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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2025–5401; Project Identifier MCAI–2025–01313–A; Amendment 39–23525; AD 2026–24–01]

RIN 2120–AA64

Airworthiness Directives; General Atomics AeroTec Systems GmbH (Type Certificate Previously Held by RUAG Aerospace Services GmbH) Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for all General Atomics AeroTec Systems GmbH (General Atomics) Model Dornier 228–100, Dornier 228–101, Dornier 228–200, Dornier 228–201, Dornier 228–202, and Dornier 228–212 airplanes. This AD was prompted by reports of specific part-numbered hydraulic pump motors becoming severely damaged by excessive heat. This AD requires replacing the affected hydraulic pump motor with an improved design hydraulic pump motor. This AD also prohibits installing an affected hydraulic pump motor on any airplane. The FAA is issuing this AD to address the unsafe condition on these products.

DATES: This AD is effective December 24, 2026.

ADDRESSES:

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2025–5401; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this final rule, the mandatory continuing airworthiness information (MCAI), any comments received, and other information. The address for Docket Operations is U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.

FOR FURTHER INFORMATION CONTACT: Doug Rudolph, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: (816) 329–4059; email: *doug.rudolph@faa.gov.*

SUPPLEMENTARY INFORMATION:

Background

The FAA issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 by adding an AD that would apply to all General Atomics Model Dornier 228–100, Dornier 228–101, Dornier 228–200, Dornier 228–201, Dornier 228–202, and Dornier 228–212 airplanes. The NPRM was published in the **Federal Register** on January 5, 2026 (91 FR 205). The NPRM was prompted by AD 2025–0172, dated August 4, 2025 (EASA AD 2025–0172) (also referred to as the MCAI), issued by the European Union Aviation Safety Agency (EASA), which is the Technical Agent for the Member States of the European Union. The MCAI states that several occurrences were reported where the hydraulic pump motor became severely damaged by excessive heat. The MCAI further states that it was determined that carbon brushes installed on the affected hydraulic pump motor were the root cause of the failures. This condition, if not corrected, could lead to an uncontained fire, possible injury to passengers and crew, and consequent loss of control of the airplane.

In the NPRM, the FAA proposed to require replacing the affected hydraulic pump motor with an improved design hydraulic pump motor. The proposed AD also prohibits installing an affected hydraulic pump motor on any airplane. The FAA is issuing this AD to address the unsafe condition on these products.

You may examine the MCAI in the AD docket at *regulations.gov* under Docket No. FAA–2025–5401.

Discussion of Final Airworthiness Directive

Comments

The FAA received comments from two commenters. The commenters were Bighorn Airways (Bighorn) and Consolidated Aircraft Supply Company, Inc. (Consolidated Aircraft). The following presents the comments received on the NPRM and the FAA's response to each comment.

Request To Withdraw the NPRM

Bighorn requested that the FAA withdraw the NPRM since it has not encountered the unsafe condition addressed by the NPRM. Bighorn based its request on its extensive operational experience of a multi-airplane fleet with over 14,000 hours.

The FAA disagrees with the request to withdraw the NPRM. The condition is based on data extrapolated from the worldwide fleet by EASA and the type certificate holder and confirmed by the FAA. The FAA has determined that this condition is unsafe and could exist or develop on other airplanes of the same type design. The FAA did not change this AD as a result of this comment.

Request To Withdraw the NPRM

Consolidated Aircraft stated that it has not experienced high motor failures in other motor assembly types with the 1259A motor.

The FAA infers that the commenter wants the NPRM withdrawn and disagrees to withdraw the NPRM based on other motor assembly types not having the same failure issues. Service history of the motor assemblies on the affected airplanes reveals failure issues. Therefore, an unsafe condition exists or could develop on other airplanes of this same type design that must be addressed by AD action. If other motor assemblies develop a similar condition, the FAA will consider additional rulemaking action. The FAA did not change this AD as a result of this comment.

Request To Redefine the Actions of AD

Consolidated Aircraft disagreed with changing the part number of the pump motor as required per the service material. Consolidated Aircraft stated that this limits available support, which affects safety. Additionally, Consolidated Aircraft stated that changing the base part number prevents unmodified hydraulic pump motors from being installed, but pointed out that this could have been done by adding a dash to the base number of the old part number.

The FAA disagrees with this comment. The type certificate holder chose to change the part number of the modified pump motor after modification per their procedures to address this

unsafe condition. The FAA will consider alternative methods of compliance (AMOCs) to address this differently if the AMOCs are submitted following paragraph (i) of this AD. Therefore, the FAA did not change this AD as a result of this comment.

Request To Extend the Compliance Time

Bighorn requested that the FAA revise the compliance time in paragraph (g), ''Required Actions'' of the proposed AD, from 200 hours time-in-service (TIS) to 600 hours TIS. The commenter stated that this interval should coincide with the next overhaul of the hydraulic pump motor to reduce the burden of an additional compliance time for replacing the hydraulic pump motor.

The FAA disagrees with the request to extend the compliance time. In developing an appropriate compliance time for this action, the FAA considered the recommendations of the manufacturer and EASA, the risk associated with the subject unsafe condition, the availability of required parts, and the practical aspect of accomplishing the required modification within a period of time that corresponds to the normal scheduled maintenance for most affected operators. According to the manufacturer, an ample number of required parts will be available to modify the U.S. fleet within the proposed compliance time. In consideration of these items as well as the reports of severely heat damaged hydraulic pump motors, the FAA has determined that the 200-hour TIS compliance time is necessary to provide an acceptable level of safety. The FAA did not change this AD as a result of this comment.

Request To Mandate Removal Time

Consolidated Aircraft requested that the FAA add a mandatory removal time for overhaul of the hydraulic pump assembly in the NPRM.

The FAA disagrees with adding a mandatory removal time for overhaul of the hydraulic pump assembly in the NPRM. Per data supplied by the type certificate holder, the motor of the pump assembly is the focus of the unsafe condition and thus the replacement of the motor per paragraph (g) of this AD is the action that addresses the unsafe condition. The pump part of the assembly is replaced on condition as opposed to a time limit replacement schedule.

Request To Require Pump Part Numbers

Consolidated Aircraft stated that it often receives the pump for overhaul, separate from the motor, resulting from extensive wear.

The FAA infers that the commenter wants the FAA to include the part numbers of the pump in the Applicability of this AD. Although there may be signs of extensive wear on the pumps of hydraulic pump assemblies, the pump motor of the assembly is specifically the focus of the MCAI and this AD. The FAA has no data, including nothing from the type certificate (TC) holder, that indicates that wear on the pumps leads to pump motor issues on affected airplanes, so the hydraulic pump part numbers are not included within the scope of the MCAI and this AD. The TC holder has not identified any instances or reports of extensive wear in these pumps. The FAA did not change this AD as a result of this comment.

Request To Add Time Between Overhaul (TBO) for Hydraulic Pump Motor and Pump/Motor Assembly

Consolidated Aircraft asked if the hydraulic pump motor [part number 1259A], and pump/motor assembly, part numbers 40178–02 and –03, have a TBO.

The FAA has confirmed there is no TBO for the hydraulic pump motor addressed by this AD, which is part number 1259A. This AD does not address the hydraulic pump/motor assembly. The FAA did not change this AD as a result of this comment.

Concern Not To Allow Pilots To Handle Tripped Circuit Breakers

Consolidated Aircraft expressed concern about the possibility that pilots having less training could incorrectly handle a hydraulic pump motor circuit breaker when it trips and mentioned that if it does trip, there should be no resetting but instead to tow the airplane if necessary.

It is common airmanship for pilots to be trained to handle not resetting the circuit breaker unless it is deemed necessary. This situation is also addressed in the ''Pilot's Operating Handbook.'' There is no additional need to include pilot actions for tripped circuit breakers within this AD. The FAA did not change this AD as a result of this comment.

Request To Include the Pump Assembly in the AD Applicability

Consolidated Aircraft stated that motor and pump serial numbers are sequential when produced and that traceability of the pump assembly is lost when the pairing of the pump assemblies and hydraulic pump motors are changed.

The FAA infers that the commenter wants the FAA to include the pump assembly in the Applicability of this AD. The FAA disagrees with including the pump assembly in the Applicability of this AD. Since there is no data indicating a safety risk with the pump assemblies paired with the hydraulic pump motors, the FAA has determined that the unsafe condition is only on the pump motor. The FAA did not change this AD as a result of this comment.

Request To Include a Placard in the Cockpit

Consolidated Aircraft requested that the FAA require a placard in the cockpit for pilots to have an observable message regarding the hydraulic pump motor duty cycle.

The FAA disagrees with requiring a placard. Since the pump assembly and the hydraulic pump motor do not continuously operate and are not used more than specified, there would be no need for an additional placard in the cockpit. The FAA did not change this AD as a result of this comment.

Request To Allow FAA-Approved Repair Stations To Complete the Modification

Consolidated Aircraft requested that FAA-approved repair stations be allowed to complete the modification to the hydraulic pump motor assembly.

The FAA infers that the commenter is wanting to modify the internal components of the old motor part number (P/N) 1259A to make it a new P/N A–752511A00B. The FAA disagrees. Currently the General Atomics service bulletin (SB) states to contact the company for a slot for modification of the pump motor to make it a new part number motor or exchange old part number motor for the new part number motor. The SB and this AD do not allow the modification/re-identification of these motors by non-company outside sources. The repair station can still modify the hydraulic pump assembly per General Atomics AeroTec Dornier 228 Service Bulletin No. SB–228–360, Rev. 0. The FAA did not change this AD as a result of this comment.

Conclusion

These products have been approved by the civil aviation authority of another country and are approved for operation in the United States. Pursuant to the FAA's bilateral agreement with this State of Design Authority, that authority

has notified the FAA of the unsafe condition described in the MCAI referenced above. The FAA reviewed the relevant data, considered any comments received, and determined that air safety requires adopting this AD as proposed. Accordingly, the FAA is issuing this AD to address the unsafe condition on these products. Except for minor editorial changes, this AD is adopted as proposed in the NPRM. None of the changes will increase the economic burden on any operator.

Costs of Compliance

The FAA estimates that this AD affects 16 airplanes of U.S. registry.

The FAA estimates the following costs to comply with this AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Replace hydraulic pump motor	3 work-hours × $85 per hour = $255	$8,900	$9,155	$146,480

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.

The FAA is 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

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 this AD:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Will not affect intrastate aviation in Alaska, 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.

List of Subjects in 14 CFR Part 39

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

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:

2026–24–01 General Atomics AeroTec Systems GmbH (Type Certificate Previously Held by RUAG Aerospace Services GmbH): Amendment 39–23525; Docket No. FAA–2025–5401; Project Identifier MCAI–2025–01313–A.

(a) Effective Date

This airworthiness directive (AD) is effective December 24, 2026.

(b) Affected ADs

None.

(c) Applicability

This AD applies to all General Atomics AeroTec Systems GmbH (type certificate previously held by RUAG Aerospace Services GmbH) Model Dornier 228–100, Dornier 228–101, Dornier 228–200, Dornier 228–201, Dornier 228–202, and Dornier 228–212 airplanes, certificated in any category.

(d) Subject

Joint Aircraft System Component (JASC) Code 2913, Hydraulic Pump, (Elect/Eng), Main.

(e) Unsafe Condition

This AD was prompted by reports of several occurrences of hydraulic pump motors becoming severely damaged by excessive heat. The FAA is issuing this AD to prevent the overheating of the hydraulic pump motor. The unsafe condition, if not addressed, could result in an uncontained fire, possible injury to passengers and crew, and loss of control of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

For airplanes with an installed hydraulic pump motor having part number (P/N) 1259A, within 200 hours time-in-service of the hydraulic pump motor (for airplanes equipped with a hydraulic system elapsed time indicator), or 600 landings (for airplanes not equipped with a hydraulic system elapsed time indicator), as applicable, after the effective date of this AD, replace the hydraulic pump motor with a hydraulic pump motor having P/N A–752511A00B.

Note to Paragraph (g): General Atomics AeroTec Dornier 228 Service Bulletin No. SB–228–360, Rev. 0, dated May 28, 2025, contains information related to this AD.

(h) Installation Prohibition

As of the effective date of this AD, do not install a hydraulic pump motor having P/N 1259A on any airplane.

(i) Alternative Methods of Compliance (AMOCs)

The Manager, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the International Validation Branch, send it to the attention of the person identified in paragraph (j)(1) of this AD and email to: *AMOC@faa.gov.* Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(j) Additional Information

(1) For more information about this AD, contact Doug Rudolph, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: (816) 329–4059; email: *doug.rudolph@faa.gov.*

(2) For material identified in this AD that is not incorporated by reference, contact General Atomics AeroTec Systems GmbH, Galileostraße 396, D–82131 Gauting, Germany; phone: +49 8153 302280; email:

custsupport.dornier228@ga-ats.com; website: *ga-ats.com/.*

(k) Material Incorporated by Reference

None.

Issued on November 17, 2026.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2026–23633 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2026–1359]

RIN 1625–AA00

Safety Zones; Annual Events Requiring Safety Zones in the Captain of the Port Lake Michigan Zone—Magnificent Mile Fireworks Display

AGENCY: Coast Guard, Department of Homeland Security.

ACTION: Notification of enforcement of regulation.

SUMMARY: The Coast Guard will enforce a safety zone for the Magnificent Mile Fireworks Display on November 21, 2026, to provide for the safety of life on navigable waterways during this fireworks display. Our regulation for marine events within the Great Lakes Coast Guard District identifies the safety zone for this event in Chicago, IL. During the enforcement period, entry into, transiting, or remaining within the safety zone is prohibited unless authorized by the Captain of the Port (COTP) Lake Michigan or his or her designated representative.

DATES: The regulations in 33 CFR 165.929 will be enforced for the Magnificent Mile Fireworks Display regulated area listed in Event 20 in Table 1 to § 165.929, from 6:55 p.m. until 7:05 p.m. on November 21, 2026.

FOR FURTHER INFORMATION CONTACT: If you have questions about this rule, call or email Lieutenant Michael Vega, Marine Safety Unit Chicago, U.S. Coast Guard; telephone (206) 815–6711, email *D09-SMB-MSUChicago-WWM@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce a safety zone regulation in 33 CFR 165.929 for the Magnificent Mile Fireworks Display listed in Event 20 in Table 1 to § 165.929, from 6:55 p.m. to 7:05 p.m. on Saturday November 21, 2026. The regulation for recurring marine events within the State of Illinois, in Event 20 in Table 1 to § 165.929, specifies the location of the safety zone for this event.

During the enforcement period, vessels must obtain permission from the COTP Lake Michigan or his or her designated representative to enter, move within, or exit a safety zone. Vessels and persons granted permission to enter the safety zone must obey all lawful orders or directions of the COTP Lake Michigan or his or her designated representative. Upon being hailed by the U.S. Coast Guard by siren, radio, flashing light or other means, the operator of a vessel must proceed as directed.

In addition to this notification of enforcement in the **Federal Register**, the Coast Guard will provide the maritime community with notification of this enforcement period via Broadcast Notice to Mariners. The COTP Lake Michigan may be reached by contacting the Coast Guard Sector Lake Michigan Command Center at (833) 900–2247. An on-scene designated representative may be reached via VHF–FM Channel 16.

R.N. Macon,

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

[FR Doc. 2026–23568 Filed 11–18–26; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2026–0830]

RIN 1625–AA00

Safety Zone; Hackensack River, Kearny and Secaucus, NJ

AGENCY: Coast Guard, Department of Homeland Security.

ACTION: Temporary interim rule and request for comments.

SUMMARY: The Coast Guard is establishing a temporary safety zone for navigable waters on the Hackensack River, in Kearny and Secaucus, NJ. The safety zone is needed to protect personnel, vessels, and the marine environment from potential hazards associated with the demolition of the existing Portal Bridge. When subject to enforcement, entry of vessels or persons into this zone is prohibited unless specifically authorized by the Captain of the Port, Sector New York, or their designated representative.

DATES:

Effective date: This rule is effective without actual notice from 6 a.m. November 19, 2026 through 11:59 p.m. on May 27, 2027. For purposes of enforcement the Coast Guard will use actual notice from 6 a.m. on November 17, 2026, through 6 a.m. November 19, 2026 The Coast Guard will only enforce this temporary safety zone during periods during which barges are within the channels at the existing bridge and demolition operations are in progress.

Comments due date: Comments and related material must be received by the Coast Guard on or before December 21, 2026.

FOR FURTHER INFORMATION CONTACT: If you have questions about this rule, contact MST1 Angelina Gerber, Sector New York Waterways Management Division, U.S. Coast Guard; telephone 718–801–2932, or email *SectorNYWWM@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
COTP Captain of the Port, Sector New York
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
PNB Portal North Bridge
§ Section
U.S.C. United States Code
WGS#84 World Geodetic System

II. Background and Authority

On September 28, 2026, the Coast Guard received sufficient information to be able to fulfill a request from the Skanska Traylor Portal North Bridge Joint Venture for a safety zone on the Hackensack River while demolishing the existing Portal North Bridge (PNB) span (River Mile 5.0). Hazards from this project include but are not limited to deployment of heavy equipment and anchored barges which will continuously obstruct vessel traffic through the navigable channel, during demolition of the existing superstructure, footings, and fender systems, which create hazards for workers and the public. The Captain of the Port, Sector New York (COTP) has determined that potential hazards associated with demolition of the existing bridge are a safety concern for anyone within the work area. Under the authority of 46 U.S.C. 70034, the COTP is issuing this rule, to protect personnel, vessels, and the marine environment in the navigable waters within the safety zone.

The Coast Guard is issuing this rule without prior notice and comment. As authorized by 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed

rulemaking (NPRM) with respect to this rule because it is impracticable. The Coast Guard was not notified of this schedule and safety zone request with sufficient time to be able to publish this rule by November 17, 2026, when the safety zone must be in place to protect personnel, vessels, and the marine environment.

For the same reason, the Coast Guard finds that under 5 U.S.C. 553(d)(3), good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**.

III. Discussion of the Rule

This temporary interim rule establishes a safety zone from 6 a.m. on November 17, 2026, until 11:59 p.m. on May 27, 2027. The safety zone will cover all navigable waters of the Hackensack River, surface to bottom, shoreline to shoreline, between the New Jersey Turnpike/I–95 Fixed Bridge (River Mile 5.3) and a line drawn from 40°44′54.52″ N, 74°05′37.59″ W, thence to 40°45′02.07″ N, 74°05′31.69″ W, approximately 1,650 feet south of the existing PNB. These coordinates are based on the World Geodetic System (WGS 84). Vessels and persons will not be allowed to enter the zone during this time, unless authorized by the Captain of the Port.

One full eight-week enforcement period prohibiting vessels or individuals from entering the safety zone is planned from approximately November 17, 2026, through January 29, 2027.

The exact dates and times of the enforcement period, during which all vessel transits through the safety zone will be prohibited, will be published in the Local Notice to Mariners, posted on the Coast Guard Navigation Center Maritime Safety Information Products page at *https://www.navcen.uscg.gov/msi,* and issued in a Broadcast Notice to Mariners via marine channel 16 (VHF–FM) as soon as practicable in response to an emergency or hazardous condition.

This rule will remain in effect through May 27, 2027, which should accommodate the possibility of project delays due to unforeseen circumstances. If the project is completed before May 27, 2027, enforcement of the safety zone will be suspended, and notice will be provided via the Local Notice to Mariners.

The Coast Guard Northeast District Local Notice to Mariners can be found at: *https://www.navcen.uscg.gov/maritime-safety-information.*

IV. Public Participation and Request for Comments

Although this regulation is published as a temporary interim rule without prior notice, public comment is nevertheless desirable to ensure that the regulation is both workable and reasonable. Commenters should identify the docket number for the regulation and give reasons for their comments. If the Coast Guard determines that changes to the temporary interim rule are necessary, the Coast Guard will publish a temporary final rule or other appropriate document.

Submitting comments. We encourage you to submit comments at *https://www.regulations.gov.* To do so, go to *https://www.regulations.gov,* type USCG–2026–0830 in the search box and click ''Search.'' Next, look for this document in the Search Results column, and click on it. Then click on the Comment option. If you cannot submit your material by using *https://www.regulations.gov,* call or email the person in the **FOR FURTHER INFORMATION CONTACT** section of this proposed rule for alternate instructions.

Viewing material in the docket. To view available documents, find the docket as described in the previous paragraph, and then select ''Supporting & Related Material'' in the Document Type column. We will post public comments in our online docket. Additional information is on the *https://www.regulations.gov* Frequently Asked Questions web page.

Personal information. We accept anonymous comments. Comments you post to *https://www.regulations.gov* will include any personal information you have provided. Contact information (such as email or mailing address) will not be available for public viewing, however, unless the submitter includes that information in the body of the docket submission. For more about privacy and submissions to the docket in response to this document, see DHS's eRulemaking System of Records notice (85 FR 14226, March 11, 2020).

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analysis based on a number of these statutes and Executive orders.

A. Impact on Small Entities

The regulatory flexibility analysis provisions of the Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, do not apply to rules that are not subject to notice and comment. Because the Coast Guard has, for good cause, waived the notice and comment requirement that would otherwise apply to this rulemaking, the Regulatory Flexibility Act's flexibility analysis provisions do not apply here.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), if this rule will affect your small business, organization, or governmental jurisdiction and you have questions, contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards by calling 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

B. Collection of Information

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

C. Federalism and Indian Tribal Governments

We have analyzed this rule under Executive Order 13132, Federalism, and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in that Order.

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

D. Unfunded Mandates Reform Act

As required by The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538), the Coast Guard certifies that this rule will not result in an annual expenditure of $100,000,000 or more (adjusted for inflation) by a State, local, or tribal government, in the aggregate, or by the private sector.

E. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National

Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment.

This rule is a safety zone. It is categorically excluded from further review under paragraph L60(a) of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 1. A Record of Environmental Consideration supporting this determination is available in the docket.

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: 46 U.S.C. 70034, 70051, 70124; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.4.

2. Add § 165.T01–0830 to read as follows:

§ 165.T01–0830 Safety Zone; Hackensack River, Kearny and Secaucus, NJ.

(a) *Location.* The following area is a safety zone: All waters of the Hackensack River from surface to bottom, shoreline to shoreline, between the New Jersey Turnpike/I–95 Fixed Bridge (River Mile 5.3) and a line drawn from 40° 44′54.52″ N, 74°05′37.59″ W, thence to 40°45′02.07″ N, 74°05′31.69″ W, approximately 1,650 feet south of the existing Portal Bridge. These coordinates are based on the World Geodetic System (WGS 84).

(b) *Definitions.* As used in this section, *designated representative* means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port New York (COTP) in the enforcement of the safety zone.

(c) *Regulations.* (1) Under the general safety zone regulations in subpart C of this part, you may not enter the safety zone described in paragraph (a) of this section unless authorized by the COTP or the COTP's designated representative.

(2) To seek permission to enter, contact the COTP or the COTP's representative on VHF–FM channel 16 or by telephone at (718) 354–4353. Those in the safety zone must comply with all lawful orders or directions given to them by the COTP or the COTP's designated representative.

(d) *Enforcement period.* This section is effective from 6 a.m. on November 17, 2026, through 11:59 p.m. on May 27, 2027, but will only be enforced during periods when barges are within the channels at the existing bridge and demolition operations are in progress. The Coast Guard will issue information of the enforcement period through Local Notice to Mariners, the Coast Guard Navigation Center Maritime Safety Information Products page at *https://www.navcen.uscg.gov/msi,* and Broadcast Notice to Mariners via marine channel 16 (VHF–FM) as soon as practicable. In addition, if the project is completed before May 27, 2027, enforcement of the safety zone will be suspended, and notice given via Local Notice to Mariners.

Doreen McCarthy

Captain, U.S. Coast Guard, Captain of the Port Sector New York.

[FR Doc. 2026–23567 Filed 11–18–26; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF THE INTERIOR

National Park Service

36 CFR Part 7

[NPS–MACA–DTS 43560; Docket ID NPS–2026–0001; PPSEMACAS0 PPMPSPD1Z.YM0000 255P103601]

RIN 1024–AE93

Mammoth Cave National Park; Bicycling and Horses

AGENCY: National Park Service, Interior.

ACTION: Final rule.

SUMMARY: The National Park Service (NPS) amends the special regulations for Mammoth Cave National Park to allow bicycle use on approximately 37 miles of multi-use trails throughout the park. This rule also will allow visitors to ride horses on the 5.4-mile Houchin Ferry North/Ollie Road.

DATES: This rule is effective December 21, 2026.

ADDRESSES: Comments received on the proposed rule are available on *https://www.regulations.gov* in Docket No. NPS–2026–0001. A copy of the Mammoth Cave National Park Comprehensive Land and River Trails Plan and Environmental Assessment and the associated Finding of No Significant Impact are available online at *https://parkplanning.nps.gov/maca* by clicking the link entitled ''Develop Land and River Trail Management Plan for Mammoth Cave National Park'' and then clicking the link entitled ''Document List.''

FOR FURTHER INFORMATION CONTACT: Barclay Trimble, Superintendent, Mammoth Cave National Park; (202) 758–2180; *Barclay_Trimble@nps.gov.* Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States.

SUPPLEMENTARY INFORMATION:

Background

History, Establishment and Purpose of the Park

Mammoth Cave National Park comprises more than 52,000 acres of land within Edmonson, Hart, and Barren Counties in Kentucky. Within Mammoth Cave National Park is Mammoth Cave. Named for the enormity of its subterranean vaults and the unparalleled extent of its passages, Mammoth Cave is the longest known cave system in the world with over 400 miles surveyed to date. The geologic features within the extensive cave system are the product of a unique set of conditions found nowhere else, all of which contribute to the largest, most complex, and best-known karst area in the world. Karst is a geologic term that refers to areas of irregular limestone in which erosion has produced features such as fissures, sinkholes, underground streams, sinking springs, and caverns. The land above the underground formations is characterized by rugged hills, valleys, and forests.

Congress authorized the establishment of the park in 1926, which was officially established in 1941 and added to in 1961 with the acquisition of Great Onyx Cave and Crystal Cave. The legislative history of the establishment of the park recognized the need to protect and conserve the stunning and unique underground formations of the cave system, but also opportunities for recreation that could be provided by lands above ground. The park's enabling legislation directs the NPS to administer the park in accordance with the laws generally applicable to the National Park System, including the NPS Organic Act. That act requires the NPS to promote and

regulate the scenery, natural and historic objects, and wild life in parks and to provide for the enjoyment of the same in such manner and by such means that will leave them unimpaired for the enjoyment of future generations. 54 U.S.C. 100101.

In 2014, the NPS published the foundation document for the park. The document states that the park's purpose is to preserve, protect, interpret, and study the internationally recognized biological and geologic features and processes associated with the longest known cave system in the world, the park's diverse forested, karst landscape, the Green and Nolin rivers, and extensive evidence of human history; and to provide and promote public enjoyment, recreation, and understanding. Today, visitors are drawn to the park by its caves, scenic river valleys, bluffs, forests, and abundant wildlife. Above ground, the park offers opportunities for ranger-led tours, surface walks, camping, hiking, horseback riding, bicycling, scenic drives, canoeing and kayaking, fishing, accessible trails, and picnicking.

Trail Use in the Park

Bicycling is allowed on approximately 19 of the 85 miles of land-based trails within the park. These multi-use trails are the Connector Trail from the Big Hollow Trailhead to the Maple Springs Trailhead (Maple Springs Connector Trail), the Big Hollow Trail, the Mammoth Cave Railroad Bike & Hike Trail, and the White Oak Trail. Bicycles also are allowed on roads that are open to public motor vehicle traffic and on four administrative roads that are closed to motor vehicle use by the public but open to motor vehicle use by the NPS for administrative purposes (the Crystal Cave, Great Onyx, Three Springs, and Union City administrative roads).

Trails, public roads, and administrative roads that are open to traditional bicycles also are open to two-wheeled electric bicycles (e-bikes). Trail-use of three-wheeled e-bikes is limited to the Mammoth Cave Railroad Bike & Hike Trail and the Maple Springs Connector Trail. The use of traditional bicycles and e-bikes is governed by State law and NPS regulations that address topics such as speed limits, operation during periods of low visibility, obeying traffic control devices, and unsafe operation. See 36 CFR 4.30.

In addition to opportunities for hiking and bicycling, visitors can ride horses on 54 miles of trail within the park, featuring wooded backcountry routes suitable for different skill levels and ages. The trails include wide, smooth dirt paths that accommodate two riders as well as narrower, single-file ridgeline trails. Horseback riding is prohibited on all park roads pursuant to NPS general regulations that prohibit the use of horses on park roads except in limited circumstances. See 36 CFR 2.16.

Comprehensive Land and River Trails Plan and Environmental Assessment

In 2022, the NPS began developing a new land and river trails management plan for the park. The NPS initiated this planning process because previous plans had become outdated, and the condition of the park's trail system had deteriorated in a way that was adversely impacting park resources and the experience of trail users. The new plan would guide trail management for several decades with the purpose of improving access to high-quality land and river-based recreational opportunities for a diverse group of trail users, including hikers, equestrians, mountain bikers, and paddlers.

After the conclusion of a preliminary planning phase that sought feedback from trail users, community groups, and the general public, the NPS published the ''Mammoth Cave National Park Comprehensive Land and River Trails Plan and Environmental Assessment'' (EA) in 2024. The EA analyzed the potential environmental impacts of a no-action alternative that would have continued current management of the trail system and an action alternative that was identified as the NPS's preferred alternative. Under the action alternative, the NPS would add approximately 66 miles of land-based trails to the park trail system. This 72 percent increase in trail mileage would create new opportunities for hiking, horseback riding, and bicycling.

Specific to bicycle use, under the preferred alternative, the NPS would (1) discontinue bicycle use on the White Oak Trail; (2) close and restore to natural conditions the Maple Springs Connector Trail; and (3) construct eight new multi-use trails where bicycle use would be allowed, resulting in a total of approximately 37 miles of trail open to bicycle use.

As described in the EA, trail construction activities would use sustainable trail techniques to manage water and limit erosion, such as trail hardening, grade reversals, outslopes, and other earthwork strategies that improve drainage. These measures would minimize trail widening and trail braiding on new and rehabilitated trails, resulting in less vegetation trampling. The NPS would implement mitigation measures to minimize the impact on native vegetation during construction.

In addition to evaluating the potential impacts of trail construction and modification activities, the EA evaluated the potential impacts of allowing bicycles on the new trails. The EA and an associated written determination required by NPS regulations evaluate the suitability of trail surfaces and soil conditions for accommodating bicycle use, life cycle maintenance costs, safety considerations, methods to prevent or minimize user conflict, and methods to protect natural and cultural resources and mitigate impacts from bicycle use. Under the preferred alternative, the NPS would convert a one-mile section of the Ugly Creek Road from a public road to an administrative road that is closed to motor vehicle use other than vehicles used by the NPS for administrative purposes. Hiking and bicycling would be allowed on the converted section of this road.

The preferred alternative also would open the Houchin Ferry North/Ollie Road (5.4 miles) to horseback riding. This change would improve the experience of equestrians by providing multiple opportunities for shorter loop rides, and a new opportunity to ride to the river and back from the northern boundary of the park. The NPS does not anticipate there will be conflicts between vehicles, equestrian users, hikers, and bicyclists because the road is used rarely by motor vehicles. All other public and administrative roads would continue to remain closed to equestrian use.

The NPS accepted public comments on the EA for 30 days. In December 2024, following a recommendation by the park superintendent, the Regional Director for Interior Region 2, South Atlantic—Gulf, signed a Finding of No Significant Impact (FONSI) that identified the preferred alternative in the EA as the selected alternative. As stated in the FONSI, the NPS believes the selected alternative will improve the conditions and sustainability of the aboveground land and water trail networks in the park and enhance the diversity and quality of visitor experiences while protecting natural and cultural resources. Implementation of the selected alternative will expand opportunities for visitors to enjoy and recreate within the park.

Final Rule

This rule implements part of the selected alternative in the FONSI by amending the special regulations for the park in 36 CFR 7.36. This rule authorizes the superintendent to

designate approximately 37 miles of multi-use trails for bicycle use in the park. The rule identifies 12 distinct trails that could be designated for bicycle use. Two trails currently designated for bicycle use—the Maple Springs Connector Trail and the White Oak Trail—are removed, consistent with plans to close those trails to bicycle use under the selected alternative. Another currently designated trail—the Mammoth Cave Railroad Bike & Hike Trail—remains on the list and another—the Big Hollow Trail—is listed as three separate segments as identified on park maps.

The rule adds the following eight new trails that will be constructed under the selected alternative:

- Brooks Knob Road Cemetery Trail;
- Brooks Knob Road Trail (up to gate);
- Crystal Cave Road Trail;
- East Entrance Trail;
- Little Hope Cemetery Trail;
- Sugar Sink Connector Trail;
- Sugar Sink Trail; and
- West Entrance Trail.

The rule includes the approximate mileage of all the identified trails. The rule requires the superintendent to notify the public of designated trails through one or more of the methods identified in 36 CFR 1.7, including publication in the Superintendent's Compendium (or written compilation) of discretionary actions and on maps available at the visitor center and on the park website. NPS regulations at 36 CFR 4.30(i) authorize superintendents to allow electric bicycles on park roads, parking areas, and administrative roads and trails that are otherwise open to traditional bicycles. Accordingly, the superintendent may decide to allow electric bicycles on any of the trails identified in the rule that are open to traditional bicycles and will notify the public pursuant to 36 CFR 1.7.

NPS general regulations in 36 CFR 2.16(c) prohibit the use of horses or pack animals on a park road, except where such travel is necessary to cross to or from designated trails, areas, or privately owned property when no alternative trails or routes have been designated, and when the road is closed to motor vehicles. Neither of these exceptions to the general rule apply to riding horses on the Houchin Ferry North/Ollie Road, which is called for in the selected alternative. Special regulations for the park, however, can amend, modify, relax, or make more stringent general regulations in 36 CFR parts 1 through 5 and part 12. See 36 CFR 1.2(c). Accordingly, this rule adds a new paragraph (d) to the special regulations for the park that allows equestrian use on the approximately 5.4-mile Houchin Ferry North/Ollie Road.

Compliance With NPS Bicycle Regulations

The EA constitutes the planning document and evaluates the criteria required by the NPS's general bicycle regulations at 36 CFR 4.30. Under the selected action in the FONSI, the NPS will allow bicycle use on approximately 37 miles of multi-use trails in the park. The EA evaluates the suitability of each trail surface and soil conditions for accommodating bicycle use, and life cycle maintenance costs, safety considerations, methods to prevent or minimize user conflict, and methods to protect natural and cultural resources and mitigate impacts associated with bicycle use.

The final trail alignments shown on the maps in the EA are based on field surveys and geographic information system (GIS) analysis. The new trail alignments have been determined at the corridor level, defined as a 60-foot-wide corridor within which the new trail would be constructed. Final trail alignments will be determined on the ground upon implementation and in consultation with park natural and cultural resources specialists, which could result in minor adjustments to the trail locations shown on the maps. If a need existed to align a trail outside of the identified corridor, the amended alignment would undergo additional review to avoid or minimize impacts on sensitive resources, and the change would be documented as an amendment to the trails management plan.

