage, and U's plan may not apply its 6-month preexisting condition exclusion with respect to C.

Example 6. —[Reserved]

Example 7. (i) *Facts.* Individual E has creditable coverage under Employer X's plan. E is provided a certificate of creditable coverage on E's last day of coverage. On the 63rd day without coverage, E submits a substantially complete application for a health insurance policy in the individual market. E's application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.* In this *Example 7*, because E applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7*, except that E's application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8*, even though E did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied E would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods—(A) Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 146.115), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual F has coverage under Group Health Plan Y from January 3, 1997 through March 25, 1997. F then becomes covered by Group Health Plan Z. F's enrollment date in Plan Z is May 1, 1997. Plan Z has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example*, Plan Z may determine, in accordance with the rules

prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that F has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to F on February 8, 1998 (82 days before the 12-month anniversary of F's enrollment (May 1)). For administrative convenience, however, Plan Z may consider that the preexisting condition exclusion will no longer apply to F on the first day of the month (February 1).

(c) *Alternative method—(1) Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan or issuer may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or health insurance coverage. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

- (i) Mental health;
- (ii) Substance abuse treatment;
- (iii) Prescription drugs;
- (iv) Dental care; or
- (v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the

alternative method, including an identification of the categories used.

(5) *Issuer notice.* With respect to health insurance coverage offered by an issuer in the small or large group market, if the insurance coverage uses the alternative method, the issuer states prominently in any disclosure statement concerning the coverage, that the issuer is using the alternative method, and includes in such statements a description of the effect of using the alternative method. This applies separately to each type of coverage offered by the health insurance issuer.

(6) *Disclosure of information on previous benefits.* See § 146.115(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(7) *Counting creditable coverage—(i) In general.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(7) are illustrated by the following example:

Example. (i) Facts. Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V*

ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) *Conclusion.* In this *Example*, Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

■ 4. Revise § 146.115 to read as follows:

§ 146.115 Certification and disclosure of previous coverage.

(a) *Certificate of creditable coverage—*

(1) *Entities required to provide certificate—(i) In General.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, in the case of a group health plan funded through an insurance policy, the issuer satisfies the certification requirement with respect to an individual if the plan actually provides a certificate that includes all the information required under paragraph (a)(3) of this section with respect to the individual.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan satisfies the certification requirements under this paragraph (a) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and a plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers—(A)(1) Responsibility of issuer for coverage period.* An issuer is not required to provide information regarding coverage

provided to an individual by another party.

(2) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) Facts. A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example*, if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(1) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy or contract ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate that reflects the period of coverage under the policy or contract. By providing that information to the plan, the issuer satisfies its obligation to provide an automatic certificate for that period of creditable coverage with respect to the individual under paragraph (a)(2)(ii) of this section. The issuer, however, must still provide a certificate upon request as required under paragraph (a)(2)(iii) of this section. In addition, the issuer is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). Moreover, if the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy or contract ceases, the issuer must still provide an automatic certificate under paragraph (a)(2)(ii) of this section. If an individual's coverage under an issuer's policy or contract ceases on the effective date for changing enrollment options under the plan, the issuer may presume (absent information to the contrary) that the individual's coverage under the plan continues. Therefore, the issuer is required to provide information to the plan in accordance with this paragraph (a)(1)(iv)(B)(1) (and is not required to provide an automatic certificate under paragraph (a)(2)(ii) of this section).

(2) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) Facts. A group health plan provides coverage under an HMO option and an indemnity option through different issuers, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example*, if an employee switches from the indemnity option to the HMO option on January 1, the indemnity issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance—*

(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of ERISA, section 4980(B)(g)(1) of the Internal Revenue Code, or section 2208 of the PHS Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 606 of ERISA, section 4980(B)(f)(6) of the Internal Revenue Code, and section 2206 of the PHS Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate must be provided at the time the individual ceases to be covered under the plan. A plan or issuer satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any

grace period for nonpayment of premiums).

(1) The cessation of temporary continuation coverage (TCC) under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefit Program) is a cessation of coverage upon which an automatic certificate must be provided.

(2) In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time after coverage ceases under the plan.

(3) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease for purposes of this paragraph (a)(2)(ii)(B) on the earliest date that a claim is denied due to the operation of the lifetime limit.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* A certificate must be provided in response to a request made by, or on behalf of, an individual at any time while the individual is covered under a plan and up to 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic

certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. Individual A terminates employment with Employer Q. A is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer Q's group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) *Conclusion.* In this *Example 1*, the automatic certificate may be provided at the same time that A is provided the COBRA notice.

Example 2. (i) Facts. Same facts as *Example 1*, except that the automatic certificate for A is not completed by the time the COBRA notice is furnished to A.

(ii) *Conclusion.* In this *Example 2*, the automatic certificate may be provided after the COBRA notice but must be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) Facts. Employer R maintains an insured group health plan. R has never had 20 employees and thus R's plan is not subject to the COBRA continuation provisions. However, R is in a State that has a State program similar to COBRA. B terminates employment with R and loses coverage under R's plan.

(ii) *Conclusion.* In this *Example 3*, the automatic certificate must be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) Facts. Individual C terminates employment with Employer S and receives both a notice of C's rights under COBRA and an automatic certificate. C elects COBRA continuation coverage under Employer S's group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, S's group health plan determines that C's COBRA continuation coverage has ceased due to a failure to make a timely payment for continuation coverage.

(ii) *Conclusion.* In this *Example 4*, the plan must provide an updated automatic certificate to C within a reasonable time after the end of the grace period.

Example 5. (i) Facts. Individual D is currently covered under the group health plan of Employer T. D requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for T's plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) *Conclusion.* In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate—*

(i) *Written certificate—(A) In General.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (or any

other medium approved by the Secretary).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2)(ii) or (iii) of this section, if—

(1) An individual who is entitled to receive the certificate requests that the certificate be sent to another plan or issuer instead of to the individual;

(2) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (such as by telephone); and

(3) The receiving plan or issuer receives the information from the sending plan or issuer through such means within the time required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(1) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(2) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(H) An educational statement regarding HIPAA, which explains:

(1) The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage);

(2) Special enrollment rights;

(3) The prohibitions against discrimination based on any health factor;

(4) The right to individual health coverage;

(5) The fact that State law may require issuers to provide additional protections to individuals in that State; and

(6) Where to get more information.

(iii) *Periods of coverage under the certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, the certificate provided must include each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 146.145(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 146.113(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures—(i) Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are

provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a written procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address).

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated individual or entity. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated individual or entity.

(5) *Special rules concerning dependent coverage—(i)(A) Reasonable efforts.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5)(i) are illustrated by the following example:

Example. (i) *Facts.* A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or

on which a person ceases to be a dependent of the employee.

(ii) *Conclusion.* In this *Example*, the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent covered by the certificate, the procedures described in paragraph (c)(5) of this section may be used to demonstrate dependent status. In addition, these procedures may be used to demonstrate that a child was covered under any creditable coverage within 30 days after birth, adoption, or placement for adoption. See also § 146.111(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules—(i) Issuers.* Issuers of group and individual health insurance are required to provide certificates of any creditable coverage they provide in the group or individual health insurance market, even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because it is not subject to the group market provisions of this part, part 7 of subtitle B of title I of ERISA, or chapter 100 of subtitle K of the Internal Revenue Code. This would include coverage provided in connection with any of the following:

(A) Creditable coverage described in sections 2701(c)(1)(G), (I) and (J) of the PHS Act (coverage under a State health benefits risk pool, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act).

(B) Coverage subject to section 2721(b)(1)(B) of the PHS Act (requiring certificates by issuers offering health insurance coverage in connection with any group health plan, including a church plan or a governmental plan (including the Federal Employees Health Benefits Program)).

(C) Coverage subject to section 2743 of the PHS Act applicable to health insurance issuers in the individual market. (However, this section does not require a certificate to be provided with respect to short-term limited duration insurance, which is excluded from the definition of "individual health insurance coverage" in 45 CFR 144.103 that is not provided in connection with a group health plan, as described in paragraph (a)(6)(i)(B) of this section.)

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to this part, provide certificates consistent with the rules of this section, see section 2791(a)(3) of the PHS Act

applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, TRICARE, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to non-Federal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHS Act applicable to non-Federal governmental plans that elect to be excluded from the requirements of subparts 1 through 3 of part A of title XXVII of the PHS Act, and section 9805(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan or issuer using the alternative method of counting creditable coverage—(1) In general.* After an individual provides a certificate of creditable coverage to a plan or issuer using the alternative method under § 146.113(c), that plan or issuer (requesting entity) must request that the entity that issued the certificate (prior entity) disclose the information set forth in paragraph (b)(2) of this section. The prior entity is required to disclose this information promptly.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category.

(3) *Charge for providing information.* The prior entity may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information—(1) Purpose.* The rules in this paragraph (c) implement section 2701(c)(4) of the PHS Act, which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 2701(e)(3) of the PHS Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual.

(2) *In general.* If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through

the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time;

(ii) The individual has creditable coverage provided by an entity that is not required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(iv) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(3) *Evidence of creditable coverage—*

(i) *Consideration of evidence—(A)* A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if—

(1) The individual attests to the period of creditable coverage;

(2) The individual also presents relevant corroborating evidence of some creditable coverage during the period; and

(3) The individual cooperates with the plan's or issuer's efforts to verify the individual's coverage.

(B) For purposes of this paragraph (c)(3)(i), cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that corroborate creditable coverage (and waiting or affiliation periods) include explanations of benefits (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant

documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting or affiliation periods) may also be corroborated through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(3) are illustrated by the following example:

Example. (i) *Facts.* Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, *W*, and requests a certificate. However, *F* (and *X*'s plan, on *F*'s behalf and with *F*'s cooperation) is unable to obtain a certificate from *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) *Conclusion.* In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(4) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine the duration of an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(5) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

■ 5. Revise § 146.117 to read as follows:

§ 146.117 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage—*(1) *In General.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as

defined in § 144.103 of this chapter) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment—*(i) *When employee loses coverage.* A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage—*(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(1) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(2) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(3) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan or issuer is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* works for Employer *X*. *A*, *A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under *X*'s group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 1*, because *A* satisfies the conditions for special

enrollment under paragraph (a)(2)(i) of this section, *A*, *A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts.* Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P*, *A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion.* In this *Example 2*, because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts.* Individual *B* works for Employer *X*. *B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 3*, because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts.* Individual *A* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4*, because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment—*(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure

of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 146.121(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage

is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 144.103 of this chapter.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1*, employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2*, *A* has experienced a loss of eligibility for coverage

that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer *Z*, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3*, *C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage—*(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries—*(1) *General.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit

package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either—

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 144.103 of this chapter) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage—(i) Request.* A plan or issuer must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin—(A) Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) Facts. An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee A is hired on September 3. A is married to B, and they have no children. On March 15 in the following year a child C is born to A and B. Before that date, A and B have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1*, the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If A satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows A to enroll either with employee-only coverage, with employee-plus-spouse coverage (for A and B), or with family coverage (for A, B, and C). The plan must allow whatever coverage is chosen to begin on March 15, the date of C's birth.

Example 2. (i) Facts. Individual D works for Employer X. X maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. D enrolls for self-only coverage in

the HMO option. Then, a child, E, is placed for adoption with D. Within 30 days of the placement of E for adoption, D requests enrollment for D and E under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2*, D and E satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow D and E to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees—(1)* If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the

individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 146.111(b).

(3) The rules of this section are illustrated by the following example:

Example. (i) *Facts.* Employer Y maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual B loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. B submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example*, B is a special enrollee. Therefore, even though B's request for enrollment coincides with an open enrollment period, B's coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

■ 6. Revise § 146.119 to read as follows:

§ 146.119 HMO affiliation period as an alternative to a preexisting condition exclusion.

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the following requirements is satisfied—

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of § 146.121 (prohibiting discrimination based on a health factor).

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date, or in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage but for the affiliation period.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(b) *Examples.* The rules of paragraph (a) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan. Benefits under the plan are provided through an HMO, which imposes a two-month affiliation period. In order to be eligible under the plan, employees must have worked for the employer for six months. Individual A begins working for the employer on February 1.

(ii) *Conclusion.* In this *Example 1*, Individual A's enrollment date is February 1 (see § 146.111(a)(2)), and both the waiting period and the affiliation period begin on this date and run concurrently. Therefore, the affiliation period ends on March 31, the waiting period ends on July 31, and A is eligible to have coverage begin on August 1.

Example 2. (i) *Facts.* A group health plan has two benefit package options, a fee-for-service option and an HMO option. The HMO imposes a 1-month affiliation period. Individual B is enrolled in the fee-for-service option for more than one month and then decides to switch to the HMO option at open season.

(ii) *Conclusion.* In this *Example 2*, the HMO may not impose the affiliation period with respect to B because any affiliation period would have to begin on B's enrollment date in the plan rather than the date that B enrolled in the HMO option. Therefore, the affiliation period would have expired before B switched to the HMO option.

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides benefits through an HMO. The plan imposes a two-month affiliation period with respect to salaried employees, but it does not impose an affiliation period with respect to hourly employees.

(ii) *Conclusion.* In this *Example 3*, the plan may impose the affiliation period with respect to salaried employees without imposing any affiliation period with respect to hourly employees (unless, under the circumstances, treating salaried and hourly employees differently does not comply with the requirements of § 146.121).

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. However, an arrangement that is in the nature of a preexisting condition exclusion cannot be an alternative to an affiliation period. Nothing in this part requires a State to receive proposals for

or approve alternatives to affiliation periods.

■ 7. Add and reserve § 146.120 to read as follows:

§ 146.120 Interaction with the Family and Medical Leave Act [Reserved]

■ 8. Revise § 146.125 to read as follows:

§ 146.125 Applicability dates.

Sections 146.111 through 146.119, § 146.143, and § 146.145 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 45 CFR parts 144 and 146, contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2004.

■ 9. Revise § 146.143 to read as follows:

§ 146.143 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part A of title XXVII of the PHS Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part A of title XXVII of the PHS Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules—(1) In general.* Subject to paragraph (c)(2) of this section, the provisions of part A of title XXVII of the PHS Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 2701 of the PHS Act which differs from the standards or requirements specified in section 2701 of the PHS Act.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the “6-month period” described in section 2701(a)(1) of the PHS Act and

§ 146.111(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the “12 months” and “18 months” described in section 2701(a)(2) of the PHS Act and § 146.111(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the “63-day period” described in sections 2701(c)(2)(A) and (d)(4)(A) of the PHS Act and §§ 146.111(a)(1)(iii) and 146.113 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the “30-day period” described in sections 2701(b)(2) and (d)(1) of the PHS Act and § 146.111(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) of the PHS Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 2701(f) of the PHS Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B) of the PHS Act.

(d) *Definitions*—(1) *State law*. For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State*. For purposes of this section the term *State* includes a State (as defined in § 144.103), any political subdivisions of a State, or any agency or instrumentality of either.

■ 10. Revise § 146.145 to read as follows:

§ 146.145 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Definition*. A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans*. [Reserved]

(b) *General exception for certain small group health plans*. The requirements of this part, other than § 146.130, do not apply to any group health plan (and group health insurance coverage) for any plan year if, on the first day of the

plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general*. The requirements of subparts B and C of this part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances*. The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general*. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan*. For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits*. Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits*. Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care*. Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements*. Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed \$500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated*. Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.

(ii) *Conditions*. Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group

health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) Facts. An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of \$100 a day.

(ii) *Conclusion.* In this *Example*, even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of \$100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in

primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) Facts. An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example*, the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* Any plan, fund, or program that would not be (but for this paragraph (d)) an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, is treated (subject to paragraph (d)(2) of this section) as an employee welfare benefit plan that is a group health plan.

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

Dated: November 24, 2004.

Mark B. McClellan,
Administrator, Centers for Medicare & Medicaid Services.

Dated: December 2, 2004.

Tommy G. Thompson,
Secretary, Department of Health and Human Services.

[FR Doc. 04-28112 Filed 12-29-04; 8:45 am]

BILLING CODE 4830-01-P; 4510-29-P; 4120-01-P

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Part 54**

[REG-130370-04]

RIN 1545-BD51

DEPARTMENT OF LABOR**Employee Benefits Security Administration****29 CFR Part 2590**

RIN 1210-AA54

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****45 CFR Part 146**

RIN 0938-AL88

Notice of Proposed Rulemaking for Health Coverage Portability: Tolling Certain Time Periods and Interaction With the Family and Medical Leave Act Under HIPAA Titles I and IV

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Notice of proposed rulemaking and request for comments.

SUMMARY: These proposed rules would clarify certain portability requirements for group health plans and issuers of health insurance coverage offered in connection with a group health plan. These rules propose to implement changes made to the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act enacted as part of the Health Insurance Portability and Accountability Act of 1996.

DATES: Written comments on this notice of proposed rulemaking are invited and must be received by the Departments on or before March 30, 2005.

ADDRESSES: Written comments should be submitted with a signed original and three copies (except for electronic submissions) to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments.

Comments to the IRS can be addressed to: CC:PA:LPD:PR (REG-130370-04), Room 5203, Internal

Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044.

In the alternative, comments may be hand-delivered between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG-130370-04), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224.

Alternatively, comments may be transmitted electronically via the IRS Internet site at: www.irs.gov/regs or via the Federal eRulemaking Portal at www.regulations.gov (IRS-REG-130370-04).

Comments to the Department of Labor can be addressed to: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW., Room C-5331, Washington, DC 20210, *Attention:* Proposed Portability Requirements.

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address. Comments may also be transmitted by e-mail to: e-ohpsca.ebsa@dol.gov.

Comments to HHS can be submitted as described below: In commenting, please refer to file code CMS-2158-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to <http://www.cms.hhs.gov/regulations/ecomments>. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2158-P, P.O. Box 8017, Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members. Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC from 9 a.m. to 4 p.m.

All submissions to the Department of Labor will be open to public inspection and copying in the Public Disclosure Room, Employee Benefits Security Administration, U.S. Department of Labor, Room N-1513, 200 Constitution Avenue, NW., Washington, DC from 8:30 a.m. to 4:30 p.m.

All submissions timely submitted to HHS will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters for the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, Monday through Friday of each week from 8:30 a.m. to 4:00 p.m. To schedule an appointment to view public comments, phone 410-786-7195.

FOR FURTHER INFORMATION CONTACT:

Dave Mlawsky, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, at 1-877-267-2323 ext. 61565; Amy Turner, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; or Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-6080.

SUPPLEMENTARY INFORMATION:**Customer Service Information**

To assist consumers and the regulated community, the Departments have issued questions and answers concerning HIPAA. Individuals interested in obtaining copies of Department of Labor publications concerning changes in health care law may call a toll free number, 1-866-444-EBSA (3272), or access the publications

on-line at www.dol.gov/ebsa, the Department of Labor's Web site. These regulations as well as other information on the new health care laws are also available on the Department of Labor's interactive web pages, *Health Elaws*. In addition, CMS's publication entitled "Protecting Your Health Insurance Coverage" is available by calling 1-800-633-4227 or on the Department of Health and Human Services' Web site (www.cms.hhs.gov/hipaa1), which includes the interactive webpages, HIPAA Online. Copies of the HIPAA regulations, as well as notices and press releases related to HIPAA and other health care laws, are also available at the above-referenced Web sites.

A. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. HIPAA amended the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) to provide for, among other things, improved portability and continuity of health coverage. Interim final regulations implementing the HIPAA provisions were first made available to the public on April 1, 1997 (published in the **Federal Register** on April 8, 1997, 62 FR 16894) (April 1997 interim rules). On December 29, 1997, the Departments published a clarification of the April 1997 interim rules as they relate to excepted benefits. On October 25, 1999, the Departments published a notice in the **Federal Register** (64 FR 57520) soliciting additional comments on the portability requirements based on the experience of plans and issuers operating under the April 1997 interim rules.

After consideration of all the comments received on the portability provisions, the Departments are publishing final regulations elsewhere in this issue of the **Federal Register**. These proposed rules address additional and discrete issues for which the Departments are soliciting further comment before promulgating final regulations.

B. Overview of the Proposed Regulations

1. Rules Relating to Creditable Coverage—26 CFR 54.9801-4, 29 CFR 2590.701-4, 45 CFR 146.113

Tolling of the 63-Day Break-in-Coverage Rule

These proposed rules would modify the 63-day break-in-coverage rules with one significant substantive change. Under the proposed rules, the beginning of the period that is used for determining whether a significant break in coverage has occurred (generally 63 days) is tolled in cases in which a certificate of creditable coverage is not provided on or before the day coverage ceases. In those cases, the significant-break-in-coverage period is tolled until a certificate is provided but not beyond 44 days after the coverage ceases.

The Departments have fashioned this tolling rule (and a similar tolling rule for the 30-day period for requesting special enrollment) in an effort to address the inequity of individuals' losing coverage without being aware that the coverage has ended while minimizing the burdens on subsequent plans and issuers that are not responsible for providing the missing or untimely certificates. Numerous situations have come to the attention of the Departments in which an individual's health coverage is terminated but in which the individual does not learn of the termination of coverage until well after it occurs. The statute generally requires that a certificate of creditable coverage be provided at the time an individual ceases to be covered under a plan. The statute, the April 1997 interim rules, and the final regulations (published elsewhere in this issue of the **Federal Register**) all permit a plan or issuer to provide the certificate at a later date if it is provided at a time consistent with notices required under a COBRA continuation provision. The statute also directs the Secretaries to establish rules to prevent a plan or issuer's failure to provide a certificate timely from adversely affecting the individual's subsequent coverage. If a plan or issuer chooses to provide a certificate later than the date an individual loses coverage, as the regulations permit in certain circumstances, these proposed

rules provide that an individual should not suffer from this rule of convenience for the plan or issuer. However, to prevent the abuse that might result from an open-ended tolling rule, an outside limit of 44 days is placed on this relief. This reflects the fact that, in most cases, plans and issuers are required to provide certificates within 44 days (although some plans and issuers may be required to provide certificates sooner than 44 days after coverage ceases and some entities are not required to provide certificates at all). The Departments have adopted this uniform limit on the tolling rule for purposes of consistency. New examples have been added to illustrate the tolling rule.

2. Evidence of Creditable Coverage—26 CFR 54.9801-5, 29 CFR 2590.701-5, 45 CFR 146.115

Information in Certificate and Model Certificate

These proposed rules would modify the required elements for the educational statement in certificates of creditable coverage to require a disclosure about the Family and Medical Leave Act. Use of the first model certificate below by group health plans and group health insurance issuers, or use of the appropriate model certificate that appears in the preamble to the related final regulations published elsewhere in this issue of the **Federal Register**, will satisfy the requirements of paragraph (a)(3)(ii) in this section of the final regulations. Similarly, for purposes of complying with those final regulations, State Medicaid programs may use the second version below, or may use the appropriate model certificate that appears in the preamble to those final regulations. Thus, until this proposed regulation is published as a final regulation, entities may use either the model certificates published below, or those published elsewhere in this issue of the **Federal Register**. For entities that choose not to use the model certificates below until this proposed regulation is published as a final regulation, we welcome comments as to the applicability date for using them.

BILLING CODE 4830-01-P

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of this certificate: _____
2. Name of group health plan: _____

3. Name of participant: _____
4. Identification number of participant: _____
5. Name of individuals to whom this certificate applies: _____

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____

7. For further information, call: _____
8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10: ☐ _____
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.]

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

➔ Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

➔ Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

➔ Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Special information for people on FMLA leave. If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count towards a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

➔ Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive web pages - Health Elaws, or <http://www.cms.hhs.gov/hipaa1>.

CERTIFICATE OF MEDICAID COVERAGE

1. Date of this certificate: _____
2. Name of state Medicaid program:

3. Name of recipient: _____
4. Identification number of recipient:

5. Name of individuals to whom this certificate applies: _____

6. Name, address, and telephone number of state Medicaid agency responsible for providing this certificate: _____

7. For further information call: _____
8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip line 9. ☐
9. Date coverage began: _____
10. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the recipient and each dependent.]

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this state Medicaid program. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under a group health plan, to help you get special enrollment in a group health plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in a group health plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage in a group health plan ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Special information for people on FMLA leave. If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count towards a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

- Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa> or <http://www.cms.hhs.gov/hipaa1>.

coverage. For individuals whose coverage ceases and a certificate of creditable coverage is not provided on or before the date coverage ceases, this regulation provides for proposed tolling rules similar to those described above for determining a significant break. That is, the special enrollment period terminates at the end of the 30-day period that begins on the first day after the earlier of the date that a certificate of creditable coverage is provided or the date 44 days after coverage ceases.

Modification of Special Enrollment Procedures and When Coverage Begins Under Special Enrollment

The April 1997 interim rules did not establish procedures for processing requests for special enrollment beyond affirming the statutory requirement that requests be made not later than 30 days after the event giving rise to the special enrollment right and providing that the same requirements could be imposed on special enrollees that were imposed on other enrollees (e.g., that the request be made in writing). Some examples in the April 1997 interim rules could be read to suggest that plans and issuers could require individuals requesting special enrollment to file completed applications for health coverage by the end of the special enrollment period.

It has been brought to the Departments' attention that some plans and issuers were imposing application requirements that could not reasonably be completed within the special enrollment period (for example, requiring the social security number of a newborn within 30 days of the birth), effectively denying individuals their right to special enroll their dependents. In this regard, the statute merely requires an employee to request special enrollment, or an individual to seek to enroll, during the special enrollment period. These proposed regulations preserve individuals' access to special enrollment by clarifying that during the special enrollment period individuals are only required to make an oral or written request for special enrollment.

The proposed regulations provide further that after a timely request, the plan or issuer may require the individual to complete all enrollment materials within a reasonable time after the end of the special enrollment period. However, the enrollment procedure may only require information required from individuals who enroll when first eligible and information about the event giving rise to the special enrollment right. While a plan can impose a deadline for submitting the completed enrollment materials, the deadline must be extended for

information that an individual making reasonable efforts cannot obtain within that deadline.

Thus, even where a plan requires social security numbers from individuals who enroll when first eligible, the plan must provide an extended deadline for receiving the social security number in the case of a newborn. In no event could a plan deny special enrollment for newborns because an employee could not provide a social security number for the newborn within the special enrollment period.

As regards the effective date of coverage for special enrollments, the proposed rules generally follow the statute, the April 1997 interim final rules, and the final regulations being published elsewhere in this issue of the **Federal Register**. However clarifications of the effective date of coverage are added to conform to the clarification of the special enrollment procedures. Where the special enrollment right results from a loss of eligibility for coverage or marriage, coverage generally must begin no later than the first day of the first calendar month after the date the plan or issuer receives the request for special enrollment. However, if the plan or issuer requires completion of additional enrollment materials, coverage must begin no later than the first day of the first calendar month after the plan or issuer receives enrollment materials that are substantially complete.

Where the special enrollment right results from a birth, coverage must begin on the date of birth. In the case of adoption or placement for adoption, coverage must begin no later than the date of such adoption or placement for adoption. If a plan or issuer requires completion of additional enrollment materials, the plan or issuer must provide benefits once the plan or issuer receives substantially complete enrollment materials. However, the benefits provided at that time must be retroactive to the date of birth, adoption, or placement for adoption.

The Departments welcome comments on these aspects of the proposed rule.

4. Interaction With the Family and Medical Leave Act—26 CFR 54.9801–7, 29 CFR 701–8, 45 CFR 146.120

The proposed rules address how the HIPAA portability requirements apply in situations where a person is on leave under the Family and Medical Leave Act of 1993 (FMLA). A general principle of FMLA is that an employee returning from leave under FMLA should generally be in the same position the employee was in before taking leave. At

issue is how to reconcile that principle of FMLA with the HIPAA rights and requirements that are triggered by an individual ending coverage under a group health plan. These proposed regulations provide specific rules that clarify how HIPAA and FMLA interact when the coverage of an employee or an employee's dependent ends in connection with an employee taking leave under FMLA.

With respect to the rules concerning a significant break in coverage, if an employee takes FMLA leave and does not continue group health coverage for any part of the leave, the period of FMLA leave without coverage is not taken into account in determining whether a significant break in coverage has occurred for the employee or any dependents. To the extent an individual needs to demonstrate that coverage ceased in connection with FMLA leave (which would toll any significant break with respect to another plan or issuer), these regulations provide that a plan or issuer must take into account all information that it obtains about an employee's FMLA leave. Further, if an individual attests to the period of FMLA leave and the individual cooperates with a plan's or issuer's efforts to verify the individual's FMLA leave, the plan or issuer must treat the individual as having been on FMLA leave for the period attested to for purposes of determining if the individual had a significant break in coverage. Nonetheless, a plan or issuer is not prevented from modifying its initial determination of FMLA leave if it determines that the individual did not have the claimed FMLA leave, provided that the plan or issuer follows procedures for reconsideration similar to those set forth in the final rules governing determinations of creditable coverage.

The question has arisen whether it would be appropriate to waive the general requirement to provide automatic certificates of creditable coverage in the case of an individual who declines coverage when electing FMLA leave if the individual will be reinstated at the end of FMLA leave. At the time an employee elects FMLA leave, the employer (as well as the employee) may not know if the employee will later return from FMLA leave and elect to be reinstated. Requiring plans and issuers to provide certificates when individuals cease health coverage in connection with FMLA leave may result in some certificates being issued when individuals ceasing coverage will not need the certificates as evidence of coverage (because of later

reinstatement). However, automatic issuance likely imposes less burden because the plan or issuer does not need to determine whether a certificate is required. Moreover, automatic issuance eliminates the need for remedial measures if an individual expected to be reinstated in fact is not later reinstated. Thus, these proposed regulations clarify there is no exception to the general rule requiring automatic certificates when coverage ends and provide that if an individual covered under a group health plan takes FMLA leave and ceases coverage under the plan, an automatic certificate must be provided.

With respect to the special enrollment rules, an individual (or a dependent of the individual) who is covered under a group health plan and who takes FMLA leave has a loss of eligibility that results in a special enrollment period if the individual's group health coverage is terminated at any time during FMLA leave and the individual does not return to work for the employer at the end of FMLA leave. This special enrollment period begins when the period of FMLA leave ends. Moreover, the rules that delay the start of the special enrollment period until the receipt of a certificate of creditable coverage continue to operate.

5. Special Rules—Excepted Plans and Excepted Benefits—26 CFR 54.9831-1, 29 CFR 2590.732, 45 CFR 146.145

Determination of Number of Plans

Various provisions in Chapter 100 of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act apply when an individual commences coverage or terminates coverage under a group health plan. For example, a certificate of creditable coverage must be provided when an individual ceases to be covered under a group health plan. Under the April 1997 interim rules, it was not always clear whether an individual changing benefit elections among those offered by an employer or employee organization was merely switching between benefit packages under a single plan or was switching from one plan to another. These proposed regulations add rules to remove this uncertainty.

Under these proposed regulations, all medical care benefits made available by an employer or employee organization (including a board of trustees of a multiemployer trust) are generally considered to constitute one group health plan (the default rule). However, the employer or employee organization can establish more than one group health plan if it is clear from the instruments governing the arrangements

to provide medical care benefits that the benefits are being provided under separate plans and if the arrangements are operated pursuant to the instruments as separate plans. A multiemployer plan and a nonmultiemployer plan are always separate plans. Under an anti-abuse rule, separate plans are aggregated to the extent necessary to prevent the evasion of any legal requirement.

These rules provide plan sponsors great flexibility while minimizing the burden of making decisions about how many plans to maintain. For example, many employers may wish to minimize the number of certificates of creditable coverage required to be furnished to continuing employees. Under the default rule, because all health benefits provided by an employer are considered a single group health plan, there is no need to furnish a certificate of creditable coverage when an employee merely switches coverage among the options made available by the employer. This need would arise only if the employer designated separate benefit packages as separate plans in the plan documents and only if the benefit packages were also operated pursuant to the plan documents as separate plans.

The anti-abuse rule limits the flexibility of these rules to prevent evasions. For example, a plan sponsor might design an arrangement under which the participation of each of many employees in the arrangement would be considered a separate plan. On the face of it, such an arrangement might appear to satisfy the requirement for a plan being exempt from the requirements of Chapter 100 of the Code, Part 7 of ERISA, and Title XXVII of the PHS Act because on the first day of the plan year each plan would have fewer than two participants who are current employees. This would give the impression that the plans would not have to comply with the prohibitions against discriminating based on one or more health factors, with the restrictions on preexisting condition exclusions, nor with any of the other requirements of Chapter 100 of the Code, Part 7 of ERISA, and Title XXVII of the PHS Act. The anti-abuse rule would require the aggregation of plans under such an arrangement to the extent necessary to make the plans subject to the requirements of Chapter 100 of the Code, Part 7 of ERISA, and Title XXVII of the PHS Act. The anti-abuse rule would apply in similar fashion to prevent the evasion of any other law that applies to group health plans or to the parties administering them or providing benefits under them.

Counting the Average Number of Employees

These proposed regulations add rules for counting the average number of employees employed by an employer during a year.¹ Various rules in Chapter 100 of the Code, Part 7 of ERISA, and Title XXVII of the PHS Act require the determination of such an average number, including the Mental Health Parity Act provisions, the guaranteed access provisions under the PHS Act for small employers, and the exemption from the excise tax under the Code for certain small employers.

Under these proposed regulations, the average number of employees employed by an employer is determined by using a full-time equivalents method. Each full-time employee employed for the entire previous calendar year counts as one employee. Full-time employees employed less than the entire previous calendar year and part-time employees are counted by totaling their employment hours in the previous calendar year (but not to exceed 40 hours for any week) and dividing that number by the annual full-time hours under the employer's general employment practices (but not exceeding 40 hours per week). Any resulting fraction is disregarded. For example, if these calculations produce a result of 50.9, the average number of employees is considered to be 50. If an employer existed for less than the entire previous calendar year (including not being in existence at all), then the determination of the average number of employees is made by estimating the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. For a multiemployer plan, the number of employees employed by the employer with the most employees is attributed to each employer with at least one employee participating in the plan.

C. Economic Impact and Paperwork Burden

Summary—Department of Labor and Department of Health and Human Services

HIPAA's group market portability provisions, which limit the scope and application of preexisting condition exclusions and establish special enrollment rights, provide a minimum standard of protection designed to increase access to health coverage. The

¹ The rules for determining the average number of employees employed by an employer during a year are not used for counting the number employed by the employer on a given day, such as the first day of a plan year.

Departments crafted these proposed regulations to secure these protections under certain special circumstances, consistent with the intent of Congress, and to do so in a manner that is economically efficient. The Departments are unable to quantify the regulations' economic benefits and costs, but believe that their benefits will justify their costs.

HIPAA's primary economic effects ensue directly from its statutory provisions. HIPAA's statutory group market portability provisions extend coverage to certain individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits, sometimes including improvements in health and relief from so-called "job lock." The costs of HIPAA's portability provisions generally include the cost of extending coverage, as well as certain attendant administrative costs. The Departments believe that the benefits of HIPAA are concentrated in a relatively small population, while the costs are distributed broadly across group plan enrollees. The economic effects of HIPAA's statutory portability provisions are discussed in detail in the preamble to the final regulation under the "Effects of the Statute" of the "Basis for Assessment of Economic Impact" section, published elsewhere in this issue of the **Federal Register**.

By clarifying and securing HIPAA's statutory portability protections, these proposed regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a small increase at the margin in the economic effects of HIPAA's statutory portability provisions.

These proposed regulations are intended to secure and implement HIPAA's group market portability and special enrollment provisions under certain special circumstances. The regulations will secure HIPAA's portability rights for individuals who are not timely notified that their coverage has ended and for individuals whose coverage ends in connection with the taking of leave that is guaranteed under FMLA. The regulations also will clarify and thereby secure individuals' special enrollment rights under HIPAA, and clarify the methodologies to be used by employers to determine the number of plans offered and the average number of individuals employed during a given year.

Additional economic benefits derive from the regulations' clarifications of HIPAA requirements. The regulations will reduce uncertainty and costly disputes between employees, employers

and issuers, and promote confidence among employees in health benefits' value, thereby promoting labor market efficiency and fostering the establishment and continuation by employers of group health plans.

Benefits under these regulations will be concentrated among a small number of affected individuals while costs will be spread thinly across group plan enrollees.

Affected individuals will generally include those who would have lost access to coverage for needed medical care after being denied HIPAA portability and/or special enrollment rights due to time spent without coverage prior to receiving a certificate or while on FMLA-guaranteed leave. The benefits of these regulations for any particular affected individual may be significant. As noted above and under "Effects of the Statute" in the "Basis for Assessment of Economic Impact" section of the preamble to the final regulation, published elsewhere in this issue of the **Federal Register**, access to coverage for needed medical care is important to individuals' health and productivity. However, the number of affected individuals, and therefore the aggregate cost of extended access to coverage under these regulations, is expected to be small, for several reasons. First, these regulations extend HIPAA rights only in instances where individuals are not timely notified that their coverage has ended or their coverage ends in connection with the taking of FMLA-guaranteed leave. Second, the period over which this regulation extends rights will often be short, insofar as certificates are often provided promptly after coverage ends and many family leave periods are far shorter than the guaranteed 12 weeks. Third, it is generally in individuals' interest to minimize periods of uninsurance. Individuals are likely to exercise their portability and special enrollment rights as soon as possible after coverage ends, which will often be before any extension of such rights under these regulations becomes effective. Fourth, only a portion of individuals who enroll in health plans in circumstances where these regulations alone guarantee their special enrollment or portability rights would otherwise have been denied such rights. Fifth, only a small minority of individuals who avoid a significant break in coverage as a direct result of these regulations would otherwise have lost coverage for needed medical care. (The affected minority would be those who suffer from preexisting conditions, join health plans that exclude coverage for such conditions, and require

treatment of such conditions during the exclusion periods.)

Affected individuals may also include some who would have been denied special enrollment rights if plans or issuers failed to recognize their requests for special enrollment or imposed unreasonable deadlines or requirements for completion of enrollment materials.

As noted above, the Departments expect that these regulations will increase at the margin the economic effects of HIPAA's statutory portability provisions. For the reasons stated immediately above, the Departments believe that these increases will be small on aggregate, adding only a small increment to the costs attributable to HIPAA's statutory portability provisions, which themselves amount to a small fraction of one percent of health plan expenditures. Additionally, as with the cost of HIPAA's statutory portability provisions, the majority of these costs will be borne by group plan enrollees. The Departments expect these regulations to have little or no perceptible negative impact on employers' propensity to offer health benefit plans or on the generosity of those plans. In sum, the Departments expect that the benefits of these regulations, which can be very large for a particular affected individual, will justify their costs. The basis for the Departments' conclusions is detailed below.

The Departments solicit comments on their conclusions and their basis for them, and empirical data or other information that would support a fuller or more accurate analysis.

Executive Order 12866—Department of Labor and Department of Health and Human Services

Under Executive Order 12866 (58 FR 551735, Oct. 4, 1993), the Departments must determine whether a regulatory action is "significant" and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a "significant regulatory action" as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as "economically significant"); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary

impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, the Departments have determined that this action raises novel policy issues arising out of legal mandates. Therefore, this notice is "significant" and subject to OMB review under Section 3(f)(4) of the Executive Order. Consistent with the Executive Order, the Departments have assessed the costs and benefits of this regulatory action. The Departments' assessment, and the analysis underlying that assessment, is detailed below. The Departments performed a comprehensive, unified analysis to estimate the costs and benefits attributable to the regulations for purposes of compliance with Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act.

Statement of Need for Proposed Action

These proposed regulations clarify and interpret the HIPAA portability provisions under Section 701 of the Employee Retirement Income Security Act of 1974 (ERISA), Section 2701 of the Public Health Service Act, and Section 9801 of the Internal Revenue Code of 1986. The regulations are needed to secure and implement HIPAA's portability rights for individuals who are not timely notified that their coverage has ended and for individuals whose coverage ends in connection with the taking of leave that is guaranteed under FMLA, and to clarify and secure individuals' special enrollment rights under HIPAA.

Economic Effects

As noted above, HIPAA's primary economic effects ensue directly from its statutory provisions. HIPAA's statutory group market portability provisions extend coverage to certain individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. The economic effects of HIPAA's statutory portability provisions is summarized above and discussed in detail under the "Basis for Assessment of Economic Impact" section of the preamble to the final regulation, published elsewhere in this issue of the **Federal Register**.

Also as noted above, by clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a

small increase at the margin in the economic effects of HIPAA's statutory portability provisions. The benefits of these regulations will be concentrated among a small number of affected individuals, while their costs will be spread thinly across plans and issuers. The regulations also will reduce uncertainty about health benefits' scope and value, thereby promoting employee health benefit coverage and labor market efficiency. The Departments believe that the regulations' benefits will justify their cost. The Departments' assessment of the expected economic effects of the regulation are summarized above and discussed in detail below.

Regulatory Flexibility Act—The Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA), imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Section 603 of the RFA stipulates that an agency, unless it certifies that a proposed rule will not have a significant economic impact on a substantial number of small entities, must present an initial regulatory flexibility analysis at the time of publication of the notice of proposed rulemaking that describes the impact of the rule on small entities and seeks public comment on such impact. Small entities include small businesses, organizations, and governmental jurisdictions.

For purposes of analysis under the RFA, the Departments consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for simplified annual reporting and disclosure if the statutory requirements of part 1 of Title I of ERISA would otherwise be inappropriate for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department of Labor has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare

plans covering fewer than 100 participants and which satisfy certain other requirements.

Further, while some small plans are maintained by large employers, most are maintained by small employers. Both small and large plans may enlist small third party service providers to perform administrative functions, but it is generally understood that third party service providers transfer their costs to their plan clients in the form of fees. Thus, the Departments believe that assessing the impact of this rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (5 U.S.C. 631 *et seq.*). The Department of Labor solicited comments on the use of this standard for evaluating the effects of the proposal on small entities. No comments were received with respect to the standard. Therefore, a summary of the initial regulatory flexibility analysis based on the 100 participant size standard is presented below.

The economic effects of HIPAA's statutory provisions on small plans are discussed extensively under the "Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services" section of the preamble to the final regulation, published elsewhere in this issue of the **Federal Register**.

By clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that these benefits are fully realized. The result is likely to be a small increase in the economic effects of HIPAA's statutory provisions. The Departments were unable to estimate the amount of this increase. However, the direct financial value of coverage extensions pursuant to HIPAA's statutory portability provisions are estimated to be approximately \$180 million for small plans, or a small fraction of one percent of total small plan expenditures.²

The regulations also will reduce uncertainty about health benefits' scope and value, thereby promoting employee

² Computer runs using Medical Expenditure Survey Household Component (MEPS-HC) and the Robert Wood Johnson Employer Health Benefits Survey determined that the share of covered private-sector job leavers at small firms average 35 percent of all covered private sector job leavers. From this, we inferred that the financial burden borne by small plans is approximately 35 percent of the total expenditures by private-sector group health plans which was estimated to be \$515 million.

health benefit coverage, including coverage under small plans, and labor market efficiency.

The benefits of these regulations will be concentrated among a small number of affected small group plan enrollees, while their costs will be spread thinly across small group plans enrollees. The benefits of these regulations for any particular affected individual, which may include improved health and productivity, may be significant. However, as previously noted, the number of affected individuals, and therefore the aggregate cost of these regulations, is expected to be small. The Departments believe that the benefits to affected individuals of the application of these regulations to small plans justify the cost to small plans of such application. The basis for the Departments' conclusions is detailed below.

The Departments generally expect the impact of the regulations on any particular small plan to be small. A very large majority of small plans are fully insured, so the cost will fall nominally on issuers rather than from plans. Issuers are expected to pass this cost back to plans and enrollees, but will spread much of it across a large number of plans, thereby minimizing the impact on any particular plan. However, it is possible that small plans that self-insure, or fully insured small plans whose premiums are tied closely to their particular claims experience, might bear all or most of the cost associated with extensions of coverage attributable directly to these regulations. The Departments have no way to quantify the incidence or magnitude of such costs, and solicit comments on such incidence and magnitude, and on whether these regulations would have a significant impact on a substantial number of small plans.

Special Analyses—Department of the Treasury

Notwithstanding the determinations of the Departments of Labor and of Health and Human Services, for purposes of the Department of the Treasury this notice of proposed rulemaking is not a significant regulatory action. Because this notice of proposed rulemaking does not impose a collection of information on small entities and is not subject to section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5), the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply pursuant to 5 U.S.C. 603(a), which exempts from the Regulatory Flexibility Act's requirements certain rules involving the internal revenue laws. Pursuant to section 7805(f) of the

Internal Revenue Code, this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Paperwork Reduction Act

Department of Labor

These proposed regulations include three separate collections of information as that term is defined in the Paperwork Reduction Act of 1995 (PRA 95), 44 U.S.C. 3502(3): the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by the Office of Management and Budget (OMB) through October 31, 2006 in accordance with PRA 95 under control numbers 1210–0101, 1210–0102, and 1210–0103.

Department of the Treasury

These proposed regulations include a collection of information as that term is defined in PRA 95: the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by OMB under control number 1545–1537.

Department of Health and Human Services

These proposed regulations include three separate collections of information as that term is defined in PRA 95: the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by OMB through June 30, 2006 in accordance with PRA 95 under control number 0938–0702.

Small Business Regulatory Enforcement Fairness Act

The rule being issued here is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and, if finalized, will be transmitted to Congress and the Comptroller General for review. The rule is not a “major rule” as that term is defined in 5 U.S.C. 804, because it is not likely to result in (1) an annual effect on the economy of \$100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or federal, state, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-

based enterprises in domestic or export markets.

Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by state, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million. These proposed regulations have no such mandated consequential effect on state, local, or tribal governments, or on the private sector.

Federalism Statement Under Executive Order 13132—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by federal agencies in formulating and implementing policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these proposed regulations have federalism implications because they may have substantial direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. However, in the Departments' view, the federalism implications of these proposed regulations are substantially mitigated because, with respect to health insurance issuers, the vast majority of States have enacted laws which meet or exceed the federal HIPAA portability standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, HIPAA added a new section to ERISA (as well as to the PHS Act) narrowly preempting State requirements for issuers of group health insurance coverage. Specifically, with respect to

seven provisions of the HIPAA portability rules, states may impose stricter obligations on health insurance issuers.³ Moreover, with respect to other requirements for health insurance issuers, states may continue to apply state law requirements except to the extent that such requirements prevent the application of HIPAA's portability, access, and renewability provisions.

In enacting these new preemption provisions, Congress intended to preempt State insurance requirements only to the extent that they prevent the application of the basic protections set forth in HIPAA. HIPAA's conference report states that the conferees intended the narrowest preemption of State laws with regard to health insurance issuers. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 205 (1996). State insurance laws that are more stringent than the federal requirements are unlikely to "prevent the application of" the HIPAA portability provisions, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance insurers that are more restrictive than the federal law.

Guidance conveying this interpretation of HIPAA's preemption provisions was published in the **Federal Register** on April 8, 1997, 62 FR 16904. These proposed regulations clarify and implement the statute's minimum standards and do not significantly reduce the discretion given the States by the statute. Moreover, the Departments understand that the vast majority of States have requirements that meet or exceed the minimum requirements of the HIPAA portability provisions.

HIPAA provides that the States may enforce the provisions of HIPAA as they pertain to issuers, but that the Secretary of Health and Human Services must enforce any provisions that a State fails to substantially enforce. To date, CMS enforces the HIPAA portability provisions in only one State in accordance with that State's specific request to do so. When exercising its responsibility to enforce the provisions of HIPAA, CMS works cooperatively

with the State for the purpose of addressing the State's concerns and avoiding conflicts with the exercise of State authority. CMS has developed procedures to implement its enforcement responsibilities, and to afford the States the maximum opportunity to enforce HIPAA's requirements in the first instance. CMS's procedures address the handling of reports that States may not be enforcing HIPAA's requirements, and the mechanism for allocating responsibility between the States and CMS. In compliance with Executive Order 13132's requirement that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of the States, the Department of Labor and CMS have engaged in numerous efforts to consult and work cooperatively with affected State and local officials.

For example, the Departments sought and received input from State insurance regulators and the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit corporation established by the insurance commissioners of the 50 States, the District of Columbia, and the four U.S. territories. In most States the Insurance Commissioner is appointed by the Governor, in approximately 14 States, the insurance commissioner is an elected official. Among other activities, it provides a forum for the development of uniform policy when uniformity is appropriate. Its members meet, discuss and offer solutions to mutual problems. The NAIC sponsors quarterly meetings to provide a forum for the exchange of ideas and in-depth consideration of insurance issues by regulators, industry representatives and consumers. CMS and the Department of Labor staff have consistently attended these quarterly meetings to listen to the concerns of the State Insurance Departments regarding HIPAA portability issues. In addition to the general discussions, committee meetings, and task groups, the NAIC sponsors the standing CMS/DOL meeting on HIPAA issues for members during the quarterly conferences. This meeting provides CMS and the Department of Labor with the opportunity to provide updates on regulations, bulletins, enforcement actions, and outreach efforts regarding HIPAA.

The Departments received written comments on the interim regulation from the NAIC and from ten States. In general, these comments raised technical issues that the Departments considered in conjunction with similar issues raised by other commenters. In a letter sent before issuance of the interim

regulation, the NAIC expressed concerns that the Departments interpret the new preemption provisions of HIPAA narrowly so as to give the States flexibility to impose more stringent requirements. As discussed above, the Departments address this concern in the preamble to the interim regulation.

In addition, the Departments specifically consulted with the NAIC in developing these proposed regulations. Through the NAIC, the Departments sought and received the input of State insurance departments regarding certain insurance industry definitions, enrollment procedures and standard coverage terms. This input is generally reflected in the discussion of comments received and changes made in Section B—Overview of the Regulations of the preamble to the final regulations published elsewhere in this issue of the **Federal Register**.

The Departments have also cooperated with the States in several ongoing outreach initiatives, through which information on HIPAA is shared among federal regulators, State regulators and the regulated community. In particular, the Department of Labor has established a Health Benefits Education Campaign with more than 70 partners, including CMS, NAIC and many business and consumer groups. CMS has sponsored conferences with the States—the Consumer Outreach and Advocacy conferences in March 1999 and June 2000, and the Implementation and Enforcement of HIPAA National State-Federal Conferences in August 1999, 2000, 2001, 2002, and 2003. Furthermore, both the Department of Labor and CMS Web sites offer links to important State web sites and other resources, facilitating coordination between the State and federal regulators and the regulated community.

Throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and the Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in Section 8(a) of Executive Order 13132, and by the signatures affixed to proposed final regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached proposed regulation,

³ States may shorten the six-month look-back period prior to the enrollment date; shorten the 12-month and 18-month maximum preexisting condition exclusion periods; increase the 63-day significant break in coverage period; increase the 30-day period for newborns, adopted children, and children placed for adoption to enroll in the plan with no preexisting condition exclusion; further limit the circumstances in which a preexisting condition exclusion may be applied (beyond the federal exceptions for certain newborns, adopted children, children placed for adoption, pregnancy, and genetic information in the absence of a diagnosis; require additional special enrollment periods; and reduce the HMO affiliation period to less than 2 months (3 months for late enrollees).

Notice of Proposed Rulemaking for Health Coverage Portability: Tolling and Certain Time Periods and Interaction with the Family and Medical Leave Act under HIPAA Titles I & IV (RIN 1210-AA54 and RIN 0938-AL88), in a meaningful and timely manner.

Basis for Assessment of Economic Impact—Department of Labor and Department of Health and Human Services

As noted above, the primary economic effects of HIPAA's portability provisions ensue directly from the statute. The Department's assessment of the economic effects of HIPAA's statutory portability provisions and the basis for the assessment is presented in detail under the "Basis for Assessment of Economic Impact" section of the preamble to the final regulation, published elsewhere in this issue of the **Federal Register**. By clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a small increase in the economic effects of HIPAA's statutory portability provisions.