The superintendent of the park signed a written determination that bicycle use on all of the trails identified in this rule and certain administrative roads that will be open to bicycle use under the selected action in the FONSI, is consistent with the protection of the park's natural, scenic, and aesthetic values; safety considerations; management objectives; and will not disturb wildlife or park resources, as required by 36 CFR 4.30. The NPS made the written determination available on the park's planning website and accepted comments on the written determination during the public comment period for the proposed rule. The Regional Director approved the written determination on August 26, 2026. The written determination is available at the URL listed in the **ADDRESSES** section.

Summary of Public Comments

The NPS published a proposed rule in the **Federal Register** on February 9, 2026 (91 FR 5700). The NPS accepted public comments for 60 days via the mail, hand delivery, and the Federal eRulemaking Portal at *https://www.regulations.gov.* Comments were accepted through April 10, 2026. The NPS received approximately 150 comments on the proposed rule. Overall, commenters broadly supported expanding recreation opportunities but stressed that effective communication, monitoring, and adaptive management will be essential to protect park resources and ensure safe, enjoyable multi-use trail experiences. Several commenters addressed potential environmental impacts of expanding bicycle use on the trail system, including impacts on soils and erosion, the aquatic ecosystem, plant communities, and park wildlife. These comments are not addressed in this final rule because they raise environmental issues that the NPS considered in the EA and FONSI. The NPS evaluated the environmental impacts of the no-action and preferred alternatives in the EA and explained the reasons for selecting the preferred alternative in the FONSI. The NPS did not identify any new significant environmental issues in the public comments on the proposed rule. After considering public comments and additional review of the proposed rule, the NPS is finalizing the proposed rule without change. A summary of the pertinent issues raised by commenters and NPS responses are provided below:

1. Comment: Some commenters stated that allowing horses on a shared-use road creates safety risks because horses may react unpredictably to bicycles or vehicles.

NPS Response: Houchin Ferry Road North experiences very low levels of use which should mitigate the potential for conflicts among vehicles, horseback riders, hikers, and bicyclists. As described in Appendix A of the EA, the NPS employs a monitoring program to track conditions related to visitor experiences, including reports of user conflicts. Monitoring helps assess progress toward desired conditions within the park, such as ensuring that:

- visitors can confidently choose appropriate recreational opportunities,
- conflicts among user groups are minimized, and
- signage and trail markings provide accurate, reliable information.

If monitoring indicates that conditions are trending away from these desired outcomes, the NPS would manage visitor concerns by implementing management strategies listed in Appendix A of the EA, such as providing appropriate trip-planning information to visitors based on

motivation and separating use types further.

2. Comment: One commenter expressed concern that transporting horses requires large pickup trucks and trailers (often 25 to 55 feet long) which would necessitate more paved parking and turnaround areas. The commenter stated that during busy periods insufficient parking could lead to parking along road shoulders, which would contribute to soil erosion and create additional traffic hazards.

NPS Response: As part of the selected alternative in the EA, both the McCoy Hollow and Wildcat Hollow parking areas will be improved to support horse-trailer use. These improvements are designed to enhance maneuverability and safe trailer parking without expanding the footprint beyond what is consistent with desired conditions and resource-protection goals. In addition to physical improvements, the NPS may implement several management strategies if monitoring indicates that parking demand is approaching or exceeding established thresholds. One such strategy is to enforce parking lot capacity limits and prevent overflow parking, including shoulder parking, to avoid soil erosion and maintain roadway safety.

3. Comment: Some commenters questioned who would be responsible for cleaning up manure from equestrian use on the road.

NPS Response: The NPS does not have sufficient staff and equipment to collect excrement on trails and roads where horseback riding is allowed. The Superintendent's Compendium for the park states that—at trailheads—manure spilled from the trailering unit and any fresh excrement must be placed in the trailering unit. This requirement will be applied to equestrian use on the Houchin Ferry North/Ollie Road to help prevent the introduction of exotic plant seeds into the park and to promote visitor enjoyment of park resources.

4. Comment: Some commenters opposed constructing new multi-use trails, citing potential impacts on the natural environment and recommending that the NPS focus on maintaining existing trails instead. Others supported creating more pedestrian-only trails due to safety concerns associated with shared-use routes. Several commenters encouraged the NPS to construct purpose-built mountain bike trails rather than additional multi-use trails, while others suggested that equestrian and bicycle use is incompatible and should occur on separate trails.

NPS Response: The NPS appreciates the range of views on shared use of trail networks within the park. The purpose of the EA was to improve the sustainability of the above-ground trail system, protect natural and cultural resources, and enhance the diversity and quality of visitor experiences. The selected alternative addresses longstanding issues such as inconsistent trail design standards, erosion, trail widening, and visitor-use conflicts and will serve as the guiding framework for trail development, maintenance, and visitor-use management over the long term. Under the selected alternative, the overall mileage of designated trails available for public use in the park would increase substantially. Many existing trails at the park follow old roadbeds or utility corridors that were never designed for recreational use. As a result, they often experience recurring erosion, poor drainage, widening, braiding, and safety issues that cannot be effectively corrected through routine maintenance alone.

A combination of new trails, improvements to degraded existing routes, decommissioning of unsustainable trails, and rehabilitation of visitor-created paths, will allow for greater resource stewardship as the trail system becomes more sustainable overall.

The NPS did not analyze an alternative that would include construction of purpose-built mountain bike trails. The preferred alternative focused on improving and managing a shared-use trail system consistent with the EA's purpose and need. A key element of the selected alternative is the development of shared-use trails designed to safely accommodate multiple user groups—hikers, bicyclists, and in some areas, equestrians. Because these trails must safely serve different types of users, they will be constructed using shared-use design principles rather than incorporating many of the specialized features typical of purpose-built mountain bike trails, such as tight berms, rollers, jumps, or flow-specific technical elements that are not safe or sustainable for hikers or equestrians.

The selected alternative will provide multiple recreational opportunities while applying trail-by-trail decisions to separate uses where safety concerns, resource sensitivities, or known user conflicts warrant it. For example, the selected alternative includes decommissioning the Maple Springs Connector due to documented conflicts between bicycle and equestrian use. Some trails will remain pedestrian-only where terrain or resource conditions make multi-use unsustainable, and equestrian use will remain north of the Green River to protect the park's highly sensitive cave and karst resources concentrated beneath the landscape to the south.

5. *Comment:* Several commenters supported allowing e-bikes on trails open to traditional bicycles, while others raised concerns about potential visitor-safety issues and resource impacts from e-bike use. One commenter stated that e-bikes belong on roads rather than trails. One organization noted that prohibiting e-bikes could hinder economic opportunity and exclude an entire user group.

NPS Response: Under existing regulations, the Superintendent has discretion to allow e-bikes in locations where traditional bicycles are allowed, including on roads or trails. 36 CFR 4.30(i). Among other policy requirements for visitor activities, the Superintedent may allow e-bikes only when doing so will not impede attainment of desired conditions for resource protection or create an unsafe environment for visitors. NPS Management Policies 2006, Section 8.1.1. Since 2021, e-bikes have been allowed on park roads and on trails where traditional bicycles are allowed. The use of e-bikes is subject to the same requirements that apply to the use of traditional bicycles, including requirements to obey traffic control devices, travel no faster than 15 mph, yield the right of way to horses and pedestrians, and avoid travel abreast of another bicycle. After trail construction, the Superintendent will have discretion to allow e-bikes on the new trails, subject to the same policy considerations that apply to all visitor activities. Successful management of visitor use relies on monitoring and informed decision-making. The NPS will use information it gains to manage the use of e-bikes and all other visitor activities to avoid unacceptable impacts to resources and visitors. The NPS will adjust indicators and thresholds for adaptive management as needed, with opportunities for stakeholder engagement when appropriate.

6. Comment: One commenter observed that, although the rule would increase the total mileage of trails eligible for bicycle use, the Superintendent must designate such trails for bicycle use before they can be used. The commenter recommended that bicycles be allowed on at least 19 miles of trails without the need for designation by the Superintendent and not subject to any closures and restrictions.

NPS Response: Establishing a fixed minimum mileage would limit the Superintendent's ability to manage trail access based on current conditions and

informed decision-making for visitor and resource protection. Consistent with the selected alternative, the NPS intends to allow bicycles on the 37-mile trail network identified for bicycle use, subject to closures and restrictions that may become necessary to protect public health and safety, natural and cultural resources, and to meet other management activities and considerations. Some trails have not been constructed and therefore will need to be designated later in time. Allowing the Superintendent to adaptively manage bicycle use is necessary to implement the selected alternative, which requires monitoring and establishes indicators and thresholds for managing visitor use to avoid unacceptable impacts.

7. Comment: Some commenters emphasized the importance of clear, consistent signage and visitor education to reduce safety conflicts on multi-use trails, including right-of-way information for hikers, cyclists, and equestrians, and guidance for safely navigating trailheads and horse-trailer areas. Many supported additional measures such as speed limits for bicycles, trail-etiquette education, and clear communication of rules, seasonal closures, and user responsibilities.

NPS Response: As stated above, bicycles and e-bikes are subject to 15 mph speed limits on all roads and trails, and the NPS intends to upgrade parking areas to support horse trailers at trailheads and at the start of the Houchin Ferry North/Ollie Road. The selected alternative includes improvements to ensure clear, consistent trail information and to enhance safety for all users. Trail names will be formally designated and used consistently on signs, maps, and other visitor materials to improve wayfinding and create a stronger sense of place. Trailheads will feature standardized signs that clearly describe trail type, allowed uses (hiking, biking, equestrian), difficulty, distance, estimated time, accessibility information, and maps, with additional wayfinding available through on-trail markers or QR codes linking to digital resources. To reduce safety conflicts on shared-use trails, the park will expand education about proper trail etiquette—such as cyclists yielding to pedestrians and pedestrians yielding to horses—and reinforce Leave No Trace principles.

Compliance With Other Laws, Executive Orders and Department Policy

Regulatory Planning and Review (E.O.s 12866 and 14192)

This rule has been determined to be not significant for purposes of E.O. 12866. This rule is a ''one-time'' enabling regulation that will authorize the Superintendent to expand consumption options for the American public by increasing opportunities for access and recreation at the park. As a result, this rule qualifies as an E.O. 14192 deregulatory action pursuant to M–25–20, ''Guidance Implementing Section 3 of Executive Order 14192, Titled 'Unleashing Prosperity Through Deregulation''' issued by the Office of Management and Budget, Office of Information and Regulatory Affairs, on March 26, 2025.

Regulatory Flexibility Act (RFA)

This rule will not have a significant economic effect on a substantial number of small entities under the RFA (5 U.S.C. 601 *et seq.*). No small entities will be directly regulated by this rule, which will allow bicycle use on approximately 37 miles of multi-use trails throughout the park and allow visitors to ride horses on the 5.4-mile Houchin Ferry North/Ollie Road. This action will not impose restrictions on local businesses in the form of fees, training, record keeping, or other measures that will increase costs. Rather, this action could lead to a slight increase in park visitation and thereby generate benefits for businesses, including small entities, through increased visitor spending. Therefore, the NPS certifies that this rule will not have a significant economic impact on a substantial number of small business entities.

Congressional Review Act

This rule is not a major rule under 5 U.S.C. 804(2). This rule:

(a) Will not have an annual effect on the economy of $100 million or more.

(b) Will not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions.

(c) Will not have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of U.S.-based enterprises to compete with foreign-based enterprises.

Unfunded Mandates Reform Act

This rule will not impose an unfunded mandate on State, local, or Tribal governments or the private sector of more than $100 million per year. This rule will not have a significant or unique effect on State, local or Tribal governments, or the private sector. It addresses public use of national park lands and imposes no requirements on other agencies or governments. A statement containing the information required by the Unfunded Mandates Reform Act (2 U.S.C. 1531 *et seq.*) is not required.

Takings (E.O. 12630)

This rule will not effect a taking of private property or otherwise have takings implications under E.O. 12630. A takings implication assessment is not required.

Federalism (E.O. 13132)

Under the criteria in section 1 of E.O. 13132, this rule will not have sufficient federalism implications to warrant the preparation of a federalism summary impact statement. This rule will only affect use of federally administered lands and waters. It will have no direct effects on other areas. A federalism summary impact statement is not required.

Civil Justice Reform (E.O. 12988)

This rule complies with the requirements of E.O. 12988. This rule:

(a) Meets the criteria of section 3(a) requiring that all regulations be reviewed to eliminate errors and ambiguity and be written to minimize litigation; and

(b) Meets the criteria of section 3(b)(2) requiring that all regulations be written in clear language and contain clear legal standards.

Consultation With Indian Tribes (E.O. 13175 and Department Policy)

The Department of the Interior strives to strengthen its government-to-government relationship with Indian Tribes through a commitment to consultation with Indian Tribes and recognition of their right to self-governance and sovereignty. The NPS has evaluated this rule under the criteria in E.O. 13175 and under the Department's Tribal consultation policy. As a result, the NPS determined that Tribal consultation is not required because this rule will have no substantial direct effect on federally recognized Indian Tribes.

Nevertheless, in support of the Department of the Interior's and the NPS's commitment to government-to-government consultation, the NPS initiated Tribal consultation for the EA on April 30, 2024, by sending letters to the following Native American Tribes affiliated with lands and waters within

the park and inviting consultation: Absentee Shawnee Tribe (Absentee-Shawnee Tribe of Indians of Oklahoma); The Chickasaw Nation; Cherokee Nation; Eastern Band of Cherokee Indians; Eastern Shawnee Tribe of Oklahoma; The Osage Nation; Shawnee Tribe; and United Keetoowah Band of Cherokee Indians in Oklahoma.

Additionally, the NPS developed a phased programmatic agreement to guide the treatment of cultural resources in the different project areas identified in the EA. The NPS invited each of these Tribes to sign on to the phased programmatic agreement. None chose to do so. The Cherokee Nation responded that they would consult with the NPS when there are defined undertakings for any project involving ground disturbance. No other Tribal responses were received.

Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.)

This rule contains no new information collections. All information collections require approval under the Paperwork Reduction Act of 1995 (PRA; 44 U.S.C. 3501 *et seq.*). The NPS may not conduct or sponsor, and you are not required to respond to a collection of information unless it displays a currently valid OMB control number.

National Environmental Policy Act of 1969 (NEPA; 42 U.S.C. 4321 et seq.)

The NPS prepared the EA to determine whether this rule would have a significant impact on the quality of the human environment under NEPA. This rule does not constitute a major Federal action significantly affecting the quality of the human environment. A detailed statement under NEPA is not required because the EA resulted in FONSI. A copy of the EA and FONSI are available online at the like provided in the **ADDRESSES** section.

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

This rule is not a significant energy action under the definition in E.O. 13211. The Office of Information and Regulatory Affairs (OIRA) determined this rule is not significant under E.O. 12866. Consequently, this rule does not meet the first criteria of a significant energy action. Also, the OIRA Administrator has not otherwise designated this rule as a significant energy action. A statement of energy effects in not required.

List of Subjects in 36 CFR Part 7

National parks, Reporting and recordkeeping requirements.

In consideration of the foregoing, the National Park Service amends 36 CFR part 7 as set forth below:

PART 7—SPECIAL REGULATIONS, AREAS OF THE NATIONAL PARK SYSTEM

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

Authority: 54 U.S.C. 100101, 100751, 320102; Sec. 7.96 also issued under D.C. Code 10–137 and D.C. Code 50–2201.07.

■ 2. In § 7.36:

■ a. Revise paragraph (c) heading and paragraph (c)(1); and

■ b. Add paragraph (d).

The revisions and addition read as follows:

§ 7.36 Mammoth Cave National Park.

* * * * *

(c) *Bicycle use.* (1) The Superintendent may designate all or a portion of the following trails as open to bicycle use. A map showing trails open to bicycle use will be available at the park visitor center and posted on the park website, and all trails or portions of trails designated for bicycle use will be published in the Superintendent's Compendium (or written compilation) of discretionary actions referred to § 1.7(b) of this chapter.

(i) Big Hollow North (approximately 5.0 miles);

(ii) Big Hollow North Shortcut (approximately 0.1 miles);

(iii) Big Hollow South (approximately 3.7 miles);

(iv) Brooks Knob Road Cemetery Trail (approximately 0.4 miles);

(v) Brooks Knob Road Trail (up to gate) (approximately 0.2 miles);

(vi) Crystal Cave Road Trail (approximately 0.1 miles);

(vii) East Entrance Trail (approximately 2.8 miles);

(viii) Little Hope Cemetery Trail (approximately 0.1 miles);

(ix) Mammoth Cave Railroad Bike & Hike Trail (approximately 9.3 miles);

(x) Sugar Sink Connector (approximately 0.2. miles);

(xi) Sugar Sink Trail (approximately 3.8 miles); and

(xii) West Entrance (approximately 11.2 miles).

* * * * *

(d) *Horses.* Equestrian use is allowed on Houchin Ferry North/Ollie Road (approximately 5.4 miles).

Kevin J. Lilly,

Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 2026–23563 Filed 11–18–26; 8:45 am]

BILLING CODE 4312–52–P

POSTAL SERVICE

39 CFR Part 111

Domestic Competitive Products Pricing and Mailing Standards Changes

AGENCY: Postal Service.

ACTION: Final rule.

SUMMARY: The Postal Service is amending *Mailing Standards of the United States Postal Service,* Domestic Mail Manual (DMM®), to reflect changes to prices and certain mailing standards changes scheduled for competitive products.

DATES: *Effective Date:* January 17, 2027.

FOR FURTHER INFORMATION CONTACT: Catherine Knox (202) 268–5636, Heather Lewis, (703) 659–3812, or Garry Rodriguez at (202) 268–7281.

SUPPLEMENTARY INFORMATION: This final rule describes new prices and product features for competitive products, by class of mail, established by the Governors of the United States Postal Service®. New prices are available under Docket Number CP2027–1 on the Postal Regulatory Commission (PRC) website at *http://www.prc.gov,* and on the Postal Explorer® website at *http://pe.usps.com.*

The Postal Service will revise *Mailing Standards of the United States Postal Service,* Domestic Mail Manual (DMM), to reflect changes to certain prices and mailing standards for the following competitive products:

- Priority Mail Express®.
- Priority Mail®.
- USPS Ground Advantage®.
- Parcel Select®.
- Extra Services.
- Mailer Services.
- Recipient Services.
- Other.

Competitive product prices and changes are identified by product as follows:

Priority Mail Express

Prices

Overall, Priority Mail Express prices will increase 5.9 percent. Priority Mail Express will continue to offer zone and Flat Rate pricing.

Retail prices will increase an average of 5.9 percent. The Flat Rate Envelope price will increase to $34.90, the Legal Flat Rate Envelope will increase to $35.20, and the Padded Flat Rate Envelope will increase to $35.85.

Commercial Base prices will increase an average of 5.9 percent.

Priority Mail

Prices

Overall, Priority Mail prices will increase 5.9 percent. Priority Mail will continue to offer zoned and Flat Rate, Retail and Commercial pricing.

Retail prices will increase an average of 5.9 percent. The Flat Rate Envelope price will increase to $12.65, the Legal Flat Rate Envelope will increase to $12.95, and the Padded Flat Rate Envelope will increase to $13.70. The Small Flat Rate Box price will increase to $13.40, and the Medium Flat Rate Boxes will increase to $24.30. The Large Flat Rate Box will increase to $33.35, and the APO/FPO/DPO Large Flat Rate Box will increase to $32.00.

Commercial prices will increase an average of 5.9 percent.

USPS Ground Advantage

Prices

Overall, USPS Ground Advantage prices will increase 5.9 percent.

USPS Ground Advantage—Retail prices will increase 5.9 percent.

USPS Ground Advantage—Commercial prices will increase 5.9 percent.

Parcel Select

Prices

The prices for Parcel Select Destination Entry will increase an average of 5.9 percent.

The prices for USPS Connect® Local will increase 6.0 percent.

Extra Services

Adult Signature Service

Adult Signature Required and Adult Signature Restricted Delivery service prices will increase 8.2 percent and 8.0 percent, respectively.

Mailer Services

Pickup on Demand Service

The Pickup on Demand® service fee will increase 7.9 percent.

USPS Tracking Plus Service

The USPS Tracking Plus® service prices will increase 8.0 percent.

USPS Label Delivery Service

The USPS Label Delivery Service™ prices will increase 9.1 percent.

USPS Delivered Duty Paid (DDP) Service

The USPS Delivered Duty Paid (DDP) Service prices will remain the same.

Recipient Services

Post Office Box Service

The competitive Post Office Box™ service prices will remain the same.

Premium Forwarding Service

Premium Forwarding Service® (PFS®) prices will increase an average of 6.8 percent.

Premium Forwarding Service Redesign

The Postal Service is redesigning Premium Forwarding Service (PFS) under a multi-phase plan. In Phase 1, the Postal Service is redesigning PFS as follows:

a. PFS Residential will be revised as follows:

1. The online enrollment fee is revised to be paid annually in full.

2. The Postal Service is adding Priority Mail Express as an option for customer reshipments of mail.

b. PFS Commercial will be revised as follows:

1. The shipment frequency is changed to daily, weekly, and monthly.

2. The Postal Service is implementing a PFS Sack Rehandling Fee, in addition to postage for shipments sent in sacks.

c. The Postal Service is revising PFS Residential and PFS Commercial to add an opt-in automatic renewal feature.

d. The Postal Service is simplifying the hazardous materials text under PFS Residential and PFS Local that prohibits their inclusion in shipments and is adding this text prohibiting hazardous materials in PFS Commercial shipments for consistency.

USPS Package Intercept Service

The USPS Package Intercept® fee will increase 8.0 percent.

USPS Package Intercept Service With Hazardous Materials and Perishables

The Postal Service is revising the DMM to also allow USPS Ground Advantage mailpieces containing eligible hazardous materials to be intercepted by removing it from the items listed as not eligible. The DMM will also be revised to clarify that mailpieces containing perishable matter are not eligible to be intercepted.

Other

Address Enhancement Service

Address Enhancement Service competitive product prices will increase 20 percent.

Package Quality Noncompliance Fee

The Package Quality Noncompliance Fee will remain the same.

Nonstandard Fees

Nonstandard Fees will increase an average of 16 percent.

Dimension Noncompliance Fee

The Dimension Noncompliance Fee will remain at $3.00.

Dimension Noncompliance Fee Renamed and Revised

On July 12, 2026, the Postal Service implemented the first phase of the Dimension Noncompliance fee requiring mailers to accurately report all parcel dimensions in a manifest. The Postal Service is implementing the second phase of this initiative. The second phase will consist of the following:

a. The Postal Service is removing accuracy as an element of the fee.

b. The Postal Service is adding weight as an element of the fee.

c. As a result of the addition of weight, the Postal Service is renaming the fee Dimension and Weight Noncompliance Fee.

d. The Postal Service is commencing to charge the Dimension and Weight Noncompliance Fee for omitting all dimensions, weight, or ESC, in the manifest.

Fuel Surcharge

The Postal Service is implementing a Fuel Surcharge. The Fuel Surcharge will be assessed on all retail and commercial priced Priority Mail Express, Priority Mail, and USPS Ground Advantage pieces, including USPS Returns, and Parcel Select pieces (except for USPS Connect Local).

In its initial phase, the Fuel Surcharge will be set at 11 percent across applicable products and must be calculated as a percentage of the base postage price of each product. In the future, the Fuel Surcharge is intended to be dynamic and self-adjusting based on relevant fuel prices. The data used to create the Fuel Surcharge will be leveraged from the U.S. Energy Information Administration website available at *eia.gov.* The ground products (USPS Ground Advantage and Parcel Select) surcharge will be based on National U.S. Average On-Highway Diesel Fuel (EPD2D) and the air products (Priority Mail Express and Priority Mail) surcharge will be based on U.S. Gulf Coast Kerosene-type Jet Fuel prices (EPJK). As such, the structure for a dynamic Fuel Surcharge is being implemented now with a fixed 11 percent surcharge across all fuel prices, with the intent that such percentages will likely be adjusted and varied in future proceedings.

The surcharge will be posted on the Postal Explorer website at *pe.usps.com,*

no later than Thursday for use on the second Sunday (10-days) following the posting by product, based on the prices of diesel and jet fuel, as described on the *eia.gov* website.

For additional information see **USPS.COM** and Publication 199, *Intelligent Mail Package Barcode (IMpb) Implementation Guide for Confirmation Services and Electronic Payment Systems,* available on the PostalPro website at *postalpro.usps.com.*

Shipping Label Noncompliance Fee

The Postal Service is implementing a Shipping Label Noncompliance Fee of $5.00. A mailpiece will be considered noncompliant when mail processing equipment detects a label with an incorrect Intelligent Mail® package barcode (IMpb®) symbology or incorrect barcode construct (content within the barcode).

This fee will be assessed on each noncompliant domestic commercial Priority Mail Express, Priority Mail, USPS Ground Advantage, and Parcel Select mailpiece, including USPS Returns (Priority Mail Express Return, Priority Mail Return, and USPS Ground Advantage Return).

Insufficient Postage (Shortpaid) and Overpaid Postage Standards for USPS Ship, APV, and PC Postage

The Postal Service is establishing standards for pieces that have insufficient postage (shortpaid) and for the refund of postage on overpaid pieces, manifested through USPS Ship, captured through the Automated Package Verification (APV) program, or with postage paid using PC Postage. The standards set forth below for insufficient postage and overpaid pieces will apply to commercial Priority Mail Express, Priority Mail, USPS Ground Advantage and Parcel Select.

The Postal Service is revising DMM section 604.8.0, *Insufficient or Omitted Postage,* to add new subsection 8.1.12 to provide the standards for the collection of postage due on pieces detected by USPS Ship or the APV program with insufficient postage. Mailers will be liable for the total amount of postage due. The Postal Service is implementing a ''Repricing Fee'' of 20 percent of the postage due on each piece detected by USPS Ship and the APV program with insufficient postage. The total postage due (insufficient postage amount plus repricing fee) will be deducted from the mailer's account.

Additionally, the Postal Service is revising DMM section 604.9.0, *Exchanges and Refunds,* to add a new subsection 9.7 to provide the standards for the refund of postage on eligible pieces mailed through USPS Ship or with PC Postage. Mailers will be required to request a refund for overpaid pieces. Refund requests for overpaid pieces will be subject to a $5.00 threshold (only refund requests for more than $5.00 will be eligible for a refund). The Postal Service is implementing a ''Repricing Fee'' of 20 percent on each piece that is eligible for a refund. Mailers will be required to apply for a refund under DMM 9.2.5, *Applying for Refund,* within the time limits provided in DMM Exhibit 604.9.2.1, *Postage and Fees Refunds,* and receive payment as provided under DMM 9.2.6, *Refund Payment.*

Overweight and Oversize Items Fee

The overweight and oversize items fee will increase 100 percent, from $200 to $400.

Resources

The Postal Service provides additional resources to assist customers with this price change for competitive products. These tools include price lists, downloadable price files, and **Federal Register** Notices, which may be found on the Postal Explorer® website at *http://pe.usps.com.*

The Postal Service adopts the described changes to *Mailing Standards of the United States Postal Service,* Domestic Mail Manual (DMM), incorporated by reference in the *Code of Federal Regulations.* We will publish an appropriate amendment to 39 CFR part 111 to reflect these changes.

List of Subjects in 39 CFR Part 111

Administrative practice and procedure, Postal Service.

Accordingly, the Postal Service amends *Mailing Standards of the United States Postal Service,* Domestic Mail Manual (DMM), incorporated by reference in the Code of Federal Regulations as follows (*see* 39 CFR 111.1):

PART 111—INCORPORATION BY REFERENCE; MAILING STANDARDS OF THE UNITED STATES POSTAL SERVICE, DOMESTIC MAIL MANUAL

■ 1. The authority citation for 39 CFR Part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 13 U.S.C. 301–307; 18 U.S.C. 1692–1737; 39 U.S.C. 101, 401–404, 414, 416, 3001–3018, 3201–3220, 3401–3406, 3621, 3622, 3626, 3629, 3631–3633, 3641, 3681–3685, and 5001.

■ 2. Revise *Mailing Standards of the United States Postal Service,* Domestic Mail Manual (DMM) as follows:

Mailing Standards of the United States Postal Service, Domestic Mail Manual (DMM)

* * * * *

100 Retail Mail Letters, Cards, Flats, and Parcels

* * * * *

110 Retail Mail Priority Mail Express

113 Prices and Eligibility0 Prices and Fees

* * * * *

[Add new section 1.10 to read as follows:]

1.10 Fuel Surcharge

Priority Mail Express pieces are subject to the Fuel Surcharge (see Postal Explorer at *pe.usps.com*). For additional information see USPS.com and Publication 199, *Intelligent Mail Package Barcode (IMpb) Implementation Guide for Confirmation Services and Electronic Payment Systems,* available on the PostalPro website at *postalpro.usps.com.*

* * * * *

120 Retail Mail Priority Mail

123 Prices and Eligibility

1.0 Prices and Fees

* * * * *

[Add new section 1.10 to read as follows:]

1.10 Fuel Surcharge

Priority Mail pieces are subject to the Fuel Surcharge (see Postal Explorer at *pe.usps.com*). For additional information see *USPS.com* and Publication 199, *Intelligent Mail Package Barcode (IMpb) Implementation Guide for Confirmation Services and Electronic Payment Systems,* available on the PostalPro website at *postalpro.usps.com.*

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130 Retail Mail First-Class Mail and USPS Ground Advantage—Retail

133 Prices and Eligibility

1.0 Prices and Fees

* * * * *

[Add new section 1.12 to read as follows:]

1.12 Fuel Surcharge

USPS Ground Advantage pieces are subject to the Fuel Surcharge (see Postal Explorer at *pe.usps.com*). For additional information see *USPS.com* and Publication 199, *Intelligent Mail Package Barcode (IMpb) Implementation Guide for Confirmation Services and Electronic Payment*

Systems, available on the PostalPro website at *postalpro.usps.com.*

* * * * *

200 Commercial Letters, Cards, Flats, and Parcels

* * * * *

210 Commercial Mail Priority Mail Express

213 Prices and Eligibility

1.0 Prices and Fees

* * * * *

1.8 Nonstandard Fees

Except for Priority Mail Express Return service, mailers of a Priority Mail Express piece are subject to a nonstandard fee (see Notice 123—Price List) as follows:

* * * * *

[Revise the text of item h to read as follows:]

h. Mailers of parcels requiring the characteristics extra-service code (ESC) under 1.8g and who have a Shipping Services file manifest or other approved electronic documentation and do not meet the requirement to include the ESC for such parcels will be assessed the Dimension and Weight Noncompliance fee under 1.9.

[Revise the heading and text of 1.9 to read as follows:]

1.9 Dimension and Weight Noncompliance Fee

Except for Flat-Rate-priced pieces and Priority Mail Express Return service pieces, mailers of Priority Mail Express parcels must include the parcel's accurate dimensions (length, width, height), weight, and when applicable the characteristics ESC (see 1.8g) in the Shipping Services file manifest or other approved electronic documentation. The mailer will be assessed the Dimension and Weight Noncompliance fee (see Notice 123—Price List) if the parcel's dimensions, weight, or the ESC are omitted. A parcel is subject to only one Dimension and Weight Noncompliance fee charge.

[Delete the ''Note:'' under 1.9 in its entirety.]

* * * * *

[Add new section 1.13 to read as follows:]

1.13 Fuel Surcharge

Priority Mail Express, including Priority Mail Express Return pieces, are subject to the Fuel Surcharge (see Postal Explorer at *pe.usps.com*). For additional information see *USPS.com* and Publication 199, *Intelligent Mail Package Barcode (IMpb) Implementation Guide for Confirmation Services and Electronic Payment Systems,* available on the PostalPro website at *postalpro.usps.com.*

[Add new section 1.14 to read as follows:]

1.14 Shipping Label Noncompliance Fee

Priority Mail Express pieces, including Priority Mail Express Return pieces, will be subject to the Shipping Label Noncompliance Fee (see Notice 123—Price List) for each noncompliant piece (*e.g.,* incorrect symbology, incorrect barcode construct (content within the barcode)).

* * * * *

220 Commercial Mail Priority Mail

223 Prices and Eligibility

1.0 Prices and Fees

* * * * *

1.10 Nonstandard Fees

Except for Flat Rate and Priority Mail Return service packages, mailers of Priority Mail pieces are subject to a nonstandard fee (see Notice 123—Price List) as follows:

* * * * *

[Revise the text of item h to read as follows:]

h. Mailers of parcels requiring the characteristics extra-service code (ESC) under 1.10g and who have a Shipping Services file manifest or other approved electronic documentation and do not meet the requirement to include the ESC for such parcels will be assessed the Dimension and Weight Noncompliance fee under 1.11.

[Revise the heading and text of 1.11 to read as follows:]

1.11 Dimension and Weight Noncompliance Fee

Except for Flat-Rate-priced pieces and Priority Mail Return service pieces, mailers of Priority Mail parcels must include the parcel's accurate dimensions (length, width, height), weight, and when applicable the characteristics ESC (see 1.10g), in the Shipping Services file manifest or other approved electronic documentation. The mailer will be assessed the Dimension and Weight Noncompliance fee (see Notice 123—Price List) if the parcel's dimensions, weight, or the ESC are omitted. A parcel is subject to only one Dimension and Weight Noncompliance fee charge.

[Delete the ''Note:'' under 1.11 in its entirety.]

* * * * *

[Add new section 1.15 to read as follows:]

1.15 Fuel Surcharge

Priority Mail, including Priority Mail Return pieces, are subject to the Fuel Surcharge (see Postal Explorer at *pe.usps.com*). For additional information see *USPS.com* and Publication 199, *Intelligent Mail Package Barcode (IMpb) Implementation Guide for Confirmation Services and Electronic Payment Systems,* available on the PostalPro website at *postalpro.usps.com.*

[Add new section 1.16 to read as follows:]

1.16 Shipping Label Noncompliance Fee

Priority Mail pieces, including Priority Mail Return pieces, will be subject to the Shipping Label Noncompliance Fee (see Notice 123—Price List) for each noncompliant piece (*e.g.,* incorrect symbology, incorrect barcode construct (content within the barcode)).

* * * * *

250 Commercial Mail Parcel Select

253 Prices and Eligibility

1.0 Prices and Fees

* * * * *

1.7 Nonstandard Fees

Except for oversized priced parcels, a Parcel Select Destination Entry or USPS Connect Local piece is subject to a nonstandard fee (see Notice 123—Price List) as follows:

* * * * *

[Revise the text of item h to read as follows:]

h. Mailers of parcels requiring the characteristics extra-service code (ESC) under 1.7g and who have a Shipping Services file manifest or other approved electronic documentation and do not meet the requirement to include the ESC for such parcels will be assessed the Dimension and Weight Noncompliance fee under 1.8.