Additional economic benefits derive from the regulations' clarifications of HIPAA's portability requirements. The regulations provide clarity through both their provisions and their examples of how those provisions apply in various circumstances. By clarifying employees' rights and plan sponsors' obligations under HIPAA's portability provisions, the regulations will reduce uncertainty and costly disputes over these rights and obligations. They will promote employers' and employees' common understanding of the value of group health plan benefits and confidence in the security and predictability of those benefits, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans by employers.⁴

⁴ The voluntary nature of the employment-based health benefit system in conjunction with the open and dynamic character of labor markets make explicit as well as implicit negotiations on compensation a key determinant of the prevalence of employee benefits coverage. It is likely that 80% to 100% of the cost of employee benefits is borne by workers through reduced wages (see for example Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in David Bradford, ed., *Tax Policy and Economy*, pp.111-143 (Cambridge, MA: MIT Press, 1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, Vol. 84 no. 3 (June 1994), pp. 622-641; Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review*, Vol. 79, No. 2 (May 1989), pp.177-183; Louise Sheiner, "Health Care Costs, Wages, and Aging," Federal Reserve Board of Governors

These proposed regulations are intended to secure and implement HIPAA's group market portability provisions under certain special circumstances. The regulations will secure HIPAA's portability rights for individuals who are not timely notified that their coverage has ended and for individuals whose coverage ends in connection with the taking of leave that is guaranteed under FMLA. The regulations also will clarify and thereby secure individuals' special enrollment rights under HIPAA, and clarify the methodologies to be used by employers to determine the number of plans offered and the average number of individuals employed during a given year.

The benefits of these regulations will be concentrated among a small number of affected individuals.

Affected individuals will generally include those who would have lost access to coverage for needed medical care after forfeiting HIPAA portability and/or special enrollment rights due to time spent without coverage prior to receiving a certificate or while on FMLA-guaranteed leave. Affected individuals may also include some who would have been denied special enrollment rights if plans or issuers failed to recognize their requests for special enrollment or imposed unreasonable deadlines or requirements for completion of enrollment materials. The benefits of these regulations for any particular affected individual may be large. As noted above, access to coverage for needed medical care is important to individuals' health and productivity. However, the number of affected individuals, and therefore the aggregate cost of extended access to coverage under these regulations, is expected to be small, for several reasons.

working paper, April 1999; Mark Pauly and Brad Herring, *Pooling Health Insurance Risks* (Washington, DC: AEI Press, 1999), Gail A. Jensen and Michael A. Morrissey, "Endogenous Fringe Benefits, Compensating Wage Differentials and Older Workers," *International Journal of Health Care Finance and Economics* Vol 1, No. 3-4 (forthcoming), and Edward Montgomery, Kathryn Shaw, and Mary Ellen Benedict, "Pensions and Wages: An Hedonic Price Theory Approach," *International Economic Review*, Vol. 33 No. 1 (Feb. 1992.), pp.111-128.) The prevalence of benefits is therefore largely dependent on the efficacy of this exchange. If workers perceive that there is the potential for inappropriate denial of benefits they will discount their value to adjust for this risk. This discount drives a wedge in the compensation negotiation, limiting its efficiency. With workers unwilling to bear the full cost of the benefit, fewer benefits will be provided. The extent to which workers perceive a federal regulation supported by enforcement authority to improve the security and quality of benefits, the differential between the employers costs and workers willingness to accept wage offsets is minimized.

First, these regulations extend HIPAA rights only in instances where individuals do not receive certificates immediately when coverage ends or their coverage ends in connection with the taking of FMLA-guaranteed leave. The Departments know of no source of data on the timeliness with which certificates are typically provided. The final regulations that accompany these proposed regulations permit plans to provide certificates with COBRA notices, up to 44 days after coverage ends. Plans, however, often do have the option of providing certificates immediately when coverage ends or even in advance, for example as part of exit packages given to terminating employees or in mailings to covered dependents in advance of birthdays that will end their eligibility for coverage. With respect to FMLA-protected leave, data provided in a 1996 report to Congress suggests that the number of employees who lose coverage in connection with FMLA-protected leave is likely to be small. The report notes that over an 18-month period just 1.2 percent of surveyed employees took what they reported to be FMLA leave. A similar survey of employers found that 3.6 percent of employees took such leave. Nearly all of those taking leave continued their health coverage. (This is not surprising, given that FMLA requires covered employers to extend eligibility for health insurance to employees on FMLA-protected leave on the same terms that applied when the employees were not on leave.) Just 9 percent of leave-takers reported that they lost some kind of employee benefit, with one-third of these reporting that they lost health insurance.⁵ Putting these numbers together and converting to an annual basis, in a given year between 0.02 percent and 0.07 percent of employees, or well under one in one thousand, might lose health coverage in connection with FMLA-protected leave. Many of these will ultimately exercise their right to be reinstated in the job from which they took leave and to exercise their FMLA-guaranteed right to resume their previous health coverage. Therefore, the number of employees who will lose coverage and then, later and at the conclusion of FMLA-protected leave, enjoy extended portability rights under HIPAA as a result of these regulations, is likely to be very small.

Second, the period over which this regulation extends rights will often be

⁵ Commission on Family and Medical Leave and U.S. Department of Labor, *A Workable Balance: Report to Congress on Family and Medical Leave Policies*, transmitted April 30, 1996.

short, insofar as certificates are often provided promptly after coverage ends and many family leave periods are far shorter than the guaranteed 12 weeks. As noted above, plans generally are required to provide certificates no later than 44 days after coverage ends and may provide them sooner. According to the aforementioned report to Congress on FMLA-protected leave, 41 percent of employees taking FMLA-protected leave did so for less than 8 days. Fifty-eight percent were on leave for less than 15 days, and two-thirds were on leave for less than 29 days. (FMLA protects leaves of up to 12 weeks, or 84 days.)

Third, it is generally in individuals' interest to minimize periods of uninsurance. Individuals are likely to exercise their portability and special enrollment rights as soon as possible after coverage ends, which will often be before any extension of such rights under these regulations becomes effective. Over one 36-month period prior to HIPAA, 71 percent of Americans had continuous coverage—that is, incurred not even a single, one-month break in coverage. Just 4 percent were uninsured for the entire period. About one-half of observed spells without insurance lasted less than 5 months. As noted above, few employees taking FMLA-protected leave had a lapse in health coverage.

Fourth, only a portion of individuals who enroll in health plans in circumstances where these regulations alone guarantee their special enrollment or portability rights would otherwise have been denied such rights. HIPAA special enrollment and portability requirements, both as specified under the final regulations and as modified under these proposed regulations, are minimum standards. Plans are free to provide additional enrollment opportunities.

Fifth, only a small minority of individuals who avoid a significant break in coverage solely as a direct result of these regulations would otherwise have lost coverage for needed medical care. The affected minority would be those who suffer from preexisting conditions, join health plans that exclude coverage for such conditions, and require treatment of such conditions during the exclusion periods. GAO estimated that HIPAA could ensure continued coverage for up to 25 million Americans.⁶ More recent estimates suggest that the number of individual policy holders and their

dependents which could be helped by HIPAA's portability provisions are more in the 14 million range.⁷ As noted above, however, the number of workers and dependents actually gaining coverage for a preexisting condition due to credit for prior coverage following a job change under HIPAA will be smaller than this. Both GAO's and our estimates of people who could benefit include all job changers with prior coverage and their dependents, irrespective of whether their new employer offers a plan, whether their new plan imposed a preexisting condition exclusion period, and whether they actually suffer from a preexisting condition.

Accounting for these narrower criteria, CBO estimated that, at any point in time, about 100,000 individuals would have a preexisting condition exclusion reduced for prior creditable coverage. An additional 45,000 would gain added coverage in the individual market. The CBO estimate demonstrates that the number of individuals actually gaining coverage for needed medical services will be a small fraction of all those whose right to such coverage HIPAA's portability provisions guarantee. Accordingly, the Departments expect that the number gaining coverage for needed services as a direct result of these regulations will be a small fraction of the already small number whose right to such coverage these regulations would establish.

The Departments attempted to estimate the number of individuals who might avoid a break in coverage because of the provision of these proposed regulations that tolls the break until the individual receives a certification but not more than 44 days. The Departments examined coverage patterns evident in the Survey of Income and Program Participation (SIPP), a longitudinal household survey that tracks transitions in coverage. SIPP interviews households once every four months. The Departments estimate that, in a given year, about 7 million individuals have breaks in coverage lasting 4 months or less. The survey data suffer from so-called "seam bias"—respondents tend to report that status as unchanged over 4-month increments. Of the 7 million

reporting breaks of 4 months or less, 6.5 million report breaks of exactly 4 months. This finding is consistent with the more general finding that breaks of 4 months or less are far more common than longer breaks. It seems likely that the 7 million breaks of 4 months or less actually included proportionate or disproportionately large shares of breaks of 1 or 2 months. Assuming the breaks are actually distributed evenly by length between 1 day and 4 months, then about one-half of the breaks, or 3.5 million breaks, would have lasted less than 63 days and therefore would not have constituted breaks for purposes of HIPAA's portability protections even without reference to the provision of this proposed regulation that tolls the break until the individual receives a certification but not more than 44 days. Approximately three-fourths of the remaining breaks or about 2.6 million breaks, would have lasted between 1 and 44 additional days and thereby potentially have been tolled until the individuals received their certifications but not more than 44 days. Thus 2.6 million provides a reasonable upper bound on the number of individuals who might avoid a break in coverage in a given year because of this tolling provision. It is not known what fraction of these would subsequently join group health plans that include preexisting condition exclusions while suffering from and requiring additional care for preexisting conditions. Comparing GAO's (20 million or more) and our (14 million) estimates of the number of individuals who could potentially benefit from HIPAA's portability protections (individuals with prior creditable coverage who join new health plans in a given year) with the CBO estimate of the number who might actually have added group coverage for needed care (100,000) produces a ratio of about 1 percent. If this proportion holds for group health plan enrollees who avoid breaks because of this tolling provision, then an upper bound of about 26,000 individuals annually might gain coverage for needed care under the proposed regulation's provision treating coverage under such programs as creditable coverage.

The Departments considered whether certain individuals whose HIPAA portability rights these proposed regulations would extend may be disproportionately likely to be in (or have dependents who are in) poor health. Specifically, individuals taking FMLA-protected leave, especially those who elect not to be reinstated in their prior jobs following FMLA-protected leave, may be so likely. On the other

⁷ We calculated these estimates using internal runs off the MEPS-HC. These runs gave the number of total job changers, total job changers that had employer-sponsored insurance (ESI), and whether this coverage had been for less than 12 months or not. Estimates for dependents were based off the ratio of policy-holders to total dependents from the March 2003 Current Population Survey (March CPS). It should be noted, however, that the EBSA estimate of 14 million does not include estimate of individuals no longer eligible for COBRA continuation coverage or individuals facing job lock, while the GAO numbers do.

⁶ U.S. General Accounting Office, Report HEHS-95-257, "Health Insurance Portability: Reform Could Ensure Continued Coverage for up to 25 Million Americans," September 1995.

hand, individuals in such circumstances are also particularly unlikely to allow their health insurance from their prior job to lapse while they are on leave. Accordingly, most such individuals' special enrollment periods and countable breaks in coverage (if any) would probably have begun at the conclusion of the FMLA-protected leave even in absence of these proposed regulations. The Departments are therefore uncertain whether individuals who would exercise HIPAA portability rights extended solely by these regulations would be more costly to insure than others exercising HIPAA portability rights, and solicit comments on this question.

Affected individuals may also include some who would have been denied special enrollment rights if plans or issuers failed to recognize their requests for special enrollment or imposed unreasonable deadlines or requirements for completion of enrollment materials.

As noted above, the Departments expect that these regulations will result in a small increase in the economic effects of HIPAA's statutory provisions. For the reasons stated immediately above, the Departments believe that this increase will be small on aggregate, adding only a small increment to the cost attributable to HIPAA's statutory portability provisions, which themselves amount to a small fraction of one percent of health plan expenditures. Thus the increase will be negligible relative to typical year-to-year increases in premiums charged by issuers, which can amount to several percentage points or more. Therefore, the Departments expect these regulations to have little or no perceptible negative impact on employers' propensity to offer health benefit plans or on the generosity of those plans. In sum, the Departments expect that the benefits of these regulations, which can be very large for a particular affected individual, will justify their costs.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping

requirements, and State regulation of health insurance.

Proposed Amendments to the Regulations

Internal Revenue Service

26 CFR Chapter I

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by:

a. Revising the entries for §§ 54.9801–4 and 54.9801–6.

b. Adding an entry in numerical order for § 54.9801–7.

The addition and revisions read as follows:

Authority: 26 U.S.C. 7805. * * *
Section 54.9801–4 also issued under 26 U.S.C. 9801(e)(3) and 9833.* * *

Section 54.9801–6 also issued under 26 U.S.C. 9801(e)(3) and 9833.

Section 54.9801–7 also issued under 26 U.S.C. 9833.* * *

§ 54.9801–1 [Amended]

Par. 2. Section 54.9801–1 is amended in paragraph (a)(1) by removing the language “54.9801–6” and adding “54.9801–7” in its place.

§ 54.9801–2 [Amended]

Par. 3. Section 54.9801–2 is amended in the first sentence by removing the language “54.9801–6” and adding “54.9801–7” in its place.

Par. 4. Section 54.9801–4 is amended by:

a. Revising paragraphs (b)(2)(iii) and (b)(2)(iv).

b. Adding *Examples 4 and 6* in paragraph (b)(2)(v).

The revisions and additions read as follows:

§ 54.9801–4 Rules relating to creditable coverage.

* * * * *

(b) *Standard method.* * * *

(2) *Counting creditable coverage.*

* * *

(iii) *Significant break in coverage defined.* A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage, except that periods described in paragraph (b)(2)(iv) of this section are not taken into account in determining a significant break in coverage. (See section 731(b)(2)(iii) of ERISA and section 2723(b)(2)(iii) of the PHS Act, which exclude from preemption state insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of state law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred. Moreover, in the case of an individual whose coverage ceases, if a certificate of creditable coverage with respect to that cessation is not provided on or before the date coverage ceases, then the period that begins on the first date that an individual has no creditable coverage and that continues through the earlier of the following two dates is not taken into account in determining whether a significant break in coverage has occurred:

(A) The date that a certificate of creditable coverage with respect to that cessation is provided; or

(B) The date 44 days after coverage ceases.

(v) *Examples.* * * *

Example 4. (i) *Facts.* Individual *B* terminates coverage under a group health plan, and a certificate of creditable coverage is provided 10 days later. *B* begins employment with Employer *R* and begins enrollment in *R*'s plan 60 days after the certificate is provided.

(ii) *Conclusion.* In this *Example 4*, even though *B* had no coverage for 69 days, the 10 days before the certificate of creditable coverage is provided are not taken into account in determining a significant break in coverage. Therefore, *B*'s break in coverage is only 59 days and is not a significant break in coverage. Accordingly, *B*'s prior coverage must be counted by *R*'s plan.

* * * * *

Example 6. (i) *Facts.* Employer *V* sponsors a group health plan. Under the terms of the plan, the only benefits provided are those provided under an insurance policy. Individual *D* works for *V* and has creditable coverage under *V*'s plan. *V* fails to pay the issuer the premiums for the coverage period beginning March 1. Consistent with applicable state law, the issuer terminates the policy so that the last day of coverage is April 30. *V* goes out of business on July 31. On August 15 *D* begins employment with Employer *W* and enrolls in *W*'s group health plan. *W*'s plan imposes a 12-month preexisting condition exclusion on all enrollees. *D* never receives a certificate of creditable coverage for coverage under *V*'s plan.

(ii) *Conclusion.* In this *Example 6*, the period from May 1 (the first day without coverage) through June 13 (the date 44 days after coverage under *V*'s plan ceases) is not

taken into account in determining a 63-day break in coverage. This is because, in cases in which a certificate of creditable coverage is not provided by the date coverage is lost, the break begins on the date the certificate is provided, or the date 44 days after coverage ceases, if earlier. Therefore, even though *D*'s actual period without coverage was 106 days (May 1 through August 14), because the period from May 1 through June 13 is not taken into account, *D*'s break in coverage is only 62 days (June 14 through August 14). Thus, *D* has not experienced a significant break in coverage, and *D*'s prior coverage must be counted by *W*'s plan.

* * * * *

Par. 5. Section 54.9801–5 is amended by:

- a. Redesignating paragraphs (a)(3)(ii)(H)(5) and (6) as paragraphs (a)(3)(ii)(H)(6) and (7), respectively.
- b. Adding a new paragraph (a)(3)(ii)(H)(5).

The addition reads as follows:

§ 54.9801–5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage.*

* * *

(3) *Form and content of certificate.*

* * *

(ii) *Required information.* * * *

(H) * * *

(5) The interaction with the Family and Medical Leave Act;

* * * * *

Par. 6. Section 54.9801–6 is amended by:

- a. Revising paragraph (a)(1).
- b. Revising paragraph (a)(4).
- c. Revising paragraph (b)(1).
- d. Revising paragraph (b)(3).
- e. Revising *Example 2* in paragraph (b)(4).
- f. Adding *Examples 3, 4, and 5* in paragraph (b)(4).

The additions and revisions read as follows:

§ 54.9801–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage—(1) In general.* A group health plan is required to permit current employees and dependents (as defined in § 54.9801–2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. Paragraph (a)(4) of this section describes procedures that a plan may require an employee to follow and describes the date by which coverage must begin. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (See section 701(f)(1) of ERISA and section 2701(f)(1) of the PHS Act, under which this

obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

* * * * *

(4) *Applying for special enrollment and effective date of coverage—(i) Request.* A plan must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (loss of eligibility for coverage, termination of employer contributions, or exhaustion of COBRA continuation coverage) to request enrollment (for the employee or the employee's dependent). For this purpose, any written or oral request made to any of the following constitutes a request for enrollment —

- (A) The plan administrator;
- (B) An issuer offering health insurance coverage under the plan;
- (C) A person who customarily handles claims for the plan (such as a third party administrator); or
- (D) Any other designated representative.

(ii) *Tolling of period for requesting special enrollment.* (A) In the case of an individual whose coverage ceases, if a certificate of creditable coverage with respect to that cessation is not provided on or before the date coverage ceases, then the period for requesting special enrollment described in paragraph (a)(4)(i) of this section does not end until 30 days after the earlier of —

- (1) The date that a certificate of creditable coverage with respect to that cessation is provided; or
- (2) The date 44 days after coverage ceases.

(B) For purposes of this paragraph (a)(4), if an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease on the earliest date that a claim is denied due to the operation of the lifetime limit. (Nonetheless, the date of a loss of eligibility for coverage is determined under the rules of paragraph (a)(3) of this section, which provides that a loss of eligibility occurs when a claim that would meet or exceed a lifetime limit on all benefits is incurred, not when it is denied.)

(C) The rules of this paragraph (a)(4)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V* provides group health coverage through a policy provided by Issuer *M*. Individual *D* works for *V* and is covered under *V*'s plan. *V* fails to pay *M* the premiums for the coverage period beginning March 1. Consistent with applicable state law, *M* terminates the policy so that the last day of coverage is April 30. On May 15, *M* provides *D* with a certificate of creditable coverage with respect to *D*'s cessation of coverage under *V*'s plan.

(ii) *Conclusion.* In this *Example 1*, the period to request special enrollment ends no earlier than June 14 (which is 30 days after May 15, the day a certificate of creditable coverage is provided with respect to *D*).

Example 2. (i) *Facts.* Same facts as *Example 1*, except *D* is never provided with a certificate of creditable coverage.

(ii) *Conclusion.* In this *Example 2*, the period to request special enrollment ends no earlier than July 13. (July 13 is 74 days after April 30, the date coverage ceases. That is, July 13 is 30 days after the end of the 44-day maximum tolling period.)

Example 3. (i) *Facts.* Individual *E* works for Employer *W* and has coverage under *W*'s plan. *W*'s plan has a lifetime limit of \$1 million on all benefits under the plan. On September 13, *E* incurs a claim that would exceed the plan's lifetime limit. On September 28, *W* denies the claim due to the operation of the lifetime limit and a certificate of creditable coverage is provided on October 3. *E* is otherwise eligible to enroll in the group health plan of the employer of *E*'s spouse.

(ii) *Conclusion.* In this *Example 3*, the period to request special enrollment in the plan of the employer of *E*'s spouse ends no earlier than November 2 (30 days after the date the certificate is provided) and begins not later than September 13, the date *E* lost eligibility for coverage.

(iii) *Reasonable procedures for special enrollment.* After an individual has requested enrollment under paragraph (a)(4)(i) of this section, a plan may require the individual to complete enrollment materials within a reasonable time after the end of the 30-day period described in paragraph (a)(4)(i) of this section. In these enrollment materials, the plan may require the individual only to provide information required of individuals who enroll when first eligible and information about the event giving rise to the special enrollment right. A plan may establish a deadline for receiving completed enrollment materials, but such a deadline must be extended for information that an individual making reasonable efforts does not obtain by that deadline.

(iv) *Date coverage must begin.* If the plan requires completion of additional enrollment materials in accordance with paragraph (a)(4)(iii) of this section, coverage must begin no later than the first day of the first calendar month beginning after the date the plan receives enrollment materials that are substantially complete. If the plan does not require completion of additional enrollment materials, coverage must begin no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment under paragraph (a)(4)(i) of this section.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *In general.* A group health plan that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes procedures that a plan may require an individual to follow and describes the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (See 29 CFR 2590.701–6(b) and 45 CFR 146.117(b), under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

* * * * *

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent). For this purpose, any written or oral request made to any of the following constitutes a request for enrollment—

- (A) The plan administrator;
- (B) An issuer offering health insurance coverage under the plan;
- (C) A person who customarily handles claims for the plan (such as a third party administrator); or
- (D) Any other designated representative.

(ii) *Reasonable procedures for special enrollment.* After an individual has requested enrollment under paragraph (b)(3)(i) of this section, a plan may require the individual to complete enrollment materials within a reasonable time after the end of the 30-day period described in paragraph (b)(3)(i) of this section. In these enrollment materials, the plan may require the individual only to provide information required of individuals who enroll when first eligible and information about the event giving rise to the special enrollment right. A plan may establish a deadline for receiving completed enrollment materials, but such a deadline must be extended for information that an individual making reasonable efforts does not obtain by that deadline.

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, if the plan requires completion of additional enrollment materials in accordance with paragraph (b)(3)(ii) of this section, coverage must begin no later than the first day of the first calendar month beginning after the date the plan receives enrollment materials that are substantially complete. If the plan does not require such additional enrollment materials, coverage must begin no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment under paragraph (b)(3)(i) of this section.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available). If the plan requires completion of additional enrollment materials in accordance with paragraph (b)(3)(ii) of this section, the plan must provide benefits (including benefits retroactively to the date of birth, adoption, or placement for adoption) once the plan receives enrollment materials that are substantially complete.

(4) *Examples.* * * *

Example 2. (i) *Facts.* Individual *D* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E*, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option and submits completed enrollment materials timely.

(ii) *Conclusion.* In this *Example 2*, *D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

Example 3. (i) *Facts.* Same facts as *Example 1*. On March 17 (two days after the birth of *C*), *A* telephones the plan administrator and requests special enrollment of *A*, *B*, and *C*. The plan administrator sends *A* an enrollment form. Under the terms of the plan, enrollment is denied unless a completed form is submitted within 30 days of the event giving rise to the special enrollment right (in this case, *C*'s birth).

(ii) *Conclusion.* In this *Example 3*, the plan does not satisfy paragraph (b)(3) of this

section. The plan may require only that *A* request enrollment during the 30-day period after *C*'s birth. *A* did so by telephoning the plan administrator. The plan may not condition special enrollment on filing additional enrollment materials during the 30-day period. To comply with paragraph (b)(3) of this section, the plan must allow *A* a reasonable time after the end of the 30-day period to submit any additional enrollment materials. Once these enrollment materials are received, the plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 4. (i) *Facts.* Same facts as *Example 3*, except that *A* telephones the plan administrator to request enrollment on April 13 (29 days after *C*'s birth). Also, under the terms of the plan, the deadline for submitting the enrollment form is 14 days after the end of the 30-day period for requesting special enrollment (thus, in this case, April 28, which is 44 days after *C*'s birth). The form requests the same information for *A*, *B*, and *C* (name, date of birth, and place of birth) as well as a copy of *C*'s birth certificate. *A* fills out the enrollment form and delivers it to the plan administrator on April 28. At that time *A* does not have a birth certificate for *C* but applies on that day for one from the appropriate government office. *A* receives the birth certificate on June 1 and furnishes a copy of the birth certificate to the plan administrator shortly thereafter.

(ii) *Conclusion.* In this *Example 4*, *A*, *B*, and *C* are entitled to special enrollment under the plan even though *A* did not satisfy the plan's requirement of providing a copy of *C*'s birth certificate by the plan's 14-day deadline. While a plan may establish such a deadline, the plan must extend the deadline for information that an individual making reasonable efforts does not obtain by that deadline. *A* delivered the enrollment form to the plan administrator by the deadline and made reasonable efforts to furnish the birth certificate that the plan requires.

Example 5. (i) *Facts.* Same facts as *Example 4*. On May 3 (after *A* has delivered the enrollment form to the plan administrator but before *A* provides the birth certificate) *A* submits claims for all medical expenses incurred for *B* and *C* from the date of *C*'s birth.

(ii) *Conclusion.* In this *Example 5*, the plan must pay all of the claims submitted by *A*. Because the plan requires that individuals seeking special enrollment complete additional enrollment materials, it is required to provide benefits once it receives enrollment materials that are substantially complete. The form that *A* submitted on April 28 was substantially complete. Because *C*'s birth is the event giving rise to the special enrollment right, on April 28 *A*, *B*, and *C* become entitled to benefits under the plan retroactive to the date of *C*'s birth.

* * * * *

Par. 7. A new § 54.9801–7 is added to read as follows:

§ 54.9801–7 Interaction with the Family and Medical Leave Act.

(a) *In general.* The rules of §§ 54.9801–1 through 54.9801–6 apply

with respect to an individual on leave under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601) (FMLA), and apply with respect to a dependent of such an individual, except to the extent otherwise provided in this section.

(b) *Tolling of significant break in coverage during FMLA leave.* In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and does not continue group health coverage for any period of FMLA leave, that period is not taken into account in determining whether a significant break in coverage has occurred under § 54.9801–4(b)(2)(iii).

(c) *Application of certification provisions—(1) Timing of issuance of certificate—(i)* In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and the individual's group health coverage is terminated during FMLA leave, an automatic certificate must be provided in accordance with the timing rules set forth in § 54.9801–5(a)(2)(ii)(B) (which generally require plans to provide certificates within a reasonable time after coverage ceases).

(ii) In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and continues group health coverage for the period of FMLA leave, but then ceases coverage under the plan at the end of FMLA leave, an automatic certificate must be provided in accordance with the timing rules set forth in § 54.9801–5(a)(2)(ii)(A) (which generally require plans to provide a certificate no later than the time a notice is required to be furnished for a qualifying event under a COBRA continuation provision).

(2) *Demonstrating FMLA leave.* (i) A plan is required to take into account all information about FMLA leave that it obtains or that is presented on behalf of an individual. A plan must treat the individual as having been on FMLA leave for a period if—

(A) The individual attests to the period of FMLA leave; and

(B) The individual cooperates with the plan's efforts to verify the individual's FMLA leave.

(ii) Nothing in this section prevents a plan from modifying its initial determination of FMLA leave if it determines that the individual did not have the claimed FMLA leave, provided that the plan follows procedures for reconsideration similar to those set forth in § 54.9801–3(f).

(d) *Relationship to loss of eligibility special enrollment rules.* In the case of an individual (or a dependent of the individual) who is covered under a group health plan and who takes FMLA leave, a loss of eligibility for coverage under § 54.9801–6(a) occurs when the period of FMLA leave ends if—

(1) The individual's group health coverage is terminated at any time during FMLA leave; and

(2) The individual does not return to work for the employer at the end of FMLA leave.

Par. 8. Section 54.9831–1 is amended by:

a. Adding paragraph (a)(2).

b. Revising paragraph (b).

c. Revising paragraph (c)(1).

d. By adding paragraph (e).

The additions and revisions read as follows:

§ 54.9831–1 Special rules relating to group health plans.

(a) *Group health plan.* * * *

(2) *Determination of number of plans.*

The number of group health plans that an employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans) maintains is determined under the rules of this paragraph (a)(2).

(i) Except as provided in paragraph (a)(2)(ii) or (iii) of this section, health care benefits provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan, unless—

(A) It is clear from the instruments governing the arrangement or arrangements to provide health care benefits that the benefits are being provided under separate plans; and

(B) The arrangement or arrangements are operated pursuant to such instruments as separate plans.

(ii) A multiemployer plan and a nonmultiemployer plan are always separate plans.

(iii) If a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion.

(b) *General exception for certain small group health plans.* The requirements of §§ 54.9801–1 through 54.9801–7, 54.9802–1, 54.9802–2, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits—(1) In general.* The requirements of §§ 54.9801–1

through 54.9801–7, 54.9802–1, 54.9802–2, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

* * * * *

(e) *Determining the average number of employees—(1) Scope.* Whenever the application of a rule in this part depends upon the average number of employees employed by an employer, the determination of that number is made in accordance with the rules of this paragraph (e).

(2) *Full-time equivalents.* The average number of employees is determined by calculating the average number of full-time equivalents on business days during the preceding calendar year.

(3) *Methodology.* For the preceding calendar year, the average number of full-time equivalents is determined by—

(i) Determining the number of employees who were employed full-time by the employer throughout the entire calendar year;

(ii) Totalling all employment hours (not to exceed 40 hours per week) for each part-time employee, and for each full-time employee who was not employed full-time with the employer throughout the entire calendar year;

(iii) Dividing the total determined under paragraph (e)(3)(ii) of this section by a figure that represents the annual full-time hours under the employer's general employment practices, such as 2,080 hours (although for this purpose not more than 40 hours per week may be used); and

(iv) Adding the quotient determined under paragraph (e)(3)(iii) of this section to the number determined under paragraph (e)(3)(i).

(4) *Rounding.* For purposes of paragraph (e)(3)(iv) of this section, all fractions are disregarded. For instance, a figure of 50.9 is deemed to be 50.

(5) *Employers not in existence in the preceding year.* In the case of an employer that was in existence for less than the entire preceding calendar year (including an employer that was not in existence at all), a determination of the average number of employees that the employer employs is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(6) *Scope of the term "employer."* For purposes of this paragraph (e), employer includes any predecessor of the employer. In addition, all persons treated as a single employer under section 414(b), (c), (m), or (o) are treated as one employer.

(7) *Special rule for multiemployer plans.* (i) With respect to the application of a rule in this part to a multiemployer plan (as defined in section 3(37) of ERISA), each employer with at least one employee participating in the plan is considered to employ the same average number of employees. That number is the highest number that results by applying the rules of paragraphs (e)(1) through (6) of this section separately to each of the employers.

(ii) The rules of this paragraph (e)(7) are illustrated by the following example:

Example. (i) Facts. Twenty five employers have at least one employee who participates in Multiemployer Plan M. Among these 25 employers, Employer K has 51 employees, determined under the rules of paragraphs (e)(1) through (6) of this section. Each of the other 24 employers has fewer than 50 employees.

(ii) *Conclusion.* With respect to the application of a rule in this part to M, each of the 25 employers is considered to employ 51 employees.

Mark E. Matthews,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons set forth above, 29 CFR Part 2590 is proposed to be amended as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

1. The authority citation for Part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c, sec. 101(g), Pub. L. 104–191, 101 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); Secretary of Labor's Order 1–2003, 68 FR 5374 (Feb. 3, 2003).

2. Section 2590.701–4 is amended by revising paragraphs (b)(2)(iii) and (b)(2)(iv) and adding *Examples 4* and *6* in paragraph (b)(2)(v) as follows:

§ 2590.701–4 Rules relating to creditable coverage.

(b) *Standard method.* * * *

(2) *Counting creditable coverage.*

(iii) *Significant break in coverage defined.* A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage, except that periods described in paragraph (b)(2)(iv) of this section are not taken into account in determining a

significant break in coverage. (See also § 2590.731(c)(2)(iii) regarding the applicability to issuers of state insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of state insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred. Moreover, in the case of an individual whose coverage ceases, if a certificate of creditable coverage with respect to that cessation is not provided on or before the date coverage ceases, then the period that begins on the first date that an individual has no creditable coverage and that continues through the earlier of the following two dates is not taken into account in determining whether a significant break in coverage has occurred:

(A) The date that a certificate of creditable coverage with respect to that cessation is provided; or

(B) The date 44 days after coverage ceases.

(v) *Examples.* The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 4. (i) Facts. Individual B terminates coverage under a group health plan, and a certificate of creditable coverage is provided 10 days later. B begins employment with Employer R and begins enrollment in R's plan 60 days after the certificate is provided.

(ii) *Conclusion.* In this *Example 4*, even though B had no coverage for 69 days, the 10 days before the certificate of creditable coverage is provided are not taken into account in determining a significant break in coverage. Therefore, B's break in coverage is only 59 days and is not a significant break in coverage. Accordingly, B's prior coverage must be counted by R's plan.

Example 6. (i) Facts. Employer V sponsors a group health plan. Under the terms of the plan, the only benefits provided are those provided under an insurance policy. Individual D works for V and has creditable coverage under V's plan. V fails to pay the issuer the premiums for the coverage period beginning March 1. Consistent with applicable state law, the issuer terminates the policy so that the last day of coverage is April 30. V goes out of business on July 31. On

August 15 D begins employment with Employer W and enrolls in W's group health plan. W's plan imposes a 12-month preexisting condition exclusion on all enrollees. D never receives a certificate of creditable coverage for coverage under V's plan.

(ii) *Conclusion.* In this *Example 6*, the period from May 1 (the first day without coverage) through June 13 (the date 44 days after coverage under V's plan ceases) is not taken into account in determining a 63-day break in coverage. This is because, in cases in which a certificate of creditable coverage is not provided by the date coverage is lost, the break begins on the date the certificate is provided, or the date 44 days after coverage ceases, if earlier. Therefore, even though D's actual period without coverage was 106 days (May 1 through August 14), because the period from May 1 through June 13 is not taken into account, D's break in coverage is only 62 days (June 14 through August 14). Thus, D has not experienced a significant break in coverage, and D's prior coverage must be counted by W's plan.

3. Section 2590.701–5 is amended by redesignating paragraphs (a)(3)(ii)(H)(5) and (6) as paragraphs (a)(3)(ii)(H)(6) and (7), respectively, and by adding a new paragraph (a)(3)(ii)(H)(5) as follows:

§ 2590.701–5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage.*

* * *

(3) *Form and content of certificate.*

* * *

(ii) *Required information.* * * *

(H) * * *

(5) The interaction with the Family and Medical Leave Act;

* * * * *

4. Section 2590.701–6 is amended by revising paragraphs (a)(1), (a)(4), (b)(1), (b)(3), and *Example 2* in paragraph (b)(4), and adding *Examples 3*, *4*, and *5* in paragraph (b)(4) as follows:

§ 2590.701–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage—(1) In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 2590.701–2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. Paragraph (a)(4) of this section describes procedures that a plan or issuer may require an employee to follow and describes the date by which coverage must begin. The special enrollment rights under this paragraph (a) apply without regard to the dates on

which an individual would otherwise be able to enroll under the plan.

* * * * *

(4) Applying for special enrollment and effective date of coverage—(i)

Request. A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (loss of eligibility for coverage, termination of employer contributions, or exhaustion of COBRA continuation coverage) to request enrollment (for the employee or the employee's dependent). For this purpose, any written or oral request made to any of the following constitutes a request for enrollment—

(A) The plan administrator;

(B) The issuer;

(C) A person who customarily handles claims for the plan (such as a third party administrator); or

(D) Any other designated representative.

(ii) Tolling of period for requesting special enrollment. (A) In the case of an individual whose coverage ceases, if a certificate of creditable coverage with respect to that cessation is not provided on or before the date coverage ceases, then the period for requesting special enrollment described in paragraph (a)(4)(i) of this section does not end until 30 days after the earlier of—

(1) The date that a certificate of creditable coverage with respect to that cessation is provided; or

(2) The date 44 days after coverage ceases.

(B) For purposes of this paragraph (a)(4), if an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease on the earliest date that a claim is denied due to the operation of the lifetime limit. (Nonetheless, the date of a loss of eligibility for coverage is determined under the rules of paragraph (a)(3) of this section, which provides that a loss of eligibility occurs when a claim that would meet or exceed a lifetime limit on all benefits is incurred, not when it is denied.)

(C) The rules of this paragraph (a)(4)(ii) are illustrated by the following examples:

Example 1. (i) Facts. Employer V provides group health coverage through a policy provided by Issuer M. Individual D works for V and is covered under V's plan. V fails to pay M the premiums for the coverage period beginning March 1. Consistent with applicable state law, M terminates the policy so that the last day of coverage is April 30. On May 15, M provides D with a certificate of creditable coverage with respect to D's cessation of coverage under V's plan.

(ii) Conclusion. In this *Example 1*, the period to request special enrollment ends no

earlier than June 14 (which is 30 days after May 15, the day a certificate of creditable coverage is provided with respect to D).

Example 2. (i) Facts. Same facts as *Example 1*, except D is never provided with a certificate of creditable coverage.

(ii) Conclusion. In this *Example 2*, the period to request special enrollment ends no earlier than July 13. (July 13 is 74 days after April 30, the date coverage ceases. That is, July 13 is 30 days after the end of the 44-day maximum tolling period.)

Example 3. (i) Facts. Individual E works for Employer W and has coverage under W's plan. W's plan has a lifetime limit of \$1 million on all benefits under the plan. On September 13, E incurs a claim that would exceed the plan's lifetime limit. On September 28, W denies the claim due to the operation of the lifetime limit and a certificate of creditable coverage is provided on October 3. E is otherwise eligible to enroll in the group health plan of the employer of E's spouse.

(ii) Conclusion. In this *Example 3*, the period to request special enrollment in the plan of the employer of E's spouse ends no earlier than November 2 (30 days after the date the certificate is provided) and begins not later than September 13, the date E lost eligibility for coverage.

(iii) Reasonable procedures for special enrollment. After an individual has requested enrollment under paragraph (a)(4)(i) of this section, a plan or issuer may require the individual to complete enrollment materials within a reasonable time after the end of the 30-day period described in paragraph (a)(4)(i) of this section. In these enrollment materials, the plan or issuer may require the individual only to provide information required of individuals who enroll when first eligible and information about the event giving rise to the special enrollment right. A plan or issuer may establish a deadline for receiving completed enrollment materials, but such a deadline must be extended for information that an individual making reasonable efforts does not obtain by that deadline.

(iv) Date coverage must begin. If the plan or issuer requires completion of additional enrollment materials in accordance with paragraph (a)(4)(iii) of this section, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives enrollment materials that are substantially complete. If the plan or issuer does not require completion of additional enrollment materials, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment under paragraph (a)(4)(i) of this section.

(b) Special enrollment with respect to certain dependent beneficiaries—(1) In

general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes procedures that a plan or issuer may require an individual to follow and describes the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

* * * * *

(3) Applying for special enrollment and effective date of coverage—(i)

Request. A plan or issuer must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent). For this purpose, any written or oral request made to any of the following constitutes a request for enrollment—

(A) The plan administrator;

(B) The issuer;

(C) A person who customarily handles claims for the plan (such as a third party administrator); or

(D) Any other designated representative.

(ii) Reasonable procedures for special enrollment. After an individual has requested enrollment under paragraph (b)(3)(i) of this section, a plan or issuer may require the individual to complete enrollment materials within a reasonable time after the end of the 30-day period described in paragraph (b)(3)(i) of this section. In these enrollment materials, the plan or issuer may require the individual only to provide information required of individuals who enroll when first eligible and information about the event giving rise to the special enrollment right. A plan or issuer may establish a deadline for receiving completed enrollment materials, but such a deadline must be extended for information that an individual making reasonable efforts does not obtain by that deadline.

(iii) Date coverage must begin—(A) Marriage. In the case of marriage, if the plan or issuer requires completion of

additional enrollment materials in accordance with paragraph (b)(3)(ii) of this section, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives enrollment materials that are substantially complete. If the plan or issuer does not require such additional enrollment materials, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment under paragraph (b)(3)(i) of this section.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available). If the plan or issuer requires completion of additional enrollment materials in accordance with paragraph (b)(3)(ii) of this section, the plan or issuer must provide benefits (including benefits retroactively to the date of birth, adoption, or placement for adoption) once the plan or issuer receives enrollment materials that are substantially complete.

(4) *Examples.* * * *

Example 2. (i) Facts. Individual *D* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E*, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option and submits completed enrollment materials timely.

(ii) *Conclusion.* In this *Example 2*, *D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

Example 3. (i) Facts. Same facts as *Example 1*. On March 17 (two days after the birth of *C*), *A* telephones the plan administrator and requests special enrollment of *A*, *B*, and *C*. The plan administrator sends *A* an enrollment form. Under the terms of the plan, enrollment is denied unless a completed form is submitted within 30 days of the event giving rise to the special enrollment right (in this case, *C*'s birth).

(ii) *Conclusion.* In this *Example 3*, the plan does not satisfy paragraph (b)(3) of this section. The plan may require only that *A* request enrollment during the 30-day period after *C*'s birth. *A* did so by telephoning the

plan administrator. The plan may not condition special enrollment on filing additional enrollment materials during the 30-day period. To comply with paragraph (b)(3) of this section, the plan must allow *A* a reasonable time after the end of the 30-day period to submit any additional enrollment materials. Once these enrollment materials are received, the plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 4. (i) Facts. Same facts as *Example 3*, except that *A* telephones the plan administrator to request enrollment on April 13 (29 days after *C*'s birth). Also, under the terms of the plan, the deadline for submitting the enrollment form is 14 days after the end of the 30-day period for requesting special enrollment (thus, in this case, April 28, which is 44 days after *C*'s birth). The form requests the same information for *A*, *B*, and *C* (name, date of birth, and place of birth) as well as a copy of *C*'s birth certificate. *A* fills out the enrollment form and delivers it to the plan administrator on April 28. At that time *A* does not have a birth certificate for *C* but applies on that day for one from the appropriate government office. *A* receives the birth certificate on June 1 and furnishes a copy of the birth certificate to the plan administrator shortly thereafter.

(ii) *Conclusion.* In this *Example 4*, *A*, *B*, and *C* are entitled to special enrollment under the plan even though *A* did not satisfy the plan's requirement of providing a copy of *C*'s birth certificate by the plan's 14-day deadline. While a plan may establish such a deadline, the plan must extend the deadline for information that an individual making reasonable efforts does not obtain by that deadline. *A* delivered the enrollment form to the plan administrator by the deadline and made reasonable efforts to furnish the birth certificate that the plan requires.

Example 5. (i) Facts. Same facts as *Example 4*. On May 3 (after *A* has delivered the enrollment form to the plan administrator but before *A* provides the birth certificate), *A* submits claims for all medical expenses incurred for *B* and *C* from the date of *C*'s birth.

(ii) *Conclusion.* In this *Example 5*, the plan must pay all of the claims submitted by *A*. Because the plan requires that individuals seeking special enrollment complete additional enrollment materials, it is required to provide benefits once it receives enrollment materials that are substantially complete. The form that *A* submitted on April 28 was substantially complete. Because *C*'s birth is the event giving rise to the special enrollment right, on April 28 *A*, *B*, and *C* become entitled to benefits under the plan retroactive to the date of *C*'s birth.

* * * * *

5. Section 2590.701–8 is added to read as follows:

§ 2590.701–8 Interaction with the Family and Medical Leave Act.

(a) *In general.* The rules of §§ 2590.701–1 through 2590.701–7 apply with respect to an individual on leave under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601)

(FMLA), and apply with respect to a dependent of such an individual, except to the extent otherwise provided in this section.

(b) *Tolling of significant break in coverage during FMLA leave.* In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and does not continue group health coverage for any period of FMLA leave, that period is not taken into account in determining whether a significant break in coverage has occurred under § 2590.701–4(b)(2)(iii).

(c) *Application of certification provisions—(1) Timing of issuance of certificate—(i)* In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and the individual's group health coverage is terminated during FMLA leave, an automatic certificate must be provided in accordance with the timing rules set forth in § 2590.701–5(a)(2)(ii)(B) (which generally require plans and issuers to provide certificates within a reasonable time after coverage ceases).

(ii) In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and continues group health coverage for the period of FMLA leave, but then ceases coverage under the plan at the end of FMLA leave, an automatic certificate must be provided in accordance with the timing rules set forth in § 2590.701–5(a)(2)(ii)(A) (which generally require plans and issuers to provide a certificate no later than the time a notice is required to be furnished for a qualifying event under a COBRA continuation provision).

(2) *Demonstrating FMLA leave.* (i) *A* plan or issuer is required to take into account all information about FMLA leave that it obtains or that is presented on behalf of an individual. A plan or issuer must treat the individual as having been on FMLA leave for a period if—

(A) The individual attests to the period of FMLA leave; and

(B) The individual cooperates with the plan's or issuer's efforts to verify the individual's FMLA leave.

(ii) Nothing in this section prevents a plan or issuer from modifying its initial determination of FMLA leave if it determines that the individual did not have the claimed FMLA leave, provided that the plan or issuer follows procedures for reconsideration similar to those set forth in § 2590.701–3(f).

(d) *Relationship to loss of eligibility special enrollment rules.* In the case of an individual (or a dependent of the individual) who is covered under a group health plan and who takes FMLA leave, a loss of eligibility for coverage under § 2590.701–6(a) occurs when the period of FMLA leave ends if —

(1) The individual's group health coverage is terminated at any time during FMLA leave; and

(2) The individual does not return to work for the employer at the end of FMLA leave.

6. Section 2590.732 is amended by adding paragraphs (a)(2) and (e) to read as follows:

§ 2590.732 Special rules relating to group health plans.

(a) *Group health plan.* * * *

(2) *Determination of number of plans.* The number of group health plans that an employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans) maintains is determined under the rules of this paragraph (a)(2).

(i) Except as provided in paragraph (a)(2)(ii) or (iii) of this section, medical care benefits provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan, unless—

(A) It is clear from the instruments governing the arrangement or arrangements to provide medical care benefits that the benefits are being provided under separate plans; and

(B) The arrangement or arrangements are operated pursuant to such instruments as separate plans.

(ii) A multiemployer plan and a nonmultiemployer plan are always separate plans.

(iii) If a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion.

* * * * *

(e) *Determining the average number of employees—*(1) *Scope.* Whenever the application of a rule in this part depends upon the average number of employees employed by an employer, the determination of that number is made in accordance with the rules of this paragraph (e).

(2) *Full-time equivalents.* The average number of employees is determined by calculating the average number of full-time equivalents on business days during the preceding calendar year.

(3) *Methodology.* For the preceding calendar year, the average number of full-time equivalents is determined by—

(i) Determining the number of employees who were employed full-time by the employer throughout the entire calendar year;

(ii) Totalling all employment hours (not to exceed 40 hours per week) for each part-time employee, and for each full-time employee who was not employed full-time with the employer throughout the entire calendar year;

(iii) Dividing the total determined under paragraph (e)(3)(ii) of this section by a figure that represents the annual full-time hours under the employer's general employment practices, such as 2,080 hours (although for this purpose not more than 40 hours per week may be used); and

(iv) Adding the quotient determined under paragraph (e)(3)(iii) of this section to the number determined under paragraph (e)(3)(i).

(4) *Rounding.* For purposes of paragraph (e)(3)(iv) of this section, all fractions are disregarded. For instance, a figure of 50.9 is deemed to be 50.

(5) *Employers not in existence in the preceding year.* In the case of an employer that was in existence for less than the entire preceding calendar year (including an employer that was not in existence at all), a determination of the average number of employees that the employer employs is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(6) *Scope of the term “employer”.* For purposes of this paragraph (e), employer includes any predecessor of the employer. In addition, all persons treated as a single employer under section 414(b), (c), (m), or (o) of the Internal Revenue Code are treated as one employer.

(7) *Special rule for multiemployer plans.* (i) With respect to the application of a rule in this part to a multiemployer plan (as defined in section 3(37) of the Act), each employer with at least one employee participating in the plan is considered to employ the same average number of employees. That number is the highest number that results by applying the rules of paragraphs (e)(1) through (6) of this section separately to each of the employers.

(ii) The rules of this paragraph (e)(7) are illustrated by the following example:

Example. (i) *Facts.* Twenty five employers have at least one employee who participates in Multiemployer Plan M. Among these 25 employers, Employer K has 51 employees, determined under the rules of paragraphs (e)(1) through (6) of this section. Each of the

other 24 employers has fewer than 50 employees.

(ii) *Conclusion.* With respect to the application of a rule in this part to M, each of the 25 employers is considered to employ 51 employees.

Signed at Washington, DC, this 1st day of December, 2004.

Ann L. Combs,

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

Department of Health and Human Services

45 CFR Subtitle A

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR Part 146 follows:

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

1. The authority citation for Part 146 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92 as amended by HIPAA (Pub. L. 104–191, 110 Stat. 1936), MHPA (Pub. L. 104–204, 110 Stat. 2944, as amended by Pub. L. 107–116, 115 Stat. 2177), NMHPA (Pub. L. 104–204, 110 Stat. 2935), WHCRA (Pub. L. 105–277, 112 Stat. 2681–436), and section 103(c)(4) of HIPAA.

2. In § 146.113, revise paragraphs (b)(2)(iii) and (b)(2)(iv), and *Examples 4* and *6* in paragraph (b)(2)(v) to read as follows:

§ 146.113 Rules relating to creditable coverage.

* * * * *

(b) *Standard method.* * * *

(2) *Counting creditable coverage.*

* * *

(iii) *Significant break in coverage defined.* A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage, except that periods described in paragraph (b)(2)(iv) of this section are not taken into account in determining a significant break in coverage. (See also § 146.143(c)(2)(iii) regarding the applicability to issuers of State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA

continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred. Moreover, in the case of an individual whose coverage ceases, if a certificate of creditable coverage with respect to that cessation is not provided on or before the date coverage ceases, then the period that begins on the first date that an individual has no creditable coverage and that continues through the earlier of the following two dates is not taken into account in determining whether a significant break in coverage has occurred:

(A) The date that a certificate of creditable coverage with respect to that cessation is provided; or

(B) The date 44 days after coverage ceases.

(v) *Examples.* * * *

Example 4. (i) *Facts.* Individual *B* terminates coverage under a group health plan, and a certificate of creditable coverage is provided 10 days later. *B* begins employment with Employer *R* and begins enrollment in *R*'s plan 60 days after the certificate is provided.

(ii) *Conclusion.* In this *Example 4*, even though *B* had no coverage for 69 days, the 10 days before the certificate of creditable coverage is provided are not taken into account in determining a significant break in coverage. Therefore, *B*'s break in coverage is only 59 days and is not a significant break in coverage. Accordingly, *B*'s prior coverage must be counted by *R*'s plan.

* * * * *

Example 6. (i) *Facts.* Employer *V* sponsors a group health plan. Under the terms of the plan, the only benefits provided are those provided under an insurance policy. Individual *D* works for *V* and has creditable coverage under *V*'s plan. *V* fails to pay the issuer the premiums for the coverage period beginning March 1. Consistent with applicable State law, the issuer terminates the policy so that the last day of coverage is April 30. *V* goes out of business on July 31. On August 15 *D* begins employment with Employer *W* and enrolls in *W*'s group health plan. *W*'s plan imposes a 12-month preexisting condition exclusion on all enrollees. *D* never receives a certificate of creditable coverage for coverage under *V*'s plan.