[Revise the heading and text of 1.8 to read as follows:]

1.8 Dimension and Weight Noncompliance Fee

Mailers of Parcel Select parcels must include the parcel's accurate dimensions (length, width, height), weight, and when applicable the characteristics ESC (see 1.7g), in the Shipping Services file manifest or other approved electronic documentation. The mailer will be assessed the Dimension and Weight Noncompliance fee (see Notice 123–Price List) if the parcel's dimensions, weight, or the ESC are omitted. A parcel is subject to only

one Dimension and Weight Noncompliance fee charge.

[Delete the ''Note:'' under 1.8 in its entirety.]

* * * * *

[Add new section 1.11 to read as follows:]

1.11 Fuel Surcharge

Except for USPS Connect Local, Parcel Select pieces are subject to the Fuel Surcharge (see Postal Explorer at *pe.usps.com*). For additional information see *USPS.com* and Publication 199, *Intelligent Mail Package Barcode (IMpb) Implementation Guide for Confirmation Services and Electronic Payment Systems,* available on the PostalPro website at *postalpro.usps.com.*

* * * * *

[Add new section 1.12 to read as follows:]

1.12 Shipping Label Noncompliance Fee

Parcel Select pieces will be subject to the Shipping Label Noncompliance Fee (see Notice 123—Price List) for each noncompliant piece (*e.g.,* incorrect symbology, incorrect barcode construct (content within the barcode)).

* * * * *

280 Commercial Mail USPS Ground Advantage—Commercial

283 Prices and Eligibility

1.0 Prices and Fees

* * * * *

1.7 Nonstandard Fees

Except for oversized priced parcels and USPS Ground Return service parcels, mailers of a USPS Ground Advantage—Commercial piece are subject to a nonstandard fee (see Notice 123–Price List) as follows:

* * * * *

[Revise the text of item h to read as follows:]

h. Mailers of parcels requiring the characteristics extra-service code (ESC) under 1.7g and who have a Shipping Services file manifest or other approved electronic documentation and do not meet the requirement to include the ESC for such parcels will be assessed the Dimension and Weight Noncompliance fee under 1.8.

[Revise the heading and text of 1.8 to read as follows:]

1.8 Dimension and Weight Noncompliance Fee

Except for USPS Ground Advantage Return service pieces, mailers of USPS Ground Advantage—Commercial parcels must include the parcel's accurate dimensions (length, width, height), weight, and when applicable the characteristics ESC (see 1.7g), in the Shipping Services file manifest or other approved electronic documentation. The mailer will be assessed the Dimension and Weight Noncompliance fee (see Notice 123–Price List) if the parcel's dimensions, weight, or the ESC are omitted. A parcel is subject to only one Dimension and Weight Noncompliance fee charge.

[Delete the ''Note:'' under 1.8 in its entirety.]

* * * * *

[Add new section 1.12 to read as follows:]

1.12 Fuel Surcharge

USPS Ground Advantage, including USPS Ground Advantage Return pieces, are subject to the Fuel Surcharge (see Postal Explorer at *pe.usps.com*). For additional information see *USPS.com* and Publication 199, *Intelligent Mail Package Barcode (IMpb) Implementation Guide for Confirmation Services and Electronic Payment Systems,* available on the PostalPro website at *postalpro.usps.com.*

* * * * *

[Add new section 1.13 to read as follows:]

1.13 Shipping Label Noncompliance Fee

USPS Ground Advantage pieces, including USPS Ground Advantage Return pieces, will be subject to the Shipping Label Noncompliance Fee (see Notice 123—Price List) for each noncompliant piece (*e.g.,* incorrect symbology, incorrect barcode construct (content within the barcode)).

* * * * *

500 Additional Mailing Services

* * * * *

507 Mailer Services

* * * * *

5.0 Package Intercept

5.1 Description of Service

* * * * *

5.1.3 Ineligible

Package Intercept is not available for:

* * * * *

[Revise the text of item d to read as follows:]

d. Mailpieces under 5.1.2e through 5.1.2h that contain hazardous materials.

[Renumber item e as item f and add new item e to read as follows:]

e. Mailpieces containing perishable matter (See Publication 52).

* * * * *

508 Recipient Services

* * * * *

7.0 Premium Forwarding Services

* * * * *

7.2 Premium Forwarding Service Residential

7.2.1 Description

[Revise the text of 7.2.1 to read as follows:]

Premium Forwarding Service Residential (PFS-Residential) provides certain residential customers (see 7.2.4), an option to have all mail addressed to their primary address shipped to a temporary address by a weekly Priority Mail Express or Priority Mail shipment. Service is available for a period of not less than 2 weeks and not more than 1 year. This optional service is separate from the forwarding service offered in 507.2.0. Customers must pay a nonrefundable enrollment fee and a weekly charge for each Priority Mail Express or Priority Mail shipment for each week of service requested as provided under 7.2.4.

* * * * *

7.2.4 Use

Participation in PFS-Residential is subject to the following additional standards:

[Revise the text of item a by adding a new last sentence to read as follows:]

a. * * * The annual online enrollment fee and amount due for the total weeks requested must be paid in full. (See Notice 123—Price List.)

[Revise the text of item b to read as follows:]

b. Service is available to eligible residential street delivery (not P.O. Box delivery) customers who submit an application online at *www.usps.com/manage/forward.htm.* Customers must pay an annual enrollment fee in full and weekly shipment charges as services are rendered, by credit card. Customers may also opt in to the automatic renewal option. Modification or cancellation of the service can only be made online when the initial request was completed online.

* * * * *

7.2.6 Weekly Priority Mail Shipments

[Revise the introductory text of 7.2.6 to read as follows:]

Premium Forwarding Service Residential shipments are dispatched weekly (on Wednesday) as Priority Mail Express or Priority Mail with USPS Tracking service. Regardless of any mailer's ancillary service endorsement on a mailpiece, and provided it fits within the shipment container, all mail

is included in the weekly Priority Mail Express or Priority Mail shipment, except as follows:

[*Revise the text of item a to read as follows:]*

a. Any mailpiece arriving at the primary address that indicates hazardous materials markings is not included in the weekly Priority Mail Express or Priority Mail shipment and must be rerouted separately via surface transportation.

* * * * *

[Revise the text of item c to read as follows:]

c. Priority Mail Express or Priority Mail is not included in the shipment if such inclusion may delay its delivery to the temporary address.

[Revise the introductory text of item d to read as follows:]

d. Any mailpiece arriving postage due at the Post Office serving a customer's primary address is not included in the weekly Priority Mail Express or Priority Mail shipment and will be rerouted separately as follows:

* * * * *

7.3 Premium Forwarding Service Commercial

* * * * *

7.3.2 Activation

[Revise the second sentence of 7.3.2 to read as follows:]

* * * Customers must specify the business P.O. Boxes (or Caller Service) or business street delivery addresses, destination address, and frequency. * * *

7.3.3 Conditions

Only the authorized recipient (or legal agent) of the business' (or organization's) mail may activate the request for PFS-Commercial service. PFS-Commercial service is subject to these conditions:

[Revise the text of 7.3.3a by adding a new second sentence to read as follows:]

a. * * * Customers may also opt in to the automatic renewal option. * * *

* * * * *

[Revise the introductory text of item c to read as follows:]

c, The postage is charged by frequency (daily, weekly, monthly) per shipment container as follows:

[Revise the text of item c1 to read as follows:]

1. A sack and its contents are considered one piece for calculating the postage price and must not exceed 70 pounds. Postage is calculated by the weight of the sack and the zone, based on the ZIP Code of the servicing Post Office and the delivery address for the shipment, minus the tare weight. Shipments in sacks are also subject to the PFS Sack Rehandling Fee (see Notice 123—Price List).

* * * * *

[Revise the text of item d to read as follows:]

d. If no mail is collected for a shipment on a designated frequency, no postage is charged.

* * * * *

[Revise the text of 7.3.3 by adding a new item k to read as follows:]

k. Any mailpiece addressed to business P.O. Boxes (including Caller Service) or business street addresses that indicates hazardous materials markings is not included in the Priority Mail Express or Priority Mail shipment and must be rerouted separately via surface transportation.

* * * * *

7.4 Premium Forwarding Service Local

* * * * *

7.4.3 Conditions

Only the residential/individual use P.O. Box customer or authorized recipient (or legal agent) of a business' (or organization's) P.O. Box mail that is on file may activate the request for PFS-Local service. PFS-Local service is subject to these conditions:

* * * * *

[*Revise the text of item g to read as follows:*]

g. Any mailpiece indicating hazardous materials markings is not included in the Priority Mail Express or Priority Mail reshipment and a delivery notice will be provided in the PFS-Local reshipment.

* * * * *

600 Basic Standards for All Mailing Services

601 Mailability

1.0 General Standards

* * * * *

1.2 Overweight Items or Oversize Items

* * * * *

1.2.3 Fee

[*Revise the text of 1.2.3 to read as follows:*]

Except for overweight or oversize items discovered during a retail transaction and returned to the mailer, mailers of retail and commercial paid overweight or oversize items reported in a manifest or found in the Postal Service network will be assessed the overweight- or oversize-items fee of $400. When applicable, the fee must be paid before the Postal Service will release the item to the mailer or addressee. The $400 overweight- or oversize-item fee may be paid by any authorized retail payment method or through USPS Ship.

* * * * *

604 Postage Payment Methods and Refunds

* * * * *

8.0 Insufficient or Omitted Postage

8.1 Insufficient Postage

8.1.1 Definition

[*Revise the first sentence of 8.1.1 to read as follows:*]

Except under 8.1.12, mail of any class, including mail indicating extra services (except Priority Mail Express, Registered Mail, and nonmachinable First-Class Mail), that is received at either the office of mailing or office of address without enough postage is marked to show the total (rounded off) deficiency of postage and fees. * * *

* * * * *

[*Revise 8.1 by adding new 8.1.12 to read as follows:*]

8.1.12 Insufficient Postage (Shortpaid) USPS Ship and APV

Commercial Priority Mail Express, Priority Mail, USPS Ground Advantage and Parcel Select detected to have insufficient postage (shortpaid) by USPS Ship or the APV program will be assessed the total postage due. Pieces detected to have insufficient postage will be subject to a 20 percent ''Repricing Fee'' on the insufficient postage due per piece. The total postage due (insufficient postage amount plus repricing fee) will be deducted from the mailer's account.

* * * * *

9.0 Exchanges and Refunds

* * * * *

9.2 Postage and Fee Refunds

* * * * *

9.2.3 Full Refund

[*Revise the introductory text of 9.2.3 to read as follows:*]

Except under 9.7, a full refund (100 percent) may be made when:

* * * * *

[*Add new 9.7 to read as follows:*]

9.7 USPS Ship or PC Postage Refunds

A refund of postage on overpaid parcels manifested using USPS Ship or paid with PC Postage will be paid on commercial Priority Mail Express,

Priority Mail, USPS Ground Advantage and Parcel Select pieces as follows:

a. A threshold for the refund of postage on eligible overpaid parcels manifested using USPS Ship or paid with PC Postage will be $5.00 (Mailers may only request a refund if the postage overpaid exceeds $5.00).

b. A Repricing Fee of 20 percent will be assessed against the refund for each parcel that exceeds the $5.00 threshold in 9.7a.

c. Customers must apply for a refund under 9.2.5, within the time limits provided in Exhibit 9.2.1, and receive payment as provided under 9.2.6.

* * * * *

Notice 123 (Price List)

[*Revise competitive prices as applicable.*]

* * * * *

Daria Schildkraut,

Attorney, Ethics and Legal Compliance.

[FR Doc. 2026–23595 Filed 11–18–26; 8:45 am]

BILLING CODE P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R09–OAR–2024–0627; FRL–12536–03–R9]

Air Plan Revisions; California; San Joaquin Valley Unified Air Pollution Control District; New Source Review; Stationary Source Permits

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is finalizing a limited approval and limited disapproval of three permitting rules as a revision to the San Joaquin Valley Unified Air Pollution Control District (SJVUAPCD or ''District'') portion of the California State Implementation Plan (SIP). These are revisions to the District's New Source Review (NSR) air permitting program rules for new and modified sources of air pollution under Clean Air Act (CAA or ''Act'') section 110(a)(2)(C) and part D of title I.

DATES: This rule is effective on December 21, 2026.

ADDRESSES: The EPA has established a docket for this action under Docket ID No. EPA–R09–OAR–2024–0627 at *https://www.regulations.gov.* All documents in the docket are listed on the *https://www.regulations.gov website.* Although listed in the index, some information is not publicly available, *e.g.,* Confidential Business Information (CBI) or other information the disclosure of which is restricted by statute. Certain other material, such as copyrighted material, is not placed on the internet and will be publicly available only in hard copy form. Publicly available docket materials are available through *https://www.regulations.gov,* or please contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section. If you need assistance in a language other than English or if you are a person with a disability who needs a reasonable accommodation at no cost to you, please contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: Nidia K. Trejo, EPA Region IX, 75 Hawthorne St., San Francisco, CA 94105; by phone: (415) 972–3968; or by email to *trejo.nidia@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document, the use of ''we,'' ''us,'' and ''our'' is intended to refer to the EPA. We use multiple abbreviations and terms in this final rule. While this list may not be exhaustive, for ease of reading and for reference purposes, the EPA defines the following terms and acronyms here:

ASTM American Society for Testing and Materials
CAA Clean Air Act
CARB California Air Resources Board
CBI confidential business information
IFD Interim Final Determination
FIP Federal Implementation Plan
NSR New Source Review
NNSR Nonattainment New Source Review
PM2.5 PM less than 2.5 μm in diameter
SIP State Implementation Plan
SJVUAPCD San Joaquin Valley Unified Air Pollution Control District
TSD Technical Support Document
VOC Volatile organic compound

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I. Executive Summary

A. What action is the EPA taking?

The Environmental Protection Agency (EPA) is finalizing a limited approval and limited disapproval of three permitting rules submitted by the San Joaquin Valley Unified Air Pollution Control District (SJVUAPCD or ''District'') as a revision to the California SIP. The submitted rules address the District's New Source Review (NSR) air permitting program rules for new and modified sources of air pollution pursuant to CAA section 110(a)(2)(C) and part D of title I. This action will update the California SIP with rules that the District has revised to address deficiencies identified in a previous limited disapproval action and to incorporate other revisions related to Nonattainment New Source Review (NNSR) requirements. We proposed this action on January 21, 2025, and held a 30-day public comment period.

B. What is the legal authority and what are the requirements?

CAA sections 110(k)(3) and 301(a) provide the EPA's statutory authority for finalizing a limited approval and limited disapproval of Rules 1020, 2020, and 2201. We have evaluated the rule revisions for compliance with CAA sections 172(c)(5), 173, 182(e), and 189(b), which establish the requirements for stationary source preconstruction permitting programs, including those specifically applicable for an Extreme ozone nonattainment area and Serious $PM_{2.5}$ nonattainment area, as well as the Federal regulations applicable to stationary source permitting at 40 CFR 51.160 through 51.165. Additionally, the EPA reviewed the rules for consistency with other general CAA requirements for SIP submittals, including requirements at CAA section 110(a)(2)(A) regarding rule enforceability and requirements at CAA sections 110(l) and 193 for SIP revisions. We have also considered whether the rules meet the Federal visibility requirements related to State NNSR programs as described in 40 CFR 51.307.

II. Background of the Proposed Action and Interim Final Determination To Defer Sanctions

On January 21, 2025 (90 FR 6928), the EPA proposed a limited approval and limited disapproval of three rules submitted for approval into the California SIP. Table 1 lists the rules addressed by this proposal with the dates they were amended or revised by the District and submitted by the California Air Resources Board (CARB), the agency that serves as the governor's designee for California SIP submittals.

TABLE 1—SUBMITTED RULES

Rule No.	Rule title	Adoption/amendment date	Submitted date
1020	Definitions	4/20/2023	10/13/2023
2020	Exemptions	12/18/2014	10/13/2023
2201	New and Modified Stationary Source Review Rule	4/20/2023	10/13/2023

The October 13, 2023 submittal of these three rules was intended to resolve deficiencies identified in our July 10, 2023 final action (''2023 NSR Action''), which included a limited disapproval of a prior version of Rule 2201. In the 2023 NSR Action, specific issues included missing and deficient definitions, impermissible interprecursor trading provisions, unapprovable exemptions to offsetting and public notice provisions, among other assorted deficiencies. The EPA also identified concerns related to the ''offset equivalency tracking system'' used to ensure that the District's permitting program collected the federally-required amount of creditable emissions reductions.

In our January 21, 2025 action, we proposed to determine that the District had fully addressed the deficiencies identified in the 2023 NSR Action, but we also proposed a limited approval of the District's October 2023 submittal because we identified other aspects of the submitted rules that were not approvable. Specifically, we identified the following deficiencies:

1. Rule 1020—Definitions

The definition of VOC in Rule 1020 is deficient because it does not include an exemption for trans-1,1,1,4,4,4-hexafluorobut-2-ene (also known as HFO–1336mzz(E)). The EPA added trans-1,1,1,4,4,4-hexafluorobut-2-ene to the list of compounds 40 CFR 51.100(s)(1) that are exempted from the definition of VOC at 40 CFR 51.100(s) on February 8, 2023 (effective April 10, 2023).[1] While this compound was added to the Federal regulations nearly contemporaneously to the District's adoption of the amendments to Rule 1020 on April 10, 2023, the absence of trans-1,1,1,4,4,4-hexafluorobut-2-ene in the Rule 1020 list of exempt compounds creates a new rule deficiency. In addition, on November 12, 2024, the EPA proposed to add (Z)-1-chloro-2,3,3,3-tetrafluoropropene (also known as HCFO–1224yd(Z)) to the list of compounds exempted from the definition of VOC.[2] The District must revise the Rule 1020 definition of VOC to match the most recent Federal definition in effect at 40 CFR 51.100(s), including the exemptions listed at 40 CFR 51.100(s)(1).[3]

2. Rule 2020—Exemptions

Several American Society for Testing and Materials (ASTM) test method citations provided in Rule 2020 are deficient because they do not include the revision or reissuance date of the specific ASTM methods.

3. Rule 2201—New and Modified Stationary Source Review Rule

The term ''Emission Reduction Credit'' is used in Rule 2201, but the term is not defined in the rule or in Rule 1020, ''Definitions.'' We note that the term is defined in Rule 2301—Emission Reduction Credit Banking, but this rule has not been submitted for SIP approval. Therefore, we find Rule 2201 deficient because it does not provide a definition for the term Emission Reduction Credit, and the term is a necessary component of an approvable NNSR program.

Please see our proposed rule for more information concerning the background for this action and for a more detailed discussion of the rationale for our limited approval and limited disapproval of the submitted rules. As described in the proposed rule, the rules listed in Table 1 are intended to replace older versions of the rules currently in the SIP.

In addition, on January 21, 2025, the EPA published an Interim Final Determination (IFD) to defer the imposition of the offset and highway sanctions triggered by the limited disapproval component of the 2023 NSR Action. [4] [5] An EPA IFD to defer sanctions is an administrative action that temporarily pauses the automatic implementation of Federal penalties against a State for failing to meet specific CAA requirements.

III. Public Comments and EPA Responses

The EPA's proposed action provided a 30-day public comment period. During this period, we received three comment letters, which are included in the docket for this action. Two comment letters are from individuals; their comments are supportive and do not raise any discernable issues that are adverse to our action as proposed. The third comment letter was submitted by the Central Valley Air Quality Coalition, Committee for a Better Arvin, Committee for a Better Shafter, Delano Guardians, and the Center on Race, Poverty & the Environment (collectively, ''Environmental Organizations''). Issues raised in this comment letter are summarized with responses below.

Comment 1: The Environmental Organizations stated that the District has not corrected all deficiencies that the EPA identified in the 2023 NSR Action, and that the EPA's proposed limited approval of the revised rules and accompanying IFD deferring sanctions are therefore unlawful and arbitrary. The commenters highlighted the EPA's findings from the 2023 NSR Action that the prior version of Rule 2201 was less stringent than Federal requirements because it did not provide an equivalent amount of time-of-use surplus emissions reductions as would have been required under the Federal program and did not provide a remedy to correct the negative VOC and NO_X balances from the District's 2019–2020 and 2020–2021 Annual Offset Equivalency Reports. According to the commenters, the revised Rule 2201 does not address this deficiency because it fails to provide sufficient offsetting emissions reductions and does not correct the VOC and NO_X deficits in the offset equivalency program.

Response: We disagree with the commenters' characterizations of our proposed action. As described below, neither the 2023 NSR Action nor the present action would require the District to provide additional offsetting emissions reductions as part of an approvable SIP submittal, and our review in each case is limited to

[1] 88 FR 8226 (February 8, 2023).

[2] 89 FR 88940 (November 12, 2024).

[3] Our proposal for this action also notes the EPA's November 12, 2024 proposal to add (Z)-1-chloro-2,3,3,3-tetrafluoropropene (also known as HCFO–1224yd(Z)) to the list of compounds exempted from the definition of VOC at 40 CFR 51.100(s)(1). 89 FR 88940 (November 12, 2024). While we have not finalized the addition of this compound to the list, the District's revision of Rule 1020 should consider any final revisions to 40 CFR 51.100(s)(1).

[4] 90 FR 6809 (January 21, 2025).

[5] 88 FR 43434 (July 10, 2023).

ensuring that the submitted rules meet applicable CAA requirements.

As an initial matter, comments relating solely to the 2023 NSR Action are outside the scope of this rulemaking because this action refers to the January 21, 2025 limited approval limited disapproval proposed action, not the 2023 NSR Action. However, we wish to clarify aspects of the 2023 NSR Action's characterization of deficiencies in the previous Rule 2201 to the extent that they are relevant to the present rulemaking. As the commenters have noted, the 2023 NSR Action includes a finding that the previous Rule 2201 equivalency system did not provide a mechanism to require the District to quantify or restore VOC and NO_X negative balances from the District's 2019–2020 and 2020–2021 Annual Offset Equivalency Reports. We explained this deficiency in the proposal for that action as follows:

> [B]ecause neither remedy provides a mechanism to require the District to quantify or restore a negative balance in the equivalency system, both remedies fail to ensure full Federal offset equivalency in the event of a shortfall. Thus, even where the District adopts all offset requirements of the Federal program in response to an equivalency failure, it will retain an historic deficit relative to the Federal program, which is not made whole under the rule. Therefore, the EPA finds that the District must revise the rule to address these deficiencies.[6]

The proposal for the 2023 NSR Action also identified as deficiencies Rule 2201's failure to require sources to provide the federally-required quantity of offsets following an equivalency failure and the lack of requirements that would prevent the equivalency system from operating with a negative balance once creditable emissions reductions had been exhausted.[7]

In describing these deficiencies, we noted that ''several shortcomings in the District's equivalency system ha[d] become apparent'' following the equivalency failures shown in the 2019–2020 and 2020–2021 annual offset equivalency reports.[8] While these ''shortcomings'' were made prominent through the annual equivalency reports, the deficiencies identified in the 2023 NSR Action relate specifically to the content of the rule (and in particular, the rule's ability to address hypothetical future offset shortfalls). At the time, we noted that the ''most straight forward way'' to address the identified deficiencies would be to directly implement the Federal offset program requirements going forward.[9] We did not require the District to retroactively apply Federal offset requirements to past permitting actions or otherwise restore a negative balance in the equivalency system. As we stated in the 2023 NSR Action, there is nothing in the SIP-approved version of Rule 2201 to require this,[10] and we are similarly unaware of any other authority to require such action.

Turning to the present action, we have considered whether SJVUAPCD has fully addressed the Rule 2201 deficiencies identified in the 2023 NSR Action. As described elsewhere in this notice and in the proposal and TSD, which are included in the docket for this action, we find that it has.[11] Specifically, we find that changes to directly apply the Federal requirements to NOx and VOC and to revise the equivalency demonstration and remedies for other pollutants have sufficiently addressed the problems identified in the previous rule and will ensure equivalency with Federal requirements going forward. Importantly, contrary to the commenters' suggestion, our proposed action did not include a finding ''that the District corrected the NSR program's negative balance of VOC and NOx offsets.'' Rather, our review is limited to ensuring that the rule meets applicable Federal requirements for NSR permitting of new and modified sources, including those requirements that were the basis for our prior limited disapproval in the 2023 NSR Action.

Comment 2: The Environmental Organizations noted that several of the commenting organizations have filed a CAA citizen suit alleging violations of Rule 2201 by the District. The commenters recounted and critiqued aspects of the 2023 NSR Action and argued that that action does not affect the enforceability of or otherwise diminish Rule 2201's requirements or remedies. The commenters indicated that the EPA should not construe their comments as waiving or conceding allegations in that suit.

Response: Comments relating to the commenters' lawsuit against the District are outside the scope of this action. The EPA is not a party to the suit, and we take no position regarding the allegations or arguments raised. As noted previously, comments related solely to the 2023 NSR Action are also outside the scope of this action.

IV. EPA Action

The comments we received on our proposed action and on our interim final determination do not change our assessment of the submitted rules, as described in our proposed action. Therefore, as authorized in CAA sections 110(k)(3) and 301(a), the EPA is finalizing a limited approval and limited disapproval of Rules 1020, 2020, and 2201. This action incorporates the submitted rules into the California SIP, including those provisions identified as deficient.

This approval is limited because the EPA is simultaneously finalizing a limited disapproval of the rules under CAA section 110(k)(3). Our limited disapproval of Rules 1020, 2020, and 2201 triggers an obligation for the EPA to promulgate a Federal Implementation Plan (FIP) unless we approve subsequent SIP revisions that correct the rule deficiencies within 24 months of this final action. Additionally, because the deficiency relates to NNSR requirements under part D of title I of the Act, the offset sanction in CAA section 179(b)(2) will be imposed in the San Joaquin Valley nonattainment area 18 months after the effective date of this action, and the highway funding sanction in CAA section 179(b)(1) will be imposed in the area six months after the offset sanction is imposed, unless the EPA approves subsequent SIP revisions that correct the rule deficiencies prior to the implementation of the sanctions. The EPA intends to work with the District to correct the deficiencies in a timely manner.

Note that the rules have been adopted by the District, and the EPA's final limited disapproval does not prevent the local agency from enforcing them. The limited disapproval would also not prevent any portion of the rules from being incorporated by reference into the federally enforceable SIP.[12]

V. Incorporation by Reference

In this rule, the EPA is finalizing regulatory text that includes incorporation by reference. In accordance with requirements of 1 CFR

[6] 87 FR 45730, 45734 (July 29, 2022).

[7] *Id.*

[8] *Id.* at 45733. We noted in particular that the 2020–2021 report ''showed a significant disconnect between the section 7 tests and remedies for all pollutants.'' *Id.* at 45734.

[9] EPA Region 9, ''Technical Support Document (TSD), Notice of Proposed Rulemaking, Revisions to the California State Implementation Plan, San Joaquin Valley Air Pollution Control District, Rule 2201—New and Modified Stationary Source Review Rule, EPA Docket # EPA–OAR–R09–2022–0420,'' June 29, 2022, 24.

[10] 88 FR 43434, 43436 (July 10, 2023).

[11] While this action includes a limited disapproval, this disapproval is based on deficiencies unrelated to the those identified in the 2023 NSR Action.

[12] Memorandum dated July 9, 1992, from John Calcagni, Director, Air Quality Management Division, Office of Air Quality Planning and Standards, U.S. EPA, to EPA Regional Air Directors, Regions I–X, Subject: ''Processing of State Implementation Plan (SIP) Submittals.''

51.5, the EPA is incorporating by reference the rules listed in Table 1 of this preamble. These rules are intended to address the CAA's statutory and regulatory requirements for NNSR permit programs for major sources emitting nonattainment air pollutants under CAA section 110(a)(2)(C) and part D of title I. The EPA has made, and will continue to make, these materials available through *https://www.regulations.gov* and at the EPA Region IX Office (please contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section of this preamble for more information).

VI. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, the EPA's role is to review State choices, and approve those choices if they meet the minimum criteria of the Act. Accordingly, this action merely approves State law as meeting Federal requirements and does not impose additional requirements beyond those imposed by State law.

Additional information about these statutes and Executive Orders can be found at *https://www.epa.gov/laws-regulations/laws-and-executive-orders.*

A. Executive Order 12866: Regulatory Planning and Review and Executive Order 13563: Improving Regulation and Regulatory Review

This action is not a significant regulatory action and was therefore not submitted to the Office of Management and Budget (OMB) for review.

B. Executive Order 14192: Unleashing Prosperity Through Deregulation

This action is not expected to be an Executive Order 14192 regulatory action because this action is not significant under Executive Order 12866.

C. Paperwork Reduction Act (PRA)

This action does not impose an information collection burden under the PRA because this action does not impose additional requirements beyond those imposed by State law.

D. Regulatory Flexibility Act (RFA)

I certify that this action will not have a significant economic impact on a substantial number of small entities under the RFA. This action will not impose any requirements on small entities beyond those imposed by State law.

E. Unfunded Mandates Reform Act (UMRA)

This action does not contain any unfunded mandate as described in UMRA, 2 U.S.C. 1531–1538, and does not significantly or uniquely affect small governments. This action does not impose additional requirements beyond those imposed by State law. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, will result from this action.

F. Executive Order 13132: Federalism

This action does not have federalism implications. It will 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.

G. Executive Order 13175: Coordination With Indian Tribal Governments

This action does not have Tribal implications, as specified in Executive Order 13175, because the SIP is not approved to apply on any Indian reservation land or in any other area where the EPA or an Indian Tribe has demonstrated that a Tribe has jurisdiction, and will not impose substantial direct costs on Tribal governments or preempt Tribal law. Thus, Executive Order 13175 does not apply to this action.

H. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

The EPA interprets Executive Order 13045 as applying only to those regulatory actions that concern environmental health or safety risks that the EPA has reason to believe may disproportionately affect children, per the definition of ''covered regulatory action'' in section 2–202 of the Executive Order. Therefore, this action is not subject to Executive Order 13045 because it merely approves State law as meeting Federal requirements. Furthermore, the EPA's Policy on Children's Health does not apply to this action.

I. Executive Order 13211: Actions That Significantly Affect Energy Supply, Distribution, or Use

This action is not subject to Executive Order 13211, because it is not a significant regulatory action under Executive Order 12866.

J. National Technology Transfer and Advancement Act (NTTAA)

Section 12(d) of the NTTAA directs the EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. The EPA believes that this action is not subject to the requirements of section 12(d) of the NTTAA because application of those requirements would be inconsistent with the CAA.

K. Congressional Review Act (CRA)

This action is subject to the CRA, and the EPA will submit a rule report to each House of the Congress and to the Comptroller General of the United States. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

L. Petitions for Judicial Review

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 19, 2027. 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 in 40 CFR Part 52

Environmental protection, Administrative practice and procedure, Air pollution control, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur dioxide, Volatile organic compounds.

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

Dated: November 9, 2026.

Michael Martucci,

Acting Regional Administrator, Region IX.

For the reasons stated in the preamble, the Environmental Protection Agency amends part 52, chapter I, title 40 of the Code of Federal Regulations as follows:

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

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

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

Subpart F—California

■ 2. Amend § 52.220, paragraph (c), table 29 by:

■ a. Revising the entry for ''1020'' under the heading ''Regulation I—General Provisions''; and

■ b. Revising the entries for ''2020'' and ''2201'' under the heading ''Regulation II—Permits''.

The revisions read as follows:

§ 52.220 Identification of plan.

* * * * *

(c) * * *

TABLE 29—EPA-APPROVED SAN JOAQUIN VALLEY UNIFIED AIR POLLUTION CONTROL DISTRICT REGULATIONS; FRESNO COUNTY AIR POLLUTION CONTROL DISTRICT REGULATIONS; KERN COUNTY AIR POLLUTION CONTROL DISTRICT REGULATIONS; KINGS COUNTY AIR POLLUTION CONTROL DISTRICT REGULATIONS; MADERA COUNTY AIR POLLUTION CONTROL DISTRICT REGULATIONS; MERCED COUNTY AIR POLLUTION CONTROL DISTRICT REGULATIONS; SAN JOAQUIN COUNTY AIR POLLUTION CONTROL DISTRICT REGULATIONS; STANISLAUS COUNTY AIR POLLUTION CONTROL DISTRICT REGULATIONS; TULARE COUNTY AIR POLLUTION CONTROL DISTRICT REGULATIONS

District citation	Title/subject	State effective date	EPA approval date	Additional explanation
*	*	*	*	*
Regulation I—General Provisions				
*	*	*	*	*
1020	Definitions	April 20, 2023	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	Submitted electronically by CARB on October 13, 2023 as an attachment to a letter of the same date.
Regulation II—Permits				
*	*	*	*	*
2020	Exemptions	December 18, 2014	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	Submitted electronically by CARB on October 13, 2023 as an attachment to a letter of the same date.
*	*	*	*	*
2201	New and Modified Stationary Source Review Rule.	August 9, 2023	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	The amendments adopted by the District on April 20, 2023 were not in effect until August 9, 2023. Submitted electronically by CARB on October 13, 2023 as an attachment to a letter of the same date.
*	*	*	*	*

* * * * *

[FR Doc. 2026–23572 Filed 11–18–26; 8:45 am]

BILLING CODE 6569–60–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2026–3764; FRL–13384–03–R3]

Air Plan Approval; Reasonably Available Control Technology (RACT) for Volatile Organic Compounds (VOC) Control Technique Guidelines (CTG) Under the 2008 and 2015 Ozone National Ambient Air Quality Standards (NAAQS)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is approving four State implementation plan (SIP) revisions submitted by the Commonwealth of Pennsylvania on May 10, 2023, January 20, 2026, February 17, 2026, and April 10, 2026, through the Pennsylvania Department of Environmental Protection (PADEP). The SIP revisions address reasonably available control technology (RACT) requirements for the 2008 and 2015 ozone national ambient air quality standards (NAAQS) relating to control technique guidelines (CTGs) for volatile organic compounds (VOC) via previously adopted CTG regulations, three new CTG regulations and permits for four facilities covered by the CTG for the Manufacture of High-Density Polyethylene, Polypropylene, and Polystyrene Resins respectively. The EPA is approving these revisions to the Pennsylvania SIP in accordance with the requirements of the Clean Air Act (CAA).

DATES: This final rule is effective on December 21, 2026.

ADDRESSES: The EPA has established a docket for this action under Docket ID Number EPA–R03–OAR–2026–3764. All documents in the docket are listed on the *www.regulations.gov* website. Although listed in the index, some information is not publicly available, *e.g.,* confidential business information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the internet and will be publicly available only in hard copy form. Publicly available docket materials are available through *www.regulations.gov,* or please contact the person identified in the **FOR FURTHER INFORMATION**

CONTACT section for additional availability information.