(ii) *Conclusion.* In this *Example 6*, the period from May 1 (the first day without coverage) through June 13 (the date 44 days after coverage under *V*'s plan ceases) is not taken into account in determining a 63-day break in coverage. This is because, in cases in which a certificate of creditable coverage is not provided by the date coverage is lost, the break begins on the date the certificate is provided, or the date 44 days after coverage ceases, if earlier. Therefore, even though *D*'s actual period without coverage was 106 days

(May 1 through August 14), because the period from May 1 through June 13 is not taken into account, *D*'s break in coverage is only 62 days (June 14 through August 14). Thus, *D* has not experienced a significant break in coverage, and *D*'s prior coverage must be counted by *W*'s plan.

* * * * *

3. In § 146.115, revise paragraphs (a)(3)(ii)(H)(5) and (6) and add paragraph (a)(3)(ii)(H)(7) to read as follows:

§ 146.115 Certification and disclosure of previous coverage.

(a) *Certificate of creditable coverage.*

* * *

(3) *Form and content of certificate.*

* * *

(ii) *Required information.* * * *

(H) * * *

(5) The interaction with the Family and Medical Leave Act;

(6) The fact that State law may require issuers to provide additional protections to individuals in that State; and

(7) Where to get more information.

* * * * *

4. In § 146.117, revise paragraphs (a)(1), (a)(4), (b)(1), (b)(3), and example 2 in paragraph (b)(4), and add examples 3, 4, and 5 in paragraph (b)(4), to read as follows:

§ 146.117 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage—*(1) *In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 144.103 of this chapter) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. Paragraph (a)(4) of this section describes procedures that a plan or issuer may require an employee to follow and describes the date by which coverage must begin. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

* * * * *

(4) *Applying for special enrollment and effective date of coverage—*(i) *Request.* A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (loss of eligibility for coverage, termination of employer contributions, or exhaustion of COBRA continuation coverage) to request enrollment (for the employee or the employee's dependent). For this purpose, any written or oral request

made to any of the following constitutes a request for enrollment —

(A) The plan administrator;

(B) The issuer;

(C) A person who customarily handles claims for the plan (such as a third party administrator); or

(D) Any other designated representative.

(ii) *Tolling of period for requesting special enrollment.* (A) In the case of an individual whose coverage ceases, if a certificate of creditable coverage with respect to that cessation is not provided on or before the date coverage ceases, then the period for requesting special enrollment described in paragraph (a)(4)(i) of this section does not end until 30 days after the earlier of—

(1) The date that a certificate of creditable coverage with respect to that cessation is provided; or

(2) The date 44 days after coverage ceases.

(B) For purposes of this paragraph (a)(4), if an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease on the earliest date that a claim is denied due to the operation of the lifetime limit.

(Nonetheless, the date of a loss of eligibility for coverage is determined under the rules of paragraph (a)(3) of this section, which provides that a loss of eligibility occurs when a claim that would meet or exceed a lifetime limit on all benefits is incurred, not when it is denied.)

(C) The rules of this paragraph (a)(4)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V* provides group health coverage through a policy provided by Issuer *M*. Individual *D* works for *V* and is covered under *V*'s plan. *V* fails to pay *M* the premiums for the coverage period beginning March 1. Consistent with applicable state law, *M* terminates the policy so that the last day of coverage is April 30. On May 15, *M* provides *D* with a certificate of creditable coverage with respect to *D*'s cessation of coverage under *V*'s plan.

(ii) *Conclusion.* In this *Example 1*, the period to request special enrollment ends no earlier than June 14 (which is 30 days after May 15, the day a certificate of creditable coverage is provided with respect to *D*).

Example 2. (i) *Facts.* Same facts as *Example 1*, except *D* is never provided with a certificate of creditable coverage.

(ii) *Conclusion.* In this *Example 2*, the period to request special enrollment ends no earlier than July 13. (July 13 is 74 days after April 30, the date coverage ceases. That is, July 13 is 30 days after the end of the 44-day maximum tolling period.)

Example 3. (i) *Facts.* Individual *E* works for Employer *W* and has coverage under *W*'s plan. *W*'s plan has a lifetime limit of \$1 million on all benefits under the plan. On

September 13, *E* incurs a claim that would exceed the plan's lifetime limit. On September 28, *W* denies the claim due to the operation of the lifetime limit and a certificate of creditable coverage is provided on October 3. *E* is otherwise eligible to enroll in the group health plan of the employer of *E*'s spouse.

(ii) *Conclusion.* In this *Example 3*, the period to request special enrollment in the plan of the employer of *E*'s spouse ends no earlier than November 2 (30 days after the date the certificate is provided) and begins not later than September 13, the date *E* lost eligibility for coverage.

(iii) *Reasonable procedures for special enrollment.* After an individual has requested enrollment under paragraph (a)(4)(i) of this section, a plan or issuer may require the individual to complete enrollment materials within a reasonable time after the end of the 30-day period described in paragraph (a)(4)(i) of this section. In these enrollment materials, the plan or issuer may require the individual only to provide information required of individuals who enroll when first eligible and information about the event giving rise to the special enrollment right. A plan or issuer may establish a deadline for receiving completed enrollment materials, but such a deadline must be extended for information that an individual making reasonable efforts does not obtain by that deadline.

(iv) *Date coverage must begin.* If the plan or issuer requires completion of additional enrollment materials in accordance with paragraph (a)(4)(iii) of this section, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives enrollment materials that are substantially complete. If the plan or issuer does not require completion of additional enrollment materials, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment under paragraph (a)(4)(i) of this section.

(b) *Special enrollment with respect to certain dependent beneficiaries—(1) In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes procedures that a plan or issuer may require an individual to follow and describes the date by which coverage must begin. The special enrollment

rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

* * * * *

(3) *Applying for special enrollment and effective date of coverage—(i) Request.* A plan or issuer must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent). For this purpose, any written or oral request made to any of the following constitutes a request for enrollment—

- (A) The plan administrator;
- (B) The issuer;
- (C) A person who customarily handles claims for the plan (such as a third party administrator); or
- (D) Any other designated representative.

(ii) *Reasonable procedures for special enrollment.* After an individual has requested enrollment under paragraph (b)(3)(i) of this section, a plan or issuer may require the individual to complete enrollment materials within a reasonable time after the end of the 30-day period described in paragraph (b)(3)(i) of this section. In these enrollment materials, the plan or issuer may require the individual only to provide information required of individuals who enroll when first eligible and information about the event giving rise to the special enrollment right. A plan or issuer may establish a deadline for receiving completed enrollment materials, but such a deadline must be extended for information that an individual making reasonable efforts does not obtain by that deadline.

(iii) *Date coverage must begin—(A) Marriage.* In the case of marriage, if the plan or issuer requires completion of additional enrollment materials in accordance with paragraph (b)(3)(ii) of this section, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives enrollment materials that are substantially complete. If the plan or issuer does not require such additional enrollment materials, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment under paragraph (b)(3)(i) of this section.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available). If the plan or issuer requires completion of additional enrollment materials in accordance with paragraph (b)(3)(ii) of this section, the plan or issuer must provide benefits (including benefits retroactively to the date of birth, adoption, or placement for adoption) once the plan or issuer receives enrollment materials that are substantially complete.

(4) *Examples.* * * *

Example 2. (i) Facts. Individual *D* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E*, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option and submits completed enrollment materials timely.

(ii) *Conclusion.* In this *Example 2*, *D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

Example 3. (i) Facts. Same facts as *Example 1*. On March 17 (two days after the birth of *C*), *A* telephones the plan administrator and requests special enrollment of *A*, *B*, and *C*. The plan administrator sends *A* an enrollment form. Under the terms of the plan, enrollment is denied unless a completed form is submitted within 30 days of the event giving rise to the special enrollment right (in this case, *C*'s birth).

(ii) *Conclusion.* In this *Example 3*, the plan does not satisfy paragraph (b)(3) of this section. The plan may require only that *A* request enrollment during the 30-day period after *C*'s birth. *A* did so by telephoning the plan administrator. The plan may not condition special enrollment on filing additional enrollment materials during the 30-day period. To comply with paragraph (b)(3) of this section, the plan must allow *A* a reasonable time after the end of the 30-day period to submit any additional enrollment materials. Once these enrollment materials are received, the plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 4. (i) Facts. Same facts as *Example 3*, except that *A* telephones the plan administrator to request enrollment on April 13 (29 days after *C*'s birth). Also, under the terms of the plan, the deadline for submitting

the enrollment form is 14 days after the end of the 30-day period for requesting special enrollment (thus, in this case, April 28, which is 44 days after C's birth). The form requests the same information for A, B, and C (name, date of birth, and place of birth) as well as a copy of C's birth certificate. A fills out the enrollment form and delivers it to the plan administrator on April 28. At that time A does not have a birth certificate for C but applies on that day for one from the appropriate government office. A receives the birth certificate on June 1 and furnishes a copy of the birth certificate to the plan administrator shortly thereafter.

(ii) *Conclusion.* In this *Example 4*, A, B, and C are entitled to special enrollment under the plan even though A did not satisfy the plan's requirement of providing a copy of C's birth certificate by the plan's 14-day deadline. While a plan may establish such a deadline, the plan must extend the deadline for information that an individual making reasonable efforts does not obtain by that deadline. A delivered the enrollment form to the plan administrator by the deadline and made reasonable efforts to furnish the birth certificate that the plan requires.

Example 5. (i) *Facts.* Same facts as *Example 4*. On May 3 (after A has delivered the enrollment form to the plan administrator but before A provides the birth certificate) A submits claims for all medical expenses incurred for B and C from the date of C's birth.

(ii) *Conclusion.* In this *Example 5*, the plan must pay all of the claims submitted by A. Because the plan requires that individuals seeking special enrollment complete additional enrollment materials, it is required to provide benefits once it receives enrollment materials that are substantially complete. The form that A submitted on April 28 was substantially complete. Because C's birth is the event giving rise to the special enrollment right, on April 28 A, B, and C become entitled to benefits under the plan retroactive to the date of C's birth.

* * * * *

5. Add new § 146.120 to read as follows:

§ 146.120 Interaction with the Family and Medical Leave Act.

(a) *In general.* The rules of this part apply with respect to an individual on leave under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601) (FMLA), and apply with respect to a dependent of such an individual, except to the extent otherwise provided in this section.

(b) *Tolling of significant break in coverage during FMLA leave.* In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and does not continue group health coverage for any period of FMLA leave, that period is not taken into account in determining whether a significant break in coverage has occurred under § 146.113(b)(2)(iii).

(c) *Application of certification provisions—*(1) *Timing of issuance of certificate—*(i) In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and the individual's group health coverage is terminated during FMLA leave, an automatic certificate must be provided in accordance with the timing rules set forth in § 146.115(a)(2)(ii)(B) (which generally require plans and issuers to provide certificates within a reasonable time after coverage ceases).

(ii) In the case of an individual (or a dependent of the individual) who is covered under a group health plan, if the individual takes FMLA leave and continues group health coverage for the period of FMLA leave, but then ceases coverage under the plan at the end of FMLA leave, an automatic certificate must be provided in accordance with the timing rules set forth in § 146.115(a)(2)(ii)(A) (which generally require plans and issuers to provide a certificate no later than the time a notice is required to be furnished for a qualifying event under a COBRA continuation provision).

(2) *Demonstrating FMLA leave.* (i) A plan or issuer is required to take into account all information about FMLA leave that it obtains or that is presented on behalf of an individual. A plan or issuer must treat the individual as having been on FMLA leave for a period if—

(A) The individual attests to the period of FMLA leave; and

(B) The individual cooperates with the plan's or issuer's efforts to verify the individual's FMLA leave.

(ii) Nothing in this section prevents a plan or issuer from modifying its initial determination of FMLA leave if it determines that the individual did not have the claimed FMLA leave, provided that the plan or issuer follows procedures for reconsideration similar to those set forth in § 146.111(f).

(d) *Relationship to loss of eligibility special enrollment rules.* In the case of an individual (or a dependent of the individual) who is covered under a group health plan and who takes FMLA leave, a loss of eligibility for coverage under § 146.117(a) occurs when the period of FMLA leave ends if—

(1) The individual's group health coverage is terminated at any time during FMLA leave; and

(2) The individual does not return to work for the employer at the end of FMLA leave.

6. In § 146.145, add paragraphs (a)(2) and (e) to read as follows:

§ 146.145 Special rules relating to group health plans.

(a) *Group health plan.* * * *

(2) *Determination of number of plans.* The number of group health plans that an employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans) maintains is determined under the rules of this paragraph (a)(2).

(i) Except as provided in paragraph (a)(2)(ii) or (iii) of this section, medical care benefits provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan, unless—

(A) It is clear from the instruments governing the arrangement or arrangements to provide medical care benefits that the benefits are being provided under separate plans; and

(B) The arrangement or arrangements are operated pursuant to such instruments as separate plans.

(ii) A multiemployer plan and a nonmultiemployer plan are always separate plans.

(iii) If a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion.

* * * * *

(e) *Determining the average number of employees—*(1) *Scope.* Whenever the application of a rule in this part depends upon the average number of employees employed by an employer, the determination of that number is made in accordance with the rules of this paragraph (e).

(2) *Full-time equivalents.* The average number of employees is determined by calculating the average number of full-time equivalents on business days during the preceding calendar year.

(3) *Methodology.* For the preceding calendar year, the average number of full-time equivalents is determined by—

(i) Determining the number of employees who were employed full-time by the employer throughout the entire calendar year;

(ii) Totalling all employment hours (not to exceed 40 hours per week) for each part-time employee, and for each full-time employee who was not employed full-time with the employer throughout the entire calendar year;

(iii) Dividing the total determined under paragraph (e)(3)(ii) of this section by a figure that represents the annual full-time hours under the employer's general employment practices, such as

2,080 hours (although for this purpose not more than 40 hours per week may be used); and

(iv) Adding the quotient determined under paragraph (e)(3)(iii) of this section to the number determined under paragraph (e)(3)(i).

(4) *Rounding.* For purposes of paragraph (e)(3)(iv) of this section, all fractions are disregarded. For instance, a figure of 50.9 is deemed to be 50.

(5) *Employers not in existence in the preceding year.* In the case of an employer that was in existence for less than the entire preceding calendar year (including an employer that was not in existence at all), a determination of the average number of employees that the employer employs is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(6) *Scope of the term "employer".* For purposes of this paragraph (e), employer includes any predecessor of the employer. In addition, all persons treated as a single employer under section 414(b), (c), (m), or (o) of the Internal Revenue Code are treated as one employer.

(7) *Special rule for multiemployer plans.* (i) With respect to the application of a rule in this part to a multiemployer plan (as defined in section 3(37) of ERISA), each employer with at least one employee participating in the plan is considered to employ the same average number of employees. That number is the highest number that results by applying the rules of paragraphs (e)(1) through (6) of this section separately to each of the employers.

(ii) The rules of this paragraph (e)(7) are illustrated by the following example:

Example. (i) *Facts.* Twenty five employers have at least one employee who participates in Multiemployer Plan M. Among these 25 employers, Employer K has 51 employees, determined under the rules of paragraphs (e)(1) through (6) of this section. Each of the other 24 employers has fewer than 50 employees.

(ii) *Conclusion.* With respect to the application of a rule in this part to M, each of the 25 employers is considered to employ 51 employees.

Dated: November 24, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: December 2, 2004.

Tommy G. Thompson,

Secretary, Department of Health and Human Services.

[FR Doc. 04-28113 Filed 12-29-04; 8:45 am]

BILLING CODE 4830-01-P; 4510-29-P; 4120-01-P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

45 CFR Part 146

RIN 0938-AL64

Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Request for information.

SUMMARY: The Departments invite comments about benefit-specific waiting periods. This solicitation is to ensure that the public can provide input into any criteria used to determine whether a benefit-specific waiting period utilized by a group health plan or issuer is a preexisting condition exclusion under HIPAA. The Departments are requesting this information to help decide whether to issue any guidance on this question, and the content of any such guidance.

DATES: The Departments request that comments be submitted on or before March 30, 2005.

ADDRESSES: Written comments should be submitted with a signed original and three copies (except for electronic submissions) to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments.

Comments to the IRS can be addressed to: CC:PA:LPD:PR (REG-130370-04), Room 5203, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044.

In the alternative, comments may be hand-delivered between the hours of 8 a.m. and 5 p.m. to: CC:PA:LPD:PR (REG-130370-04), Courier's Desk, Internal Revenue Service, 1111

Constitution Avenue, NW., Washington DC 20224.

Alternatively, comments may be transmitted electronically via the IRS Internet site at: www.irs.gov/regs.

Comments to the Department of Labor can be addressed to: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW., Room C-5331, Washington, DC 20210, *Attention:* Benefit-Specific Waiting Period Comments.

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address. Comments may also be transmitted to the Department of Labor by e-mail to: E-OHPSCA.EBSA@dol.gov.

Comments to HHS can be submitted as described below:

In commenting, please refer to file code CMS 2150-NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

Electronically. You may submit electronic comments to <http://www.cms.hhs.gov/regulations/ecommments> (attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

By mail. You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2150-NC, P.O. Box 8017, Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members. Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and

retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC from 9 a.m. to 4 p.m.

All submissions to the Department of Labor will be open to public inspection and copying in the Public Disclosure Room, Employee Benefits Security Administration, U.S. Department of Labor, Room N-1513, 200 Constitution Avenue, NW., Washington, DC from 8:30 a.m. to 4:30 p.m.

All submissions timely submitted to HHS will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters for the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786-7195.

FOR FURTHER INFORMATION CONTACT:

Dave Mlawsky, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, at 1-877-267-2323 ext. 61565; Amy Turner, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; or Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-6080.

SUPPLEMENTARY INFORMATION:

Customer Service Information

To assist consumers and the regulated community, the Departments have issued questions and answers concerning HIPAA. Individuals interested in obtaining copies of Department of Labor publications concerning changes in health care law may call a toll free number, 1-866-444-EBSA (3272), or access the publications on-line at www.dol.gov/ebsa, the Department of Labor's Web site. These regulations as well as other information on the new health care laws are also available on the Department of Labor's interactive Web pages, *Health Elaws*. In addition, CMS's publication entitled "Protecting Your Health Insurance Coverage" is available by calling 1-800-633-4227 or on the Department of Health and Human Services' Web site (www.cms.hhs.gov/hipaa1), which includes the interactive Web pages, HIPAA Online. Copies of the HIPAA regulations, as well as notices and press

releases related to HIPAA and other health care laws, are also available at the above-referenced Web sites.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted on August 21, 1996 (Pub. L. 104-191). HIPAA amended the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) to provide for, among other things, improved portability and continuity of health coverage in the group and the individual insurance markets, including group health plan coverage provided in connection with employment. Health coverage is regulated in part by the federal government, through the Code, ERISA, the PHS Act and other federal provisions, and in part by the states.

The portability, access, and renewability provisions of HIPAA are set forth in Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act (referred to below as the HIPAA portability provisions). The HIPAA portability provisions are designed to improve the availability and portability of health insurance coverage by limiting exclusions for preexisting conditions and providing credit for prior coverage, guaranteeing availability of health coverage for small employers, prohibiting discrimination against employees and dependents based on health status, and guaranteeing renewability of health insurance coverage for employers and individuals. The HIPAA portability provisions also include rules that guarantee access to individual health coverage for certain people who lose their group coverage. These provisions also set forth other requirements imposed on health insurance issuers.

The Departments issued interim regulations published in the **Federal Register** on April 8, 1997 to carry out these provisions. Today, elsewhere in this issue of the **Federal Register**, the Departments are publishing final regulations governing the HIPAA portability requirements. Also being published is a set of proposed regulations addressing additional and discrete issues with an invitation for comments.

Included in today's final regulations is an example illustrating that a plan providing first-day coverage for other medical/surgical benefits but imposing a waiting period on benefits for pregnancy is imposing a preexisting condition exclusion. Because HIPAA prohibits imposing a preexisting condition

exclusion on pregnancy benefits, the final regulations clarify that this plan provision is impermissible. Several comments (including those of several state insurance commissioners' offices) have asked the Departments to clarify that a preexisting condition exclusion would also include any benefit-specific waiting period or other temporary exclusion of specific benefits. Essentially, these comments argue that some plans and issuers use benefit-specific waiting periods that are, in effect, preexisting condition exclusions that do not comply with HIPAA's statutory limits. The rationale for this argument is that these exclusion periods are likely to affect principally individuals who had a condition before the first day of any coverage under the plan or health insurance coverage. In addition, other comments suggest that these exclusions violate HIPAA's nondiscrimination provisions. Nonetheless, the comments do not suggest that it would be impermissible to impose a waiting period for all benefits available under the plan or to impose permanent exclusions on specific benefits (that is, these types of exclusions would not be considered a preexisting condition exclusion nor would they be considered discrimination based on health status).

Comments

The Departments welcome further comments on this issue of benefit-specific waiting periods. In particular, the Departments are interested in comments reflecting the experience of group health plans, health insurance issuers, states, individuals, and other interested parties with waiting periods on specific benefits such as tonsillectomies, hernia repairs, and organ transplants. Rules under consideration might also affect plans that cover only emergency services for an initial period; comments on these types of provisions are also welcome. One possible standard for determining whether a benefit-specific waiting period is operating as a preexisting condition exclusion is whether the waiting period is likely to affect principally individuals who had a condition before the first day of any coverage under the plan or health insurance coverage. Several factors affect the application of such a standard to a particular plan's waiting period, including the relevant population considered to determine whether the impact is likely to affect principally individuals who had a condition before the first day of coverage, the condition to which a plan's waiting period is applied, and the length of a plan's

waiting period (because, generally, as the waiting period becomes longer, a greater number of individuals affected will not have had the condition before enrolling). The Departments welcome comments on this standard and these factors, and also invite suggestions for alternative standards.

In order to quantify the costs and benefits associated with an interpretation that certain benefit-specific waiting periods function as preexisting condition exclusions, the Departments are interested also in comments, studies, surveys, or reports on the prevalence of such exclusions in group health coverage and individual health insurance coverage, what types of conditions or treatments are subject to benefit-specific waiting periods, the duration of such periods, and alternative cost-control mechanisms that may be available.

Signed at Washington, DC, this 8th day of December, 2004.

Nancy J. Marks,

*Associate Chief Counsel/Division Counsel,
Tax Exempt and Government Entities,
Internal Revenue Service, Department of the
Treasury.*

Signed at Washington, DC, this 9th day of December, 2004.

William F. Sweetnam, Jr.,

*Benefits Tax Counsel, Department of the
Treasury.*

Signed at Washington, DC, this 1st day of December, 2004.

Ann L. Combs,

*Assistant Secretary, Employee Benefits
Security Administration, U.S. Department of
Labor.*

Dated: November 24, 2004.

Mark B. McClellan,

*Administrator, Centers for Medicare &
Medicaid Services.*

Dated: December 2, 2004.

Tommy G. Thompson,

*Secretary, Department of Health and Human
Services.*

[FR Doc. 04-28114 Filed 12-29-04; 8:45 am]

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Federal Register

**Thursday,
December 30, 2004**

Part IV

Department of Housing and Urban Development

24 CFR Part 91

**Revisions and Updates to Consolidated
Plan; Proposed Rule**

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT**24 CFR Part 91**

[Docket No. FR-4923-P-01; HUD 2004-0028]

RIN 2501-AD07

Revisions and Updates To Consolidated Plan

AGENCY: Office of the Secretary, HUD.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend the consolidated plan regulations of state and local governments to make clarifying and streamlining changes that are expected to make the consolidated plan of state and local jurisdictions more results-oriented and useful to communities in assessing their own progress toward addressing the problems of low-income areas. The consolidated plan is the document that is submitted to HUD by jurisdictions that receive funding under any of HUD's Community Planning and Development formula grant programs and serves as the jurisdiction's planning document for the use of the funds received under these programs. The proposed rule would eliminate some obsolete and redundant provisions and make other changes that would conform the consolidated plan regulations with HUD's public housing regulations that govern the Public Housing Agency (PHA) Plan.

DATES: *Comment due date:* January 31, 2005.

ADDRESSES: Interested persons are invited to submit comments regarding this rule to the Regulations Division, Office of General Counsel, Room 10276, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410-0500. Interested persons may also submit comments electronically through either:

- The federal electronic rulemaking Portal at www.regulations.gov; or
 - The HUD electronic Web site at www.epa.gov/feddocket. Follow the link entitled "View Open HUD Dockets."
- Commenters should follow the instructions provided on that site to submit comments electronically.

Facsimile (FAX) comments are not acceptable. In all cases, communications must refer to the docket number and title. All comments and communications submitted will be available, without revision, for public inspection and copying between 8 a.m. and 5 p.m. weekdays at the above address. Copies are also available for inspection and downloading at www.epa.gov/feddocket.

FOR FURTHER INFORMATION CONTACT:

Salvatore Sclafani, CPD Office of Policy Development and Coordination, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410-7000, telephone, (202) 708-1817 extension 4364 (this is not a toll-free number). Hearing-or speech-impaired individuals may access this number through TTY by calling the toll-free Federal Information Relay Service at (800) 877-8339.

SUPPLEMENTARY INFORMATION:**I. Background**

HUD published a final rule on January 5, 1995 (60 FR 1896) for the "Consolidated Submission for Community Planning and Development Programs" that consolidated and streamlined the planning, application, and reporting requirements for HUD's Community Development Block Grant (CDBG), Emergency Shelter Grant (ESG), HOME Investment Partnerships (HOME), and Housing Opportunities for Persons with AIDS (HOPWA) formula programs into a consolidated planning document (consolidated plan) and a consolidated annual performance report. The final rule for the PHA Plan, published in the **Federal Register** on October 21, 1999 (64 FR 56844), established the procedures and requirements for the submission of PHA Plans that provide a mechanism for defining long-term and short-term needs and strategies. Both the consolidated plan and the PHA Plan resulted from an extensive consultation process that involved numerous stakeholders representing the interests of state and local governments and low-income persons.