FOR FURTHER INFORMATION CONTACT: Sean Silverman, Planning & Implementation Branch (3AD30), Air & Radiation Division, U.S. Environmental Protection Agency, Region III, 1600 John F Kennedy Boulevard, Philadelphia, Pennsylvania 19103. The telephone number is (215) 814–5511. Mr. Silverman can also be reached via electronic mail at *silverman.sean@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this rule, the use of ''we,'' ''us,'' or ''our'' is intended to refer to the EPA. We use multiple abbreviations and terms in this rule. While this list may not be exhaustive, for ease of reading and for reference purposes, the EPA defines the following terms and acronyms here:

CAA—Clean Air Act
CBI—Confidential Business Information
CFR—Code of Federal Regulations
CTG—Control Technique Guidelines
EPA—Environmental Protection Agency
FR—Federal Register
IFD—Interim Final Determination
NAAQS—National Ambient Air Quality Standards
NPRM—Notice of Proposed Rulemaking
PADEP—Pennsylvania Department of Environmental Protection
NSR—New Source Review
RACT– Reasonably Available Control Technology
ppb—Parts per billion
PSD—Prevention of Significant Deterioration
SIP—State Implementation Plan
SOCMI—Synthetic Organic Chemical Manufacturing Industry
tpy—Tons per year
TSD—Technical Support Document
VOC—Volatile Organic Compounds

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I. Background

On August 16, 2024,[1] the EPA took final action to disapprove portions of two Pennsylvania SIP revisions received on August 13, 2018, that among other things, were intended to satisfy the VOC CTG RACT requirements for the 2008 ozone NAAQS. Specifically, the EPA disapproved the portions of both SIP submittals related to CTGs for the 2008 8-hour ozone NAAQS but approved certain clarifying amendments and a negative declaration submitted by PADEP. In that disapproval, the EPA determined that it erred in its previous December 14, 2020 approval[2] of the VOC CTG RACT portion of PADEP's RACT certification SIP, as the record did not provide sufficient support that the regulations identified by PADEP implemented the VOC CTG RACT requirements of the 2008 8-hour ozone NAAQS.

On May 10, 2023, January 20, 2026, February 17, 2026, and April 10, 2026, PADEP submitted four SIP revisions to the EPA to address VOC CTG RACT SIP requirements for the 2008 and 2015 ozone NAAQS. On July 16, 2026, the EPA proposed approval of these SIP revisions.[3] In that July 16, 2026 notice of proposed rulemaking (NPRM), the EPA proposed that through a combination of new CTG regulations, permits adopting standards from CTGs incorporated into the SIP, recertification of previously approved CTG regulations, and a robust record and supporting analysis that Pennsylvania met the VOC CTG RACT standards for the 2008 and 2015 ozone NAAQS. Furthermore, in that NPRM the EPA proposed that PADEP had addressed the deficiencies laid out in the August 16, 2024 disapproval, and as a result, simultaneously issued an Interim Final Determination (IFD)[4] staying the application of the offset sanction and deferring the application of the highway sanction triggered by the EPA's August 16, 2024 disapproval. The reasons for the proposed approval and the IFD were stated in the proposal for this action and will not be restated here.

The public comment period for the proposed approval and IFD ended on August 17, 2026. The EPA received no comments on either the proposed approval or IFD.

II. Summary of SIP Revision and EPA Analysis

On January 20, 2026, PADEP submitted a revision to its SIP certifying that through a combination of: (1) regulations previously approved into the SIP; (2) regulations proposed to be approved into the SIP; and (3) portions of redacted permits proposed to be incorporated into the SIP that RACT is being implemented for VOC sources covered by a CTG to meet Pennsylvania's RACT requirements under the CAA and implementing regulations for the 2008 and 2015 ozone NAAQS. PADEP submitted four SIP revisions to accomplish this (herein collectively referred to as the VOC CTG RACT SIP) and a robust supporting analysis. A description of these submissions is summarized below.

On May 10, 2023, PADEP submitted the first of the four revisions to its SIP establishing RACT requirements to control VOC emissions from sources covered by the following CTGs: (1) Shipbuilding and Ship Repair Operations (Surface Coating), 61 FR 44050 (August 27, 1996);[5] (2) Large Petroleum Dry Cleaners, EPA–450/3–82–009;[6] (3) Control of Volatile Organic Compound Leaks from Synthetic Organic Chemical Polymer and Resin Manufacturing Equipment, EPA–450/3–83–006;[7] (4) Control of Volatile Organic Compound Emissions from Air Oxidation Processes in Synthetic Organic Chemical Manufacturing Industry (SOCMI), EPA–450/3–84–015;[8] and (5) Control of Volatile Organic Compound Emissions from Reactor Processes and Distillation Operations in Synthetic Organic Chemical Manufacturing Industry, EPA–450/4–91–031.[9]

On January 20, 2026, a second SIP submission was received which contained supporting analysis for all four SIP submissions demonstrating that the submittals meet VOC CTG RACT requirements for the 2008 and 2015 ozone NAAQS. The bulk of this submission relates to PADEP's previously SIP-adopted regulations and associated analysis.

On February 17, 2026, a third SIP submission was received containing portions of three redacted permits for specific facilities. In lieu of adopting new regulations to address VOC CTG RACT from manufacturing high density polyethylene, polypropylene and polystyrene resins (CTG EPA 450/3–83–008, November 1983),[10] PADEP sought to incorporate by reference into the Pennsylvania SIP portions of redacted permits for each source subject to this

[1] *See* 89 FR 66599 (Aug. 16, 2024).

[2] *See* 85 FR 80625 (Dec. 14, 2020).

[3] *See* 91 FR 43577 (July 16, 2026).

[4] *See* 91 FR 43544 (July 16, 2026).

[5] The CTG for Shipbuilding and Ship Repair Operations (Surface Coating) has no standalone document, it is a combination of the information in 61 FR 44050 (August 27, 1996) and the previously published ACT. Alternative Control Technology Document—Surface Coating Operations at Shipbuilding and Ship Repair Facilities.

[6] Control of Volatile Organic Compound Emissions from Large Petroleum Dry Cleaners.

[7] Control of Volatile Organic Compound Leaks from Synthetic Organic Chemical Polymer and Resin Manufacturing Equipment.

[8] Control of Volatile Organic Compound Emissions from Air Oxidation Processes in Synthetic Organic Chemical Manufacturing Industry.

[9] Control of Volatile Organic Compound Emissions from Reactor Processes and Distillation Operations in Synthetic Organic Chemical Manufacturing Industry.

[10] See Control of Volatile Organic Compound Emissions from Manufacture of High-Density Polyethylene, Polypropylene, and Polystyrene Resins.

CTG. The February 17, 2026 SIP submission certifies that these redacted permits contain conditions that are consistent with or more stringent than the CTG and implement VOC CTG RACT Requirements for these sources for the 2008 and 2015 ozone NAAQS. The February 17th submission contained the redacted permits for Multiplastics Extrusions Hazelton (permit 40–00083), Rohm & Haas Co Bristol (permit 09–00015), and Shell Chemical Appalachia (permit 04–00740).

On April 10, 2026, a fourth SIP submission was received from PADEP certifying that a permit for the BASF Monaca Plant (permit 04–00306), which was submitted to and approved by the EPA as RACT for the 1997 ozone NAAQS, meets or exceeds the CTG requirements for controlling VOC emissions from manufacturing high density polyethylene, polypropylene and polystyrene resins (EPA–450/3–83–008, November 1983) and remains sufficient to implement VOC CTG RACT for the 2008 and 2015 ozone NAAQS.

Other specific requirements of Pennsylvania's VOC CTG RACT SIP revisions for the 2008 and 2015 ozone NAAQS and the rationale for the EPA's proposed (and now final) action are explained in the NPRM, and its associated technical support document (TSD) and will not be restated here.

III. EPA's Response to Comments Received

No public comments were received on the NPRM.

IV. Final Action

The EPA is approving Pennsylvania's May 10, 2023, January 20, 2026, February 17, 2026, and April 10, 2026 SIP revisions to the Pennsylvania SIP as proposed in the EPA's July 16, 2026 NPRM. In addition, the EPA is determining that these SIP revisions addressed the requirements of the 2008 and 2015 ozone NAAQS for CTGs and addressed the deficiencies identified in EPA's August 16, 2024 partial disapproval. Finalization of this approval permanently stops the offset sanctions which took effect on March 16, 2026 and prevents the imposition of highways sanctions which were set to take effect on September 16, 2026.

V. Incorporation by Reference

In this document, the EPA is finalizing regulatory text that includes incorporation by reference. In accordance with requirements of 1 CFR 51.5, the EPA is finalizing the incorporation by reference of the amendments to 25 Pa. Code Chapters 121.1, 129.52, and newly added 25 Pa. Code Chapters 129.63b and 129.71a effective January 21, 2023 (see annex A of the May 10, 2023 submission). The EPA is also finalizing the incorporation by reference of portions of permits described in section II of this preamble as redacted in Pennsylvania's February 20, 2026 SIP revision. The EPA has made, and will continue to make, these materials generally available through *www.regulations.gov* and at the EPA Region III Office (please contact the person identified in the For Further Information Contact section of this preamble for more information). Therefore, these materials have been approved by the EPA for inclusion in the SIP, have been incorporated by reference by the EPA into that plan, are fully federally enforceable under sections 110 and 113 of the CAA as of the effective date of the final rule of the EPA's approval, and will be incorporated by reference in the next update to the SIP compilation.[11]

VI. Statutory and Executive Order Reviews

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Clean Air Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, the EPA's role is to approve State choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves State law as meeting Federal requirements and does not impose additional requirements beyond those imposed by State law. For that reason, this action:

- Is not a significant regulatory action subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Is not an Executive Order 14192 (90 FR 9065, February 6, 2025) regulatory action because this action is not significant under Executive Order 12866;
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not subject to Executive Order 13045 (62 FR 19885, April 23, 1997) because it approves a State program;
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001); and
- Is not subject to requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act.

In addition, the SIP is not approved to apply on any Indian reservation land or in any other area where the EPA or an Indian Tribe has demonstrated that a Tribe has jurisdiction. In those areas of Indian country, the rule does not have Tribal implications and will not impose substantial direct costs on Tribal governments or preempt Tribal law as specified by Executive Order 13175 (65 FR 67249, November 9, 2000).

This action is subject to the Congressional Review Act, and the EPA will submit a rule report to each House of the Congress and to the Comptroller General of the United States. 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 January 19, 2027. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Amy Van Blarcom-Lackey,

Regional Administrator, Region III.

For the reasons stated in the preamble, the EPA amends 40 CFR part 52 as follows:

[11] 62 FR 27968 (May 22, 1997).

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

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

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

Subpart NN—Pennsylvania

■ 2. In § 52.2020:

■ a. The table in paragraph (c)(1) is amended:

■ i. Under ''Chapter 121—General Provisions'' by revising the first entry for ''Section 121.1''; and

■ ii. Under ''Chapter 129—Standards for Sources'' by:

■ A. Revising the entry for ''Section 129.52''; and

■ B. Adding the entries for ''Section 129.63b'' and ''Section 129.71a'' in alphanumerical order;

■ b. The table in paragraph (d)(1) is amended by adding entries for ''Multiplastics Extrusions Inc/Hazelton'', ''Rohm & Haas Co/Bristol'', and ''Shell Chem Appalachia/Petrochemicals Complex'' at the end of the table; and

■ c. The table in paragraph (e)(1) is amended by adding entries for ''PA VOC CTG RACT Certification for the 2008 and 2015 Ozone National Ambient Air Quality Standard'' and ''PA BASF VOC CTG RACT Certification'' at the end of the table.

The revisions and additions read as follows:

§ 52.2020 Identification of plan.

* * * * *

(c) * * *

(1) * * *

State citation	Title/subject	State effective date	EPA approval date	Additional explanation/§ 52.2063 citation
*	*	*	*	*
Chapter 121—General Provisions				
121.1	Definitions	1/21/2023	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	
*	*	*	*	*
Chapter 129—Standards for Sources				
*	*	*	*	*
Sources of VOCs				
*	*	*	*	*
129.52	Surface coating processes	1/21/2023	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	Revised 129.52(a), 129.52(c), add Shipbuilding and Ship repair coatings to Table I.
*	*	*	*	*
129.63b	Control of VOC emissions from large petroleum dry cleaning facilities.	1/21/2023	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	New section 129.63b is added.
*	*	*	*	*
129.71a	Control of VOC emissions from the synthetic organic chemical manufacturing industry—air oxidation, distillation and reactor processes.	1/21/2023	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	New section 129.71a is added.
*	*	*	*	*

* * * * *

(d) * * *

(1) * * *

Name of source	Permit No.	County	State effective date	EPA approval date	Additional explanations/§§ 52.2063 and 52.2064 citations [1]
*	*	*	*	*	*
Multiplastics Extrusions Inc/Hazelton.	40–00083	Luzerne	8/4/2025	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	VOC CTG RACT emission limits and associated compliance parameters in unredacted portions of the permit submitted to the EPA on February 4, 2026. See also § 52.2064(n)(1).

Name of source	Permit No.	County	State effective date	EPA approval date	Additional explanations/§§ 52.2063 and 52.2064 citations [1]
Rohm & Haas Co/Bristol	09–00015	Bucks	5/31/2023	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	VOC CTG RACT emission limits and associated compliance parameters in unredacted portions of the permit submitted to the EPA on February 4, 2026. See also § 52.2064(n)(2).
Shell Chem Appalachia/Petrochemicals Complex.	04–00740C	Beaver	3/1/2021	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	VOC CTG RACT emission limits and associated compliance parameters in unredacted portions of the permit submitted to the EPA on February 4, 2026. See also § 52.2064(n)(3).

[1] The cross-references that are not § 52.2064 are to material that pre-date the notebook format. For more information, see § 52.2063.

* * * * *

(e) * * *

(1) * * *

Name of non-regulatory SIP revision	Applicable geographic area	State submittal date	EPA approval date	Additional explanation
*	*	*	*	* *
PA VOC CTG RACT Certification for the 2008 and 2015 Ozone National Ambient Air Quality Standard.	Statewide	1/20/2026	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	Certification that Pennsylvania's Previously SIP-approved VOC CTG RACT Regulations, permits incorporated into the SIP and New CTG RACT Regulations codified at 25 Pa Code Sections 121.1, 129.52, 129.63b and 129.71a meet VOC CTG RACT requirements for the 2008 and 2015 Ozone NAAQS.
PA BASF VOC CTG RACT Certification.	Statewide	4/10/2026	11/19/2026, 91 FR [INSERT **FEDERAL REGISTER** PAGE WHERE THE DOCUMENT BEGINS].	Certification that Pennsylvania's Previously SIP-approved permit for the BASF Facility (permit 04–00306) meet or exceed VOC CTG RACT requirements for the Control of Volatile Organic Compound Emissions from Manufacture of High-Density Polyethylene, Polypropylene, and Polystyrene Resins operations at the BASF facility.

* * * * *

■ 3. Amend § 52.2064 by adding paragraph (n) to read as follows:

§ 52.2064 EPA-approved Source-Specific Reasonably Available Control Technology (RACT) for Volatile Organic Compounds (VOC) and Oxides of Nitrogen (NO_X).

* * * * *

(n) Approval of source-specific RACT requirements for 2008 and 2015 8-hour ozone national ambient air quality standards for the facilities listed in this paragraph (n) are incorporated as specified. (Rulemaking Docket No. EPA–R03–OAR–2026–3764.)

(1) Multiplastics Extrusions Inc.—Incorporating by reference Permit No. 40–00083, effective August 4, 2025, as redacted by Pennsylvania.

(2) Rohm & Haas Co—Incorporating by reference Permit No. 09–00015, effective May 31, 2023, as redacted by Pennsylvania.

(3) Shell Chem Appalachia LLC—Incorporating by reference Plan Approval Permit No. 04–00740C, effective March 1, 2021, as redacted by Pennsylvania.

[FR Doc. 2026–23583 Filed 11–18–26; 8:45 am]

BILLING CODE 6569–60–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[EPA–R06–OAR–2023–0478; FRL–12671–02–R6]

Approval and Promulgation of State Air Quality Plans for Designated Facilities and Pollutants; Texas; Control of Emissions From Existing Municipal Solid Waste Landfills

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: Pursuant to the Federal Clean Air Act (CAA or the Act), the Environmental Protection Agency (EPA) is approving the CAA section 111(d) State plan submitted by the State of Texas for sources subject to the Municipal Solid Waste (MSW) Landfills Emission Guidelines (EG). The Texas MSW landfills plan was submitted to fulfill the State's obligations under CAA section 111(d) to implement and enforce the requirements under the MSW Landfills EG. The EPA is approving the State plan and amending the agency regulations in accordance with the requirements of the CAA.

DATES: This rule is effective on December 21, 2026. The incorporation by reference of certain material listed in this rule is approved by the Director of the Federal Register as of December 21, 2026.

ADDRESSES: The EPA has established a docket for this action under Docket ID No. EPA–R06–OAR–2023–0478. All documents in the docket are listed on the *https://www.regulations.gov* website. Although listed in the index, some information is not publicly available, *e.g.,* Confidential Business Information or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the internet. Publicly available docket materials are available electronically through *https://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Kevin Kim, EPA Region 6 Office, SO_2 and Regional Haze Section; telephone number: 214–665–8554; email address: *kim.kevin@epa.gov.* Please call or email the contact listed above if you need alternative access to material indexed but not provided in the docket.

SUPPLEMENTARY INFORMATION: Throughout this document ''we,'' ''us,'' and ''our'' means the EPA.

I. Background

The background for this action is discussed in detail in our March 4, 2026, proposed rule (91 FR 10556) and accompanying Technical Support

Document (TSD). In that document, we proposed to approve the Texas MSW landfills plan submitted by the Texas Commission on Environmental Quality (TCEQ) in accordance with the requirements of CAA section 111(d) and to amend 40 CFR part 62, subpart SS, to codify the EPA's approval. We proposed to find that the Texas MSW landfills plan, submitted by TCEQ on September 15, 2023, is as protective as the Federal requirements provided under the MSW landfills EG, codified at 40 CFR part 60, subpart Cf.

II. Response to Comments

We received three comments on our proposed rule: two in support and one in opposition. We appreciate the supportive comments and have noted them in the record; no changes are made in response. A summary of the adverse comment and our response to it are provided below.

Comment: The commenter asserted that proposed rules must secure stronger landfill gas capture and monitoring, faster organics diversion so that less methane is generated, and more public transparency about which sites may get exemptions. The commenter additionally provided their perspective on the landfill industry and operators and expressed concern for nearby communities while providing their comments. The commenter asked why the EPA is allowing less stringent rules from the State and stated that landfill operators should be accountable for their landfill emissions and put up safeguards for methane capture.

Response: The EPA acknowledges the commenter's concerns on addressing landfill emissions and protecting affected communities. Under CAA section 111(d), the EPA must approve a State plan that meets Federal requirements and appropriately implements the applicable emission guidelines, including provisions for enforceable limits, monitoring, reporting, and compliance schedules. Under 40 CFR 60.24(f), a State may apply less stringent emission standards or longer compliance schedules than otherwise required if the State demonstrates one or more of the following: (1) that, due to plant age, location, or basic process design, the cost of control is unreasonable; (2) that installing the necessary control equipment is physically impossible; or (3) that other factors specific to the facility (or class of facilities) make a less stringent standard or a later final compliance date significantly more reasonable.

Texas adopted 30 TAC section 113.2406(a) to explicitly exempt MSW landfills that have not accepted waste since October 9, 1993, and have no remaining design capacity from State regulations at Chapter 113, Subchapter D, Division 6, continuing an existing Division 1 exemption (30 TAC section 113.2060(2)(A)) but rephrasing it as a stand-alone exemption rather than embedding it in the definition of ''existing MSW landfill.'' This exemption is less stringent than the default Federal applicability in 40 CFR part 60, subparts Cc and Cf, because it excludes landfills that stopped accepting waste between November 8, 1987, and October 9, 1993.[1] TCEQ justifies the change under 40 CFR 60.24(f), which allows less stringent standards or longer compliance schedules for any of the three potential justifications detailed in the previous paragraph. In 1998, TCEQ[2] found only one landfill (City of Killeen) was briefly above the 50 megagrams per year (Mg/yr) nonmethane organic compound (NMOC) control threshold (to install a gas collection and control system for closed landfills) and projected that landfill would fall below this threshold by 2004. The EPA's 1999 approval likewise concluded that controlling these closed landfills would yield little emission benefit relative to cost. Given the passage of time, TCEQ asserts that none of the landfills that closed between 1987–1993 would currently exceed 50 Mg/yr NMOC, and TCEQ includes the prior State plan analysis[3] in support of maintaining the exemption. Therefore, these closed landfills in Texas would not be subject to gas collection and control system requirements nor would it likely result in a reduction in NMOC or landfill emissions even if Texas did not exempt these landfills as part of its current MSW landfills plan. The EPA finds that TCEQ has adequately demonstrated, consistent with 40 CFR 60.24(f), that a less stringent standard is reasonable for the applicable facilities, and approves of the provision, as adopted at 30 TAC section 113.2406(a).

In its assessment of Texas's plan, the EPA concluded that Texas's plan met Federal requirements under CAA section 111(d), the CAA section 111(d) implementing regulations at 40 CFR part 60, subpart B, and the applicable provisions under the MSW landfill emission guidelines at 40 CFR part 60, subpart Cf. While the EPA's action does not mandate organics diversion or rules beyond the landfill emission guidelines, the plan requires landfill gas collection and control, surface monitoring, corrective action, and reporting, with the EPA and TCEQ retaining full enforcement authority alongside citizens' recourse. Approving this plan would allow State implementation of substantively similar requirements from the Federal Plan that are already in effect and would provide for better enforcement oversight of landfill gas regulation. The EPA would continue to provide Federal oversight of landfill requirements under the emission guidelines.

III. Final Action

In this final action, the EPA is amending 40 CFR part 62, subpart SS, to reflect approval of the Texas MSW landfills plan from TCEQ, received on September 15, 2023, in accordance with CAA section 111(d). As part of that plan approval, the EPA is approving the State regulations at Texas Administrative Code Title 30, Chapter 113: Standards of Performance for Hazardous Air Pollutants and for Designated Facilities and Pollutants, Subchapter D: Designated Facilities and Pollutants, Division 6: 2016 Emission Guidelines For Existing Municipal Solid Waste Landfills, sections 113.2400 through 113.2412 (30 TAC sections 113.2400 through 113.2412) as the enforceable mechanism of the State plan.

IV. Incorporation by Reference

In accordance with the requirements of 1 CFR 51.5, we are finalizing regulatory text that includes the incorporation by reference of Texas Administrative Code Title 30, Chapter 113: Standards of Performance for Hazardous Air Pollutants and for Designated Facilities and Pollutants, Subchapter D: Designated Facilities and Pollutants, Division 6: 2016 Emission Guidelines For Existing Municipal Solid Waste Landfills, sections 113.2400 through 113.2412, adopted July 14, 2023, and effective July 19, 2023 (30 TAC sections 113.2400 through 113.2412), which is part of the CAA section 111(d) Plan applicable to existing MSW landfills subject to the MSW Landfills Emission Guidelines, at 40 CFR part 60, subpart Cf, within TCEQ's jurisdiction in the State of Texas. The regulatory provisions of 30 TAC sections 113.2400 through

[1] The MSW landfills EG contains gas collection and control system requirements for designated facilities (as defined in the EG) that have accepted waste after November 8, 1987, that meet specific design capacity and NMOC (nonmethane organic compound) emission rate thresholds (50 megagrams per year (Mg/yr) for closed landfills).

[2] At the time the Texas 1998 MSW landfill plan was submitted, TCEQ was called the Texas Natural Resource Conservation Commission (TNRCC).

[3] *See* (1) 23 TexReg 10876 (October 1998); (2) EPA's previous approval of Texas's 1998 MSW landfill plan at 64 FR 32427 (June 17, 1999); and (3) appendix C.5, attachment 1 of Texas's 2023 MSW landfill plan submission.

113.2412 incorporate the MSW Landfills Emission Guidelines promulgated by the EPA at 40 CFR part 60, subpart Cf, and establish emission standards and compliance times for the control of municipal solid waste landfills, as defined in subpart Cf, that commenced construction, modification, or reconstruction on or before July 17, 2014. The EPA has made and will continue to make 30 TAC sections 113.2400 through 113.2412 generally available at the EPA Region 6 office (please contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section of this preamble for more information). They are also available at: *https://www.regulations.gov* and *http://www.sos.texas.gov/tac/index.shtml.* This incorporation by reference has been approved by the Director of the Federal Register and the State plan is federally enforceable under the CAA as of the effective date of this final rulemaking.

V. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a CAA section 111(d)/129 submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7411(d); 42 U.S.C. 7429; 40 CFR part 60, subparts B and Cf; and 40 CFR part 62, subpart A. Thus, in reviewing CAA section 111(d)/129 State plan submissions, the EPA's role is to approve State choices, provided that they meet the criteria of the Act and implementing regulations. Accordingly, this action merely approves State law as meeting Federal requirements and does not impose additional requirements beyond those imposed by State law. For that reason:

A. Executive Order 12866: Regulatory Planning and Review

This action is not a significant regulatory action as defined in Executive Order 12866 (58 FR 51735, October 4, 1993) and was therefore not subject to a requirement for Executive Order 12866 review.

B. Executive Order 14192: Unleashing Prosperity Through Deregulation

This action is not an Executive Order 14192 (90 FR 9065, February 6, 2025) regulatory action because this action is not significant under Executive Order 12866.

C. Paperwork Reduction Act (PRA)

This action does not impose an information collection burden under the PRA (44 U.S.C. 3501 *et seq.*) because it does not contain any information collection activities.

D. Regulatory Flexibility Act (RFA)

This action is certified to not have a significant economic impact on a substantial number of small entities under the RFA (5 U.S.C. 601 *et seq.*). This action will approve a State plan pursuant to CAA section 111(d) and will therefore have no net regulatory burden for all directly regulated small entities.

E. Unfunded Mandates Reform Act (UMRA)

This action does not contain any unfunded mandate as described in UMRA, 2 U.S.C. 1531 through 1538, and does not significantly or uniquely affect small governments. This action imposes no enforceable duty on any State, local, or Tribal governments or the private sector.

F. Executive Order 13132: Federalism

This action does not have federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). It will 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.

G. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This action will not apply to areas of Indian country within Texas and therefore does not have Tribal implications as specified in E.O. 13175 (65 FR 67249, November 9, 2000). This action will neither impose substantial direct compliance costs on federally recognized Tribal governments, nor preempt Tribal law. This action will not impose substantial direct compliance costs on federally recognized Tribal governments because no actions will be required of Tribal governments. This action will also not preempt Tribal law as no Texas Tribe implements a regulatory program under the CAA and thus does not have applicable or related Tribal laws.

H. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

The EPA interprets Executive Order 13045 (62 FR 19885, April 23, 1997) as applying only to those regulatory actions that concern environmental health or safety risks that the EPA has reason to believe may disproportionately affect children, per the definitions of ''covered regulatory action'' in section 2–202 of the Executive Order. Therefore, this action is not subject to Executive Order 13045 because it approves a State program.

I. Executive Order 13211: Actions That Significantly Affect Energy Supply, Distribution and Use

This action is not subject to Executive Order 13211 (66 FR 28355, May 22, 2001), because it is not a significant regulatory action under Executive Order 12866.

J. National Technology Transfer and Advancement Act

This rulemaking does not involve technical standards. This action is not subject to requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act.

This action is subject to the Congressional Review Act, and the EPA will submit a rule report to each House of the Congress and to the Comptroller General of the United States. 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 January 19, 2027. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements (see CAA section 307(b)(2)).

List of Subjects in 40 CFR Part 62

Environmental protection, Administrative practice and procedure, Air pollution control, Incorporation by reference, Intergovernmental relations, Reporting and recordkeeping requirements, Waste treatment and disposal.

Dated: November 9, 2026.

Walter Mason,

Regional Administrator, Region 6.

For the reasons stated in the preamble, the Environmental Protection Agency amends 40 CFR part 62 as follows:

PART 62—APPROVAL AND PROMULGATION OF STATE PLANS FOR DESIGNATED FACILITIES AND POLLUTANTS

■ 1. The authority citation for part 62 continues to read as follows:

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

Subpart SS—Texas

■ 2. Amend § 62.10850 by revising paragraph (b)(3) to read as follows:

§ 62.10850 Identification of plan.

* * * * *

(b) * * *

(3) Control of landfill gas emissions from existing municipal solid waste landfills, submitted by the Texas Commission on Environmental Quality on September 15, 2023.

* * * * *

■ 3. Revise § 62.10880 to read as follows:

§ 62.10880 Texas Commission on Environmental Quality.

(a) *Identification of plan.* Control of air emissions from existing municipal solid waste landfills, as adopted by the State of Texas on July 14, 2023, effective July 19, 2023, and submitted on September 15, 2023, by the Texas Commission on Environmental Quality (TCEQ) Commissioner in a letter dated September 15, 2023. The plan includes the regulatory provisions cited in paragraph (d) of this section, which the EPA incorporates by reference.

(b) *Identification of sources.* The plan, as adopted by the State of Texas on July 14, 2023, effective July 19, 2023, and submitted on September 15, 2023, applies to existing municipal solid waste landfills subject to the Municipal Solid Waste Landfills Emission Guidelines, at 40 CFR part 60, subpart Cf, within its jurisdiction in the State of Texas.

(c) *Effective Date.* The effective date of the plan is December 21, 2026.

(d) *Incorporation by reference.* The material listed in this paragraph (d) is incorporated by reference in this section with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. All approved incorporation by reference (IBR) material is available for inspection at the EPA and at the National Archives and Records Administration (NARA). Contact the EPA Region 6 office at 1201 Elm Street, Suite 500, Dallas, Texas 75270; telephone number: 214–665–2200. For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.* The material may be obtained from the State of Texas, Office of the Secretary of State, Texas Register, P.O. Box 12887, Austin, Texas 78711; telephone number: (512) 463–5561; email address: *register@sos.texas.gov;* website: *https://www.sos.texas.gov/tac/index.shtml.*

(1) Texas Administrative Code Title 30, Chapter 113: Standards of Performance for Hazardous Air Pollutants and for Designated Facilities and Pollutants, Subchapter D: Designated Facilities and Pollutants, Division 6: 2016 Emission Guidelines For Existing Municipal Solid Waste Landfills, sections 113.2400 through 113.2412; effective July 19, 2023. (30 TAC sections 113.2400 through 113.2412)

(2) [Reserved]

[FR Doc. 2026–23580 Filed 11–18–26; 8:45 am]

BILLING CODE 6569–60–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

48 CFR Part 332

RIN 0991–AB86

Health and Human Services Acquisition Regulations; Correction

AGENCY: Department of Health and Human Services (HHS).

ACTION: Correcting amendment.

SUMMARY: This document corrects technical and typographical errors in the final rule that appeared in the **Federal Register** on November 18, 2015, titled ''Health and Human Services Acquisition Regulations.''

DATES: Effective November 19, 2026.

FOR FURTHER INFORMATION CONTACT: Blenda Perez, Senior Procurement Analyst, Acquisition Policy Division, *Acquisition_Policy@hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2015–28214 of November 18, 2015 (80 FR 72150), there was a technical error that is identified and corrected in this correcting document.

II. Summary of Errors

On page 72165 in the regulations text for section 332.702, we included an erroneous statutory reference.

III. Correction of Errors

In section 332.702, the statutory citation ''13 U.S.C. 1342'' is being corrected to read ''31 U.S.C. 1342''.

List of Subjects in 48 CFR Part 332

Government procurement.

For the reasons stated in the preamble, HHS amends 48 CFR part 332 as follows:

PART 332—CONTRACT FINANCING

■ 1. The authority citation for part 332 continues to read as follows:

Authority: 5 U.S.C. 301; 40 U.S.C. 121(c)(2).

332.702 [Amended]

■ 2. Amend section 332.702 by removing ''13 U.S.C. 1342'' and adding ''31 U.S.C. 1342'' in its place.

Liesl I. Fowler,

Executive Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2026–23617 Filed 11–18–26; 8:45 am]

BILLING CODE 4150–24–P

Proposed Rules

Federal Register
Vol. 91, No. 222
Thursday, November 19, 2026

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 TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2026–13820; Project Identifier MCAI–2025–01552–T]

RIN 2120–AA64

Airworthiness Directives; ATR—GIE Avions de Transport Régional Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to supersede Airworthiness Directive (AD) 2021–12–17, which applies to certain ATR—GIE Avions de Transport Régional Model ATR42–300, –320, and –500 airplanes; and all Model ATR72–101, –102, –201, –202, –211, –212, and –212A airplanes. AD 2021–12–17 requires a detailed visual inspection of each affected part for deficiencies (sealant blockage and out of tolerance ligaments), and depending on findings, accomplishment of applicable corrective actions. Since the FAA issued AD 2021–12–17, it was determined that additional seat track part numbers and airplanes may be affected. This proposed AD would continue to require the actions in AD 2021–12–17 and would require inspections of additional parts. This proposed AD would also limit the installation of affected parts. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this proposed AD by January 4, 2027.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2026–13820; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, the mandatory continuing airworthiness information (MCAI), any comments received, and other information. The street address for Docket Operations is listed above.

Material Incorporated by Reference:

- For European Union Aviation Safety Agency (EASA) material identified in this proposed AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu.* You may find this material on the EASA website at *ad.easa.europa.eu.* It is also available at *regulations.gov* under Docket No. FAA–2026–13820.
- You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

FOR FURTHER INFORMATION CONTACT: Yaser Osman, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 860–386–1786; email: *9-AVS-AIR-BACO-COS@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments using a method listed under the **ADDRESSES** section. Include ''Docket No. FAA–2026–13820; Project Identifier MCAI–2025–01552–T'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may amend this proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *regulations.gov*, including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Yaser Osman, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 860–386–1786; email: *9-AVS-AIR-BACO-COS@faa.gov.* Any commentary that the FAA receives which is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

The FAA issued AD 2021–12–17, Amendment 39–21604 (86 FR 34621, June 30, 2021) (AD 2021–12–17), for certain ATR—GIE Avions de Transport Régional Model ATR42–300, –320, and –500 airplanes; and all Model ATR72–101, –102, –201, –202, –211, –212, and –212A airplanes. AD 2021–12–17 was prompted by an MCAI originated by EASA, which is the Technical Agent for the Member States of the European Union. EASA issued AD 2020–0097R1, dated May 28, 2020 (EASA AD 2020–0097R1), to correct an unsafe condition.

AD 2021–12–17 requires a detailed visual inspection of each affected part for deficiencies (sealant blockage and out of tolerance ligaments), and depending on findings, accomplishment of applicable corrective actions. The FAA issued AD 2021–12–17 to address structural failure of the seat track

attachment during an emergency landing, possibly resulting in injury to occupants, and affecting emergency evacuation.

Actions Since AD 2021–12–17 Was Issued

Since the FAA issued AD 2021–12–17, EASA superseded EASA AD 2020–0097R1 and issued EASA AD 2025–0205R3, dated December 8, 2025 (EASA AD 2025–0205R3) (also referred to as the MCAI), to correct an unsafe condition for all ATR—GIE Avions de Transport Régional Model ATR42–200, –300, –320, –400, and –500 airplanes; and all Model ATR72–101, –102, –201, –202, –211, –212, and –212A airplanes. Model ATR42–400 airplanes are not certificated by the FAA and are not included on the U.S. type certificate data sheet; this proposed AD therefore does not include those airplanes in the applicability. The MCAI states that since EASA AD 2020–0097R1 was issued it was determined additional seat track part numbers might be affected and additional airplanes need to be inspected. EASA AD 2025–0205R3 also specifies that airplanes with certain configurations do not need to do the inspection and corrective actions.

The FAA is proposing this AD to address a structural failure of the seat track attachment during an emergency landing, possibly resulting in injury to occupants, and affecting emergency evacuation. You may examine the MCAI in the AD docket at *regulations.gov* under Docket No. FAA–2026–13820.

Explanation of Retained Requirements

Although this proposed AD does not explicitly restate the requirements of AD 2021–12–17, this proposed AD would retain all of the requirements of AD 2021–12–17. Those requirements are referenced in EASA AD 2025–0205R3, which, in turn, is referenced in paragraph (g) of this proposed AD.

Material Incorporated by Reference Under 1 CFR part 51

The FAA reviewed EASA AD 2025–0205R3, which specifies procedures for a detailed visual inspection of each affected seat track for deficiencies (sealant blockage and out of tolerance ligaments), and corrective actions if necessary. Corrective actions include replacement of seat track sections, and replacement of the entire seat track. EASA AD 2025–0205R3 specifies configurations on which the inspection and corrective actions are not required as well as conditions under which the corrective actions may be postponed. EASA AD 2025–0205R3 also limits the installation of affected parts.

This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

These products have been approved by the civil aviation authority of another country and are approved for operation in the United States. Pursuant to the FAA's bilateral agreement with this State of Design Authority, that authority has notified the FAA of the unsafe condition described in the MCAI referenced above. The FAA is issuing this NPRM after determining that the unsafe condition described previously is likely to exist or develop in other products of the same type design.

Proposed AD Requirements in This NPRM

This proposed AD would require accomplishing the actions specified in EASA AD 2025–0205R3 described previously, except for any differences identified as exceptions in the regulatory text of this proposed AD.

Explanation of Required Compliance Information

In the FAA's ongoing efforts to improve the efficiency of the AD process, the FAA developed a process to use some civil aviation authority (CAA) ADs as the primary source of information for compliance with requirements for corresponding FAA ADs. The FAA has been coordinating this process with manufacturers and CAAs. As a result, the FAA proposes to incorporate EASA AD 2025–0205R3 by reference in the FAA final rule. This proposed AD would, therefore, require compliance with EASA AD 2025–0205R3 in its entirety through that incorporation, except for any differences identified as exceptions in the regulatory text of this proposed AD. Using common terms that are the same as the heading of a particular section in EASA AD 2025–0205R3 does not mean that operators need comply only with that section. For example, where the AD requirement refers to ''all required actions and compliance times,'' compliance with this AD requirement is not limited to the section titled ''Required Action(s) and Compliance Time(s)'' in EASA AD 2025–0205R3. Material required by EASA AD 2025–0205R3 for compliance will be available at *regulations.gov* under Docket No. FAA–2026–13820 after the FAA final rule is published.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 33 airplanes of U.S. registry. The FAA estimates the following costs to comply with this proposed AD:

ESTIMATED COSTS FOR REQUIRED ACTIONS

Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Up to 40 work-hours × $85 per hour = $3,400	$0	$3,400	$112,200

The FAA estimates the following costs to do any necessary on-condition actions that would be required based on the results of any required actions. The FAA has no way of determining the number of aircraft that might need these on-condition actions:

ESTIMATED COSTS OF ON-CONDITION ACTIONS

Labor cost	Parts cost	Cost per product
Up to 270 work-hours × $85 per hour = $22,950	(*)	$22,950

*The FAA has received no definitive data on which to base the cost estimates for the parts cost for the on-condition actions specified in this proposed AD.

According to the manufacturer, some or all of the costs of this proposed AD may be covered under warranty, thereby reducing the cost impact on affected individuals. The FAA does not control warranty coverage for affected individuals. As a result, the FAA has included all known costs in the cost estimate.

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.

The FAA is 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

The FAA 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 this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Would not affect intrastate aviation in Alaska, 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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, 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 FAA amends § 39.13 by:

■ a. Removing Airworthiness Directive (AD) 2021–12–17, Amendment 39–21604 (86 FR 34621, June 30, 2021); and

■ b. Adding the following new AD:

ATR—GIE Avions de Transport Régional: Docket No. FAA–2026–13820; Project Identifier MCAI–2025–01552–T.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by January 4, 2027.

(b) Affected ADs

This AD replaces AD 2021–12–17, Amendment 39–21604 (86 FR 34621, June 30, 2021) (AD 2021–12–17).

(c) Applicability

This AD applies to all ATR—GIE Avions de Transport Régional Model ATR42–200, –300, –320, and –500 airplanes; and all Model ATR72–101, –102, –201, –202, –211, –212, and –212A airplanes, certificated in any category.

(d) Subject

Air Transport Association (ATA) of America Code 53, Fuselage.

(e) Unsafe Condition

This AD was prompted by reports of defective seat tracks and a determination that additional airplanes and seat track part numbers are affected. The FAA is issuing this AD to address a structural failure of the seat track attachment during an emergency landing, possibly resulting in injury to occupants, and affecting emergency evacuation.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Requirements

Except as specified in paragraph (h) of this AD: Comply with all required actions and compliance times specified in, and in accordance with, European Union Aviation Safety Agency (EASA) AD 2025–0205R3, dated December 8, 2025 (EASA AD 2025–0205R3).

(h) Exceptions to EASA AD 2025–0205R3

(1) Where EASA AD 2025–0205R3 refers to October 6, 2025 (the effective date of the original issue of EASA AD 2025–0205), this AD requires using the effective date of this AD.

(2) Where paragraph (2) EASA AD 2025–0205R3 specifies ''deficiencies are found, as defined in the SB'', this AD requires replacing that text with ''any sealant blockage or out of tolerance ligament is found''.

(3) This AD does not adopt the ''Remarks'' section of EASA AD 2025–0205R3.

(i) No Reporting Requirement

Although the material referenced in EASA AD 2025–0205R3 specifies to submit certain information to the manufacturer, this AD does not include that requirement.

(j) Additional AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or responsible Flight Standards Office, as appropriate. If sending information directly to the manager of the International Validation Branch, send it to the attention of the person identified in paragraph (k) of this AD and email to: *AMOC@faa.gov.* Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the responsible Flight Standards Office.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain instructions from a manufacturer, the instructions must be accomplished using a method approved by the Manager, International Validation Branch, FAA; or EASA; or ATR—GIE Avions de Transport Régional's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(k) Additional Information

For more information about this AD, contact Yaser Osman, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 860–386–1786; email: *9-AVS-AIR-BACO-COS@faa.gov.*

(l) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference of the material listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this material as applicable to do the actions required by this AD, unless this AD specifies otherwise.

(i) European Union Aviation Safety Agency (EASA) AD 2025–0205R3, dated December 8, 2025.

(ii) [Reserved]

(3) For EASA material identified in this AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu.* You may find this material on the EASA website at *ad.easa.europa.eu.*

(4) You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

(5) You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.*

Issued on November 17, 2026.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2026–23581 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2026–13822; Project Identifier MCAI–2025–01841–T]

RIN 2120–AA64

Airworthiness Directives; Dassault Aviation Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to supersede Airworthiness Directive (AD) 2024–15–02, which applies to all Dassault Aviation Model MYSTERE–FALCON 900 airplanes. AD 2024–15–02 requires revising the existing maintenance or inspection program, as applicable, to incorporate new or more restrictive airworthiness limitations. Since the FAA issued AD 2024–15–02, the FAA has determined that new or more restrictive airworthiness limitations are necessary. This proposed AD would continue to require the actions in AD 2024–15–02 and would require revising the existing maintenance or inspection program, as applicable, to incorporate new or more restrictive airworthiness limitations. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this proposed AD by January 4, 2027.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2026–13822; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, the mandatory continuing airworthiness information (MCAI), any comments received, and other information. The street address for Docket Operations is listed above.

Material Incorporated by Reference:

- For European Union Aviation Safety Agency (EASA) material identified in this proposed AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu.* You may find this material on the EASA website at *ad.easa.europa.eu.* It is also available at *regulations.gov* under Docket No. FAA–2026–13822.
- You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

FOR FURTHER INFORMATION CONTACT: Christopher J. Spencer, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 516–228–7332; email: *9-AVS-AIR-BACO-COS@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments using a method listed under the **ADDRESSES** section. Include ''Docket No. FAA–2026–13822; Project Identifier MCAI–2025–01841–T'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may amend this proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *regulations.gov,* including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Christopher J Spencer, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 516–228–7332; email: *9-AVS-AIR-BACO-COS@faa.gov.* Any commentary that the FAA receives which is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

The FAA issued AD 2024–15–02, Amendment 39–22793 (89 FR 72974, September 9, 2024) (AD 2024–15–02), for all Dassault Aviation Model MYSTERE–FALCON 900 airplanes. AD 2024–15–02 was prompted by an MCAI originated by EASA, which is the Technical Agent for the Member States of the European Union. EASA issued EASA AD 2024–0036, dated January 31, 2024 (EASA AD 2024–0036), to correct an unsafe condition.

AD 2024–15–02 requires revising the existing maintenance or inspection program, as applicable, to incorporate new or more restrictive airworthiness limitations. The FAA issued AD 2024–15–02 to address reduced structural integrity of the airplane.

Actions Since AD 2024–15–02 Was Issued

Since the FAA issued AD 2024–15–02, EASA superseded EASA AD 2024–0036 dated January 31, 2024, and issued EASA AD 2025–0292, dated December 19, 2025 (EASA AD 2025–0292) (also referred to as the MCAI), for all Dassault Aviation Model MYSTERE–FALCON 900 airplanes. The MCAI states that new or more restrictive airworthiness limitations have been developed.

The FAA is proposing this AD to address reduced structural integrity of the airplane.

You may examine the MCAI in the AD docket at *regulations.gov* under Docket No. FAA–2026–13822.

Explanation of Retained Requirements

Although this proposed AD does not explicitly restate the requirements of AD 2024–15–02, this proposed AD would

retain all of the requirements of AD 2024–15–02. Those requirements are referenced in EASA AD 2025–0292, which, in turn, is referenced in paragraph (g) of this proposed AD.

Material Incorporated by Reference Under 1 CFR Part 51

EASA AD 2025–0292 specifies new or more restrictive airworthiness limitations for airplane structures and safe life limits.

This proposed AD would also require EASA AD 2024–0036, which the Director of the Federal Register approved for incorporation by reference as of October 15, 2024 (89 FR 72974, September 9, 2024).

This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

These products have been approved by the civil aviation authority of another country and are approved for operation in the United States. Pursuant to the FAA's bilateral agreement with this State of Design Authority, that authority has notified the FAA of the unsafe condition described in the MCAI referenced above. The FAA is issuing this NPRM after determining that the unsafe condition described previously is likely to exist or develop in other products of the same type design.

Proposed AD Requirements in This NPRM

This proposed AD would retain all requirements of AD 2024–15–02. This proposed AD would require revising the existing maintenance or inspection program, as applicable, to incorporate additional new or more restrictive airworthiness limitations, which are specified in EASA AD 2025–0292 already described, as proposed for incorporation by reference. Any differences with EASA AD 2025–0292 are identified as exceptions in the regulatory text of this proposed AD.

This proposed AD would require revisions to certain operator maintenance documents to include new actions (*e.g.,* inspections). Compliance with these actions is required by 14 CFR 91.403(c). For airplanes that have been previously modified, altered, or repaired in the areas addressed by this proposed AD, the operator may not be able to accomplish the actions described in the revisions. In this situation, to comply with 14 CFR 91.403(c), the operator must request approval for an alternative method of compliance (AMOC) according to paragraph (m)(1) of this proposed AD.

Explanation of Required Compliance Information

In the FAA's ongoing efforts to improve the efficiency of the AD process, the FAA developed a process to use some civil aviation authority (CAA) ADs as the primary source of information for compliance with requirements for corresponding FAA ADs. The FAA has been coordinating this process with manufacturers and CAAs. As a result, the FAA proposes to retain the Incorporation by Reference (IBR) of EASA AD 2024–0036 and incorporate EASA AD 2025–0292 by reference in the FAA final rule. This proposed AD would, therefore, require compliance with EASA AD 2024–0036 and EASA AD 2025–0292 through that incorporation, except for any differences identified as exceptions in the regulatory text of this proposed AD. Using common terms that are the same as the heading of a particular section in EASA AD 2024–0036 or EASA AD 2025–0292 does not mean that operators need comply only with that section. For example, where the AD requirement refers to ''all required actions and compliance times,'' compliance with this AD requirement is not limited to the section titled ''Required Action(s) and Compliance Time(s)'' in EASA AD 2024–0036 or EASA AD 2025–0292. Material required by EASA AD 2024–0036 is available at *regulations.gov* by searching for and locating Docket No. FAA–2024–1300 and material required by EASA AD 2025–0292 for compliance will be available at *regulations.gov* by searching for and locating Docket No. FAA–2026–13822 after the FAA final rule is published.

Airworthiness Limitation ADs Using the New Process

The FAA's process of incorporating by reference MCAI ADs as the primary source of information for compliance with corresponding FAA ADs has been limited to certain MCAI ADs (primarily those with service bulletins as the primary source of information for accomplishing the actions required by the FAA AD). However, the FAA is now expanding the process to include MCAI ADs that require a change to airworthiness limitation documents, such as airworthiness limitation sections.

For these ADs that incorporate by reference an MCAI AD that changes airworthiness limitations, the FAA requirements are unchanged. Operators must revise the existing maintenance or inspection program, as applicable, to incorporate the information specified in the new airworthiness limitation document. The airworthiness limitations must be followed according to 14 CFR 91.403(c) and 91.409(e).

The previous format of the airworthiness limitation ADs included a paragraph that specified that no alternative actions (*e.g.,* inspections) or intervals may be used unless the actions and intervals are approved as an AMOC in accordance with the procedures specified in the AMOCs paragraph under ''Additional AD Provisions.'' This new format includes a ''New Provisions for Alternative Actions and Intervals'' paragraph that does not specifically refer to AMOCs, but operators may still request an AMOC to use an alternative action or interval.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 138 airplanes of U.S. registry. The FAA estimates the following costs to comply with this proposed AD:

The FAA estimates the total cost per operator for the retained actions from AD 2024–15–02 to be $7,650 (90 work-hours × $85 per work-hour).

The FAA has determined that revising the existing maintenance or inspection program takes an average of 90 work-hours per operator, although the agency recognizes that this number may vary from operator to operator. Since operators incorporate maintenance or inspection program changes for their affected fleet(s), the FAA has determined that a per-operator estimate is more accurate than a per-airplane estimate. Therefore, the FAA estimates the average total cost per operator for the new proposed actions to be $7,650 (90 work-hours × $85 per work-hour).

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.

The FAA is 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

The FAA 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 this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Would not affect intrastate aviation in Alaska, 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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, 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 FAA amends § 39.13 by:

■ a. Removing Airworthiness Directive (AD) 2024–15–02, Amendment 39–22793 (89 FR 72974, September 9, 2024); and

■ b. Adding the following new AD:

Dassault Aviation: Docket No. FAA–2026–13822; Project Identifier MCAI–2025–01841–T.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by January 4, 2027.

(b) Affected ADs

This AD replaces AD 2024–15–02, Amendment 39–22793 (89 FR 72974, September 9, 2024) (AD 2024–15–02).

(c) Applicability

This AD applies to all Dassault Aviation Model MYSTERE–FALCON 900 airplanes, certificated in any category.

(d) Subject

Air Transport Association (ATA) of America Code 05, Time Limits/Maintenance Checks.

(e) Unsafe Condition

This AD was prompted by a determination that new or more restrictive airworthiness limitations are necessary. The FAA is issuing this AD to address reduced structural integrity of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Retained Revision of the Existing Maintenance or Inspection Program, With a New Terminating Action

This paragraph restates the requirements of paragraph (j) of AD 2024–15–02, with a new terminating action. Except as specified in paragraph (h) of this AD: Comply with all required actions and compliance times specified in, and in accordance with, European Union Aviation Safety Agency (EASA) AD 2024–0036, dated January 31, 2024 (EASA AD 2024–0036). Accomplishing the revision of the existing maintenance or inspection program required by paragraph (j) of this AD terminates the requirements of this paragraph.

(h) Retained Exceptions to EASA AD 2024–0036, With No Changes

This paragraph restates the exceptions specified in paragraph (k) of AD 2024–15–02, with no changes.

(1) This AD does not adopt the requirements specified in paragraphs (1) and (2) of EASA AD 2024–0036.

(2) Paragraph (3) of EASA AD 2024–0036 specifies revising ''the approved AMP'' within 12 months after its effective date, but this AD requires revising the existing maintenance or inspection program, as applicable, within 90 days after October 15, 2024 (the effective date of AD 2024–15–02).

(3) The initial compliance time for doing the tasks specified in paragraph (3) of EASA AD 2024–0036 is at the applicable ''limitations'' and ''associated thresholds'' as incorporated by the requirements of paragraph (3) of EASA AD 2024–0036, or within 90 days after October 15, 2024 (the effective date of AD 2024–15–02), whichever occurs later.

(4) This AD does not adopt the provisions specified in paragraphs (4) and (5) of EASA AD 2024–0036.

(5) This AD does not adopt the ''Remarks'' section of EASA AD 2024–0036.

(i) Retained Restrictions on Alternative Actions and Intervals, With a New Exception

This paragraph restates the requirements of paragraph (l) of AD 2024–15–02, with a new exception. Except as required by paragraph (j) of this AD, after the existing maintenance or inspection program has been revised as required by paragraph (g) of this AD, no alternative actions (*e.g.,* inspections) or intervals are allowed unless they are approved as specified in the provisions of the ''Ref. Publications'' section of EASA AD 2024–0036.

(j) New Revision of the Existing Maintenance or Inspection Program

Except as specified in paragraph (k) of this AD: Comply with all required actions and compliance times specified in, and in accordance with, EASA AD 2025–0292, dated December 19, 2025 (EASA AD 2025–0292). Accomplishing the revision of the existing maintenance or inspection program required by this paragraph terminates the requirements of paragraph (g) of this AD.

(k) Exceptions to EASA AD 2025–0292

(1) This AD does not adopt the requirements specified in paragraphs (1) and (2) of EASA AD 2025–0292.

(2) Paragraph (3) of EASA AD 2025–0292 specifies revising the approved aircraft maintenance program (AMP) within 12 months after its effective date, but this AD requires revising the existing maintenance or inspection program, as applicable, within 90 days after the effective date of this AD.

(3) The initial compliance time for doing the tasks specified in paragraph (3) of EASA AD 2025–0292 is at the applicable limitations and associated thresholds as incorporated by the requirements of paragraph (3) of EASA AD 2025–0292, or within 90 days after the effective date of this AD, whichever occurs later.

(4) This AD does not adopt the provisions specified in paragraphs (4) and (5) of EASA AD 2025–0292.

(5) This AD does not adopt the ''Remarks'' section of EASA AD 2025–0292.

(l) New Provisions for Alternative Actions and Intervals

After the existing maintenance or inspection program has been revised as required by paragraph (j) of this AD, no alternative actions (*e.g.,* inspections) and intervals are allowed unless they are approved as specified in the provisions of the ''Ref. Publications'' section of EASA AD 2025–0292.

(m) Additional AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or responsible Flight Standards Office, as appropriate. If sending information directly to the manager of the International Validation Branch, send it to the attention of the person identified in paragraph (n) of this AD and email to: *AMOC@faa.gov*. Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the responsible Flight Standards Office.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain instructions from a manufacturer, the instructions must be accomplished using a method approved by the Manager, International Validation Branch, FAA; or EASA; or Dassault Aviation's EASA Design Organization Approval (DOA). If approved by the DOA,

the approval must include the DOA-authorized signature.

(n) Additional Information

For more information about this AD, contact Christopher J Spencer, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 516–228–7332; email: *9-AVS-AIR-BACO-COS@faa.gov.*

(o) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the material listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this material as applicable to do the actions required by this AD, unless this AD specifies otherwise.

(3) The following material was approved for IBR on [DATE 35 DAYS AFTER PUBLICATION OF THE FINAL RULE].

(i) European Union Aviation Safety Agency (EASA) AD 2025–0292, dated December 19, 2025.

(ii) [Reserved]

(4) The following material was approved for IBR on October 15, 2024 (89 FR 72974, September 9, 2024).

(i) EASA AD 2024–0036, dated January 31, 2024.

(ii) [Reserved]

(5) For EASA material identified in this AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu.* You may find this material on the EASA website at *ad.easa.europa.eu.*

(6) You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

(7) You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.*

Issued on November 17, 2026.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2026–23584 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2026–13818; Project Identifier MCAI–2026–00537–R]

RIN 2120–AA64

Airworthiness Directives; Airbus Helicopters

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to supersede Airworthiness Directive (AD) 2026–12–08, which applies to all Airbus Helicopters Model AS350B2, AS350B3, EC130B4, and EC130T2 helicopters. AD 2026–12–08 requires revising the airworthiness limitations section (ALS) of the existing maintenance manual (MM) or instructions for continued airworthiness (ICA) and the existing approved maintenance or inspection program, as applicable. Since the FAA issued AD 2026–12–08, a determination was made that new and more restrictive airworthiness limitations and maintenance tasks are necessary. This proposed AD would require incorporating these airworthiness limitations and maintenance tasks into the ALS of the existing MM or ICA and the existing approved maintenance or inspection program, as applicable. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this NPRM by January 4, 2027.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* (202) 493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2026–13818; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, the mandatory continuing airworthiness information (MCAI) any comments received, and other information. The street address for Docket Operations is listed above.

Material Incorporated by Reference:

- For European Union Aviation Safety Agency (EASA) material identified in this proposed AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; phone: +49 221 8999 000; email: *ADs@easa.europa.eu;* website: *easa.europa.eu.*
- You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 10101 Hillwood Parkway, Fort Worth, TX 76177. For information on the availability of this material at the FAA, call (817) 222–5110.

FOR FURTHER INFORMATION CONTACT: Raymond Miller, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: (316) 946–4190; email: *raymond.f.miller@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments using a method listed under **ADDRESSES**. Include ''Docket No. FAA–2026–13818; Project Identifier MCAI–2026–00537–R'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may amend the proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *regulations.gov*, including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Raymond Miller, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590. Any commentary that the FAA receives which is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

The FAA issued AD 2026–12–08, Amendment 39–23378 (91 FR 36077, June 16, 2026), (AD 2026–12–08), for all Airbus Helicopters Model AS350B2, AS350B3, EC130B4, and EC130T2 helicopters. AD 2026–12–08 was prompted by an MCAI originated by EASA, which is the Technical Agent for the Member States of the European Union. EASA issued EASA AD 2025–0137, dated June 27, 2025; corrected October 29, 2025, (EASA AD 2025–0137).

AD 2026–12–08 requires revising the ALS of the existing MM or ICA and the existing approved maintenance or inspection program, as applicable. The FAA issued AD 2026–12–08 to prevent failure of critical parts and primary structural components, which if not addressed, could result in loss of control of the helicopter.

Actions Since AD 2026–12–08 Was Issued

On May 26, 2026, EASA superseded AD 2025–0137 and issued EASA AD 2026–0101 (EASA AD 2026–0101) (also referred to as the MCAI). The MCAI states that new or more restrictive airworthiness limitations and maintenance tasks have been developed. Additionally, the MCAI states that the airworthiness limitations are identified as mandatory for continued airworthiness and that Airbus Helicopters has issued applicable ALS revisions to specify new and more restrictive life limits and maintenance tasks.

You may examine the MCAI in the AD docket at *regulations.gov* under Docket No. FAA–2026–13818.

Material Incorporated by Reference Under 1 CFR Part 51

The FAA reviewed EASA AD 2026–0101, which specifies replacing components before exceeding their life limits and accomplishing all applicable maintenance tasks within thresholds and intervals specified in the ALS. Depending on the results of the maintenance tasks, EASA AD 2026–0101 specifies accomplishing corrective action(s) or contacting Airbus Helicopters for approved instructions and accomplishing those instructions.

In addition, EASA AD 2026–0101 specifies revising the Aircraft Maintenance Programme (AMP) by incorporating the limitations, tasks, and associated thresholds and intervals described in the specified ALS, as applicable. Revising the AMP constitutes terminating action for the requirement to record accomplishment of the actions of replacing components before exceeding their life limits and accomplishing maintenance tasks within thresholds and intervals specified in the applicable ALS as specified in EASA AD 2026–0101, for demonstration of AD compliance on a continued basis.

This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

These products have been approved by the civil aviation authority (CAA) of another country and are approved for operation in the United States. Pursuant to the FAA's bilateral agreement with this State of Design Authority, that authority has notified the FAA of the unsafe condition described in the MCAI referenced above. The FAA is issuing this NPRM after determining that the unsafe condition described previously is likely to exist or develop on other products of the same type design.

Proposed AD Requirements in This NPRM

This proposed AD would require accomplishing the actions specified in EASA AD 2026–0101, described previously, as incorporated by reference, except for any differences identified as exceptions in the regulatory text of this proposed AD. See ''Differences Between this Proposed AD and the MCAI'' for a discussion of the general differences included in this proposed AD.

Differences Between This Proposed AD and the MCAI

Where EASA AD 2026–0101 specifies revising the approved AMP within 12 months after the effective date of EASA AD 2026–0101, this proposed AD would require revising the ALS of the existing MM or ICA and the existing approved maintenance or inspection program, as applicable, within 30 days after the effective date of this proposed AD.

Explanation of Required Compliance Information

In the FAA's ongoing efforts to improve the efficiency of the AD process, the FAA developed a process to use some CAA ADs as the primary source of information for compliance with requirements for corresponding FAA ADs. The FAA has been coordinating this process with manufacturers and CAAs. As a result, the FAA proposes to incorporate EASA AD 2026–0101 by reference in the FAA final rule. This proposed AD would, therefore, require compliance with EASA AD 2026–0101 in its entirety through that incorporation, except for any differences identified as exceptions in the regulatory text of this proposed AD. Using common terms that are the same as the heading of a particular section in EASA AD 2026–0101 does not mean that operators need comply only with that section. For example, where the AD requirement refers to ''all required actions and compliance times,'' compliance with this AD requirement is not limited to the section titled ''Required Action(s) and Compliance Time(s)'' in EASA AD 2026–0101. Material required by EASA AD 2026–0101 for compliance will be available at *regulations.gov* under Docket No. FAA–2026–13818 after the FAA final rule is published.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 1,163 helicopters of U.S. registry.

The FAA estimates the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Revise ALS	1 work-hour × $85 per hour = $85	$0	$85	$98,855

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.

The FAA is 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

The FAA 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) Would not affect intrastate aviation in Alaska, 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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, 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 FAA amends § 39.13 by:

■ a. Removing Airworthiness Directive 2026–12–08, Amendment 39–23378 (91 FR 36077, June 16, 2026); and

■ b. Adding the following new airworthiness directive:

Airbus Helicopters: Docket No. FAA–2026–13818; Project Identifier MCAI–2026–00537–R.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by January 4, 2027.

(b) Affected ADs

This AD replaces AD 2026–12–08, Amendment 39–23378 (91 FR 36077, June 16, 2026).

(c) Applicability

This AD applies to all Airbus Helicopters Model AS350B2, AS350B3, EC130B4, and EC130T2 helicopters, certificated in any category.

(d) Subject

Air Transport Association (ATA) of America Code 05, Time limits/maintenance checks.

(e) Unsafe Condition

This AD was prompted by new or more restrictive airworthiness limitations and maintenance tasks. The FAA is issuing this AD to prevent failure of critical parts and primary structural components, which if not addressed, could result in loss of control of the helicopter.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Requirements

Except as specified in paragraphs (h) and (i) of this AD: Comply with all required actions and compliance times specified in, and in accordance with, European Union Aviation Safety Agency AD 2026–0101, dated May 26, 2026 (EASA AD 2026–0101).

(h) Exceptions to EASA AD 2026–0101

(1) Where EASA AD 2026–0101 refers to its effective date, this AD requires using the effective date of this AD.

(2) This AD does not adopt paragraphs (1), (2), (4), and (5) of EASA AD 2026–0101.

(3) Where paragraph (3) of EASA AD 2026–0101 specifies ''Within 12 months after the effective date of this AD, revise the approved AMP'', this AD requires replacing that text with ''Within 30 days after the effective date of this AD, revise the airworthiness limitations section of the existing maintenance manual or instructions for continued airworthiness and the existing approved maintenance or inspection program, as applicable''.

(4) The initial compliance time for doing the tasks specified in paragraph (3) of EASA AD 2026–0101 is on or before the applicable ''limitations'' and ''associated thresholds'' as incorporated by the requirements of paragraph (3) of EASA AD 2026–0101 or within 30 days after the effective date of this AD, whichever occurs later.

(5) This AD does not adopt the ''Remarks'' section of EASA AD 2026–0101.

(i) Provisions for Alternative Actions and Intervals

After the action required by paragraph (g) of this AD has been done, no alternative actions and associated thresholds and intervals, including life limits, are allowed unless they are approved as specified in the provisions of the ''Ref. Publications'' section of EASA AD 2026–0101.

(j) Alternative Methods of Compliance (AMOCs):

(1) The Manager, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the International Validation Branch, send it to the attention of the person identified in paragraph (k) of this AD and email to: *AMOC@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(k) Additional Information

For more information about this AD, contact Raymond Miller, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: (316) 946–1490; email: *raymond.f.miller@faa.gov.*

(l) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference of the material listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this material as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) European Union Aviation Safety Agency (EASA) AD 2026–0101, dated May 26, 2026.

(ii) [Reserved]

(3) For EASA material identified in this AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; phone: +49 221 8999 000; email: *ADs@easa.europa.eu;* website: *easa.europa.eu.* You may find the EASA material on the EASA website at *ad.easa.europa.eu.*

(4) You may view this material FAA, Airworthiness Products Section, Operational Safety Branch, 10101 Hillwood Parkway, Fort Worth, TX 76177. For information on the availability of this material at the FAA, call (817) 222–5110.

(5) You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.*

Issued on November 17, 2026.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2026–23569 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2026–13819; Project Identifier MCAI–2025–01531–R]

RIN 2120–AA64

Airworthiness Directives; Airbus Helicopters Deutschland GmbH (AHD) Helicopters

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to adopt a new airworthiness directive (AD) for certain Airbus Helicopters Deutschland GmbH (AHD) Model EC135P1, EC135P2, EC135P2+, EC135P3, EC135T1, EC135T2, EC135T2+, EC135T3 and EC635T2+ helicopters. This proposed AD was prompted by a determination that the manufacturer's service material does not provide complete instructions for the inspections after a hard landing. This proposed AD would require a one-time inspection of the tail rotor control system and, depending on the inspection results, corrective actions. This proposed AD would also require revision of the existing aircraft maintenance manual (MM) or instructions for continued airworthiness (ICA) and the existing approved maintenance or inspection program, as applicable. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this NPRM by January 4, 2027.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* (202) 493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2026–13819; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, the mandatory continuing airworthiness information (MCAI), any comments received, and other information. The street address for Docket Operations is listed above.

Material Incorporated by Reference:

- For European Union Aviation Safety Agency (EASA) material identified in this proposed AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; phone: +49 221 8999 000; email: *ADs@easa.europa.eu;* website: *easa.europa.eu.* You may find the EASA material on the EASA website at *ad.easa.europa.eu.*
- You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 10101 Hillwood Parkway, Fort Worth, TX 76177. For information on the availability of this material at the FAA, call (817) 222–5110.

FOR FURTHER INFORMATION CONTACT: Shailesh Malla, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410 Westbury, NY 11590; phone: (817) 222–5584; email: *shailesh.malla@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments using a method listed under **ADDRESSES**. Include ''Docket No. FAA–2026–13819; Project Identifier MCAI–2025–01531–R'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may amend this proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *regulations.gov*, including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Shailesh Malla, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410 Westbury, NY 11590. Any commentary that the FAA receives which is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

EASA, which is the Technical Agent for the Member States of the European Union, has issued EASA AD 2020–0102, dated May 6, 2020 (EASA AD 2020–0102) (also referred to as the MCAI), to correct an unsafe condition on certain AHD Model EC135 P1, EC135 P2, EC135 P2+, EC135 P3, EC135 T1, EC135 T2, EC135 T2+, EC135 T3, EC635 P2+, EC635 P3, EC635 T1, EC635 T2+ and EC635 T3 helicopters. The MCAI states that the master service manual (MSM) for Model EC135 and EC635 does not provide complete instructions for the inspections after a hard landing. This condition, if not corrected, could lead to missed identification of tail rotor control damage, which could result in component or system failure and reduced control of the helicopter.

You may examine the MCAI in the AD docket at *regulations.gov* under Docket No. FAA–2026–13819.

Material Incorporated by Reference Under 1 CFR Part 51

The FAA reviewed EASA AD 2020–0102, which specifies procedures for inspecting the tail rotor control system and, if a discrepancy is found, accomplishing the applicable corrective actions. EASA AD 2020–0102 also specifies that accomplishing the inspection of the tail rotor control system in accordance with the instructions of the aircraft MM is an alternative method for the inspection in accordance with the service material. Additionally, EASA AD 2020–0102 specifies that revising the Aircraft Maintenance Program (AMP) of a helicopter by incorporating the qualified instructions as defined in EASA AD 2020–0102 is a terminating action for recording compliance.

The FAA also reviewed Aircraft Maintenance Manual 05–51–00, 6–3, Conditional Inspections after Special Operational Incidents—Inspection,

Dated March 28, 2025, which specifies conditional inspections after a hard landing.

This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

These products have been approved by the civil aviation authority (CAA) of another country and are approved for operation in the United States. Pursuant to the FAA's bilateral agreement with this State of Design Authority, that authority has notified the FAA of the unsafe condition described in the MCAI referenced above. The FAA is issuing this NPRM after determining that the unsafe condition described previously is likely to exist or develop on other products of the same type design.

Proposed AD Requirements in This NPRM

This proposed AD would require accomplishing the actions specified in EASA AD 2020–0102, described previously, as incorporated by reference, except for any differences identified as exceptions in the regulatory text of this AD. See ''Differences Between this Proposed AD and the MCAI'' for a discussion of the general differences included in this proposed AD.

Differences Between This Proposed AD and the MCAI

The MCAI applies to AHD Model EC635 P2+, EC635 P3, EC635 T1, and EC635 T3 helicopters, whereas this proposed AD would not because these model helicopters do not have an FAA type certificate. The MCAI requires accomplishing corrective actions in accordance with the qualified instructions as defined in the MCAI, whereas this proposed AD would require those corrective actions be accomplished in accordance with a method approved by the Manager, International Validation Branch, FAA; or EASA; or AHD Design Organization Approval (DOA).