In Fiscal Year (FY) 2002, the President's Management Agenda directed HUD to work with local stakeholders to streamline the consolidated plan, making it more results-oriented and useful to communities in assessing their own progress toward addressing the problems of low-income areas. To launch this activity, several HUD Office of Community Planning and Development (CPD) Field Offices held focus group sessions with grantees and other stakeholders in February 2002, to discuss ways to streamline the consolidated plan and improve performance measurement. On March 14, 2002, CPD convened a national planning meeting to introduce the concept of the Consolidated Plan Improvement Initiative to a national audience that included public interest groups, grantees, other stakeholders, along with staff from HUD headquarters

and field offices, and the Office of Management and Budget (OMB).

At a meeting of these stakeholders, participants agreed that addressing the issues of streamlining and performance measurement would be best served by small working groups that represent the full range of people involved in and affected by the consolidated plan, including grantee practitioners, public interest groups, HUD staff, and other stakeholders. Six working groups were identified to assess alternative planning requirements, examine and suggest performance measures, and identify communities that would be willing to test pilots of alternative planning procedures. Alternative planning procedures were tested by representatives of state and local governments that participated in eight pilots. A steering committee coordinated the work of the six working groups and reviewed ideas under consideration to make the consolidated plan more useful and results oriented.

One pilot looked at streamlining the plan by referencing existing documents to avoid requiring redundant information. Another pilot evaluated alternative means of satisfying non-housing community development plan requirements. A third pilot addressed alternative formats for submission of consolidated plans, action plans, and performance reporting. The fourth pilot explored ways to enhance the citizen participation process. The fifth pilot involved development and use of templates. The sixth pilot involved coordination of consolidated plan and public housing agency plan. The seventh pilot explored the development and review of tools to submit consolidated plans, track results, and report performance. The eighth pilot documented useful practices for streamlining and performance measurement. An analysis of these pilots helped HUD determine how the consolidated planning process and regulatory requirements might be made more streamlined, results-oriented, and ultimately more useful to communities in addressing the needs of their low-income residents and areas.

II. This Proposed Rule

This proposed rule resulted from an extensive consultation process that involved stakeholders representing the interests of state and local governments and low-income persons. The Department carefully considered ideas generated by several working groups that were established to explore alternative planning requirements and suggestions for improving the consolidated plan. Representatives from

the following national groups participated in the process: Council of State Community Development Agencies, National Community Development Association, National Association for County, Community and Economic Development, National Association of Housing and Redevelopment Officials, and National Low Income Housing Coalition.

The proposed rule builds on the existing framework that established the consolidated plan as a collaborative process whereby a community establishes a unified plan of community development actions. That framework gave states and local governments the flexibility to use existing plans and strategies to help citizens understand the jurisdiction's priority needs, and assess the jurisdiction's progress toward meeting identified goals and objectives through measurable indicators.

This rule also conforms the consolidated plan regulations to sections 568 and 583 of the Quality Housing and Work Responsibility Act of 1998 (Pub. L. 105–276, 112 Stat. 2461, approved October 21, 1998, codified at 42 U.S.C. 12705) that required state or local consolidated plans to describe the manner that the jurisdiction will help address the needs of public housing, and that a consolidated plan from a state or unit of general local government in which any troubled PHA is located must include a description of the manner in which the state or unit of local government will provide financial or other assistance to remove the PHA's troubled designation. This rule also makes certain other conforming amendments and clarification changes.

A. Concise, Action-Oriented Management Tool

The general view of the groups participating in the Consolidated Plan Improvement Initiative was that the consolidated plan should be a concise, action-oriented management tool that would be more understandable to the public and more useful to decision makers in the community. This view is consistent with ideas expressed in the conference report accompanying the Cranston-Gonzalez National Affordable Housing Act that stated that the (housing) strategies “will serve not only as effective monitoring tools for the Department, but also as concise, useful, action-oriented management tools for States and local governments.” (H.R. Conf. Rep. 101–943, October 25, 1990). In accordance with this view, § 91.200 (b); § 91.205(a), (b), (c); § 91.215 (d), (e), (h), (i), (j); § 91.220(b)(1); § 91.300(b); § 91.305(a), (b), (c); § 91.315(d), (e), (h), (i), (j); and § 91.320(b)(1) are modified to

emphasize the format of the descriptions should be a concise summary, not a detailed narrative. In addition, § 91.1(b)(4) is amended to read the consolidated plan serves as “a management tool for assessing performance and tracking results.”

B. Citizen Participation

HUD regulations that concern citizen participation would be amended at § 91.1 to include citizens, organizations, businesses, and other stakeholders among those that should be involved in the citizen participation process and at §§ 91.105 and 91.115 to encourage the participation of local and regional institutions and other organizations (including businesses, developers, community and faith-based organizations) in the process of developing and implementing the consolidated plan. Jurisdictions would be encouraged to explore alternative public involvement techniques (such as focus groups and the use of the Internet) and quantitative ways to measure efforts that encourage citizen participation in a shared vision for change in communities and neighborhoods, and the review of program performance.

HUD also invites comment on whether an executive summary would be a useful tool for citizens as well as jurisdictions. For example, the format of the executive summary could include two items: (1) A list of the significant short and long-term performance goals (for grantee activities and the communities/neighborhoods assisted); and (2) the major activities and projects grantees plan to fund to achieve those goals. HUD is particularly interested in comments on what specific information should be included in an executive summary and whether the benefit of an executive summary would outweigh the burden.

C. Clarification of Chronic Homelessness

HUD's regulations that concern the homeless are amended to include and emphasize the needs of unaccompanied homeless individuals with a disabling condition who have been continuously homeless for a year or more or have had at least four episodes of homelessness in the past three years. The rule would amend § 91.5 to include a definition of a chronically homeless person. This definition is consistent with the January 23, 2003 Notice of Funding Availability (NOFA) for the Collaborative Initiative to Help End Chronic Homelessness (68 FR 4018). In addition, clarifications are made at §§ 91.100(a)(2) and 91.110 that indicate the jurisdiction shall consult with other public and private agencies

that provide assisted housing, health services, and social services to determine what resources are available to address the needs of any persons that are chronically homeless. Clarifying changes are made at § 91.210 and § 91.310 to include persons that are chronically homeless in the brief inventory of facilities and services that meet the emergency shelter, transitional housing, permanent supportive housing, and permanent housing needs of homeless persons within the jurisdiction. A clarifying amendment is made to the regulations that govern the strategic plan at § 91.215(c) and § 91.315(c) to include the chronically homeless in a jurisdiction's efforts to address homelessness. The regulations that govern the action plan are also amended at § 91.220(g) and § 91.320(g) to include specific action steps to end chronic homelessness. These changes are designed to bring the consolidated plan more in line with the Administration's goal of ending chronic homelessness by 2012.

D. Removal of Barriers to Affordable Housing

HUD regulations that concern barriers to affordable housing would contain clarifying amendments at §§ 91.220 and 91.320, adding a new paragraph (h) that requires each jurisdiction to describe specific actions it plans to take during the next year to address the public policies, procedures, and processes of the jurisdiction that impact the cost of developing, maintaining, or improving affordable housing. Addressing regulatory barriers to affordable housing is a component of a housing strategy. Barrier removal will not only make it easier to find and get approval for affordable housing sites but it will also allow available subsidies to go further in meeting local housing needs. The removal of regulatory barriers to affordable housing has also become a top Administration priority. HUD Form HUD–27300, used for competitive grants, can serve as a useful guidance document in assisting jurisdictions identify the specific policies, procedures or process that impact the cost of developing, maintaining or improving affordable housing.

E. Clarifications of Strategic Plan Provisions

A change is made to §§ 91.215(a)(4) and (a)(5) and 91.315(a)(4) to make the sections clearer that the summary of specific objectives must identify proposed accomplishments the jurisdiction hopes to achieve in quantitative terms over a specified time period (e.g., one, two, three or more

years), or in other measurable terms as identified by the jurisdiction. The strategic plan must also describe how funds expected to be available will be used to address identified needs. HUD is adding a new § 91.215(a)(6) and § 91.315(a)(6) to encourage grantees to include outcomes in the strategic plan. Similar clarifying change are made to §§ 91.215(b)(2), (b)(3) and 91.315(b)(2) and (b)(3) to clarify that specific housing objectives must identify the number of extremely low-income, low-income, and moderate-income families to whom the jurisdiction will provide affordable housing as defined in 24 CFR 92.252 for rental housing and 24 CFR 92.254 for homeownership over a specific time period. The affordable housing section must describe how the characteristics of the housing market will influence the use of funds made available for rental assistance, production of new units, rehabilitation of existing units, or acquisition of existing units. In addition, §§ 91.215(b)(2), 91.215(d), 91.315(b)(2), and 91.315(d) would be amended to indicate if a jurisdiction plans to use HOME funds for tenant-based assistance, it must specify local market conditions that lead to the choice of this option.

Priorities and Priority Needs

HUD invites comment on whether assigning "priority" needs, especially the assigning "relative" allocation priorities of "High" "Medium" and "Low" pursuant to §§ 91.215(a)(1) and (2) is useful. For housing, a "High" priority means activities to address the unmet need "will be funded" with federal funds. A "Medium" priority means activities to address the unmet need "may be funded" with federal funds, if available. A "Low" priority means the jurisdiction "will not fund" activities to address the unmet need, but will consider certifications of consistency for other entities' applications for federal assistance. HUD would welcome suggestion on alternatives for indicating general priorities for allocating investment. Section 105(b)(7) of the Cranston-Gonzalez National Affordable Housing Act requires the jurisdiction to indicate the general priorities for allocating investment among different activities and housing needs. Section 105(b)(8) requires the jurisdiction describe the reasons for allocation priorities. §§ 91.215(a)(1) and (2) are amended to more closely conform with the language in the statute.

The proposed rule also contains a change to § 91.215(e)(1) that eliminates the provision dealing with "dollars to address" in the priority community

development needs table that some jurisdictions do not find useful and adds a requirement that the plan include an estimate of the number of abandoned buildings, using the locality's definition.

Clarifying changes are made to §§ 91.215(e)(2) and 91.315(e)(2) requiring that neighborhood revitalization strategies identify long-term and short-term objectives (*e.g.*, physical improvements, social initiatives and economic empowerment), in terms of measures of outputs and outcomes expected to be achieved in the area through the use of HUD programs. These changes will make the consolidated plan more results or outcome oriented.

A clarification would be made to § 91.215(h) indicating jurisdictions may include policies for providing training and employment opportunities to residents under section 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u) and 24 CFR part 135.

F. Action Plan

A clarification is made at § 91.220(b) indicating federal resources include Section 8 funds made available to the jurisdiction and competitive McKinney-Vento Homeless Assistance Act funds. A clarification is also made at § 91.220(g) that CDBG funds includes proceeds from Section 108 loan guarantees.

This proposed rule would add the following requirements to the action plan. The first change would add a new provision at § 91.220(b)(3) and § 91.320(b)(3) that would require a jurisdiction to include a summary of the annual objectives the jurisdiction expects to achieve during the forthcoming program year.

The second change would add a new provision at § 91.220(d) and § 91.320(d) to require a jurisdiction to measure outcomes for some of the proposed activities that are included in its action plan. These may include specific outcome measures to be issued in future HUD guidance so that the outcomes can be aggregated on a national basis, as well as locally identified outcomes to meet local needs. Outcomes are defined as benefits that result from a program that typically relate to a change in conditions, status, attitudes, skills, knowledge, or behavior. Common outcomes could include measures of improved quality of life for program beneficiaries, improved quality of program assisted local housing stock, or revitalization of a neighborhood. HUD plans to develop outcome measures in consultation with grantees and public interest groups, as well as specific

comments that are made in response to this proposed rule. The Department is participating in an effort with the Council of State Community Development Agencies, the National Association for County, Community, and Economic Development, and the National Community Development Association to develop workable outcome measures that will be acceptable to the Department and its grantees.

The third change would add a provision at § 91.220(e) that would require the jurisdiction to estimate the percentage of funds the jurisdiction plans to dedicate to target areas. Target areas might include areas such as neighborhood revitalization strategy areas, neighborhood improvement areas, or other low- and moderate-income service areas in which block grant assistance activities are being carried out in a concentrated manner.

The fourth change would add specific provisions at a new § 91.220(f) and § 91.320(f) to require the jurisdiction to specify one-year goals for the number of homeless, non-homeless, and special needs families to be provided affordable housing through activities that provide rental assistance, production of new units, rehabilitation of existing units, or acquisition of existing units using funds made available to the jurisdiction. This change will make the annual action plan submission more results oriented and focus more attention on how formula grant funds are used to provide affordable housing.

The fifth change would add a new § 91.220(j)(1)(iv) to require CDBG grantees to identify the estimated amount of CDBG funds that will benefit persons of low- and moderate-income. The sixth change would add a new § 91.220(j)(3) to require HOPWA grantees to specify one-year goals for the number of households to be provided with housing through the use of HOPWA funds for activities that provide short-term rent, mortgage and utility assistance payments to prevent homelessness of the individual or family; tenant-based rental assistance; and units provided in housing facilities that are being developed, leased or operated with HOPWA funds.

Finally, changes at §§ 91.220(k) and 91.320(k) would require a concise summary of the citizen participation and consultation process (including efforts to broaden public participation), a summary of comments or views received, and a summary of comments or views not accepted and a rationale for not accepting the comments.

G. Submission Requirements

Changes are made to § 91.15(b)(1) to clarify that a summary of the citizen participation and consultation process must be submitted on an annual basis together with the action plan and certifications.

Clarifying changes are made to § 91.15(b)(2) indicating the housing and homeless needs assessment, housing market analysis, and strategic plan sections must be submitted at least once every five years, or at such time as jointly agreed upon by HUD and the jurisdiction. This will allow jurisdictions the flexibility to submit and update plans in a manner that facilitates orderly program management. A new provision at § 91.15(b)(3) would allow jurisdictions to make amendments that extend the time period covered by their plan if agreed upon by HUD. This provision would be used to coordinate consolidated plans with the time periods used for cooperation agreements, other local plans, or the availability of data.

H. Exceptions

A clarifying change is made to the exceptions at § 91.20 to remove an obsolete requirement that applied only for FY 1995 and to indicate that exceptions may be granted from submission deadlines for consolidated plans and performance reports required under §§ 91.15 and 91.520. Only the last exception (*i.e.* from the implementation guidelines) is modified to the extent the requirement is not required by statute or regulation.

I. Public and Assisted Housing

This proposed rule would make a number of additional conforming and clarifying changes to part 91. The conforming changes would add the provisions at § 91.2 that would require the PHA Plan (24 CFR part 903) to include a certification of consistency with the applicable consolidated plan by the appropriate state or local official and a description of the manner in which the applicable contents of the PHA Plan are consistent with the consolidated plan. Conforming changes are made to §§ 91.100(c), 91.105, and 91.210 to remove reference to the Comprehensive Grant Program and substitute references to the PHA Plan. The housing needs section at § 91.205 is revised to include the needs of public housing residents and families on the public housing and section 8 tenant-based waiting list among those considered in estimating the housing needs of the jurisdiction. The housing market analysis section at § 91.210 is

also revised to include the expiration of Section 8 contracts as an example of affordable housing expected to be lost from the assisted housing inventory.

Redundant and obsolete provisions dealing with organizational relationships between the jurisdiction and PHA, including the appointing authority for the commissioners or board of the housing agency; relationships regarding hiring, contracting and procurement; provision of services funded by the jurisdiction; and review by the jurisdiction of proposed development sites, of the comprehensive plan of the public housing agency, and of any proposed demolition or disposition of public housing developments are removed at § 91.215 (i)(2) since this information is available in the PHA Plan.

This rule amends §§ 91.215(k) and 91.315(l), to include the requirements of sections 568 and 583 of the Quality Housing and Work Responsibility Act of 1998 (42 U.S.C. § 12705). The strategic plan of a jurisdiction must describe the manner in which the jurisdiction will address the needs of public housing and the financial or other assistance the jurisdiction will provide to improve the operations of a public housing agency designated as “troubled” in order to remove such designation. However, this rule does not require a State to describe the manner in which financial or other assistance is provided to a troubled public housing agency if that agency is located entirely within the boundaries of a unit of local government that must submit a housing strategy to HUD. Corresponding changes are made at § 91.220(f) and § 91.320(f). This rule would also include among the needs of public housing, the need to increase the number of accessible units required by section 504 voluntary compliance agreements.

In addition, this rule also adds a conforming change at § 91.500(b)(4) that would provide that the failure to include a description of the manner in which a jurisdiction will provide financial or other assistance to remove a PHA’s troubled designation may cause HUD to disapprove a plan or determine that it is substantially incomplete.

J. State Method of Distribution

This proposed rule would amend § 91.320(g) to resolve some apparent confusion that states and state grantees have regarding the Method of Distribution requirements. In meetings with states and state organizations, as well as from monitoring visits, it has become clear that many states are not aware that the entire rating and ranking process needed to be transparent. This

proposed rule clarifies that the state must document how it selected state CDBG applications for funding so that it can be easily reviewed by citizens, HUD staff, and the Inspector General. The revised rule indicates the Method of Distribution, the application manual, or other generally available state publication that is referenced in the Method of Distribution, must contain a description of all of the rating and ranking criteria that is used to select applications from local governments for funding. If the description of the rating and ranking criteria is published in a document other than the Method of Distribution, the Method of Distribution must include a listing of all of the state’s selection criteria. This includes any criteria that might be used by a state’s senior management that affect final funding selection decisions. HUD’s purpose is to ensure full disclosure to units of general local government and citizens of all criteria affecting how funding decisions are to be made and not to dictate how a state selects its grantees. The process should be transparent so that potential applicants will have a clear indication of what they have to do to prepare a successful application.

The proposed rule also makes clear that HUD’s approval of the consolidated plan does not necessarily confer approval of a state’s actual implementation of its Method of Distribution, or compliance with the requirements of Section 91.320(g)(1)(i) as HUD may determine in a subsequent monitoring or audit of the state’s Method of Distribution.

HUD specifically welcomes comments on this rule from states, units of general local government participating in the State Community Development Block Grant Program, and citizens affected by the State CDBG program.

III. Findings and Certifications

Justification for 30-Day Comment Period

In general, HUD publishes a proposed rule for a 60-day public comment period on all proposed rules, however, HUD is reducing its usual 60-day public comment period to 30 days for this proposed rule. The Department developed these clarifying changes in response to suggestions by affected parties and after extensive consultation with interested stakeholders representing the interests of state and local governments and low-income persons. In addition, many jurisdictions are in the process of preparing their consolidated plans for FY2005 and publication of an updated rule that would guide the development of their

plans. Therefore, HUD is publishing this proposed rule with a 30-day public comment period because the rule makes clarifying and conforming changes to a regulation to make it more internally consistent and to conform to recent statutory changes. HUD welcomes comments on the rule, and these comments will be taken into consideration in developing the final rule.

Paperwork Reduction Act

The proposed new information collection requirements contained in §§ 91.15, 91.215, 91.220, 91.315, 91.320, and 91.520 have been submitted to the Office of Management and Budget (OMB) for review under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). Under this Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection

of information unless the collection displays a valid control number. The current information collection requirements for the consolidated plan at 24 CFR part 91 have been approved by the Office of Management and Budget under OMB Approval No. 2506–0117.

Information on the estimated public reporting burden is provided in the following table:

Information collection, 24 CFR part 91	Number of respondents	Frequency of response	Burden hours	Total hours
Consolidated Plan				
<i>Localities</i>				
• Strategic Plan Development § 91.215)	1,000	1	220	220,000
• Action Plan Development (§ 91.220)	1,000	1	112	112,000
<i>States</i>				
• Strategic Plan Development (§ 91.315)	50	1	604	30,200
• Action Plan Development (§ 91.320)	50	1	374	18,700
Performance Report (§§ 91.15, 91.520)				
• Localities	1,000	1	162	162,000
• States	50	1	252	12,600
*Abbreviated Strategy	100	.....	.....	8,200
Total Burden .....	.....	.....	.....	563,700

*Respondents that submit abbreviated plans are those local governments that are required by statute to submit an abbreviated plan because they receive direct funds from HUD and are not formula grantees. For example, local governments that are recipients of lead based paint grants.

In accordance with 5 CFR 1320.8(d)(1), HUD is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.*, permitting electronic submission of responses.

Interested persons are invited to submit comments regarding the information collection requirements in this proposal. Under the provisions of 5 CFR 1320, OMB is required to make a decision concerning this collection of information between 30 and 60 days after today's publication date. Therefore, any comment on the information collection requirements is best assured of having its full effect if OMB receives the comment within 30 days of today's publication. This time frame does not affect the deadline for comments to the

agency on the proposed rule, however. Comments must refer to the proposal by name and docket number (FR–4923–P–01) and must be sent to:

Mark D. Menchik, HUD Desk Officer,
Office of Management and Budget, New
Executive Office Building, Washington,
DC 20503, *Mark_D.*
Menchik@omb.eop.gov;

and

Shelia Jones, Reports Liaison Officer,
Office of the Assistant Secretary for
Community Planning and Development,
Department of Housing and Urban
Development, 451 7th Street, SW.,
Room 7232, Washington, DC 20410.

Environmental Impact

A Finding of No Significant Impact with respect to the environment has been made in accordance with HUD regulations at 24 CFR part 50, which implement section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332). The Finding of No Significant Impact is available for public inspection weekdays between the hours of 8 a.m. and 5 p.m. in the Office of the Rules Docket Clerk, Office of General Counsel, Room 10276, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410–0500.

Impact on Small Entities

The Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*), generally requires

an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. There are no anti-competitive discriminatory aspects of the rule with regard to small entities and there are not any unusual procedures that need to be complied with by small entities. Accordingly, the undersigned certifies that this rule will not have a significant economic impact on a substantial number of small entities. Notwithstanding HUD's determination that this rule will not have a significant economic impact on a substantial number of small entities, HUD specifically invites comments regarding less burdensome alternatives to this rule that will meet HUD's objectives as described in this preamble.

Executive Order 13132, Federalism

Executive Order 13132, entitled "Federalism," prohibits an agency from publishing any rule that has federalism implications if the rule either imposes substantial direct compliance costs on state and local governments and is not required by statute, or the rule preempts state law, unless the agency meets the consultation and funding requirements of section 6 of the executive order. This proposed rule does not have federalism implications and does not impose substantial direct compliance costs on

state and local governments or preempt state law within the meaning of the executive order.

Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) establishes requirements for federal agencies to assess the effects of their regulatory actions on state, local, and tribal governments and on the private sector. This proposed rule does not impose a federal mandate on any state, local, or tribal government, or on the private sector, within the meaning of the Unfunded Mandates Reform Act of 1995.

Regulatory Planning and Review

The Office of Management and Budget (OMB) reviewed this rule under Executive Order 12866, entitled “Regulatory Planning and Review.” OMB determined that this rule is a “significant regulatory action” as defined in section 3(f) of the order (although not an economically significant regulatory action under the order). Any changes made to the rule as a result of that review are identified in the docket file, which is available for public inspection in the office of the Department’s Rules Docket Clerk, Office of General Counsel, Room 10276, 451 Seventh Street, SW., Washington, DC 20410–0500.

Catalog of Federal Domestic Assistance

The applicable Catalog of Federal Domestic Assistance (CFDA) program number is 14.218.

List of Subjects in 24 CFR Part 91

Aged, Grant programs-housing and community development, Homeless, Individuals with disabilities, Low- and moderate-income housing, Reporting and recordkeeping requirements.

Accordingly, for the reasons stated in the preamble, HUD proposes to amend 24 CFR part 91 as follows:

PART 91—CONSOLIDATED SUBMISSIONS FOR COMMUNITY PLANNING AND DEVELOPMENT PROGRAMS

1. The authority citation for part 91 continues to read as follows:

Authority: 42 U.S.C. 3535(d), 3601–3619, 5301–5315, 11331–11388, 12701–12711, 12741–12756, and 12901–12912.

2. In § 91.1, revise paragraph (b) to read as follows:

§ 91.1 Purpose.

* * * * *

(b) *Functions of plan.* The consolidated plan serves the following functions:

- (1) A planning document for the jurisdiction, which builds on a participatory process among citizens, organizations, businesses, and other stakeholders;
 - (2) An application for federal funds under HUD’s formula grant programs for jurisdictions;
 - (3) A strategy to be followed in carrying out HUD programs; and
 - (4) A management tool for assessing performance and tracking results.
3. Add § 91.2(d) to read as follows:

§ 91.2 Applicability.

* * * * *

(d) The Public Housing Agency Plan submission (PHA Plan) (see 24 CFR part 903) includes a certification by the appropriate state or local official that the PHA Plan is consistent with the applicable consolidated plan for the jurisdiction in which the public housing agency is located and must describe the manner in which the applicable contents of the PHA Plan are consistent with the consolidated plan.

4. Amend § 91.5 by adding alphabetically definitions for “chronically homeless person” and “disabling condition” to read as follows:

§ 91.5 Definitions.

* * * * *

Chronically homeless person. An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g. living on the streets) and/or in an emergency shelter during that time.

* * * * *

Disabling condition. For the purposes of chronic homelessness, a disabling condition is a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual’s ability to work or perform one or more activities of daily living.

* * * * *

5. Revise § 91.15 to read as follows:

§ 91.15 Submission date.

(a) *General.* (1) In order to facilitate continuity in its program and to provide accountability to citizens, each jurisdiction should submit its

consolidated plan to HUD at least 45 days before the start of its program year. (But see § 92.104 of this subtitle with respect to newly eligible jurisdictions under the HOME program.) With the exception of the August 16 date noted in paragraph (a)(2) of this section, HUD may grant a jurisdiction an extension of the submission deadline for good cause.