Additionally, the MCAI requires for certain helicopters, inspecting the helicopter after each hard landing, whereas this proposed AD would require all applicable helicopters to perform these inspections within 12 months after the effective date of this proposed AD. Furthermore, the MCAI specifies that revising the AMP by incorporating the qualified instructions as defined in the MCAI is a terminating action for recording compliance, whereas this proposed AD would require revising the existing aircraft MM or ICA and the existing approved maintenance or inspection program, as applicable, by incorporating certain qualified instructions.

Explanation of Required Compliance Information

In the FAA's ongoing efforts to improve the efficiency of the AD process, the FAA developed a process to use some CAA ADs as the primary source of information for compliance with requirements for corresponding FAA ADs. The FAA has been coordinating this process with manufacturers and CAAs. As a result, the FAA proposes to incorporate EASA AD 2020–0102 by reference in the FAA final rule. This proposed AD would, therefore, require compliance with EASA AD 2020–0102 in its entirety through that incorporation, except for any differences identified as exceptions in the regulatory text of this proposed AD. Using common terms that are the same as the heading of a particular section in EASA AD 2020–0102 does not mean that operators need comply only with that section. For example, where the AD requirement refers to ''all required actions and compliance times,'' compliance with this AD requirement is not limited to the section titled ''Required Action(s) and Compliance Time(s)'' in EASA AD 2020–0102. Material required by EASA AD 2020–0102 for compliance will be available at *regulations.gov* under Docket No. FAA–2026–13819 after the FAA final rule is published.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 289 helicopters of U.S. registry.

The FAA estimates the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspect the tail rotor control system	4 work-hours × $85 per hour = $340	$0	$340	$98,260
Revise maintenance program	1 work-hour × $85 per hour = $85	0	85	24,565

The conditional inspections, repairs, or replacements needed as a result of inspecting the tail rotor control system could vary significantly from helicopter to helicopter. The FAA has no way of determining the costs to accomplish these actions or the number of helicopters that may require repair.

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.

The FAA is 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

The FAA 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 this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Would not affect intrastate aviation in Alaska, 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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, 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 FAA amends § 39.13 by adding the following new airworthiness directive:

Airbus Helicopters Deutschland GmbH (AHD): Docket No. FAA–2026–13819; Project Identifier MCAI–2025–01531–R.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by January 4, 2027.

(b) Affected ADs

None.

(c) Applicability

This AD applies to Airbus Helicopters Deutschland GmbH (AHD) Model EC135P1, EC135P2, EC135P2+, EC135P3, EC135T1, EC135T2, EC135T2+, EC135T3 and EC635T2+ helicopters, certificated in any category, all serial numbers up to and including 1276.

Note 1 to paragraph (c): Helicopters with an EC135P3H designation are Model EC135P3 helicopters, and helicopters with an EC135T3H designation are Model EC135T3 helicopters.

(d) Subject

Joint Aircraft System Component (JASC) Code 6720, Tail rotor control system.

(e) Unsafe Condition

This AD was prompted by a determination that the manufacturer's service material does not provide complete instructions for the inspections after a hard landing. The FAA is issuing this AD to address and correct incomplete inspection instructions. The unsafe condition, if not addressed, could result in missed identification of tail rotor control damage, which could result in component or system failure and reduced control of the helicopter.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Requirements

Except as specified in paragraphs (h) and (i) of this AD: Comply with all required actions and compliance times specified in, and in accordance with, European Union Aviation Safety Agency (EASA) AD 2020–0102, dated May 6, 2020 (EASA AD 2020–0102).

(h) Exceptions to EASA AD 2020–0102

(1) Where EASA AD 2020–0102 refers to its effective date, this AD requires using the effective date of this AD.

(2) Where paragraph (1) of EASA AD 2020–0102 applies only to Group 1 helicopters, this AD requires paragraph (1) of EASA AD 2020–0102 to apply to Group 1 and Group 2 helicopters.

(3) This AD does not adopt paragraph (2) of EASA AD 2020–0102.

(4) Where paragraph (5) of EASA AD 2020–0102 specifies ''Revising the AMP of a helicopter by incorporating the qualified instructions, as defined in this AD, ensures continued accomplishment of those instructions for that helicopter. Consequently, after that AMP revision, it is not necessary that accomplishment of any action as required by this AD is recorded for AD compliance demonstration on a continued basis.'', this AD requires replacing this text with ''For Group 1 and Group 2 helicopters, within 30 days after the effective date of this AD, revise the existing maintenance manual or instructions for continued airworthiness and the existing approved maintenance or inspection program, as applicable, by incorporating the Aircraft Maintenance Manual 05–51–00, 6–3, Conditional Inspections after Special Operational Incidents—Inspection, Dated March 28, 2025''.

(5) Where the material referenced in EASA AD 2020–0102 specifies to contact the manufacturer prior to doing the special instructions after a hard landing, this AD requires corrective actions in accordance with a method approved by the Manager, International Validation Branch, FAA; or EASA; or Airbus Helicopters Deutschland GmbH Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(6) Where the material referenced in EASA AD 2020–0102 specifies to perform an ''Ease of Movement check'', this AD requires replacing that text with ''Ease of movement inspection''.

(7) This AD does not adopt the ''Remarks'' section of EASA AD 2020–0102.

(i) No Reporting Requirement

Although the material referenced in EASA AD 2020–0102 specifies to submit certain information to the manufacturer, this AD does not require that action.

(j) Special Flight Permits

Special flight permits, as described in 14 CFR 21.197 and 21.199, are not allowed.

(k) Alternative Methods of Compliance (AMOCs)

(1) The Manager, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the International Validation Branch, send it to the attention of the person identified in paragraph (l) of this AD and email to: *AMOC@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(l) Additional Information

For more information about this AD, contact Shailesh Malla, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410 Westbury, NY 11590; phone: (817) 222–5584; email: *shailesh.malla@faa.gov.*

(m) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference of the material listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this material as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) European Union Aviation Safety Agency (EASA) AD 2020–0102 dated May 6, 2020.

(ii) Aircraft Maintenance Manual 05–51–00, 6–3, Conditional Inspections after Special Operational Incidents—Inspection, Dated March 28, 2025.

(3) For EASA material identified in this AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; phone: +49 221 8999 000; email: *ADs@easa.europa.eu;* website: *easa.europa.eu.* You may find the EASA material on the EASA website at *ad.easa.europa.eu.*

(4) For AHD material identified in this AD, contact Airbus Helicopters, 2701 North Forum Drive, Grand Prairie, TX 75052; phone: (972) 641–0000 or (800) 232–0323; fax: (972) 641–3775; website: *airbus.com/en/products-services/helicopters/hcare-services/airbusworld.*

(5) You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 10101 Hillwood Parkway, Fort Worth, TX 76177. For information on the availability of this material at the FAA, call (817) 222–5110.

(6) You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.*

Issued on November 17, 2026.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2026–23576 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2026–13821; Project Identifier MCAI–2025–01619–T]

RIN 2120–AA64

Airworthiness Directives; Dassault Aviation Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to supersede Airworthiness Directive (AD) 2024–14–09, which applies to certain Dassault Aviation Model FALCON 7X, FALCON 900EX, and FALCON 2000EX airplanes. AD 2024–14–09 requires replacement of certain titanium screws, adds other locations for screw replacement, and revises the applicability from AD 2022–02–10. Since the FAA issued AD 2024–14–09, affected parts have been found in other areas of certain FALCON 7X airplanes as well as in additional FALCON 7X airplanes. This proposed AD would continue to require the actions in AD 2024–14–09 and would require expanding the applicability to additional airplanes, expanding the locations for screw replacement, and revising the compliance times for parts replacement. This AD would also limit the installation of affected parts under certain conditions. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this proposed AD by January 4, 2027.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2026–13821; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, the mandatory continuing airworthiness information (MCAI), any comments received, and other information. The street address for Docket Operations is listed above.

Material Incorporated by Reference:

- For Dassault Aviation material identified in this proposed AD, contact Dassault Falcon Jet Corporation, Teterboro Airport, P.O. Box 2000, South Hackensack, NJ 07606; telephone 201–440–6700; website *dassaultfalcon.com*.
- For European Union Aviation Safety Agency (EASA) material identified in this proposed AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu*. You may find this material on the EASA website at *ad.easa.europa.eu*. It is also available at *regulations.gov* under Docket No. FAA–2026–13821.
- You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

FOR FURTHER INFORMATION CONTACT: Amanda F. Pieraccini, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 516–228–7329; email: *9-AVS-AIR-BACO-COS@faa.gov*.

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments using a method listed under the **ADDRESSES** section. Include ''Docket No. FAA–2026–13821; Project Identifier MCAI–2025–01619–T'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may amend this proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *regulations.gov*, including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Amanda F. Pieraccini, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 516–228–7329; email: *9-AVS-AIR-BACO-COS@faa.gov*. Any commentary that the FAA receives which is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

The FAA issued AD 2024–14–09, Amendment 39–22790 (89 FR 72966, September 9, 2024) (AD 2024–14–09), for certain Dassault Aviation Model FALCON 7X, FALCON 900EX, and FALCON 2000EX airplanes. AD 2024–14–09 was prompted by MCAI originated by EASA, which is the Technical Agent for the Member States of the European Union. EASA issued EASA AD 2023–0207, dated November 21, 2023 (EASA AD 2023–0207), to correct an unsafe condition.

AD 2024–14–09 requires replacement of certain titanium screws, adds other locations for screw replacement, and revises the applicability. The FAA issued AD 2024–14–09 to address failure of an affected screw installed in a critical location, possibly resulting in reduced structural integrity of the airplane.

Actions Since AD 2024–14–09 Was Issued

Since the FAA issued AD 2024–14–09, EASA superseded EASA AD 2023–0207 and issued EASA AD 2025–0228R1, dated February 6, 2026 (EASA AD 2025–0228R1) (also referred to as the MCAI), to correct an unsafe condition for certain Dassault Aviation Model FALCON 7X, FALCON 900EX, and FALCON 2000EX airplanes. The MCAI states that since EASA issued EASA AD 2023–0207, it was determined that affected parts have been installed in additional areas of certain Model FALCON 7X airplanes already included in the applicability of EASA AD 2023–0207. The MCAI also states that it was

determined that additional Model FALCON 7X airplanes were not included in the applicability of EASA AD 2023–0207. The MCAI further states that the compliance time for parts replacement specified in EASA AD 2023–0207 can be defined in flight cycles (FC) only; therefore, the calendar-based compliance times were removed.

The FAA is proposing this AD to address failure of an affected screw installed in a critical location, possibly resulting in reduced structural integrity of the airplane. You may examine the MCAI in the AD docket at *regulations.gov* under Docket No. FAA–2026–13821.

Explanation of Retained Requirements

Although this proposed AD does not explicitly restate the requirements of AD 2024–14–09, this proposed AD would retain all of the requirements of AD 2024–14–09. Those requirements are referenced in EASA AD 2025–0228R1, which, in turn, is referenced in paragraph (g) of this proposed AD.

Material Incorporated by Reference Under 1 CFR Part 51

EASA AD 2025–0228R1 specifies procedures for replacing certain Decomatic titanium screws, including an inspection of the bore dimension and corrective actions (oversizing or repair). EASA AD 2025–0228R1 also limits installation of certain Decomatic titanium screws.

This proposed AD would also require Dassault Service Bulletin 7X–467, Revision 2, dated March 20, 2023, which the Director of the Federal Register approved for incorporation by reference as of October 15, 2024 (89 FR 72966, September 9, 2024).

This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

These products have been approved by the civil aviation authority of another country and are approved for operation in the United States. Pursuant to the FAA's bilateral agreement with this State of Design Authority, that authority has notified the FAA of the unsafe condition described in the MCAI and material referenced above. The FAA is issuing this NPRM after determining that the unsafe condition described previously is likely to exist or develop in other products of the same type design.

Proposed AD Requirements in This NPRM

This proposed AD would require accomplishing the actions specified in EASA AD 2025–0228R1 described previously, except for any differences identified as exceptions in the regulatory text of this proposed AD.

Explanation of Required Compliance Information

In the FAA's ongoing efforts to improve the efficiency of the AD process, the FAA developed a process to use some civil aviation authority (CAA) ADs as the primary source of information for compliance with requirements for corresponding FAA ADs. The FAA has been coordinating this process with manufacturers and CAAs. As a result, the FAA proposes to incorporate EASA AD 2025–0228R1 by reference in the FAA final rule. This proposed AD would, therefore, require compliance with EASA AD 2025–0228R1 in its entirety through that incorporation, except for any differences identified as exceptions in the regulatory text of this proposed AD. Using common terms that are the same as the heading of a particular section in EASA AD 2025–0228R1 does not mean that operators need comply only with that section. For example, where the AD requirement refers to ''all required actions and compliance times'', compliance with this AD requirement is not limited to the section titled ''Required Action(s) and Compliance Time(s)'' in EASA AD 2025–0228R1. Service information required by EASA AD 2025–0228R1 for compliance will be available at *regulations.gov* under Docket No. FAA–2026–13821 after the FAA final rule is published.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 52 airplanes of U.S. registry. The FAA estimates the following costs to comply with this proposed AD:

ESTIMATED COSTS FOR REQUIRED ACTIONS

Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Up to 250 work-hours × $85 per hour = $21,250.	Up to $524 *	Up to $21,774	Up to $1,132,248.

* The FAA estimates that the rental of special tooling to accomplish replacement of any affected Decomatic titanium screw on Model FALCON 7X airplanes, serial number (S/N) 423 through 443 (inclusive), to be $524 per day.

According to the manufacturer, some or all of the costs of this proposed AD may be covered under warranty, thereby reducing the cost impact on affected individuals. The FAA does not control warranty coverage for affected individuals. As a result, the FAA has included all known costs in the cost estimate.

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.

The FAA is 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

The FAA 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 this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Would not affect intrastate aviation in Alaska, 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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, 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 FAA amends § 39.13 by:

■ a. Removing Airworthiness Directive (AD) 2024–14–09, Amendment 39–22790 (89 FR 72966, September 9, 2024); and

■ b. Adding the following new AD:

Dassault Aviation: Docket No. FAA–2026–13821; Project Identifier MCAI–2025–01619–T.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by January 4, 2027.

(b) Affected ADs

This AD replaces AD 2024–14–09, Amendment 39–22790 (89 FR 72966, September 9, 2024) (AD 2024–14–09).

(c) Applicability

This AD applies to Dassault Aviation airplanes identified in paragraphs (c)(1) through (3) of this AD, certificated in any category, as identified in European Union Aviation Safety Agency (EASA) AD 2025–0228R1, dated February 6, 2026 (EASA AD 2025–0228R1).

(1) Model FALCON 7X airplanes.

(2) Model FALCON 900EX airplanes.

(3) Model FALCON 2000EX airplanes.

(d) Subject

Air Transport Association (ATA) of America Code 51, Standard Practices/Structures.

(e) Unsafe Condition

This AD was prompted by a report of an improper heat treatment process applied during the manufacturing of certain Decomatic titanium screws, and by the determination that affected parts in additional areas on certain airplanes, as well as additional airplanes, are subject to the unsafe condition. The FAA is issuing this AD to address failure of an affected screw installed in a critical location, possibly resulting in reduced structural integrity of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Requirements

Except as specified in paragraph (h) of this AD: Comply with all required actions and compliance times specified in, and in accordance with, EASA AD 2025–0228R1.

(h) Exceptions to EASA AD 2025–0228R1

(1) Where EASA AD 2025–0228R1 refers to October 30, 2025 (the effective date of the original issue of EASA AD 2025–0228), this AD requires using the effective date of this AD.

(2) Where the ''Ref Publications'' section of EASA AD 2025–0228R1 specifies ''Dassault SB 7X–467 original issue dated 16 November 2020, Rev. 1 dated 12 December 2022, Rev. 2 dated 20 March 2023, Rev. 03 dated 11 March 2024, Rev. 04 dated 22 April 2024, Rev. 05 dated 09 September 2024 and Rev. 06 dated 10 April 2025 (including its Erratum dated 09 June 2025)'', this AD requires replacing that text with ''Dassault Service Bulletin 7X–467, Rev. 06 dated April 10, 2025 (including its Erratum dated June 09, 2025)''.

(3) This AD does not adopt the ''Remarks'' section of EASA AD 2025–0228R1.

(i) Credit for Previous Actions

(1) For Model FALCON 7X airplanes: This paragraph provides credit for the actions specified in paragraph (g) of this AD, if those actions were performed before October 15, 2024 (the effective date of AD 2024–14–09) using Dassault Service Bulletin 7X–467, dated November 16, 2020, provided the additional work specified in Dassault Service Bulletin 7X–467, Revision 2, dated March 20, 2023, and the additional work specified in the applicable SB as defined in EASA AD 2025–0228R1 is accomplished within the applicable compliance time specified in EASA AD 2025–0228R1.

(2) For Model FALCON 7X airplanes: This paragraph provides credit for the actions specified in paragraph (g) of this AD, if those actions were performed before the effective date of this AD using Dassault Service Bulletin 7X–467, Revision 2, dated March 20, 2023, Dassault Service Bulletin 7X–467, Revision 3, dated March 11, 2024, Dassault Service Bulletin 7X–467, Revision 4, dated April 22, 2024, or Dassault Service Bulletin 7X–467, Revision 5, dated September 9, 2024, provided the additional work specified in the applicable SB as defined in EASA AD 2025–0228R1 is accomplished within the applicable compliance time specified in EASA AD 2025–0228R1.

(j) Additional AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or responsible Flight Standards Office, as appropriate. If sending information directly to the manager of the International Validation Branch, send it to the attention of the person identified in paragraph (k)(1) of this AD and email to: *AMOC@faa.gov*. Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the responsible Flight Standards Office.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain instructions from a manufacturer, the instructions must be accomplished using a method approved by the Manager, International Validation Branch, FAA; or EASA; or Dassault Aviation's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(k) Additional Information

(1) Amanda F. Pieraccini, Aviation Safety Engineer, FAA, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; phone: 516–228–7329; email: *9-AVS-AIR-BACO-COS@faa.gov*.

(2) Material identified in this AD that is not incorporated by reference is available at the address specified in paragraph (l)(5) of this AD.

(l) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the material listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this material as applicable to do the actions required by this AD, unless this AD specifies otherwise.

(3) The following material was approved for IBR on [DATE 35 DAYS AFTER PUBLICATION OF THE FINAL RULE].

(i) European Union Aviation Safety Agency (EASA) AD 2025–0228R1, dated February 6, 2026.

(ii) [Reserved]

(4) The following material was approved for IBR on October 15, 2024 (89 FR 72966, September 9, 2024).

(i) Dassault Service Bulletin 7X–467, Revision 2, dated March 20, 2023.

(ii) [Reserved]

(5) For Dassault Aviation material identified in this AD, contact Dassault Falcon Jet Corporation, Teterboro Airport, P.O. Box 2000, South Hackensack, NJ 07606; telephone 201–440–6700; website *dassaultfalcon.com*.

(6) For EASA material identified in this AD, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu*. You may find this material on the EASA website at *ad.easa.europa.eu*.

(7) You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

(8) You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov*.

Issued on November 17, 2026.

Steven W. Thompson,

Acting Deputy Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2026–23579 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF THE TREASURY

Financial Crimes Enforcement Network

31 CFR Part 1010

RIN 1506–AB78

Customer Due Diligence Requirements for Covered Financial Institutions

AGENCY: Financial Crimes Enforcement Network (FinCEN), Treasury.

ACTION: Proposed rule.

SUMMARY: FinCEN is issuing this proposed rule to strengthen customer due diligence requirements under the Customer Due Diligence Rule consistent with the policy goals of, and as directed by, Executive Order 14406, *Restoring Integrity to America's Financial System.* Specifically, the proposal ensures financial institutions covered by the Customer Due Diligence Rule collect sufficient information to verify the identities of beneficial owners of legal entity customers and maintain the authority, where warranted, to obtain additional information, including information relevant to whether the beneficial owners of legal entity customers possess lawful immigration status and employment authorization in the United States when such information is relevant to assessing risks.

DATES: Comments must be received by January 19, 2027.

ADDRESSES: Comments must be submitted in one of the following two ways (please choose only one of the ways listed):

• Electronically at *https://www.regulations.gov.* Follow the ''Submit a comment'' instructions under Docket FINCEN–2026–0298. If you are reading this document on federalregister.gov, you may use the green ''SUBMIT A PUBLIC COMMENT'' button beneath this rulemaking's title to submit a comment to the *regulations.gov* docket.

• You may mail written comments to the following address: Regulatory and Strategic Affairs Division, Financial Crimes Enforcement Network, P.O. Box 39, Vienna, VA 22183. Mailed comments must be received by the close of the comment period.

All comments will be made available to the public. Do not include personal identifiable information in submissions; submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication a comment that contains threats of violence, classified information, or information potentially related to a whistleblower submission or that identifies a whistleblower. Comments may be submitted anonymously. When multiple comments are submitted with identical or near-identical content, FinCEN may post only a single representative example of identical or substantially identical comments. All related documents and comments are posted on *https://www.regulations.gov.*

In accordance with 5 U.S.C. 553(b)(4), a summary of this proposed rule may be found at *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: FinCEN's Regulatory Support Section by submitting an inquiry at *www.fincen.gov/contact.*

SUPPLEMENTARY INFORMATION:

I. Scope

This proposed rule would amend the Customer Due Diligence (CDD) Rule, which was promulgated under authorities provided by the Bank Secrecy Act (BSA), to strengthen certain customer due diligence requirements. This proposed rule supports the efforts of the Department of the Treasury to make the CDD Rule more effective, risk-based, and focused on the greatest threats to financial institutions and national security, as well as promote Treasury's efforts to reduce unnecessary regulatory burden consistent with Executive Order 14192, *Unleashing Prosperity Through Deregulation.* This proposal implements the directive in Executive Order 14406, *Restoring Integrity to America's Financial System* (hereinafter ''Executive Order 14406'') to propose changes to applicable BSA regulations to strengthen risk-based customer due diligence requirements.

II. Background and Authority

A. The Bank Secrecy Act

Enacted in 1970 and amended several times since, the BSA is designed to combat money laundering, the financing of terrorism, and other illicit finance risks.[1] Congress has authorized the Secretary of the Treasury to administer the BSA. The Secretary has in turn delegated the authority to implement, administer, and enforce compliance with the BSA and its associated regulations to the Director of FinCEN.[2]

Since its original enactment, Congress has expanded the BSA to address various aspects of anti-money laundering (AML) and countering the financing of terrorism (CFT) compliance, including through expansion of the BSA. In 1992, the Annunzio-Wylie Anti-Money Laundering Act[3] gave the Secretary authority to require financial institutions, as defined in the BSA regulations, to ''carry out'' AML programs and to prescribe minimum standards for such programs, including: ''(A) the development of internal policies, procedures, and controls; (B) the designation of a compliance officer; (C) an ongoing employee training program; and (D) an independent audit function to test programs.''[4]

Later, the USA PATRIOT Act further amended the BSA, reinforcing the Annunzio-Wylie framework by making it mandatory for financial institutions to maintain AML programs that meet minimum prescribed standards.[5] The USA PATRIOT Act also, among other things, directed the Secretary to set minimum standards for financial institutions regarding customer identity in connection with the opening of accounts, commonly referred to as customer identification program (CIP) requirements,[6] and expanded the definition of ''financial institution'' under the BSA, and by extension the AML program requirement, to cover certain other financial industry participants (*e.g.,* credit unions and futures commission merchants).[7]

[1] Certain parts of the Currency and Foreign Transactions Reporting Act, its amendments, and the other statutes relating to the subject matter of that Act, are collectively referred to as the Bank Secrecy Act or BSA. These statutes are codified at 12 U.S.C. 1829b, 12 U.S.C. 1951–1960, and 31 U.S.C. 5311–5314 and 5316–5336 and notes thereto, with implementing regulations at 31 CFR chapter X.

[2] *See* Treasury Order 180–01, at ¶ 3 (Jan. 14, 2020), *https://home.treasury.gov/about/general-information/orders-and-directives/treasury-order-180-01; see also* 31 U.S.C. 310(b)(2)(I) (providing that the Director of FinCEN shall ''[a]dminister the requirements of subchapter II of chapter 53 of this title, chapter 2 of title I of Public Law 91–508, and section 21 of the Federal Deposit Insurance Act, to the extent delegated such authority by the Secretary of the Treasury'').

[3] Section 1517 of Public Law 102–550, 106 Stat. 3672 (Oct. 28, 1992) (Annunzio-Wylie).

[4] Section 1517(b) of Public Law 102–550 (amending 31 U.S.C. 5318(h)(1)).

[5] *See* 31 U.S.C. 5318(h), as added by section 352 of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (USA PATRIOT Act), Public Law 107–56, 115 Stat. 272 (Oct. 26, 2001).

[6] *See* 31 U.S.C. 5318(*l*) as added by section 326 of the USA PATRIOT Act.

[7] *See* 31 U.S.C. 5312(a)(2)(E) and 31 U.S.C. 5312(c), as added by section 321 of the USA PATRIOT Act.

Finally, on January 1, 2021, Congress enacted the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (FY 2021 NDAA), of which the Anti-Money Laundering Act (AML Act) was a component.[8] Among the purposes of the AML Act, as stated by Congress, was to reinforce that required policies, procedures and controls should support the need for AML/CFT programs to be ''risk-based.'' [9] Consistent with the goals of the AML Act, Treasury recognizes the urgent need to modernize the AML/CFT regime in the United States so that it is effective, risk-based, and focused on the greatest threats to financial institutions and national security.[10]

B. The Customer Due Diligence Rule

FinCEN has implemented these statutory mandates and authorities by promulgating program rules, among other requirements. Most notably in a 2016 rulemaking, FinCEN, in consultation with the Federal functional regulators, incorporated both general and specific customer due diligence (CDD) requirements into FinCEN's regulations.[11]

First, the 2016 rulemaking required banks, brokers and dealers in securities, mutual funds, and futures commission merchants and introducing brokers in commodities (collectively ''covered financial institutions'') to implement and maintain, as part of their AML programs, ''appropriate risk-based procedures for conducting ongoing customer due diligence,'' including ''[u]nderstanding the nature and purpose of customer relationships for the purposes of developing a customer risk profile'' and ''[c]onducting ongoing monitoring'' both ''to identify and report suspicious transactions'' and ''on a risk basis, to maintain and update customer information.'' [12] This became what is now colloquially known as the ''fifth pillar'' of an AML compliance program.[13]

Second, the CDD rulemaking codified at 31 CFR 1010.230 a requirement that covered financial institutions ''identify and verify beneficial owners of legal entity customers.'' [14] Under what became known as the ''ownership prong'' of this requirement, covered financial institutions collect the names and identifying information of ''[e]ach individual, if any, who, directly or indirectly . . . owns 25 percent or more of the equity interests'' of the legal entity customer.[15] Under what became known as the ''control prong'' of this requirement, covered financial institutions collect the name and identifying information of ''[a] single individual with significant responsibility to control, manage, or direct a legal entity customer.'' [16] For the status of the specified individuals as beneficial owners of the legal entity customer, covered financial institutions could ''rely on the information supplied by the legal entity customer . . . provided that [the covered financial institution] has no knowledge of facts that would reasonably call into question the reliability of such information.'' [17] For verification of the identity of the individual beneficial owners, covered financial institutions, at a minimum, would have to follow procedures containing all of the elements required for verification of individual account-holders under applicable CIP regulations.[18] Covered financial institutions were required to undertake this identification and verification ''at the time a new account is opened,'' meaning every time that a legal entity customer opened a new account.[19]

C. Recent Modifications to CDD Rule Obligations

In 2026, FinCEN used its authority under the BSA to grant exceptive relief to covered financial institutions from the requirement to identify and verify the identities of beneficial owners of legal entity customers at each new account opening.[20] That order, FIN–2026–R001, acknowledged that the CDD Rule requires a covered financial institution to identify and verify a legal entity customer's beneficial owners each time that customer opens an account with the covered financial institution, regardless of how little time passes between account openings or whether the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information last obtained about the customer. Consistent with the Trump Administration's policy of reducing unnecessary regulatory burden and enhancing the risk-based framework of the AML/CFT regulations, FinCEN granted relief so that a covered financial

[8] William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021, Public Law 116–283, 134 Stat. 3388 (Jan. 1, 2021).

[9] Section 6002(4) of the FY 2021 NDAA; *see also* 31 U.S.C. 5311(2), (3) as added by section 6101 of the AML Act (establishing that among the purposes of the BSA are to prevent money laundering and terrorist financing through the establishment of ''risk-based programs'' and facilitate the ''tracking of money that has been sourced through criminal activity''). Section 5318(h), as amended by section 6101 the AML Act, also requires that when prescribing minimum standards for programs under this section, the Secretary shall take into account certain factors: (i) financial institutions are spending private compliance funds for a public and private benefit, including protecting the United States financial system from illicit finance risks; (ii) extension of financial services to the underbanked and the facilitation of financial transactions, including remittances, coming from the United States and abroad in ways that simultaneously prevent criminal persons from abusing formal or informal financial services networks are key U.S. policy goals; (iii) effective AML/CFT programs safeguard national security and generate significant public benefits by preventing flow of illicit funds in the financial system and by assisting law enforcement and national security agencies with identification and prosecution of persons attempting money laundering and other illicit activity in the financial system; and (iv) AML/CFT programs should be reasonably designed to assure and monitor compliance with BSA requirements and be risk-based, including ensuring that more attention and resources of financial institutions be directed towards higher risk customers and activities than lower risk. FinCEN took these factors into consideration when preparing this proposal.

[10] *See, e.g.,* FinCEN, *Anti-Money Laundering and Countering the Financing of Terrorism Programs,* 91 FR 18704, 18708 (Apr. 10, 2026) (discussing Treasury's guiding principles for BSA reform and providing examples of steps taken to implement a modernized BSA regulatory and supervisory regime).

[11] FinCEN, *Customer Due Diligence Requirements for Financial Institutions,* 81 FR 29398 (May 11, 2016).

[12] FinCEN, *Customer Due Diligence Requirements for Financial Institutions,* 81 FR at 29457 (setting out the regulatory text); *see also id.* at 29450, note 185; 31 CFR 1020.210(b)(2)(v), 1023.210(b)(5), 1024.210(b)(5), 1026.210(b)(5).

[13] As indicated above, the other pillars are the four requirements listed in 31 U.S.C. 5318(h): ''(A) the development of internal policies, procedures, and controls; (B) the designation of a compliance officer; (C) an ongoing employee training program; and (D) an independent audit function to test programs.''

[14] FinCEN, *Customer Due Diligence Requirements for Financial Institutions,* 81 FR at 29451 (*codified at* 31 CFR 1010.230(a)).

[15] *Id.* (*codified at* 31 CFR 1010.230(d)(1)).

[16] *Id.* (*codified at* 31 CFR 1010.230(d)(2)).

[17] *Id. (codified at* 31 CFR 1010.230(b)(2)).

[18] *Id.* (*codified at* 31 CFR 1010.230(b)(2)). The CIP regulations are category-specific rules establishing the requirements for some categories of financial institutions, including all covered financial institutions, in connection with customer identification and verification of identity. *See* 31 CFR 1020.220 (CIP for banks), 31 CFR 1023.220 (CIP for brokers and dealers in securities), 31 CFR 1024.220 (CIP for mutual funds), 31 CFR 1026.220 (CIP for futures commission merchants and introducing brokers in commodities).

[19] FinCEN, *Customer Due Diligence Requirements for Financial Institutions,* 81 FR at 29451 (*codified at* 31 CFR 1010.230(a)(1)). CDD Rule requirements were effective long before the passage of the Corporate Transparency Act, and the two legal authorities differ in numerous ways. The CTA's objective, creating a nationwide system of direct reporting to the federal government of highly useful information related to beneficial ownership, is different from that of the CDD Rule, as are its definition of beneficial owner, the information in which it is interested, the entities reporting that information, and the recipients of that information.

[20] *See* FinCEN, FIN–2026–R001, *Exceptive Relief from Requirement to Identify and Verify Beneficial Owners at Each Account Opening* (Feb. 13, 2026), *https://www.fincen.gov/system/files/2026-02/FinCEN-Order-CCDExceptiveRelief.pdf.*

institution—instead of being required to undertake identification and verification ''at the time a new account is opened''—''may instead limit its identification and verification of the identities of beneficial owners . . . to the following scenarios: (1) when a legal entity customer first opens an account with a covered financial institution; (2) any time thereafter when the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer; and (3) as needed based on a covered financial institution's risk-based procedures for conducting ongoing customer due diligence.'' [21] FinCEN noted in its exceptive relief order that it would consider whether to codify this relief via a rulemaking.

D. Executive Order 14406: Restoring Integrity to America's Financial System

On May 19, 2026, President Donald J. Trump issued Executive Order 14406 to further the Administration's policy of ''restor[ing] integrity to America's financial system, safeguard[ing] financial institutions against structural risks, and deter[ring] fraud and abuse.'' [22] The Executive Order highlighted risks to the financial system caused by illicit cross-border financial activity and extension of credit or financial services to the inadmissible and removable alien population. To address these risks, it emphasized the importance of the Federal government adopting tailored measures to safeguard the financial system from illicit use and promote safe and sound lending and other practices by financial institutions and stated the need for financial institutions to have in place ''proper know-your-customer practices'' to prevent abuse of the system and be attentive to ''credit risks posed by the extension of . . . consumer credit to the inadmissible and removable alien population.'' [23] The Executive Order requires actions by various Federal agencies, including changes to the CDD Rule and consideration of changes to CIP rules.[24]

This proposal would implement section 3(b) of Executive Order 14406. Section 3(b) directs the Secretary—in consultation with the ''appropriate Federal functional financial regulators,'' defined in the Executive Order as the Board of Governors of the Federal Reserve System (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC), and the National Credit Union Administration (NCUA)—to propose changes to applicable implementing regulations of the BSA to strengthen risk-based customer due diligence requirements for covered financial institutions. Section 3(b) of the Executive Order specifies that such changes should ensure that ''(i) institutions collect and verify sufficient customer identity information to reasonably identify the nominal and beneficial owners of accounts in order to assess risks related to illicit finance, sanctions evasion, fraud, or other unlawful activity; and (ii) institutions maintain the authority, where warranted by other risk indicators or supervisory concerns, to obtain additional information necessary to resolve material compliance concerns, including information relevant to whether account holders possess lawful immigration status and employment authorization in the United States when such information is relevant to assessing risks associated with fraud, identity misrepresentation, sanctions evasion, or other illicit financial activity, as part of a risk-based customer due diligence program.''

E. Other FinCEN Proposed Rules

In developing its proposal to implement section 3(b) of Executive Order 14406, FinCEN has considered other relevant FinCEN regulations—both those in effect and those in consideration—that are relevant to customer due diligence and mitigation of customer risk to inform the specifics of this proposed rule.

FinCEN has issued proposed rules further emphasizing the risk-based approach to AML/CFT programs for covered financial institutions, as well as permitted payment stablecoin issuers (PPSIs).[25] Those rules, if finalized as proposed, would, among other things, require each covered financial institution and PPSI to establish a risk-based set of internal policies, procedures, and controls that must be reasonably designed to conduct ongoing customer due diligence. Under these proposed requirements, if finalized, covered financial institutions must establish and maintain a written AML/CFT program that includes appropriate risk-based procedures for conducting ongoing customer due diligence, to include, but not be limited to, understanding the nature and purpose of customer relationships for the purpose of developing a customer risk profile.

Notably, those proposals are consistent with Executive Order 14406's directive to adopt tailored measures to safeguard the financial system from illicit use and ensure that institutions maintain risk-based customer due diligence programs.[26] Most importantly,

[21] *Id.*

[22] Executive Order 14406 of May 19, 2026, *Restoring Integrity to America's Financial System,* 91 FR 30479 (May 22, 2026).

[23] *Id.*

[24] Section 3(a) directed the Secretary to issue a formal Advisory to financial institutions regarding the risks associated with the exploitation of the United States financial system by non-work authorized populations and their employers. Executive Order 14406 of May 19, 2026, *Restoring Integrity to America's Financial System,* 91 FR at 30480. The Secretary, through FinCEN and jointly with the FDIC, OCC, and NCUA, on June 5, 2026, issued an advisory that urged financial institutions to be vigilant against fraud schemes and other suspicious or potentially criminal activities involving the unlawful employment of illegal aliens and the associated risks to the integrity of the U.S. financial system. *See* FinCEN, FIN–2026–A002, *Joint Advisory on Non-Work Authorized Populations and Their Employers and Risks to the Integrity of the U.S. Financial System* (June 5, 2026), *https://www.fincen.gov/system/files/2026-06/FinCEN-Advisory-Non-Work-Authorized-Populations.pdf.* Section 4 directed the Consumer Financial Protection Bureau (CFPB) to consider clarifying that potential deportation and loss of wages are factors that could adversely affect a non-work authorized borrower's ability to repay an extension of credit under the ''ability-to-repay'' standards, and it required the FDIC, OCC, and NCUA to issue guidance regarding the management of the potential credit risks posed by the non-work authorized population. Executive Order 14406 of May 19, 2026, *Restoring Integrity to America's Financial System,* 91 FR at 30480–81. The CFPB issued its statement on June 8, 2026. *See* CFPB, *Statement on Ability to Repay and Immigration Status,* 91 FR 34607 (June 8, 2026). The FDIC, OCC, and NCUA subsequently published interagency guidance. FDIC, OCC, and NCUA, *Interagency Guidance on Lending to Individuals Not Legally Authorized to Work in the United States* (July 13, 2026), *https://www.occ.gov/news-issuances/news-releases/2026/nr-ia-2026-57a.pdf.*

[25] FinCEN, *Anti-Money Laundering and Countering the Financing of Terrorism Programs,* 91 FR 18704 (Apr. 10, 2026); FinCEN, *Permitted Payment Stablecoin Issuer Anti-Money Laundering/Countering the Financing of Terrorism Program and Sanctions Program Requirements,* 91 FR 18582 (Apr. 10, 2026); *see also* FinCEN, OCC, FRB, FDIC, and NCUA, *Permitted Payment Stablecoin Issuer Customer Identification Program,* 91 FR 37234 (June 22, 2026). FinCEN's proposal implementing the GENIUS Act's anti-money laundering obligations for PPSIs also proposes changes to 31 CFR 1010.230. The potential changes under both proposals would be complementary rather than conflicting.

[26] This proposal is one element of broader CDD Rule revisions, including those required by the Corporate Transparency Act. The CTA directed Treasury to revise the CDD Rule to: (1) bring it into conformity with the AML Act of 2020, including the CTA; (2) account for financial institutions' access to beneficial ownership information reported to FinCEN so financial institutions may confirm beneficial ownership information provided directly to them for the purpose of facilitating their compliance with anti-money laundering, countering the financing of terrorism, and customer due diligence requirements; and (3) reduce any burdens on financial institutions and legal entity customers that are, in light of the CTA, unnecessary or duplicative. Section 6403(d)(1)(A)-(C) of the FY 2021 NDAA. The current proposal is not the

the proposals would, if finalized, ensure internal policies, procedures, and controls—including those relating to conducting ongoing customer due diligence—must be reasonably designed to mitigate assessed risk, including by allocating more attention and resources toward higher-risk customers and activities rather than toward lower-risk customers and activities.[27]

III. Overview of the Proposal

In drafting this proposed rule, FinCEN has considered how it can best strengthen the CDD Rule by adopting tailored measures to safeguard the financial system, including by ensuring that covered financial institutions have risk-based collection and verification requirements and direct compliance resources towards higher risk customers as directed by Executive Order 14406. In addition to implementing the directive in section 3(b) of Executive Order 14406, FinCEN also seeks to further the Trump Administration's efforts to modernize the AML/CFT regime by making it more effective, risk-based, and focused on the greatest threats to national security, while reducing unnecessary regulatory burden.

After considering the existing regulations, proposals, and obligations, as well as the directives in Executive Order 14406, FinCEN assesses that targeted amendments to the CDD Rule—specifically, § 1010.230—best effectuate the goals of Executive Order 14406. Specifically, this proposal includes three targeted revisions to the CDD Rule codified at § 1010.230, in addition to other minor regulatory clarifications.

First, consistent with Executive Order 14406, the proposal would strengthen risk-based customer due diligence requirements for covered financial institutions by making explicit that, where warranted by other risk indicators or supervisory concerns, a covered financial institution may obtain additional information necessary to resolve material compliance concerns, including information relevant to whether account holders possess lawful immigration status and employment authorization in the United States when such information is relevant to assessing risks associated with fraud, identity misrepresentation, sanctions evasion, or other illicit financial activity, as part of a risk-based customer due diligence program.

Second, FinCEN is proposing to formally incorporate the exceptive relief provided in FIN–2026–R001. This change would formally eliminate the requirement for covered financial institutions to repeatedly collect and verify beneficial ownership information in cases where there is no reason to believe that the customer's beneficial ownership information has changed since it was last collected, and the circumstances do not indicate a risk-based need to collect and verify beneficial ownership information. By codifying this relief, FinCEN is ensuring that covered financial institutions will continue to benefit from the flexibility to direct compliance resources consistent with their own assessments of risk.

Third, the proposal would specify in § 1010.230 the pieces of information a covered financial institution must collect relating to beneficial owners. This would involve moving the specific details of the requirement to collect information about beneficial owners from the rule's Appendix A into the rule itself. Most, but not all, of those details would not change. The proposal would, however, restrict the ability to satisfy the information collection requirement by collecting a beneficial owner's Individual Taxpayer Identification Number (ITIN). Additional flexibilities described in the proposal would allow institutions to obtain information from third parties. FinCEN assesses that these proposed changes would ensure that covered financial institutions collect sufficient, appropriate information to be able to verify the identities of beneficial owners while making it less burdensome for covered financial institutions to reasonably identify beneficial owners. As a result, FinCEN expects covered financial institutions will be both able to use their resources more efficiently and better positioned to assess risks related to illicit finance, sanctions evasion, fraud, or other unlawful activity.

In developing this proposal, as directed by Executive Order 14406, FinCEN consulted with the Board of Governors of the Federal Reserve System, the Office of the Comptroller of the Currency, the Federal Deposit Insurance Corporation, and the National Credit Union Administration. Additionally, FinCEN consulted the staff of the Securities and Exchange Commission and the Commodity Futures Trading Commission, which are the primary Federal functional regulators for additional categories of institutions covered by the CDD Rule, specifically brokers and dealers in securities, mutual funds, and futures commission merchants and introducing brokers.[28]

IV. Section-By-Section Analysis

A. Proposed Amendment to 31 CFR 1010.230(a)—In General

As mentioned above, this rulemaking is rooted in FinCEN's authority to ''prescribe minimum standards for programs'' intended to ''guard against money laundering and the financing of terrorism through financial institutions . . . including . . . the development of internal policies, procedures, and controls[.]'' [29] Consistent with Executive Order 14406's emphasis on assessing the risk associated with beneficial owners, the proposed language would clarify that covered financial institutions are required to establish and maintain written procedures reasonably designed to identify and verify *the identity of* beneficial owners of legal entity customers. This proposed addition of the words ''the identity of'' to § 1010.230(a) is intended to make clear that covered financial institutions are required to collect and verify *identifying information* on a beneficial owner (*i.e.,* to verify the individual's existence and identity), not whether that individual is actually a beneficial owner of the legal entity that is the covered financial institution's customer. This is consistent with language in the current rule that a covered financial institution may rely on the information supplied by the legal entity customer regarding the identity of its beneficial owner or owners, provided that it has no knowledge of facts that would reasonably call into question the reliability of such information.[30] This proposed language is intended as a clarification and does not change covered financial institutions' existing obligations to verify the identities of beneficial owners.

FinCEN is also proposing to add ''countering the financing of terrorism'' to the reference in § 1010.230 to ''anti-

revision to the CDD Rule that addresses the issues specified by the CTA. FinCEN recently issued a final rule regarding beneficial ownership reporting requirements, which limits reporting to foreign entities registered to do business in the United States. FinCEN, *Beneficial Ownership Information Reporting Requirement Revision,* 91 FR 52508 (Aug. 14, 2026). FinCEN has determined that, given how recently the new beneficial ownership reporting regime has been finalized, such changes are more appropriately considered as part of a separate rulemaking. Additionally, FinCEN has proposed, as required by the GENIUS Act, applying CDD obligations to PPSIs. *See* OFAC and FinCEN, *Permitted Payment Stablecoin Issuer Anti-Money Laundering/Countering the Financing of Terrorism Program and Sanctions Program Requirements,* 91 FR at 18604. This proposal, with respect to PPSIs, if finalized, would apply to PPSIs as a category of institution covered by CDD obligations.

[27] *See, e.g.,* 91 FR at 18717–18.

[28] As noted in note 26 above, if FinCEN's proposed rule regarding PPSIs is finalized, the list will also include PPSIs.

[29] *See* 31 U.S.C. 5318(h)(1)(A), (2).

[30] FinCEN, *Customer Due Diligence Requirements for Financial Institutions,* 81 FR at 29407.

money laundering compliance programs.'' The inclusion of countering the financing of terrorism is a technical change, consistent with other FinCEN proposals, which reflects a statutory change requiring institutions to account for risks related to terrorist financing.[31]

B. Proposed Amendment to 31 CFR 1010.230(b)—Identification and Verification

1. Proposed 31 CFR 1010.230(b)(1)(i)—Timing

The proposal would codify the exemptive relief provided in FIN–2026–R001 by amending § 1010.230(b)(1)(i). FinCEN expects that this proposed change, if finalized, will ensure covered financial institutions continue to benefit from the flexibility to allocate compliance resources to focus on customers that present higher risks related to illicit finance, sanctions evasion, fraud, and other unlawful activity as indicated in Executive Order 14406.

The current rule requires a covered financial institution to identify the beneficial owner(s) of each legal entity customer every time a new account is opened, subject to certain limited exemptions. Covered financial institutions and their trade associations have characterized this requirement as unnecessarily burdensome, particularly in situations involving legal entity customers whose business happens to involve the frequent creation of new accounts. Where there is no reason to think that the customer's beneficial ownership information has changed since last collected, they have pointed out, repeated collection and verification of the same information wastes resources that, deployed in a more risk-conscious manner, could improve overall risk management.

The proposed rule would address these concerns by replacing the rigid account opening requirement with a more flexible, risk-based approach. The proposed rule provides that a covered financial institution must identify the beneficial owner(s) of a legal entity customer: (1) when the legal entity customer first opens an account with the covered financial institution; (2) any time thereafter when the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer; and (3) as needed based on a covered financial institution's risk-based procedures for conducting ongoing customer due diligence. The proposal would eliminate the requirement for covered financial institutions to collect a legal entity customer's beneficial ownership information at each new account opening except, among other circumstances, as needed based on a covered financial institution's risk-based procedures for conducting ongoing customer due diligence. Whether a financial institution has knowledge of facts that would reasonably call into question the reliability of previously obtained beneficial ownership information would depend upon the facts and circumstances. Notably, if a covered financial institution elects, as part of its risk-based procedures, to continue collecting beneficial ownership information at each account opening, it would be permitted to do so under the proposed rule. FinCEN expects this change would, consistent with the policy goals of Executive Order 14406, improve the risk-based nature of the CDD Rule by allowing financial institutions to focus on higher risk customers, including those that present risks related to illicit finance, sanctions evasion, fraud, and other unlawful activity.

FinCEN requests comment on the timing element of the proposal. Specifically, FinCEN seeks comment on whether ''any time thereafter when the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer'' is an appropriate trigger for identification and verification of beneficial owners.

Additionally, one of the three circumstances in which FinCEN's exceptive relief specifies that beneficial ownership information should be collected—and therefore one of the circumstances in which this proposal requires that it be collected—is ''when the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer.'' FinCEN requests comment on its use of ''reliability.'' If, for example, the covered financial institution has reason to believe there has been a change in ownership of the legal entity, the covered financial institution might not be questioning the ''reliability'' so much as the continuing accuracy of the information originally provided. FinCEN therefore requests comment on whether ''reliability'' should be used, defined in a more specific fashion, or supplemented.

2. Proposed 31 CFR 1010.230(b)(1)(ii)—Information To Collect

The proposed rule would make two changes relating to the information potentially collected by financial institutions under § 1010.230. Both changes support the policy directives of Executive Order 14406 by ensuring institutions collect information sufficient to reasonably identify the beneficial owners of legal entity customers for the specific purpose of assessing risks related to illicit finance, sanctions evasion, fraud, or other unlawful activity. One change would make explicit the information a covered financial institution must collect, while the second would ensure that covered financial institutions can collect additional information, where warranted by other risk indicators or supervisory concerns, to assess risks associated with fraud, identity misrepresentation, sanctions evasion, or other illicit financial activity.

This combination reinforces the original CDD Rule's balancing of categorical and risk-based elements. FinCEN has assessed that this balance not only ensures that a covered financial institution will collect sufficient information with regard to beneficial owners of its legal entity customers, but also provides flexibility for a covered financial institution to collect additional information for particular beneficial owners where warranted by risk. In doing so, FinCEN aims to strengthen the risk-based element of the CDD Rule, including by ensuring that institutions maintain the authority to collect additional information based on risk, while still maintaining the categorical aspect of the CDD Rule.

The proposed rule in general requires that a covered financial institution must obtain information about each beneficial owner of a legal entity customer sufficient to allow the institution to identify, and to verify the identity of, the beneficial owner. FinCEN proposes these changes to make plain the specific information that covered financial institutions are required to obtain about beneficial owners of legal entities. The proposed rule specifies a discrete list of information that a covered financial institution must obtain about each beneficial owner of a legal entity customer, which includes a qualifying identifying number for the individual.

[31] *See, e.g.,* FinCEN, *Anti-Money Laundering and Countering the Financing of Terrorism Programs,* 91 FR at 18711 (proposing adding ''countering the financing of terrorism'' to references to ''anti-money laundering program'' to reflect USA PATRIOT Act obligation to account for risks related to terrorist financing and to reflect new statutory language in the AML Act amending 31 U.S.C. 5318(h)(1)).

Under this proposal the regulatory text would set out a list of identifying numbers that may be used to satisfy this requirement, including a Social Security number, or for non-U.S. persons a passport number with country of issuance, an alien identification card, or a number and country of any other government-issued document evidencing nationality or residence and bearing a photograph—all of which are included in the existing certification form in Appendix A to the current rule. The proposal also specifies that an Individual Taxpayer Identification Number (ITIN) is not an acceptable substitute for a Social Security number.[32] This specification recognizes that an ITIN, as the IRS has noted, is ''issued . . . for federal tax purposes only.'' [33] It also reinforces the analysis set forth in FinCEN's recent advisory that recognized the use of an ITIN in lieu of a Social Security number or valid employment authorization document may be identified as a risk factor requiring enhanced due diligence.[34] Recognizing the risk associated with ITINs, FinCEN proposes to exclude their use as an identifying number for a beneficial owner. It expects that ITIN holders legally in the United States and authorized to work will have alternative identification including, for example, a foreign passport or an alien identification card.

While new in the rule itself, the proposed language identifying core pieces of information is substantively the same as the current rule's optional Appendix A form. The proposed rule returns the appendix to its proper function of providing material supplementary to the regulation, rather than stating the regulatory requirement itself. In maintaining that continuity, FinCEN seeks to preserve a workable level of flexibility for covered financial institutions in complying with this requirement. FinCEN seeks comment on the workability of its specific proposal that an ITIN cannot substitute for a Social Security number under this provision, as well as whether it should make other changes, either specifically to permit or to prohibit acceptance of other identification numbers or documents.

As noted earlier in this section, the proposed rule has a second goal: that covered financial institutions maintain the authority to collect additional information. The proposed rule does this by proposing regulatory text stating that, where warranted by other risk indicators or supervisory concerns, a covered financial institution may obtain additional information necessary to mitigate indicated risk or address supervisory concerns, including when relevant to assessing risks associated with fraud, identity misrepresentation, sanctions evasion, or other illicit financial activity, lawful immigration status or employment authorization in the United States. This is intended to make clear that, in situations of heightened risk or supervisory concern, a financial institution may consider obtaining additional information in order to confirm a beneficial owner's identity. It is also intended to make clear that such additional information can include immigration status and employment authorization information.

FinCEN anticipates providing additional guidance, alerts, or advisories to financial institutions, including highlighting new and emerging threats and typologies that may further feed into financial institutions' risk-based assessments. Providing this type of feedback through supplemental documents, rather than in specific regulatory text, will allow both Treasury and the financial institutions to more quickly adapt to address new and emerging threats and typologies and allow financial institutions to assess risks associated with fraud, identity misrepresentation, sanctions evasion, or other illicit financial activity, including illicit activity relating to a lack of lawful immigration status or employment authorization in the United States.

This proposal does not specify situations that present heightened risks, instead deferring that judgment to financial institutions and allowing them greater flexibility to identify such situations, relying on appropriate risk-based practices. However, such situations may well be judged to include instances where the identifying information for a beneficial owner residing in the United States presented to covered financial institutions includes documentation issued by a foreign government, rather than an identity document issued by a United States federal or state government agency. An individual may even present an ITIN and represent it to be a Social Security number, which could be a risk factor warranting additional inquiry.

Moreover, the CDD Rule is critical to aiding a covered financial institution's efforts to detect and report suspicious activity, including activity that could expose the institution to loss. Immigration and employment status would also be germane to reasonably assessing risk if the beneficial owner were providing a financial guarantee based on the beneficial owner's income from U.S. employment—income that might be in jeopardy if the beneficial owner were not legally authorized to work in the United States. Thus, a covered financial institution's compliance with the CDD Rule and its efforts to detect and report suspicious activity may aid the institution in evaluating risk outside of illicit finance.[35]

This permissiveness, however, should not be misinterpreted. The proposed language providing that a covered financial institution ''may'' obtain such additional information is not intended to suggest any reduction of the requirement to conduct ongoing due diligence or to verify the identity of each beneficial owner according to risk-based procedures that contain, at a minimum, the same elements financial institutions are required to use to verify the identity of individual customers under applicable CIP requirements. It is intended to reinforce the individual covered financial institution's authority, where warranted by other risk indicators or supervisory concerns, to demand additional information as part of a risk-based customer due diligence program.

FinCEN is interested in receiving comments on whether this rulemaking strikes an appropriate balance between mandating information collection and recognition that covered financial institutions may be better placed to assess what information they should

[32] IRS, *Instructions for Form W–7 (12/2024)* (revised Dec. 2024), *https://www.irs.gov/instructions/iw7* (directing individuals not to apply for an ITIN if they ''have an SSN or [are] eligible to get an SSN'').

[33] *See, e.g.,* IRS, *Individual taxpayer identification number (ITIN)* (last accessed Nov. 3, 2026), *https://www.irs.gov/tin/itin/individual-taxpayer-identification-number-itin.* Notably, to obtain an ITIN an individual must provide documents that both establish identity and connection to a foreign country. IRS, *Instructions for Form W–7 (12/2024)* (revised Dec. 2024), *https://www.irs.gov/instructions/iw7.* In some cases, documents required by the IRS to establish either foreign status or identity could also be used under the proposed rule, including a passport, a visa issued by the U.S. Department of State, or national identification card meeting certain requirements. *Id.*

[34] FinCEN, FIN–2026–A002, *Joint Advisory on Non-Work Authorized Populations and Their Employers and Risks to the Integrity of the U.S. Financial System* (June 5, 2026), *https://www.fincen.gov/system/files/2026-06/FinCEN-Advisory-Non-Work-Authorized-Populations.pdf* (noting that ''the use of an ITIN in lieu of an SSN or valid employment authorization document may be identified as a risk factor requiring enhanced due diligence to ensure the account is not being utilized to facilitate the unlawful employment of unlawful aliens'').

[35] Immigration status or status as a permanent resident of the United States may be relevant for financial institutions in evaluating risks other than illicit finance risks, such as credit risks of borrowers. *See Interagency Guidance on Lending to Individuals Not Legally Authorized to Work in the United States, supra* note 24; *see also* 12 CFR 1002.6(b)(7).

collect. FinCEN is also interested in receiving comments on whether its proposed approach mitigates the risks identified in Executive Order 14406, including by providing covered financial institutions sufficient authority to collect necessary information.

3. Proposed 31 CFR 1010.230(b)(1)(iii)—Sources of Information

The proposed rule also would improve the risk-based nature of the CDD Rule by providing more flexibility in how a covered financial institution obtains information, which is expected to reduce compliance burden. In doing so, this change supports Executive Order 14406 by allowing those financial institutions to direct resources to higher risk customers and activities, including customers that present risks related to illicit finance, sanctions evasion, fraud, and other unlawful activity as indicated in Executive Order 14406.

The CDD Rule specifies that covered financial institutions must obtain information about a legal entity customer's beneficial owners ''from the individual opening the account on behalf of the legal entity customer,'' using the optional certification form found at Appendix A to the rule or its substantive equivalent.[36] Some have attempted to read the regulation as allowing the collection of information from third parties along the lines of the bank-specific CIP Rule's special provision for the opening of individual credit card accounts, provided that a representative of the legal entity customer certified the accuracy of the information.[37] However, given the equivocal support that the CDD Rule's preamble provides for this interpretation, many covered financial institutions have been collecting beneficial ownership directly from their customers every time it was required, despite the time and expense of this practice.[38]

The proposed addition of paragraph (b)(1)(iii) would offer covered financial institutions clarity by providing that a covered financial institution may obtain any information described in paragraph (b)(1)(ii) by acquiring it from a third-party source. Regardless of the source from which information is obtained, a covered financial institution must comply with the certification requirement set forth in paragraph (b)(1)(iv). Similarly, regardless of the source from which information was obtained, a covered financial institution must comply with the requirement to identify the beneficial owner(s) of a legal entity customer any time after the legal entity customer first opens an account with the covered financial institution when the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer.

4. Proposed 31 CFR 1010.230(b)(1)(iv)—Certification

Relatedly, the proposed rule also would improve the risk-based nature of the CDD Rule by providing more flexibility about when an institution must obtain a new certification for an existing legal entity customer. This enables a covered financial institution to rely on beneficial ownership information previously obtained from a certification provided in connection with the initial opening of an account by the legal entity customer with the covered financial institution. This change supports Executive Order 14406 by allowing financial institutions to focus on higher risk customers and activities, instead of activities that result in unnecessary information collection untethered from the risk of a particular customer.

The proposal provides that when a legal entity customer first opens an account with a covered financial institution, the covered financial institution obtaining information on the legal entity customer's beneficial owners must obtain a certification from the individual opening the account on behalf of the legal entity customer that the information obtained is accurate to the best of the individual's knowledge. A covered financial institution may, but is not required, to use the standardized certification form contained in Appendix A to § 1010.230. If the standardized certification form is not used, a covered financial institution must obtain from the individual opening the account the information required by the standardized certification form by another means.

The proposal also provides that, when obtaining information on beneficial owners as needed based on a covered financial institution's risk-based procedures for conducting ongoing customer due diligence, a covered financial institution may rely on beneficial ownership information previously obtained from a certification provided in connection with the initial opening of an account by the legal entity customer with the covered financial institution. In order to rely on such a prior certification, the covered financial institution must obtain from a representative of the legal entity customer either oral or written confirmation that such information is up to date and accurate to the best of the individual's knowledge. This confirmation may, but is not required to, take the form of the standardized certification form in Appendix A of this section. Thus, certification remains essential to collection of beneficial ownership information, but the proposal grants flexibility to institutions with respect to the form of certification obtained.

The covered financial institution must maintain a record of such certification or confirmation, whether the certification or confirmation is oral or written. If a covered financial institution is unable to obtain a necessary certification or confirmation that previously obtained beneficial ownership information is up-to-date and accurate, or if the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer, the covered financial institution must identify and verify the identities of the beneficial owners of the legal entity customer in accordance with the general requirements of § 1010.230.

5. Proposed 31 CFR 1010.230(b)(2)—Verification

Under this proposal, § 1010.230 would contain a discrete list of information that covered financial institutions must collect, which would serve as the factual basis for their verification of the identities of the beneficial owners of their legal entity customers. The presence of this list could create confusion given § 1010.230's current cross-reference to the CIP rules, which encompass those rules' own list of information that must

[36] 31 CFR 1010.230(b)(1).

[37] *See, e.g.,* 31 CFR 1020.220(a)(2)(i)(C) (credit card account opening CIP rule for banks). Notably, in the CIP Rule context FinCEN and the Federal Banking Agencies granted exceptive relief to permit banks to obtain Tax Identification Number information from a third-party source rather than the customer for all accounts, provided that the bank otherwise complies with the CIP Rule. *See* FinCEN, OCC, FDIC, NCUA, *Order—Customer Identification Program* (June 27, 2025), *https://www.fincen.gov/system/files/2025-06/CIP-TIN-Exemption-Order-final508.pdf; FinCEN and Board, Order—Customer Identification Program* (July 31, 2025), *https://www.fincen.gov/system/files/shared/CIP-TIN-Exemption-Order-Board-only-508.pdf.*

[38] *See* FinCEN, *Customer Due Diligence Requirements for Financial Institutions,* 81 FR at 29405–29406. The best argument for the expansive reading is based on the negative inference to be drawn from the statement ''FinCEN declines to permit reliance solely upon previously gathered alternate sources of beneficial ownership information.'' *See* 81 FR at 29406.

be collected for CIP compliance purposes. The cross-reference currently requires covered financial institutions to have procedures that ''contain the elements required for verifying the identity of customers that are individuals under § 1020.220(a)(2) of this chapter (for banks); § 1023.220(a)(2) of this chapter (for brokers or dealers in securities); § 1024.220(a)(2) of this chapter (for mutual funds); or § 1026.220(a)(2) of this chapter (for futures commission merchants or introducing brokers in commodities).'' [39] Sections (a)(2)(ii) and (a)(2)(iii) of the CIP rules concern procedures for customer verification and procedures in situations where verification is impossible. Section (a)(2)(i) of those rules, however, is a list of customer information that a financial institution is required to collect about each individual or corporate customer. Among other things, section (a)(2)(i) of those rules specifically allows use of ''a taxpayer identification number,'' *i.e.* an ITIN, for a non-U.S. person, which would not be permitted under this proposal and should not be misinterpreted to apply to the CDD Rule.

To clarify which aspects of the CIP rules do and do not apply for purposes of the CDD Rule, FinCEN proposes amending § 1010.230(b)(2). That change will clarify that a covered financial institution must have customer due diligence verification procedures that reflect the requirements of that institution's CIP rule, but also that covered financial institutions must adhere to proposed § 1010.230(b)(1)(ii), which specifies the information to be collected. This change is designed to clarify but not change the current CDD Rule's adoption of CIP verification procedural standards while recognizing that the information a financial institution can use to verify an identity will, if this proposal is adopted, be different under the CIP and CDD Rules. FinCEN requests comment on challenges that may arise from different information collection requirements for CIP and CDD obligations, and whether the revised cross-reference is sufficiently clear.

In addition, given the continuing reference to, and incorporation of the standards of, the CIP rule, FinCEN solicits comments about the need for the CDD Rule itself to qualify the compliance standard of its verification requirement with the phrase ''to the extent reasonable and practicable''—a phrase that is already found in the CIP rule.[40] Alternatively, FinCEN solicits comments on whether it should dispense with cross-references altogether and insert in the CDD Rule all of the specific appropriate procedural language now found in the CIP rule itself, even if such insertion simply reproduces relevant CIP rule language.

V. Effective Date

FinCEN proposes that the rule would be effective 90 days after publication in the **Federal Register**.

VI. Requests for Comment

FinCEN seeks comments on all aspects of the proposed rule and specifically seeks comments on the following topics. For all responses, commenters are encouraged to provide the basis for any conclusions drawn in their comments.

1. Do the information collection requirements proposed in this rulemaking strike an appropriate balance, including between providing covered financial institutions sufficient direction in information collection, as well as discretion to require more information when risk warrants additional collection?

2. Is the information that the proposal requires covered financial institutions to collect and verify sufficient for them to reasonably identify most beneficial owners and assess beneficial ownership-related risks related to illicit finance, sanctions evasion, fraud, or other unlawful activity? If not, what additional or alternative information should covered financial institutions be required to collect?

3. Does the proposal provide covered financial institutions sufficient certainty that, where warranted, they maintain the ability to collect additional information, including relating to whether beneficial owners possess lawful immigration status and employment authorization in the United States? Should the proposed text be refined in any way?

4. Under the proposal, a covered financial institution may be required to collect beneficial ownership information ''any time thereafter [that is, after the initial collection] when the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer.'' Is this circumstance an appropriate trigger for identification and verification of beneficial owners? Does it need to be refined or clarified, and if so how? For example, could ''reliability'' be supplemented with another measure, such as ''accuracy'' or ''continuing accuracy,'' given that, if the covered financial institution has reason to believe there has been a change in ownership of the legal entity, the covered financial institution might not be questioning the ''reliability'' so much as the continuing accuracy of the information originally provided?

5. Does the proposal's prohibition on use of an ITIN in lieu of a Social Security number appropriately balance risk? Does it represent any compliance challenges for covered financial institutions, including because of the potential divergent approach between the information permitted to be collected under the CIP rules and the CDD Rule? Would additional FinCEN guidance help address those challenges?

6. Should FinCEN consider alternatives to prohibiting use of an ITIN? For example, should FinCEN allow collection of an ITIN for verification purposes but require a covered financial institution to undertake additional steps, such as further due diligence measures or submission of additional information or documentation? Describe benefits and drawbacks of such alternatives.

7. Are there circumstances where an individual lawfully present in the United States would have an ITIN, but no other number or document specified in the proposal? If yes, how could FinCEN account for such scenarios while still accounting for the risk addressed by Executive Order 14406?

8. The CDD Rule incorporates some language borrowed from the CIP rules, and it also cross-references the CIP rules. In general, should FinCEN dispense with cross-references altogether and insert in the CDD Rule all of the specific appropriate procedural language of the CIP rule itself? Whether or not FinCEN adopts this global solution, should FinCEN retain the phrase ''to the extent reasonable and practicable,'' borrowed from the CIP rules, in the verification section of the CDD Rule? Should it use an alternative standard? If the phrase is deleted, what will be the effect?

9. The CDD Rule requirement is, generally speaking, ''categorical,'' imposing essentially the same core requirements with respect to all of a covered financial institution's non-exempt legal entity customers. Should FinCEN provide greater flexibility to covered financial institutions to adjust their due diligence efforts with respect to legal entity customers and their beneficial owners downward with decreased risk, not simply upward with

[39] 31 CFR 1010.230(b)(2).

[40] *See, e.g.,* 31 CFR 1020.220(a)(2).

respect to increased risk? What lower risk scenarios might be identified, under which on a risk-basis financial institutions should be permitted to collect less or different information related to beneficial ownership?

10. Should the recordkeeping requirement of the CDD Rule, 31 CFR 1010.230(i), be amended to better account for written or verbal confirmations contemplated under the proposed revisions to 31 CFR 1010.230(b)(1)(iv)(B)? The existing language of 31 CFR 1010.230(i)(1)(i) requires covered financial institutions to keep records that include ''For identification, any identifying information obtained by the covered financial institution pursuant to paragraph (b) of this section [the paragraph requiring collection of information], including without limitation the certification (if obtained)[.]'' Is it clear that the phrase ''any identifying information obtained'' includes a confirmation that information previously collected has not changed, or should the text be amended to explicitly address the matter of such confirmations about previously collected information?

11. The Appendix A form provides a list of corporate positions that could have ''significant responsibility for managing the legal entity,'' which includes ''Vice President'' and ''Treasurer.'' Should these or any other positions be listed as possible control persons? Alternatively, should any of these or other positions be excluded from the category of control person?

12. Should FinCEN consider a longer or shorter implementation period? Why?

VII. Severability

As part of this proposal, FinCEN proposes that if one portion of the proposed regulation, if finalized, is found to be invalid, the invalidated portion of the regulation should be severed with the remaining portions of the regulation remaining in full force and effect. FinCEN's position is that invalidation of any one provision, or application thereof to any one person or circumstance, does not, and should not, affect any other provision in this proposed regulation. Each provision serves an important, related, but distinct purpose and application, designed to benefit the public by protecting the U.S. financial system from illicit financial activity. FinCEN accordingly has proposed each provision such that invalidity to one provision would not undermine the operability or usefulness of the other provisions.

VIII. Executive Order 14294 Fighting Overcriminalization in Federal Regulations

Executive Order 14294 *Fighting Overcriminalization in Federal Regulations* requires that agencies promulgating regulations potentially subject to criminal enforcement explicitly describe the conduct subject to criminal enforcement, the authorizing statutes, and the *mens rea* standard applicable to those offenses.[41] Section 5 of Executive Order 14294 directs that all future notices of proposed rulemaking and final rules published in the **Federal Register**, the violation of which may constitute criminal regulatory offenses, should include a statement identifying that the rule or proposed rule is a criminal regulatory offense and the authorizing statute.[42] Executive Order 14294 directs agencies to draft this statement in consultation with the Department of Justice.[43]

Executive Order 14294 further directs that the regulatory text of all NPRMs and final rules with criminal consequences published in the **Federal Register** after May 9, 2025 should explicitly state a *mens rea* requirement for each element of a criminal regulatory offense, accompanied by citations to the relevant provisions of the authorizing statute.