(2) In no event will HUD accept a submission earlier than November 15 or later than August 16 of the Federal fiscal year for which the grant funds are appropriated. Failure to submit the plan by August 16 will automatically result in a loss of the CDBG funds to which the jurisdiction would otherwise be entitled.

(3) A jurisdiction may have a program year that coincides with the Federal fiscal year (e.g., October 1, 2003 through September 30, 2004 for Federal fiscal year 2004 funds). However, the consolidated plan may not be submitted earlier than November 15 of the Federal fiscal year and HUD has the period specified in § 91.500 to review the consolidated plan.

(4) See § 91.20 for HUD field office authorization to grant exceptions to these provisions.

(b) *Frequency of submission.* (1) The summary of the citizen participation and consultation process, the action plan, and the certifications must be submitted on an annual basis.

(2) The housing, and homeless needs assessment, market analysis, and strategic plan must be submitted at least once every five years, or at such time agreed upon by HUD and the jurisdiction in order to facilitate orderly program management, coordinate consolidated plans with time periods used for cooperation agreements, other plans, or the availability of data.

(3) A jurisdiction may make amendments that extend the time period covered by their plan if agreed upon by HUD.

6. Revise § 91.20 to read as follows:

§ 91.20 Exceptions.

The HUD Field Office may grant a jurisdiction an exception from the submission deadline for plans and reports and from a requirement in the implementation guidelines for good cause, as determined by the field office and reported in writing to HUD Headquarters unless the requirement is required by statute or regulation.

7. In § 91.100, revise paragraphs (a) and (c) to read as follows:

§ 91.100 Consultation: local governments.

(a) *General.* (1) When preparing the consolidated plan, the jurisdiction shall consult with other public and private

agencies that provide assisted housing, health services, and social services (including those focusing on services to children, elderly persons, persons with disabilities, persons with HIV/AIDS and their families, homeless persons) during preparation of the consolidated plan.

(2) When preparing the portion of the consolidated plan describing the jurisdiction's homeless strategy, the jurisdiction shall consult with public and private agencies that provide assisted housing, health services, and social services to determine what resources are available to address the needs of any persons that are chronically homeless.

(3) When preparing the portion of its consolidated plan concerning lead-based paint hazards, the jurisdiction shall consult with State or local health and child welfare agencies and examine existing data related to lead-based paint hazards and poisonings, including health department data on the addresses of housing units in which children have been identified as lead poisoned.

(4) When preparing the description of priority nonhousing community development needs, a unit of general local government must notify adjacent units of general local government, to the extent practicable. The nonhousing community development plan must be submitted to the state, and, if the jurisdiction is a CDBG entitlement grantee other than an urban county, to the county.

(5) The jurisdiction also should consult with adjacent units of general local government, including local government agencies with metropolitan-wide planning responsibilities, particularly for problems and solutions that go beyond a single jurisdiction.

* * * * *

(c) *Public housing.* The jurisdiction shall consult with the local public housing agency (PHA) concerning consideration of public housing needs and planned programs and activities. This consultation will help provide a better basis for the certification by the authorized official that the PHA Plan is consistent with the consolidated plan and the local government's description of the manner in which it will address the needs of public housing and, where necessary, the manner in which it will provide financial or other assistance to a troubled PHA to improve its operations and remove such designation. It will also help ensure that activities with regard to local drug elimination, neighborhood improvement programs, and resident programs and services, funded under a public housing agency's program and

those funded under a program covered by the consolidated plan are fully coordinated to achieve comprehensive community development goals.

8. In § 91.105, paragraph (a)(2)(ii) is revised and paragraph (a)(2)(iii) is revised to read as follows:

§ 91.105 Citizen participation plan; local governments.

(a) * * *

(2) * * *

(ii) These requirements are designed especially to encourage participation by low- and moderate-income persons, particularly those living in slum and blighted areas and in areas where CDBG funds are proposed to be used, and by residents of predominantly low- and moderate-income neighborhoods, as defined by the jurisdiction. A jurisdiction also is expected to take whatever actions are appropriate to encourage the participation of all its citizens, including minorities and non-English speaking persons, as well as persons with disabilities. The jurisdiction shall encourage the participation of local and regional institutions and other organizations (including businesses, developers, community and faith-based organizations) in the process of developing and implementing the consolidated plan. The jurisdiction should also explore alternative public involvement techniques and quantitative ways to measure efforts that encourage citizen participation in a shared vision for change in communities and neighborhoods, and the review of program performance, for example, use of focus groups, use of Internet, etc.

(iii) The jurisdiction shall encourage, in conjunction with consultation with public housing agencies, the participation of residents of public and assisted housing developments, in the process of developing and implementing the consolidated plan, along with other low-income residents of targeted revitalization areas in which the developments are located. The jurisdiction shall make an effort to provide information to the public housing agency about consolidated plan activities related to its developments and surrounding communities so that the public housing agency can make this information available at the annual public hearing required for the PHA Plan.

* * * * *

9. Revise § 91.110 to read as follows:

§ 91.110 Consultation; States.

When preparing the consolidated plan, the State shall consult with other

public and private agencies that provide assisted housing (including any State housing agency administering public housing), health services, and social services (including those focusing on services to children, elderly persons, persons with disabilities, persons with HIV/AIDS and their families, homeless persons) during preparation of the consolidated plan. When preparing the portion of the consolidated plan describing the state's homeless strategy, the state shall consult with public and private agencies that provide assisted housing, health services, and social services to determine what resources are available to address the needs of any persons that are chronically homeless. When preparing the portion of its consolidated plan concerning lead-based paint hazards, the State shall consult with State or local health and child welfare agencies and examine existing data related to lead-based paint hazards and poisonings, including health department data on the addresses of housing units in which children have been identified as lead poisoned. When preparing its method of distribution of assistance under the CDBG program, a State must consult with local governments in nonentitlement areas of the State.

10. Revise § 91.115(a)(2) to read as follows:

§ 91.115 Citizen participation plan; states.

(a) * * *

(2) *Encouragement of citizen participation.* The citizen participation plan must provide for and encourage citizens to participate in the development of the consolidated plan, any substantial amendments to the consolidated plan, and the performance report. These requirements are designed especially to encourage participation by low- and moderate-income persons, particularly those living in slum and blighted areas and in areas where CDBG funds are proposed to be used and by residents of predominantly low- and moderate-income neighborhoods. A State also is expected to take whatever actions are appropriate to encourage the participation of all its citizens, including minorities and non-English speaking persons, as well as persons with disabilities. The State shall encourage the participation of statewide and regional institutions and other organizations (including businesses, developers, community and faith-based organizations) in the process of developing and implementing the consolidated plan. The state should also explore alternative public involvement techniques that encourage a shared vision of change for the community and

the review of program performance, for example, use of focus groups, use of Internet.

* * * * *

11. Revise § 91.200 to read as follows:

§ 91.200 General.

(a) A complete consolidated plan consists of the information required in § 91.205 through § 91.230, submitted in accordance with instructions prescribed by HUD (including tables and narratives), or in such other format as jointly agreed upon by HUD and the jurisdiction.

(b) The jurisdiction shall describe the lead agency or entity responsible for overseeing the development of the plan and the significant aspects of the process by which the consolidated plan was developed, the identity of the agencies, groups, organizations, and others who participated in the process, and a description of the jurisdiction's consultations with social service agencies and other entities. It also shall include a concise summary of the citizen participation process, public comments, and efforts made to broaden public participation in the development of the consolidated plan.

12. Revise § 91.205(a), (b) and (c) to read as follows:

§ 91.205 Housing and homeless needs assessment.

(a) *General.* The consolidated plan must provide a concise summary of the jurisdiction's estimated housing needs projected for the ensuing five-year period. Housing data included in this portion of the plan shall be based on U.S. Census data, as provided by HUD, as updated by any properly conducted local study, or any other reliable source that the jurisdiction clearly identifies and should reflect the consultation with social service agencies and other entities conducted in accordance with § 91.100 and the citizen participation process conducted in accordance with § 91.105. For a jurisdiction seeking funding on behalf of an eligible metropolitan statistical area under the HOPWA program, the needs described for housing and supportive services must address the needs of persons with HIV/AIDS and their families throughout the eligible metropolitan statistical area.

(b) *Categories of persons affected.* (1) The plan shall estimate the number and type of families in need of housing assistance for extremely low-income, low-income, moderate-income, and middle-income families, for renters and owners, for elderly persons, for single persons, for large families, public housing residents, families on the public housing and section 8 tenant-

based waiting list, persons with HIV/AIDS and their families, and for persons with disabilities. The description of housing needs shall include a concise summary of the cost burden and severe cost burden, overcrowding (especially for large families), and substandard housing conditions being experienced by extremely low-income, low-income, moderate-income, and middle-income renters and owners compared to the jurisdiction as a whole. (The jurisdiction must define in its consolidated plan the terms "standard condition" and "substandard condition but suitable for rehabilitation.")

(2) For any of the income categories enumerated in paragraph (b)(1) of this section, to the extent that any racial or ethnic group has disproportionately greater need in comparison to the needs of that category as a whole, assessment of that specific need shall be included. For this purpose, disproportionately greater need exists when the percentage of persons in a category of need who are members of a particular racial or ethnic group in a category of need is at least 10 percentage points higher than the percentage of persons in the category as a whole.

(c) *Homeless needs.* The plan must provide a concise summary of the nature and extent of homelessness (including rural homelessness), addressing separately the need for facilities and services for homeless individuals and homeless families with children, both sheltered and unsheltered, and homeless subpopulations, in accordance with a table prescribed by HUD. This description must include the characteristics and needs of low-income individuals and families with children (especially extremely low-income) who are currently housed but threatened with homelessness. The plan also must contain a brief narrative description of the nature and extent of homelessness by racial and ethnic group, to the extent information is available.

* * * * *

13. In § 91.210, paragraphs (b)(1), (b)(2), and (c) are revised to read as follows:

§ 91.210 Housing market analysis.

* * * * *

(b) *Public and assisted housing.* (1) The plan must describe and identify the public housing developments and the number of public housing units in the jurisdiction, the physical condition of such units, the restoration and revitalization needs, results from the Section 504 needs assessment (*i.e.*, assessment of needs of tenants and applicants on waiting list for accessible

units, as required by 24 CFR 8.25), and the public housing agency's strategy for improving the management and operation of such public housing and for improving the living environment of low- and moderate-income families residing in public housing. The consolidated plan must identify the public housing developments in the jurisdictions that are participating in an approved PHA Plan.

(2) The jurisdiction shall include a description of the number and targeting (income level and type of family served) of units currently assisted by local, state, or federally funded programs, and an assessment of whether any such units are expected to be lost from the assisted housing inventory for any reason, for example, expiration of Section 8 contracts.

(c) *Homeless facilities.* The plan must include a brief inventory of facilities and services that meet the emergency shelter, transitional housing, permanent supportive housing, and permanent housing needs of homeless persons within the jurisdiction, including any persons that are chronically homeless.

* * * * *

14. In § 91.215, revise paragraphs (a)(1) through (a)(6), (b)(2), (b)(3), (c), (d), (e), (h), (i), (j) and (k) to read as follows:

§ 91.215 Strategic plan.

(a) * * *

(1) Indicate the general priorities for allocating investment geographically within the jurisdiction (or within the EMSA for the HOPWA program) and among different activities and needs, as identified in tables prescribed by HUD.

(2) Describe the reasons for assigning the priority (including the relative priority, where required) given to each category of priority needs;

(3) Identify any obstacles to meeting underserved needs;

(4) Summarize the priorities and specific objectives the jurisdiction intends to initiate and/or complete during the time period covered by the strategic plan. For each specific objective, identify proposed accomplishments the jurisdiction hopes to achieve in quantitative terms over a specified time period (*e.g.*, one, two, three or more years), or in other measurable terms as identified and defined by the jurisdiction;

(5) Describe how funds that are reasonably expected to be available will be used to address identified needs for the period covered by the plan;

(6) Where known, grantees should include proposed outcomes measures for some of the proposed accomplishments listed in paragraph

(a)(4) of this section in accordance with guidance to be issued by HUD.

(b) * * *

(2) The affordable housing section shall indicate how the characteristics of the housing market will influence the use of funds made available for rental assistance, production of new units, rehabilitation of existing units, or acquisition of existing units (including preserving affordable housing units that may be lost from the assisted housing inventory for any reason). If the jurisdiction intends to use HOME funds for tenant-based assistance, it must specify local market conditions that lead to the choice of this option.

(3) The affordable housing section shall include specific objectives that describe proposed accomplishments the jurisdiction hopes to achieve and must specify the number of extremely low-income, low-income, and moderate-income families to whom the jurisdiction will provide affordable housing as defined in 24 CFR 92.252 for rental housing and 24 CFR 92.254 for homeownership over a specific time period.

(c) *Homelessness.* With respect to homelessness, the consolidated plan must include the priority homeless needs table prescribed by HUD and must describe the jurisdiction's strategy for the following:

(1) Helping low-income families avoid becoming homeless;

(2) Reaching out to homeless persons and assessing their individual needs;

(3) Addressing the emergency shelter and transitional housing needs of homeless persons; and

(4) Helping homeless persons (especially any persons that are chronically homeless) make the transition to permanent housing and independent living.

(d) *Other special needs.* With respect to supportive needs of the non-homeless, the consolidated plan must provide a concise summary of the priority housing and supportive service needs of persons who are not homeless but require supportive housing (*i.e.*, elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addiction, persons with HIV/AIDS and their families, and public housing residents). If the jurisdiction intends to use HOME funds for tenant-based assistance to assist one or more of these subpopulations, it must specify local market conditions that lead to the choice of this option.

(e) *Nonhousing community development plan.* (1) If the jurisdiction seeks assistance under the Community Development Block Grant program, the

consolidated plan must provide a concise summary of the jurisdiction's priority non-housing community development needs eligible for assistance under HUD's community development programs by CDBG eligibility category, in accordance with a table prescribed by HUD. This community development component of the plan must state the jurisdiction's specific long-term and short-term community development objectives (including economic development activities that create jobs), which must be developed in accordance with the primary objective of the CDBG program to develop viable urban communities by providing decent housing and a suitable living environment and expanding economic opportunities, principally for low-income and moderate-income persons. The plan shall also include an estimate of the number of abandoned buildings, using the jurisdiction's definition.

(2) A jurisdiction that elects to carry out a neighborhood revitalization strategy that includes the economic empowerment of low-income residents with respect to one or more of its areas may submit this strategy as part of its community development plan. The strategy must identify long-term and short-term objectives (*e.g.*, physical improvements, social initiatives and economic empowerment), expressing them in terms of measures of outputs and outcomes expected to be achieved in the neighborhood through the use of HUD programs. If HUD approves such a strategy, the jurisdiction can obtain greater flexibility in the use of the CDBG funds in the revitalization area(s) as described in 24 CFR part 570, subpart C.

* * * * *

(h) *Anti-poverty strategy.* The consolidated plan must provide a concise summary of the jurisdiction's goals, programs, and policies for reducing the number of poverty level families and how the jurisdiction's goals, programs, and policies for producing and preserving affordable housing, set forth in the housing component of the consolidated plan, will be coordinated with other programs and services for which the jurisdiction is responsible and the extent to which they will reduce (or assist in reducing) the number of poverty level families, taking into consideration factors over which the jurisdiction has control. These policies may include the jurisdiction's policies for providing employment and training opportunities to section 3 residents pursuant to 24 CFR part 135.

(i) *Institutional structure.* (1) The consolidated plan must provide a concise summary of the institutional structure, including private industry, nonprofit organizations, community and faith-based organizations, and public institutions, through which the jurisdiction will carry out its housing, homeless, and community development plan, assessing the strengths and gaps in that delivery system.

(2) The plan must provide a concise summary of what the jurisdiction will do to overcome gaps in the institutional structure for carrying out its strategy for addressing its priority needs.

(j) *Coordination.* The consolidated plan must provide a concise summary of the jurisdiction's activities to enhance coordination between public and assisted housing providers and private and governmental health, mental health, and service agencies. With respect to the preparation of its homeless strategy, the jurisdiction must describe efforts in addressing the needs of persons that are chronically homeless. With respect to the public entities involved, the plan must describe the means of cooperation and coordination among the State and any units of general local government in the metropolitan area in the implementation of its consolidated plan.

(k) *Public housing.* The consolidated plan must describe the manner in which the plan of the jurisdiction will address the needs of public housing, including the need to increase the number of accessible units where required by a section 504 voluntary compliance agreement. The consolidated plan must also describe the jurisdiction's activities to encourage public housing residents to become more involved in management and participate in homeownership. If the public housing agency is designated as "troubled" by HUD under 24 CFR part 902, the jurisdiction must describe the manner in which it will provide financial or other assistance to improve its operations and remove the "troubled" designation.

15. Revise § 91.220 to read as follows:

§ 91.220 Action plan.

The action plan must include the following:

(a) *Form application.* Standard Form 424;

(b) *Resources and objectives.* (1) Federal resources. The consolidated plan must provide a concise summary of the federal resources (including grant funds and program income) expected to be made available. Federal resources include Section 8 funds made available to jurisdictions and competitive McKinney-Vento Homeless Assistance Act funds.

(2) *Other resources.* The consolidated plan must indicate resources from private and state and local sources that are reasonably expected to be made available to address the needs identified in the plan. The plan must explain how Federal funds will leverage those additional resources, including a description of how matching requirements of the HUD programs will be satisfied. Where the jurisdiction deems it appropriate, it may indicate publicly owned land or property located within the jurisdiction that may be used to address the needs identified in the plan;

(3) *Annual objectives.* The consolidated plan must contain a summary of the annual objectives the jurisdiction expects to achieve during the forthcoming program year.

(c) *Activities to be undertaken.* A description of the activities the jurisdiction will undertake during the next year to address priority needs and objectives. This description of activities shall estimate the number and type of families that will benefit from the proposed activities, the specific local objectives and priority needs (identified in accordance with § 91.215) that will be addressed by the activities using formula grant funds and program income the jurisdiction expects to receive during the program year, proposed accomplishments, and a target date for completion of the activity. This information is to be presented in the form of a table prescribed by HUD;

(d) *Outcome measures.* Each jurisdiction must provide outcome measures for activities included in its action plan in accordance with guidance to be issued by HUD.

(e) *Geographic distribution.* A description of the geographic areas of the jurisdiction (including areas of low-income and minority concentration) in which it will direct assistance during the ensuing program year, giving the rationale for the priorities for allocating investment geographically. When appropriate, jurisdictions should estimate the percentage of funds they plan to dedicate to target areas.

(f) *Affordable housing.* The jurisdiction must specify one-year goals for the number of homeless, non-homeless, and special needs households to be provided affordable housing through activities that provide rental assistance, production of new units, rehabilitation of existing units, or acquisition of existing units using funds made available to the jurisdiction. The term affordable housing shall be as defined in 24 CFR 92.252 for rental housing and 24 CFR 92.254 for homeownership.

(g) *Homeless and other special needs activities.* Activities it plans to undertake during the next year to address emergency shelter and transitional housing needs of homeless individuals and families (including subpopulations), to prevent low-income individuals and families with children (especially those with incomes below 30 percent of median) from becoming homeless, to help homeless persons make the transition to permanent housing and independent living, specific action steps to end chronic homelessness, and to address the special needs of persons who are not homeless identified in accordance with § 91.215(d);

(h) *Barriers to Affordable Housing.* Actions it plans to take during the next year to address public policies, procedures and processes of the jurisdiction that impact the cost of developing, maintaining or improving affordable housing. Such policies, procedures and processes include but are not limited to: land use controls, tax policies affecting land, zoning ordinances, building codes, fees and charges, growth limitations and policies affecting the return on residential investment.

(i) *Other actions.* (1) *General.* Actions it plans to take during the next year to address obstacles to meeting underserved needs, foster and maintain affordable housing, evaluate and reduce lead-based paint hazards, reduce the number of poverty level families, develop institutional structure, and enhance coordination between public and private housing and social service agencies (see § 91.215 (a), (b), (g), (h), (i), and (j)).

(2) *Public housing.* Actions it plans to take during the next year to address the needs of public housing and actions to encourage public housing residents to become more involved in management and participate in homeownership. If the public housing agency is designated as “troubled” by HUD under part 902 of this title, the jurisdiction must describe the manner in which it will provide financial or other assistance to improve its operations and remove the “troubled” designation.

(j) *Program-specific requirements—(1) CDBG.* (i) A jurisdiction must describe activities planned with respect to all CDBG funds expected to be available during the program year (including program income that will have been received before the start of the next program year), except that an amount generally not to exceed ten percent of such total available CDBG funds may be excluded from the funds for which eligible activities are described if it has

been identified for the contingency of cost overruns.

(ii) CDBG funds expected to be available during the program year includes the following:

(A) Any program income that will have been received before the start of the next program year and that has not yet been programmed;

(B) Proceeds from Section 108 loan guarantees that will be used during the year to address the priority needs and specific objectives identified in its strategic plan;

(C) Surplus from urban renewal settlements;

(D) Grant funds returned to the line of credit for which the planned use has not been included in a prior statement or plan; and

(E) Income from float-funded activities. The full amount of income expected to be generated by a float-funded activity must be shown, whether or not some or all of the income is expected to be received in a future program year. To assure that citizens understand the risks inherent in undertaking float-funded activities, the recipient must specify the total amount of program income expected to be received and the month(s) and year(s) that it expects the float-funded activity to generate such program income.

(iii) An “urgent needs” activity (one that is expected to qualify under § 570.208(c) of this title) may be included only if the jurisdiction identifies the activity in the action plan and certifies that the activity is designed to meet other community development needs having a particular urgency because existing conditions pose a serious and immediate threat to the health or welfare of the community and other financial resources are not available.

(iv) The plan shall identify the estimated amount of CDBG funds that will be used for activities that benefit persons of low- and moderate-income. The information about activities shall be in sufficient detail, including location, to allow citizens to determine the degree to which they are affected.

(2) *HOME.* (i) For HOME funds, a participating jurisdiction shall describe other forms of investment that are not described in § 92.205(b) of this title.

(ii) If the participating jurisdiction intends to use HOME funds for homebuyers, it must state the guidelines for resale or recapture, as required in § 92.254 of this subtitle.

(iii) If the participating jurisdiction intends to use HOME funds to refinance existing debt secured by multifamily housing that is being rehabilitated with HOME funds, it must state its

refinancing guidelines required under 24 CFR 92.206(b). The guidelines shall describe the conditions under which the participating jurisdictions will refinance existing debt. At minimum, the guidelines must:

(A) Demonstrate that rehabilitation is the primary eligible activity and ensure that this requirement is met by establishing a minimum level of rehabilitation per unit or a required ratio between rehabilitation and refinancing.

(B) Require a review of management practices to demonstrate that disinvestment in the property has not occurred; that the long term needs of the project can be met; and that the feasibility of serving the targeted population over an extended affordability period can be demonstrated.

(C) State whether the new investment is being made to maintain current affordable units, create additional affordable units, or both.

(D) Specify the required period of affordability, whether it is the minimum 15 years or longer.

(E) Specify whether the investment of HOME funds may be jurisdiction-wide or limited to a specific geographic area, such as a neighborhood identified in a neighborhood revitalization strategy under 24 CFR 91.215(d)(2) or a Federally designated Empowerment Zone or Enterprise Community.

(F) State that HOME funds cannot be used to refinance multifamily loans made or insured by any Federal program, including CDBG.

(iv) If the participating jurisdiction will receive funding under the American Dream Downpayment Initiative (ADDI) (*see* 24 CFR part 92, subpart M), it must include:

(A) A description of the planned use of the ADDI funds;

(B) A plan for conducting targeted outreach to residents and tenants of public and manufactured housing and to other families assisted by public housing agencies, for the purposes of ensuring that the ADDI funds are used to provide downpayment assistance for such residents, tenants, and families; and

(C) A description of the actions to be taken to ensure the suitability of families receiving ADDI funds to undertake and maintain homeownership.

(3) *HOPWA*. For HOPWA funds, the jurisdiction must specify one-year goals for the number of households to be provided housing through the use of HOPWA activities for: short-term rent, mortgage and utility assistance payments to prevent homelessness of

the individual or family; tenant-based rental assistance; and units provided in housing facilities that are being developed, leased or operated with HOPWA funds.

(k) A concise summary of the citizen participation and consultation process (including efforts to broaden public participation) (24 CFR 91.200(b)), a summary of comments or views, and a summary of comments or views not accepted and the reasons therefore. (24 CFR 91.105(b)(5))

16. Revise § 91.300(b) to read as follows:

§ 91.300 General.

* * * * *

(b) The state shall describe the lead agency or entity responsible for overseeing the development of the plan and the significant aspects of the process by which the consolidated plan was developed, the identity of the agencies, groups, organizations, and others who participated in the process, and a description of the state's consultations with social service agencies and other entities. It also shall include a concise summary of the citizen participation process, public comments, and efforts made to broaden public participation in the development of the consolidated plan.

17. In § 91.305, revise paragraphs (a), (b), and (c) to read as follows:

§ 91.305 Housing and homeless needs assessment.

(a) *General*. The consolidated plan must provide a concise summary of the state's estimated housing needs projected for the ensuing five-year period. Housing data included in this portion of the plan shall be based on U.S. Census data, as provided by HUD, as updated by any properly conducted local study, or any other reliable source that the jurisdiction clearly identifies and should reflect the consultation with social service agencies and other entities conducted in accordance with § 91.110 and the citizen participation process conducted in accordance with § 91.115. For a State seeking funding under the HOPWA program, the needs described for housing and supportive services must address the needs of persons with HIV/AIDS and their families in areas outside of eligible metropolitan statistical areas.

(b) *Categories of persons affected*. (1) The plan shall estimate the number and type of families in need of housing assistance for extremely low-income, low-income, moderate-income, and middle-income families, for renters and owners, for elderly persons, for single persons, for large families, for persons

with HIV/AIDS and their families, and for persons with disabilities. The description of housing needs shall include a concise summary of the cost burden and severe cost burden, overcrowding (especially for large families), and substandard housing conditions being experienced by extremely low-income, low-income, moderate-income, and middle-income renters and owners compared to the state as a whole. (The state must define in its consolidated plan the terms "standard condition" and "substandard condition but suitable for rehabilitation.")

(2) For any of the income categories enumerated in paragraph (b)(1) of this section, to the extent that any racial or ethnic group has disproportionately greater need in comparison to the needs of that category as a whole, assessment of that specific need shall be included. For this purpose, disproportionately greater need exists when the percentage of persons in a category of need who are members of a particular racial or ethnic group in a category of need is at least 10 percentage points higher than the percentage of persons in the category as a whole.

(c) *Homeless needs*. The plan must provide a concise summary of the nature and extent of homelessness (including rural homelessness) within the state, addressing separately the need for facilities and services for homeless individuals and homeless families with children, both sheltered and unsheltered, and homeless subpopulations, in accordance with a table prescribed by HUD. This description must include the characteristics and needs of low-income individuals and families with children (especially extremely low-income) who are currently housed but threatened with homelessness. The plan also must contain a brief narrative description of the nature and extent of homelessness by racial and ethnic group, to the extent information is available.

* * * * *

18. Revise § 91.310(b) to read as follows:

§ 91.310 Housing market analysis.

* * * * *

(b) *Homeless facilities*. The plan must include a brief inventory of facilities and services that meet the emergency shelter, transitional housing, permanent supportive housing, and permanent housing needs of homeless persons within the jurisdiction, including any persons that are chronically homeless.

* * * * *

19. Revise § 91.315(a)(4), (a)(6), (b)(2), (b)(3), (c), (d), (e), (h), (i), (j), and (l) as follows:

§ 91.315 Strategic plan.

(a) * * *

(4) Summarize the priorities and specific objectives the State intends to initiate and/or complete during the time period covered by the strategic plan, describing how the proposed distribution of funds will address identified needs. For each specific objective, identify proposed accomplishments the state hopes to achieve in quantitative terms over a specified time period (*e.g.*, one, two, three or more years), or in other measurable terms as identified and defined by the jurisdiction;

* * * * *

(6) Where known, grantees should include proposed outcomes measures for some of the proposed accomplishments listed in paragraph (a)(4) of this section in accordance with guidance to be issued by HUD.

(b) * * *

(2) The affordable housing section shall indicate how the characteristics of the housing market will influence the use of funds made available for rental assistance, production of new units, rehabilitation of existing units, or acquisition of existing units (including preserving affordable housing units that may be lost from the assisted housing inventory for any reason). If the State intends to use HOME funds for tenant-based assistance, it must specify local market conditions that lead to the choice of this option.

(3) The affordable housing section shall include specific objectives that describe proposed accomplishments the state hopes to achieve and must specify the number of extremely low-income, low-income, and moderate-income families to whom the jurisdiction will provide affordable housing as defined in 24 CFR 92.252 for rental housing and 24 CFR 92.254 for homeownership over a specific time period.

(c) *Homelessness.* With respect to homelessness, the consolidated plan must include the priority homeless needs table prescribed by HUD and must describe the state's strategy for the following:

(1) Helping low-income families avoid becoming homeless;

(2) Reaching out to homeless persons and assessing their individual needs;

(3) Addressing the emergency shelter and transitional housing needs of homeless persons; and

(4) Helping homeless persons (especially any persons that are chronically homeless) make the

transition to permanent housing and independent living.

(d) *Other special needs.* With respect to supportive needs of the non-homeless, the consolidated plan must provide a concise summary of the priority housing and supportive service needs of persons who are not homeless but require supportive housing (*i.e.*, elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addiction, persons with HIV/AIDS and their families, and public housing residents). If the State intends to use HOME funds for tenant-based assistance to assist one or more of these subpopulations, it must specify local market conditions that lead to the choice of this option.

(e) *Nonhousing community development plan.* (1) If the State seeks assistance under the CDBG Program, the consolidated plan must concisely describe the State's priority nonhousing community development needs that affect more than one unit of general local government. These priority needs must be described by CDBG eligibility category, reflecting the needs of persons or families for each type of activity. This community development component of the plan must state the State's specific long-term and short-term community development objectives (including economic development activities that create jobs), which must be developed in accordance with the primary objective of the CDBG program to develop viable urban communities by providing decent housing and a suitable living environment and expanding economic opportunities, principally for low-income and moderate-income persons.

(2) A State may elect to allow units of general local government to carry out a community revitalization strategy that includes the economic empowerment of low income residents, in order to obtain the additional flexibility available as provided in 24 CFR part 570, subpart I. A State must approve a local government's revitalization strategy before it may be implemented. If a State elects to allow revitalization strategies in its program, the method of distribution contained in a State's action plan pursuant to § 91.320(j)(1) must reflect the State's process and criteria for approving local governments' revitalization strategies. The strategy must identify the long-term and short-term objectives (*e.g.* physical improvements, social initiatives and economic empowerment), expressing them in terms of measures of outputs and outcomes expected to be achieved through the use of HUD programs. The

State's process and criteria are subject to HUD approval.

* * * * *

(h) *Anti-poverty strategy.* The consolidated plan must provide a concise summary of the state's goals, programs, and policies for reducing the number of poverty level families and how the state's goals, programs, and policies for producing and preserving affordable housing, set forth in the housing component of the consolidated plan, will be coordinated with other programs such as Temporary Aid for Needy Families as well as employment and training programs and services for which the state is responsible and the extent to which they will reduce (or assist in reducing) the number of poverty level families, taking into consideration factors over which the jurisdiction has control.

(i) *Institutional structure.* (1) The consolidated plan must provide a concise summary of the institutional structure, including private industry, nonprofit organizations, and public institutions, through which the state will carry out its housing, homeless, and community development plan, assessing the strengths and gaps in that delivery system.

(2) The plan must provide a concise summary of what the state will do to overcome gaps in the institutional structure for carrying out its strategy for addressing its priority needs.

(j) *Coordination.* The consolidated plan must provide a concise summary of the state's activities to enhance coordination between public and assisted housing providers and private and governmental health, mental health, and service agencies. With respect to the preparation of its homeless strategy, the state must describe efforts in addressing the needs of persons that are chronically homeless. With respect to the public entities involved, the plan must describe the means of cooperation and coordination among the state and any units of general local government in the metropolitan area in the implementation of its consolidated plan.

* * * * *

(l) *Public housing.* With respect to public housing, the consolidated plan must do the following:

(1) *Resident initiatives.* For a State that has a State housing agency administering public housing funds, the consolidated plan must describe the State's activities to encourage public housing residents to become more involved in management and participate in homeownership;

(2) *Public housing needs.* The consolidated plan must describe the

manner in which the plan of the State will address the needs of public housing; and

(3) *Troubled public housing agencies.*

If a public housing agency located within a State is designated as "troubled" by HUD under part 902 of this title, the strategy for the State or unit of local government in which any troubled public housing agency is located must describe the manner in which the State or unit of general local government will provide financial or other assistance to improve the public housing agency's operations and remove the "troubled" designation. A State is not required to describe the manner in which financial or other assistance is provided if the troubled public housing agency is located entirely within the boundaries of a unit of general local government that must submit a consolidated plan to HUD.

20. Revise § 91.320 to read as follows:

§ 91.320 Action plan.

The action plan must include the following:

(a) *Form application.* Standard Form 424;

(b) *Resources and objectives.* (1) Federal resources. The consolidated plan must provide a concise summary of the Federal resources expected to be made available. These resources include grant funds and program income.

(2) *Other resources.* The consolidated plan must indicate resources from private and non-Federal public sources that are reasonably expected to be made available to address the needs identified in the plan. The plan must explain how federal funds will leverage those additional resources, including a description of how matching requirements of the HUD programs will be satisfied. Where the State deems it appropriate, it may indicate publicly owned land or property located within the State that may be used to carry out the purposes identified in the plan;

(3) *Annual objectives.* The consolidated plan must contain a summary of the annual objectives the State expects to achieve during the forthcoming program year.

(c) *Activities.* A description of the State's method for distributing funds to local governments and nonprofit organizations to carry out activities, or the activities to be undertaken by the State, using funds that are expected to be received under formula allocations (and related program income) and other HUD assistance during the program year and how the proposed distribution of funds will address the priority needs and specific objectives described in the consolidated plan;

(d) *Outcome measures.* Each State must provide outcome measures for activities included in its action plan in accordance with guidance to be issued by HUD. For the Community Development Block Grant Program this would include activities that are likely to be funded as a result of the implementation of the State's Method of Distribution.

(e) *Geographic distribution.* A description of the geographic areas of the State (including areas of low-income and minority concentration) in which it will direct assistance during the ensuing program year, giving the rationale for the priorities for allocating investment geographically. When appropriate, the State should estimate the percentage of funds they plan to dedicate to target area(s).

(f) *Affordable housing goals.* The state must specify one-year goals for the number of homeless, non-homeless, and special needs households to be provided affordable housing through activities that provide rental assistance, production of new units, rehabilitation of existing units, or acquisition of existing units using funds made available to the state. The term affordable housing shall be as defined in 24 CFR 92.252 for rental housing and 24 CFR 92.254 for homeownership.

(g) *Homeless and other special needs activities.* Activities it plans to undertake during the next year to address emergency shelter and transitional housing needs of homeless individuals and families (including subpopulations), to prevent low-income individuals and families with children (especially those with incomes below 30 percent of median) from becoming homeless, to help homeless persons make the transition to permanent housing and independent living, specific action steps to end chronic homelessness, and to address the special needs of persons who are not homeless identified in accordance with § 91.315(d);

(h) *Barriers to Affordable Housing.* Actions it plans to take during the next year to address public policies, procedures, and processes of the State that impact the cost of developing, maintaining, or improving affordable housing. Such policies, procedures, and processes include but are not limited to: land use controls, tax policies affecting land, zoning ordinances, building codes, fees and charges, growth limitations, and policies affecting the return on residential investment.

(i) *Other actions.* Actions it plans to take during the next year to implement its strategic plan and address obstacles to meeting underserved needs, foster

and maintain affordable housing (including the coordination of Low-Income Housing Tax Credits with the development of affordable housing), evaluate and reduce lead-based paint hazards, reduce the number of poverty level families, develop institutional structure, enhance coordination between public and private housing and social service agencies, address the needs of public housing (including providing financial or other assistance to troubled public housing agencies), and encourage public housing residents to become more involved in management and participate in homeownership.

(j) *Program-specific requirements.* In addition, the plan must include the following specific information: (1) The method of distribution shall contain a description of all criteria used to select applications from local governments for funding, including the relative importance of the criteria—if the relative importance has been developed. The action plan must include a description of how all CDBG resources will be allocated among all funding categories and the threshold factors and grant size limits that are to be applied. If the State intends to aid nonentitlement units of general local government in applying for guaranteed loan funds under 24 CFR part 570, subpart M, it must describe available guarantee amounts and how applications will be selected for assistance. If a State elects to allow units of general local government to carry out community revitalization strategies, the method of distribution shall reflect the State's process and criteria for approving local governments' revitalization strategies. (The statement of the method of distribution must provide sufficient information so that units of general local government will be able to understand and comment on it and be able to prepare responsive applications.)

(i) The method of distribution shall contain a description of all criteria used to select applications from local governments for funding. Notwithstanding, the method of distribution may provide a summary of the selection criteria, (providing that all criteria are listed) as long as the details are contained in application manuals or other official state publications that are widely distributed to potential applicants. The action plan must include a description of how all CDBG resources will be allocated among all funding categories and the threshold factors and grant size limits that are to be applied. If the State intends to aid nonentitlement units of general local

government in applying for guaranteed loan funds under 24 CFR part 570, subpart M, it must describe available guarantee amounts and how applications will be selected for assistance. If a State elects to allow units of general local government to carry out community revitalization strategies, the method of distribution shall reflect the State's process and criteria for approving local government's revitalization strategies. The statement of the method of distribution must provide sufficient information so that units of general local government will be able to understand and comment on it, understand on what criteria and information their application will be judged, and be able to prepare responsive applications. This means that all selection criteria must be included in at least summary form, with the details included in other application materials that are widely distributed to potential applicants. If final funding decisions will be made by senior management, the Method of Distribution must include the criteria that senior management will use to make the decisions.

(ii) The State shall keep records to document its funding decision reached under the Method of Distribution described in paragraph (i) above so that they can be reviewed by HUD, the Inspector General, the Government Accountability Office and citizens pursuant to the requirements of § 570.493(a).

(iii) Approval of the Consolidated Plan under § 91.500 shall not be deemed to indicate that the Method of Distribution is in compliance with the requirements of paragraph (i) above, and HUD may monitor the Method of Distribution as part of its review and audit as provided in § 570.493(a)(1).

(2) *HOME*. (i) The State shall describe other forms of investment that are not described in Sec. 92.205(b) of this subtitle.

(ii) If the State intends to use HOME funds for homebuyers, it must state the guidelines for resale or recapture, as required in § 92.254 of this subtitle.

(iii) If the State intends to use HOME funds to refinance existing debt secured by multifamily housing that is being rehabilitated with HOME funds, it must state its refinancing guidelines required

under 24 CFR 92.206(b). The guidelines shall describe the conditions under which the State will refinance existing debt. At minimum, the guidelines must:

(A) Demonstrate that rehabilitation is the primary eligible activity and ensure that this requirement is met by establishing a minimum level of rehabilitation per unit or a required ratio between rehabilitation and refinancing.

(B) Require a review of management practices to demonstrate that disinvestment in the property has not occurred; that the long term needs of the project can be met; and that the feasibility of serving the targeted population over an extended affordability period can be demonstrated.

(C) State whether the new investment is being made to maintain current affordable units, create additional affordable units or both.

(D) Specify the required period of affordability, whether it is the minimum 15 years or longer.

(E) Specify whether the investment of HOME funds may be jurisdiction-wide or limited to a specific geographic area, such as a neighborhood identified in a neighborhood revitalization strategy under 24 CFR 91.215(e)(2) or a Federally designated Empowerment Zone or Enterprise Community.

(F) State HOME funds cannot be used to refinance multifamily loans made or insured by any Federal program, including CDBG.

(iv) If the state will receive funding under the American Dream Downpayment Initiative (ADDI) (*see* 24 CFR part 92, subpart M), it must include:

(A) A description of the planned use of the ADDI funds;

(B) A plan for conducting targeted outreach to residents and tenants of public and manufactured housing and to other families assisted by public housing agencies, for the purposes of ensuring that the ADDI funds are used to provide downpayment assistance for such residents, tenants, and families; and

(C) A description of the actions to be taken to ensure the suitability of families receiving ADDI funds to undertake and maintain homeownership, such as provision of housing counseling to homebuyers.

(3) *ESG*. The State shall state the process for awarding grants to State recipients and a description of how the State intends to make its allocation available to units of local government and nonprofit organizations (including community and faith-based organizations).

(4) *HOPWA*. The State shall state the method of selecting project sponsors (including community and faith-based organizations).

(k) A concise summary of the citizen participation and consultation process (including efforts to broaden public participation) (24 CFR 91.200 (b)), a summary of comments or views, and a summary of comments or views not accepted and the reasons therefore. (24 CFR 91.105 (b)(5)).

21. In § 91.500, revise paragraph (b)(3) and add paragraph (b)(4) to read as follows:

§ 91.500 HUD approval action.

* * * * *

(b) * * *

(3) A plan for which a certification is rejected by HUD as inaccurate, after HUD has inspected the evidence and provided due notice and opportunity to the jurisdiction for comment; and

(4) A plan that does not include a description of the manner in which the unit of general local government will provide financial or other assistance to a public housing agency if the public housing agency is designated as "troubled" by HUD.

* * * * *

22. Revise § 91.520 by adding paragraph (g) to read as follows:

§ 91.520 Performance reports.

* * * * *

(g) The report will include a comparison of the proposed versus actual outcomes for each outcome measure submitted with the consolidated plan. The report must explain variances between the proposed and actual outcomes.

Dated: November 30, 2004.

Nelson R. Bregón,

General Deputy Assistant Secretary for Community Planning and Development.

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Federal Register

**Thursday,
December 30, 2004**

Part V

The President

**Memorandum of December 8, 2004—
Assignment of Functions Implementing
the HELP Commission Act**

**Presidential Determination No. 2005–10 of
December 8, 2004—Waiver of Restrictions
on Providing Funds to the Palestinian
Authority**

**Presidential Determination No. 2005–14 of
December 15, 2004—Suspension of
Limitations Under the Jerusalem Embassy
Act**

Presidential Documents

Title 3—

Memorandum of December 8, 2004

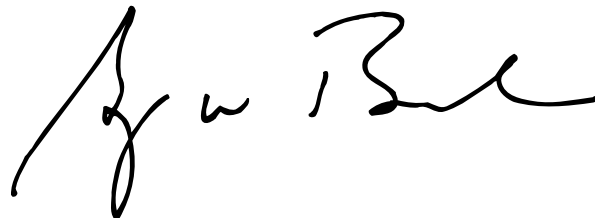
The President

Assignment of Functions Implementing the HELP Commission Act

Memorandum for the Secretary of State [and] the Administrator of the United States Agency for International Development

By the authority vested in me as President by the Constitution and laws of the United States, including section 301 of title 3, United States Code:

1. The functions of the President under subsection 637(k) of the Commerce, Justice and State, the Judiciary, and Related Agencies Appropriations Act, 2004 (Division B, Public Law 108–199)(22 U.S.C. 2394b(k))(the “Act”) are assigned to the Secretary of State (Secretary).
2. The Administrator of the United States Agency for International Development shall provide support to assist the Secretary in the performance of functions assigned by this memorandum, and the heads of executive departments and agencies with information concerning assistance programs shall furnish promptly to the Secretary, consistent with applicable law, such information as the Secretary may request to assist in fulfillment of these responsibilities for the preparation of the report to which subsection 637 (k) refers.
3. The Secretary shall coordinate the receipt by departments and agencies of requests from the HELP Commission under section 637(e) of the Act for information and their responses to such requests. Such departments and agencies shall provide relevant information and responses promptly. The Secretary shall ensure that such responses occur in a manner consistent with the President’s constitutional authority to withhold information that could impair foreign relations, national security, the deliberate processes of the Executive, or the performance of the Executive’s constitutional duties.
4. Heads of executive departments and agencies shall assist the Secretary in the implementation of this memorandum.
5. The Secretary is authorized and directed to publish this memorandum in the **Federal Register**.



THE WHITE HOUSE,
Washington, December 8, 2004.

Presidential Documents

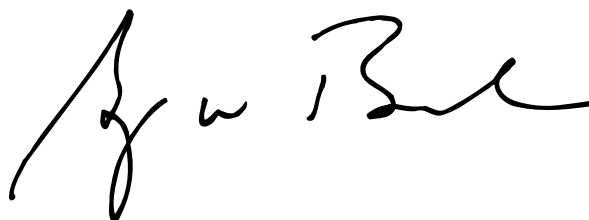
Presidential Determination No. 2005–10 of December 8, 2004

Waiver of Restrictions on Providing Funds to the Palestinian Authority

Memorandum for the Secretary of State

Pursuant to the authority vested in me as President by the Constitution and laws of the United States, including section 552(b) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2004 (Div. D, Public Law 108–199) (the “Act”), as carried forward under Public Law 108–309, as amended, I hereby certify that it is important to the national security interests of the United States to waive the provisions of section 552(a) of the Act, as carried forward, in order to provide funds appropriated to carry out chapter 4 of part II of the Foreign Assistance Act of 1961 to the Ministry of Finance of the Palestinian Authority for budget support.

You are authorized and directed to transmit this determination to the Congress, accompanied by a report in accordance with section 552(d) of the Act, and to publish the determination in the **Federal Register**.



THE WHITE HOUSE,
Washington, December 8, 2004.

Presidential Documents

Presidential Determination No. 2005–14 of December 15, 2004

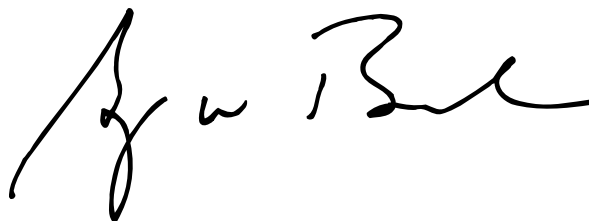
Suspension of Limitations Under the Jerusalem Embassy Act

Memorandum for the Secretary of State

Pursuant to the authority vested in me as President by the Constitution and the laws of the United States, including section 7(a) of the Jerusalem Embassy Act of 1995 (Public Law 104–45) (the “Act”), I hereby determine that it is necessary to protect the national security interests of the United States to suspend for a period of 6 months the limitations set forth in sections 3(b) and 7(b) of the Act. My Administration remains committed to beginning the process of moving our embassy to Jerusalem.

You are hereby authorized and directed to transmit this determination to the Congress, accompanied by a report in accordance with section 7(a) of the Act, and to publish the determination in the **Federal Register**.

This suspension shall take effect after transmission of this determination and report to the Congress.



THE WHITE HOUSE,
Washington, December 15, 2004.

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Federal Register

Vol. 69, No. 250

Thursday, December 30, 2004

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LIST OF PUBLIC LAWS

This is a continuing list of public bills from the current session of Congress which have become Federal laws. It may be used in conjunction with "PLUS" (Public Laws Update Service) on 202-741-6043. This list is also available online at http://www.archives.gov/federal_register/public_laws/public_laws.html.

The text of laws is not published in the **Federal Register** but may be ordered in "slip law" (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202-512-1808). The text will also be made available on the Internet from GPO Access at <http://www.gpoaccess.gov/plaws/index.html>. Some laws may not yet be available.

H.R. 480/P.L. 108-459

To redesignate the facility of the United States Postal Service located at 747 Broadway in Albany, New York, as the "United States Postal Service Henry Johnson Annex". (Dec. 21, 2004; 118 Stat. 3873)

H.R. 2119/P.L. 108-460

To provide for the conveyance of Federal lands, improvements, equipment, and resource materials at the Oxford Research Station in Granville County, North Carolina, to the State of North Carolina. (Dec. 21, 2004; 118 Stat. 3874)

H.R. 2523/P.L. 108-461

To designate the United States courthouse located at

125 Bull Street in Savannah, Georgia, as the "Tomochichi United States Courthouse". (Dec. 21, 2004; 118 Stat. 3875)

H.R. 3124/P.L. 108-462

To designate the facility of the United States Geological Survey and the United States Bureau of Reclamation located at 230 Collins Road, Boise, Idaho, as the "F.H. Newell Building". (Dec. 21, 2004; 118 Stat. 3876)

H.R. 3147/P.L. 108-463

To designate the Federal building located at 324 Twenty-Fifth Street in Ogden, Utah, as the "James V. Hansen Federal Building". (Dec. 21, 2004; 118 Stat. 3877)

H.R. 3204/P.L. 108-464

Benjamin Franklin Commemorative Coin Act (Dec. 21, 2004; 118 Stat. 3878)

H.R. 3242/P.L. 108-465

Specialty Crops Competitiveness Act of 2004 (Dec. 21, 2004; 118 Stat. 3882)

H.R. 3734/P.L. 108-466

To designate the Federal building located at Fifth and Richardson Avenues in Roswell, New Mexico, as the "Joe Skeen Federal Building". (Dec. 21, 2004; 118 Stat. 3888)

H.R. 3884/P.L. 108-467

To designate the Federal building and United States courthouse located at 615 East Houston Street in San Antonio, Texas, as the "Hipolito F. Garcia Federal Building and United States Courthouse". (Dec. 21, 2004; 118 Stat. 3889)

H.R. 4232/P.L. 108-468

To redesignate the facility of the United States Postal Service located at 4025 Feather Lakes Way in Kingwood, Texas, as the "Congressman Jack Fields Post Office". (Dec. 21, 2004; 118 Stat. 3890)

H.R. 4324/P.L. 108-469

Thrift Savings Plan Open Elections Act of 2004 (Dec. 21, 2004; 118 Stat. 3891)

H.R. 4620/P.L. 108-470

To confirm the authority of the Secretary of Agriculture to collect approved State commodity assessments on behalf of the State from the proceeds of marketing assistance loans. (Dec. 21, 2004; 118 Stat. 3894)

H.R. 4807/P.L. 108-471

To designate the facility of the United States Postal Service located at 140 Sacramento Street in Rio Vista, California, as the "Adam G. Kinser Post Office Building". (Dec. 21, 2004; 118 Stat. 3895)

H.R. 4847/P.L. 108-472

To designate the facility of the United States Postal Service located at 560 Bay Isles Road in Longboat Key, Florida, as the "Lieutenant General James V. Edmundson Post Office Building". (Dec. 21, 2004; 118 Stat. 3896)

H.R. 4968/P.L. 108-473

To designate the facility of the United States Postal Service located at 25 McHenry Street in Rosine, Kentucky, as the "Bill Monroe Post Office". (Dec. 21, 2004; 118 Stat. 3897)

H.R. 5360/P.L. 108-474

American History and Civics Education Act of 2004 (Dec. 21, 2004; 118 Stat. 3898)

H.R. 5364/P.L. 108-475

To designate the facility of the United States Postal Service located at 5505 Stevens Way in San Diego, California, as the "Earl B. Gilliam/Imperial Avenue Post Office Building". (Dec. 21, 2004; 118 Stat. 3900)

H.R. 5365/P.L. 108-476

To treat certain arrangements maintained by the YMCA Retirement Fund as church plans for the purposes of certain provisions of the Internal Revenue Code of 1986, and for other purposes. (Dec. 21, 2004; 118 Stat. 3901)

H.R. 5370/P.L. 108-477

To designate the facility of the United States Postal Service located at 4985 Moorhead Avenue in Boulder, Colorado, as the "Donald G. Brotzman Post Office Building". (Dec. 21, 2004; 118 Stat. 3903)

H.R. 4829/P.L. 108-478

To designate the facility of the United States Postal Service located at 103 East Kleberg in Kingsville, Texas, as the "Irma Rangel Post Office Building". (Dec. 21, 2004; 118 Stat. 3904)

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