Willful violations of the regulations set forward in this proposed rule, if finalized, may be subject to criminal penalties pursuant to 31 U.S.C. 5322 and regulations promulgated in 31 CFR chapter X. The statutory authority for criminal liability requires a *mens rea* of willfulness as an element pursuant to 31 U.S.C. 5322(a) and 31 U.S.C. 5322(b). FinCEN's existing regulation, 31 CFR 1010.840, that sets out criminal penalties for violations of regulations promulgated in 31 CFR chapter X also includes a *mens rea* of willfulness. In drafting this statement, FinCEN has consulted with the Department of Justice.

IX. Regulatory Impact Analysis

FinCEN has analyzed this proposed rule as required under Executive Orders 12866, 13563, and 14192; the Regulatory Flexibility Act (RFA); the Unfunded Mandates Reform Act (UMRA); and the Paperwork Reduction Act (PRA). This section presents the findings of its analysis, including a discussion of the expected incremental economic effects of the proposed rule relative to the current regulatory baseline and invites comment on all aspects of this analysis, including any data or information that would assist FinCEN in better quantifying the costs, cost savings, or other effects of the proposed rule.

The proposed rule would amend the CDD Rule, 31 CFR 1010.230, primarily by making three overarching revisions, and introduce certain minor regulatory clarifications. These revisions, as discussed in section III: (1) make it explicit that covered financial institutions may obtain additional information necessary to mitigate indicated risk or address supervisory concerns; (2) incorporate FinCEN's exceptive relief and required information, permissible sources, and certification; and (3) specify pieces of information required to be collected, while providing additional flexibility in how such information is obtained. The following analysis focuses on the expected incremental economic effects of these revisions.

As a threshold matter, FinCEN does not expect the proposed amendments would have a significant economic effect. Among other things, the proposal would not expand the set of covered financial institutions, would not expand the definition of legal entity customer, would not require covered financial institutions to collect beneficial ownership information from a new class of customers, and would not impose a new mandatory reporting or recordkeeping requirement. Instead, the proposal would codify regulatory flexibility that reduces duplicative beneficial ownership identification and verification at repeat account openings while identifying select risk-based triggers for obtaining and updating information when appropriate. The proposed clarification regarding the collection of additional information in heightened-risk circumstances is itself risk based; it does not impose a categorical obligation to collect any particular additional document or information, nor does it expand the pre-existing authority or obligation of covered financial institutions to collect risk-relevant information.[44]

A. Analysis of Impact

1. Broad Economic Considerations

As it proposes these amendments to § 1010.230, FinCEN remains mindful of the fundamental economic tensions observed in the original rule. The analysis in the CDD Rule framed beneficial ownership requirements as addressing externalities associated with

[41] Executive Order 14292 of May 9, 2026, *Fighting Overcriminalization in Federal Regulations,* 90 FR 20363, 20364 (May 14, 2025).

[42] *Id.*

[43] *Id.*

[44] *See supra* section IV.B.2.

illicit finance. Covered financial institutions bear the private costs of collecting and verifying beneficial ownership information, while many of the benefits of improved transparency, including reduced money laundering, terrorist financing, fraud, sanctions evasion, and related illicit activity, accrue broadly to the public, law enforcement, national security agencies, and the financial system as a whole. Absent a standard of collection requirements, covered financial institutions may underinvest in beneficial ownership information collection, particularly if they believe more rigorous requirements could place them at a competitive disadvantage relative to institutions with less comprehensive practices.

Prior FinCEN analysis also recognized cross-border spillovers.[45] Jurisdictions with less stringent AML/CFT standards may become more attractive destinations for laundering proceeds generated by illicit activity elsewhere, allowing those jurisdictions to receive capital inflows without bearing the full social costs of the underlying crimes. A clear and consistent CDD framework can help mitigate this concern by improving beneficial ownership transparency and making it more costly for illicit actors to misuse legal entities to access the U.S. financial system.

The proposed revisions build on that same general framework but are expected to have more limited incremental economic effects than the original CDD Rule. Rather than creating a new beneficial ownership information-collection obligation, the proposal would clarify and refine existing CDD requirements, reduce duplicative collection at repeat account openings, and preserve risk-based authority to obtain additional information when warranted by risk indicators or supervisory concerns. Thus, the relevant economic trade-off is not whether to impose a new beneficial ownership framework, but how best to preserve the benefits of beneficial ownership transparency while reducing unnecessary or duplicative compliance activity.

Having taken the original animating concerns into consideration, FinCEN believes the proposed amendments would enhance the balance of imposing private costs on financial institutions for the public benefit of standardized due diligence practices.

2. Institutional Baseline and Affected Parties

a. Regulatory Baseline

The anticipated incremental economic effects of the proposed rule were analyzed against a counterfactual state of the world in which a covered financial institution's obligations under the BSA would maintain the *status quo.* For purposes of this analysis, FinCEN considered the most salient component of the regulatory baseline to be comprised of both the original CDD Rule, as currently implemented and interpreted, and FinCEN's February 2026 exceptive relief.[46] Additionally, the impact analysis takes into account that covered financial institutions continue to be subject to, among other obligations, applicable AML/CFT program, customer identification, suspicious activity reporting, and recordkeeping requirements under the BSA. FinCEN further took into consideration that covered financial institutions' business practices may be subject to other regulatory standards and requirements that govern operating risks.[47]

Using this baseline, FinCEN does not expect the proposed rule to impose significant incremental costs because the primary change is to codify and make durable an existing form of relief, while clarifying that covered financial institutions may obtain additional information in risk-based circumstances. In the alternative, if the proposed rule were evaluated relative to the pre-relief requirement to identify and verify beneficial owners each time a legal entity customer opened a new account, the proposed rule would be expected to generate cost savings by eliminating duplicative beneficial ownership collection and verification at repeat account openings.

b. Baseline of Affected Parties

The primary affected parties of the proposed amendments are the covered financial institutions already subject to the CDD Rule and, indirectly, their current and prospective legal entity customers and beneficial owners. Because the proposal would not expand the definition of covered financial institution, legal entity customer, account, or beneficial owner, FinCEN does not expect the proposal to impose new compliance costs on any newly affected population. FinCEN encourages commenters who do not share this expectation to submit comments on the subject, ideally supported by specific information.

i. Covered Financial Institutions

The proposed rule would apply to all financial institutions currently subject to the CDD Rule: banks, brokers or dealers in securities (broker-dealers), mutual funds, and futures commission merchants (FCMs) and introducing brokers in commodities (IBCs). FinCEN estimates that there are approximately 14,554 potentially affected covered financial institutions, consisting of 8,988 banks; 3,277 brokers-dealers; 1,335 mutual funds; and 954 FCMs and IBCs.[48] While these estimates provide a useful reference point for the total population of financial institutions with CDD obligations, they do not identify how many covered financial institutions have legal entity customers that open more than one account with the same institution during a given period. As such, the estimates of expected affected covered financial institutions summarized in table 1 are provided for illustrative purposes only.

[45] *See* FinCEN, *Customer Due Diligence Requirements for Financial Institutions,* 81 FR at 29432–33; FinCEN, *Notice of Availability of Regulatory Impact Assessment and Initial Regulatory Flexibility Analysis Regarding the Customer Due Diligence Requirements for Financial Institutions,* 80 FR 80308 (Dec. 24, 2015).

[46] Covered financial institutions also currently have flexibility under the February 2026 exceptive relief order to identify and verify beneficial owners at the first account opening, when facts reasonably call previously obtained information into question, and as otherwise required by risk-based ongoing customer due diligence procedures.

[47] *See, e.g., Interagency Guidance on Lending to Individuals Not Legally Authorized to Work in the United States, supra* note 24.

[48] For a complete description of the sources of data and methodologies utilized to form these estimates, see the endnotes provided in table 1. As previously discussed, FinCEN has separately proposed to apply CDD Rule obligations to a proposed new type of regulated financial institution, PPSIs. *See supra* section II.E, note 28. Because that proposal is not yet finalized, meaning that PPSIs are not currently a covered financial institution, this analysis does not incorporate PPSIs. Notably, however, FinCEN has estimated that the number of PPSIs would be small. *See* OFAC and FinCEN, *Permitted Payment Stablecoin Issuer Anti-Money Laundering/Countering the Financing of Terrorism Program and Sanctions Compliance Program Requirements,* 91 FR at 18628 (estimating 50 PPSIs).

TABLE 1—ESTIMATES OF COVERED FINANCIAL INSTITUTIONS BY TYPE

Covered financial institution type [a]	Number of financial institutions
Banks with a Federal functional regulator [b]	[c] 8,623
Banks without a Federal functional regulator [d]	[e] 365
Broker-dealers [f]	[g] 3,277
Mutual funds [h]	[i] 1,335
FCMs and IBCs [j]	[k] 954
Total	14,554

[a] *See* 31 U.S.C. 5312(a)(2); *see also* 31 CFR 1010.100(t) (definition of financial institution).
[b] *See* 31 CFR 1010.100(t)(1); *see also* 31 CFR 1010.100(d), 31 CFR 1020.210(a).
[c] This includes 4,336 FDIC-insured depository institutions (*i.e.,* federally regulated banks) according to the FDIC's *Quarterly Bank Profile* for 2025 Q4, p. 2 (*https://www.fdic.gov/quarterly-banking-profile/past-quarterly-banking-profiles*). It also includes 4,287 NCUA-insured credit unions as of December 31, 2025, according to the NCUA's *Quarterly Credit Union Data Summary: 2025 Q4,* p. i (*https://ncua.gov/analysis/credit-union-corporate-call-report-data/quarterly-data-summary-reports*).
[d] *See* 31 CFR 1020.210(b).
[e] The Board of Governors of the Federal Reserve System Master Account and Services Database (*https://www.federalreserve.gov/paymentsystems/master-account-and-services-database-existing-access.htm*) contains data as of November 30, 2025, on financial institutions that use Federal Reserve Bank financial services, including those with no additional Federal regulator. FinCEN used this data to identify 365 banks and credit unions with no additional Federal regulator using Federal Reserve Bank financial services.
[f] *See* 31 U.S.C. 5312(a)(2)(G); *see also* 31 CFR 1010.100(t)(2).
[g] This estimate is based on U.S. Securities and Exchange Commission (SEC) data on active broker-dealers, *see Company Information About Active Broker-Dealers* (last updated Oct. 1, 2026), December 2025 Data table (*https://www.sec.gov/foia-services/frequently-requested-documents/company-information-about-active-broker-dealers*), which listed 3,277 active broker-dealers registered with the SEC as of December 31, 2025.
[h] *See* 31 U.S.C. 5312(a)(2)(I); *see also* 31 CFR 1010.100(t)(10) and 31 CFR 1010.100(gg).
[i] This estimate is based on the number of registered investment companies filing Form N–1A in SEC's *Annual Registered Investment Company Update: Form N–CEN Data, Period Ending December 2025* (May 2026), table 1.3, p. 4 (*https://www.sec.gov/files/annual-registered-investment-company-update-20260512.pdf*).
[j] *See* 31 U.S.C. 5312(a)(2)(H); *see also* 31 CFR 1010.100(t)(8–9).
[k] According to Commodity Futures Trading Commission data on FCMs, *see Financial Data for FCMs,* December 31, 2025 data, (*https://www.cftc.gov/MarketReports/financialfcmdata/index.htm*), there were 66 registered FCMs as of December 31, 2025. The number of IBCs as of December 31, 2025 (888) was obtained from the National Futures Association "NFA Membership and Registration" website (*https://www.nfa.futures.org/registration-membership/membership-and-directories.html*). Because deduplication of entities registered as both FCMs and IBCs was not feasible, this estimate may double-count some entities registered in both categories. FinCEN, however, believes this subpopulation may be small.

ii. Legal Entity Customers and Their Beneficial Owners

Legal entity customers and their beneficial owners are also affected because covered financial institutions obtain and verify beneficial ownership information when a legal entity customer first opens an account and, as applicable, when facts call prior information into question or risk-based procedures otherwise require it. FinCEN cannot estimate the total number of unique legal entity customers or beneficial owners that may be directly affected parties from the estimated 5,465,250 [49] annual responses projected using its historical methodology because that measure may include multiple responses for the same legal entity customer and information concerning multiple beneficial owners. Because the 1.5-account-per-day assumption that informed that estimate is based on limited information developed for the CDD Rule in 2016, and a 2024 banking-industry survey has since suggested that it may be low,[50] FinCEN considers 5,457,750 a rough estimate and requests comments that include current data on legal entity account openings, including variation by institution type and size.

c. Current Market Practices

Covered financial institutions currently use a range of processes to manage account-opening, customer due diligence, customer identification, and beneficial ownership information-related activities. These processes may be implemented through internal systems, third-party vendors, core processors, transfer agents, introducing and carrying broker relationships, or other operational arrangements, depending on the institution type and business model. Many covered financial institutions maintain customer or party master files and account master records that allow the institution to associate multiple accounts with the same legal entity customer. The degree of centralization, comingling of data and automation varies by institution size, product mix, and technology architecture.

FinCEN expects that covered financial institutions have already developed policies and procedures to obtain and verify beneficial ownership information for legal entity customers and to update customer information on a risk basis. FinCEN also expects that some covered financial institutions have revised or begun revising their procedures in response to the February 2026 exceptive relief. As a result, the proposed rule is expected to align the text of the CDD Rule with practices that many

[49] *See* FinCEN, *Customer Due Diligence Requirements for Financial Institutions Final Rule,* 81 FR at 29448 (explaining that FinCEN had no direct data on annual legal entity account openings by small financial institutions and that the estimate, based in part on information from one very large financial institution, assumed small institutions would open at most 1.5 such accounts per day, and probably fewer); *see also* FinCEN, *Agency Information Collection Activities; Proposed Renewal; Comment Request; Renewal Without Change of the Beneficial Ownership Requirements for Legal Entity Customers,* 84 FR 72137, 72138 n.9 (Dec. 30, 2019); FinCEN, *Agency Information Collection Activities; Proposed Renewal; Comment Request; Renewal Without Change of the Beneficial Ownership Requirements for Legal Entity Customers,* 89 FR 14148, 14149 n.16 (Feb. 26, 2024) (applying an average of 1.5 new legal entity accounts per business day to all covered financial institutions). Applying that rate to the 14,554 covered financial institutions identified in Table 1 and 250 business days yields 5,457,750 legal entity customer accounts opened per year (14,554 × 1.5 × 250). Industry comments suggest the estimate may be low, at least for banks.

[50] *See* American Bankers Association, *Letter to FinCEN on CDD PRA Rule,* Docket No. FINCEN–2024–0008, OMB Control No. 1506–0070, at 5 (Apr. 26, 2024) (reporting that 92 percent of 141 surveyed banks disagreed with the 1.5-account estimate and that 94 percent of those respondents characterized it as ''very low''), *https://www.aba.com/-/media/documents/comment-letter/clfincencdd20240426.pdf?rev=07c23ff3932e4fe5a5f3f7033bb57344.*

institutions may already have adopted or planned to adopt.

3. Description of Proposed Regulation

For purposes of the RIA, FinCEN considered the various components of the proposed rule with a view towards the specific features or elements that may generate, either directly or indirectly, an economic benefit or cost or lead to changes in a market participant's incentives in a way that may generate economic benefits or costs.[51] To balance the completeness of the RIA with the desire for expositional clarity and ease of tractability between the proposed regulatory text and sections IV (Section-by-Section Analysis) and IX (Regulatory Impact Analysis), FinCEN has included table2, to provide a mapping of the various components of the proposed rulemaking as presented in sectionIV to their analogous categorization in the RIA.

TABLE 2—OVERVIEW/MAPPING OF THE PROPOSED RULE

Elements of the proposed rule	Section IV analysis	Discussed in RIA subsection(s)	Proposed regulatory text location
Revise the general requirement to clarify that covered financial institutions must establish and maintain written procedures reasonably designed to identify and verify the identity of beneficial owners of legal entity customers, and include such procedures in their AML/CFT programs.	IV.A	IX.A.3	1010.230(a).
Add ''countering the financing of terrorism'' to the reference to anti-money laundering compliance programs.	IV.A	IX.A.3	1010.230(a).
Replace the current requirement to identify and verify beneficial owners at each new account opening with a timing framework requiring identification and verification: (1) when the legal entity customer first opens an account with the covered financial institution; (2) when the institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer; and (3) as needed based on risk-based procedures for conducting ongoing customer due diligence.	IV.B.1	IX.A.1, IX.A.3, IX.A.4.a, IX.A.4.b, IX.C, IX.E.	1010.230(b)(1)(i).
Specify the minimum information that a covered financial institution must obtain about each beneficial owner, including name, date of birth, address, and an identifying number, unless risk-based procedures warrant obtaining more information.	IV.B.2	IX.A.3, IX.A.4.a, IX.A.4.b, IX.E.	1010.230(b)(1)(ii)(A)–(D)
Clarify that, for a U.S. person beneficial owner, the required identifying number is a Social Security number, and that for U.S. and non-U.S. persons, an ITIN is not an acceptable substitute for a Social Security number.	IV.B.2	IX.A.3, IX.A.4.a, IX.A.4.b, IX.E.	1010.230(b)(1)(ii)(D)
Clarify that, where warranted by other risk indicators or supervisory concerns, a covered financial institution may obtain additional information necessary to mitigate indicated risk or address supervisory concerns, including when relevant to assessing risks associated with fraud, identity misrepresentation, sanctions evasion, or other illicit financial activity, information relevant to lawful immigration status and employment authorization in the United States.	IV.B.2	IX.A.1, IX.A.3, IX.A.4.a, IX.A.4.b, IX.E.	1010.230(b)(1)(ii)
Permit covered financial institutions to obtain required beneficial ownership information from a third-party source, subject to compliance with the certification requirement.	IV.B.3	IX.A.1, IX.A.3, IX.A.4.a, IX.A.4.b, IX.E.	1010.230(b)(1)(iii)
Require a covered financial institution, when obtaining beneficial ownership information at the first account opening, to obtain a certification from the individual opening the account on behalf of the legal entity customer that the information obtained is accurate to the best of that individual's knowledge; retain use of the standardized certification form as optional.	IV.B.4	IX.A.3, IX.A.4.a, IX.A.4.b, IX.E.	1010.230(b)(1)(iv)(A)
Permit a covered financial institution, when obtaining beneficial ownership information as needed based on risk-based ongoing CDD procedures, to rely on information previously obtained from a certification provided at the first account opening, provided that a representative of the legal entity customer gives oral or written confirmation that the information is up to date and accurate to the best of the individual's knowledge.	IV.B.4	IX.A.1, IX.A.3, IX.A.4.a, IX.A.4.b, IX.E.	1010.230(b)(1)(iv)(B)
Clarify the verification cross-reference to the applicable CIP rules so that covered financial institutions must use verification procedures containing the elements required for verifying the identity of individual customers, while avoiding ambiguity that the CIP information-collection list governs beneficial ownership information collection under the CDD Rule.	IV.B.5	IX.A.3, IX.A.4.b	1010.230(b)(2)
Retain the provision allowing a covered financial institution to rely on information supplied by the legal entity customer regarding the identity of its beneficial owner or owners, provided that the institution has no knowledge of facts that would reasonably call into question the reliability of such information.	IV.B.5	IX.A.3	1010.230(b)(2)

4. Anticipated Economic Effects

a. Expected Benefits

FinCEN expects the proposed rule to produce several categories of benefits. First, codifying the relief from beneficial ownership identification and verification at every repeat account opening should reduce duplicative compliance activity. Covered financial institutions would be able to rely on beneficial ownership information obtained at the first account opening unless facts reasonably call the reliability of that information into question or risk-based procedures otherwise require additional or updated information. This should reduce repetitive customer outreach, duplicative collection of identification information, and associated account-opening delays.

Second, the proposed rule should improve regulatory clarity. Codifying the February 2026 exceptive relief in the CDD Rule would reduce uncertainty about the continued availability and operation of that relief and would allow covered financial institutions to design policies, procedures, systems, and training around the text of the regulation. Clearer regulatory text may also promote more consistent supervisory expectations across covered financial institutions and functional regulators, possibly reducing examination costs.

Third, the proposal should better align the CDD Rule with a risk-based

[51] *See infra* section IX.A.4.

approach to AML/CFT compliance. The proposal would preserve the ability, and where applicable the obligation, of covered financial institutions to update or obtain additional information when facts call previously obtained beneficial ownership information into question or when risk-based procedures indicate that additional or updated information is appropriate. At the same time, the proposal would avoid requiring covered financial institutions to repeat the same identification and verification steps at every account opening without regard to risk or whether the institution already has reliable information about the legal entity customer.

Fourth, the proposed clarification concerning additional information in heightened-risk or supervisory-concern circumstances may help covered financial institutions resolve material compliance concerns involving fraud, identity misrepresentation, sanctions evasion, or other illicit financial activity. By clarifying that covered financial institutions may obtain additional information where warranted by risk indicators or supervisory concerns, the proposal may support more effective risk assessment while avoiding a categorical, one-size-fits-all requirement.

FinCEN has not quantified these benefits at this stage because public data are limited regarding the number of repeat account openings by the same legal entity customer at the same covered financial institution and regarding the degree to which institutions have already implemented the February 2026 exceptive relief.

b. Expected Costs

FinCEN does not expect the proposed rule to impose significant economic costs. The proposal would not impose a new obligation to file reports with FinCEN, would not require covered financial institutions to retain a new category of records, would not expand the population of covered financial institutions, and would not impose a new mandatory customer due diligence procedure for all accounts or all customers.

Covered financial institutions may incur limited one-time costs to review the final rule and revise policies, procedures, forms, account-opening workflows, monitoring processes, or training materials. FinCEN expects these costs to be small because covered financial institutions already maintain CDD policies and procedures and because the proposed rule generally aligns with existing exceptive relief and ordinary-course risk-based due diligence practices. To the extent an institution has already implemented the February 2026 exceptive relief, any incremental implementation cost attributable to this proposal should be further reduced.

FinCEN does not expect that its specification of information covered financial institutions must collect and exclusion of ITINs will impose significant costs. FinCEN believes its proposed regulatory text largely aligns with current practices, though some institutions may incur limited one-time costs to review the final rule and revise policies, procedures, forms, account-opening workflows, monitoring processes, or training materials accordingly.

FinCEN does not expect the proposed clarification regarding additional information in heightened-risk circumstances to require covered financial institutions to collect additional information in every case. The proposed language would clarify that an institution may consider obtaining additional information where warranted by risk indicators or supervisory concerns and where the information is relevant to resolving material compliance concerns. FinCEN does not expect this clarification to result in significant recurring costs.

FinCEN also does not expect the proposed rule to have significant adverse effects on competition, innovation, access to financial services, or market structure. By reducing duplicative collection and verification requirements, the proposal may reduce account-opening friction for legal entity customers, including small businesses.

5. Consideration of Alternatives

In developing the proposed rule, FinCEN considered several policy alternatives, including alternatives specifically tailored to accommodate small entities that may otherwise be disproportionately burdened by regulatory compliance. FinCEN invites comment on these alternatives, and on any other alternatives that were not considered here but could reasonably be expected to accomplish the same policy objectives with equal or greater efficiency.

a. Alternative 1: Strictly Risk-Based Information Collection

First, FinCEN considered adopting an entirely risk-based approach to the determination of the types of information that covered financial institutions would have to collect in order to identify and verify the identity of beneficial owners of legal entity customers.[52] In contrast to the proposed rule, the alternative considered would eliminate the proposed list of required information and instead grant covered financial institutions complete discretion to determine what information to obtain from a beneficial owner of a legal entity customer, based upon the institution's own risk-based analysis.

FinCEN believes that the proposed rule, which specifies certain information that a covered financial institution must collect, appropriately acknowledges a continuing need for a minimum standard, supplemented, rather than replaced, by tailoring based on risk. FinCEN is concerned that declining to set a minimum requirement for information to be collected across covered financial institutions would make it easier for illicit actors to enter into the financial system by persuading covered financial institutions that they are low-risk customers and therefore should not provide much, if any, identifying information, or by targeting covered financial institutions with less comprehensive CDD programs or less sophisticated risk-analysis capabilities. In return for focusing on heightened risks, the financial services industry as a whole might obtain some regulatory relief, but in FinCEN's judgment not significantly more than the proposal itself provides. Accordingly, FinCEN has opted against this alternative. This alternative could reduce compliance costs for some covered financial institutions by allowing them to collect less information for beneficial owners they determine to present lower risk. The cost savings would likely arise from reduced customer outreach, fewer information fields collected, and potentially shorter account-opening processes in low-risk cases. The magnitude of those savings, however, is uncertain and may be limited because the proposed rule already reduces duplicative compliance activity by eliminating repeated beneficial ownership identification and

[52] The proposed rule sets out a discrete list of information that a covered financial institution must obtain about each beneficial owner of a legal entity customer: name; date of birth; residential or business street address, or if the beneficial owner does not have a residential or business street address an Army Post Office (APO) or Fleet Post Office (FPO) box number, or the residential or business street address of next of kin or of another contact individual; and (1) for a U.S. person, a Social Security number (not including an ITIN), or (2) for a non-U.S. person, (a) a Social Security number (not including an ITIN); (b), a passport number and country of issuance; (c) an alien identification card number; or (d) a number and country of issuance of any other government-issued document evidencing nationality or residence and bearing a photograph or similar safeguard.

verification at repeat account openings unless facts or risk-based procedures call for updated information. The proposed rule also already permits covered financial institutions to obtain additional information only where warranted by risk indicators or supervisory concerns, rather than imposing a categorical obligation to collect additional information in every case.

This alternative would also likely provide greater discretion and potentially greater burden reduction in some low-risk circumstances, but at the cost of reduced uniformity, less regulatory certainty, and potentially weaker beneficial ownership transparency. This trade-off may be particularly important for smaller or less technologically sophisticated covered financial institutions. Although the alternative could appear less burdensome because it would allow such institutions to collect less information in some cases, it could also require them to make and document more case-specific judgments about what information is sufficient to identify and verify beneficial owners. That added discretion could increase uncertainty, training needs, supervisory risk, and inconsistency in implementation.

FinCEN therefore expects that the proposed rule would better balance costs and benefits. Compared with the alternative, the proposed rule is expected to preserve more of the AML/CFT, countering fraud, countering sanctions-evasion, and countering illicit-finance benefits associated with a uniform beneficial ownership identification baseline, while still reducing burden through relief from duplicative collection at repeat account openings, greater flexibility to use third-party sources, and risk-based authority to obtain additional information when warranted. Accordingly, FinCEN preliminarily assesses that the alternative would likely provide, at most, modest additional compliance cost savings relative to the proposal, while presenting greater risks to regulatory consistency and the effectiveness of customer due diligence.

b. Alternative 2: Additional Data Collection Requirements

FinCEN separately considered a version of the proposed rule that would have required covered financial institutions to collect additional information beyond what this proposal would require by expanding the list of information an institution must obtain about each beneficial owner of a legal entity customer beyond the beneficial owner's name, date of birth, address, and qualifying identifying number. The goal of such an enhanced data collection requirement would be to reduce uncertainty about whether the information that a covered financial institution can be relied upon to collect will be sufficient to perform a meaningful analysis of beneficial ownership-related risks.

FinCEN believes that such an approach would be overly prescriptive and inconsistent with the aim of Executive Order 14406 to improve the risk-based nature of the CDD Rule by allowing financial institutions to focus on higher-risk customers, including those that present risks related to illicit finance, sanctions evasion, fraud, and other unlawful activity. FinCEN believes that the proposed rule would ensure that covered financial institutions collect sufficient information concerning the beneficial owners of their legal entity customers, while providing the necessary flexibility for a covered financial institution to collect additional information for specific beneficial owners where such collection is warranted by risk. The small benefit in terms of increased regulatory certainty that the alternative would achieve would come at significant cost to covered financial institutions. Thus, FinCEN rejected this alternative approach.

This alternative would likely produce greater regulatory certainty than the proposed rule by specifying additional information that covered financial institutions must obtain from each beneficial owner of a legal entity customer. A more prescriptive information-collection requirement could reduce ambiguity about whether an institution has collected enough information to conduct a meaningful beneficial ownership risk assessment and could promote more uniform practices across covered financial institutions.

However, relative to the proposed rule, this alternative would likely impose materially greater costs, by requiring additional information in all cases, including for legal entity customers and beneficial owners that present lower risk and for whom the additional information may have limited marginal value. The principal costs of this alternative would likely include increased customer outreach, longer account-opening processes, additional form and system changes, additional training, and greater compliance and quality-control burdens. These costs would be recurring because institutions would have to collect any additional information for each covered beneficial owner whenever beneficial ownership information is required. The alternative could also increase burden on legal entity customers and beneficial owners by requiring them to provide additional information even when no risk-based factor suggests that the information is needed.

FinCEN preliminarily assesses that the proposed rule better balances costs and benefits. Compared with the alternative, the proposed rule preserves a clear minimum standard, maintains flexibility to collect additional information in higher-risk circumstances, and avoids imposing additional recurring burden on all covered financial institutions, legal entity customers, and beneficial owners.

c. Alternative 3: Delayed Effective Date for Small Financial Institutions

FinCEN separately and additionally considered modifying the proposed rule to provide a delayed effective date for small financial institutions as defined by the RFA, as a way of minimizing costs to small businesses. However, FinCEN does not believe that implementation of the proposed rule would impose a significant burden on small financial institutions, as much of the proposal is permissive rather than prescriptive or captures existing industry practices. Additionally, FinCEN is mindful that by introducing a staggered effective date by financial institution size, this may inadvertently create confusion or unequal burdens for the small businesses that are the legal entity customers of covered financial institutions by causing them to face different standards of information provision based on the size of the institutions where they maintain an account. Accordingly, FinCEN has opted against this alternative.

This alternative could reduce near-term implementation burden for small covered financial institutions by giving them additional time to review the final rule and make any needed updates to policies, procedures, forms, workflows, systems, or training materials. A delayed effective date could be most useful in providing additional time for small institutions with less automated account-opening systems, fewer compliance personnel, or greater reliance on third-party vendors or core processors whose services might be more difficult to obtain or more expensive for small financial institutions if required to compete with larger institutions in the run-up to a universal, industry-wide effective date.

FinCEN expects, however, that the incremental benefit of this alternative

would be limited. The proposed rule is not expected to impose significant costs because it would not expand the population of covered financial institutions, legal entity customers, accounts, or beneficial owners, and would not impose new mandatory reporting, recordkeeping, or customer information collection requirements. A delayed effective date for small financial institutions would also delay the benefits of regulatory clarity and burden reduction for those institutions.

FinCEN preliminarily assesses that the proposed rule better balances costs and benefits. A delayed effective date for small financial institutions could provide some additional implementation flexibility, but the likely cost savings would be modest because the proposal is expected to reduce, rather than increase, recurring beneficial ownership collection and verification obligations. The proposed rule also aligns with practices that at least some institutions have already revised or begun revising in response to the February 2026 exceptive relief.

B. Executive Orders 12866, 13563, and 14192

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, to the extent permitted by law, to select regulatory approaches that maximize net benefits, including potential economic, environmental, public health and safety, distributive, and equity effects. Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility.

FinCEN has considered the expected costs and benefits of the proposed rule and does not anticipate that it would introduce an effect of $100 million or more on the economy in a given year. Notwithstanding a lack of expected economic significance under section 3(f)(1) of Executive Order 12866, the proposed rule has been reviewed by the Office of Management and Budget (OMB) and found to otherwise meet the criteria for a significant regulatory action under section 3(f) of Executive Order 12866. Accordingly, FinCEN has conducted the requisite regulatory impact analysis and included a summary thereof in section IX.A.

FinCEN expects that this action, when finalized, would be an Executive Order 14192 deregulatory action because it is expected to reduce compliance burden and to have total costs less than zero. The proposal would codify relief from duplicative beneficial ownership identification and verification at repeat account openings and would not impose a new mandatory reporting, recordkeeping, or customer information collection requirement.

C. Regulatory Flexibility Act

The RFA requires an agency either to provide an initial regulatory flexibility analysis with a proposed rule or to certify that the proposed rule, if promulgated, would not have a significant economic impact on a substantial number of small entities. The proposed rule would apply to covered financial institutions, some of which are small entities. However, the proposal would not expand the categories of covered financial institutions, would not impose a new reporting or recordkeeping requirement, and would not require covered financial institutions to collect additional information in all cases.

FinCEN expects that any one-time costs for small covered financial institutions would be limited to ordinary-course review of the final rule and conforming updates to policies, procedures, forms, training, or workflows. FinCEN expects those costs to be small because small covered financial institutions already maintain CDD procedures and because the proposal is expected to reduce rather than increase recurring beneficial ownership collection and verification obligations for repeat account openings. Accordingly, FinCEN certifies that the proposed rule, if finalized, would not have a significant economic impact on a substantial number of small entities.

D. Unfunded Mandates Reform Act

Section 202 of the UMRA,[53] Public Law 104–4, requires that an agency prepare a budgetary impact statement before promulgating a rule that may result in new, incremental expenditures by State, local, and Tribal governments, in the aggregate, or by the private sector, of $193 million or more in any one year ($100 million in 1995, adjusted for inflation).[54] If a budgetary impact statement is required, section 202 of the UMRA also requires an agency to identify and consider a reasonable number of regulatory alternatives before promulgating a rule. FinCEN has determined that this rule will not result in increased expenditures by State, local, and Tribal governments, or by the private sector, of $193 million or more. Accordingly, FinCEN has not prepared a budgetary impact statement.

E. Paperwork Reduction Act

Under the PRA, 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 OMB. Written comments and recommendations for the proposed information collection can be submitted by visiting *https://www.reginfo.gov/public/do/PRAMain*. Find this particular document by selecting ''Currently Under Review—Open for Public Comments'' or by using the search function. Comments are welcome and must be received by January 19, 2027.

In accordance with requirements of the PRA, 44 U.S.C. 3506(c)(2)(A), and its implementing regulations, 5 CFR part 1320, the following information concerns the collection of information as it relates to the amendments to covered financial institutions' AML/CFT program regulations.

1. Description of Affected Financial Institutions and OMB Control Numbers

OMB Control Number(s): 1506–0020, 1506–0035, 1506–0081, 1506–0088, and 1506–0070.

The proposed amendments, if adopted, may affect covered financial institutions' recordkeeping activities, and as a result, burdens incurred. To the extent that covered financial institutions' CDD-related recordkeeping burdens are currently accounted for under FinCEN OMB control numbers, they have been so primarily under OMB control number 1506–0070,[55] with additional components currently accounted for under 1506–0081 (applicable to Investment Advisers)[56] or under proposal to be accounted for under OMB control numbers 1506–0020 (Mutual Funds), 1506–0035 (Banks Without a Federal Functional Regulator), and 1506–0088 (PPSIs).[57]

[53] 2 U.S.C. 1532.

[54] The U.S. Bureau of Economic Analysis reports the annual value of the gross domestic product implicit price deflator for calendar year 1995 (the year UMRA was enacted) as 66.939, and as 128.974 for calendar year 2025 (the most recent available). Thus, the inflation-adjusted estimate for $100 million is 128.974 ÷ 66.939 × $100 million, or $192.7 million. *See* U.S. Bureau of Economic Analysis, Table 1.1.9. Implicit Price Deflators for Gross Domestic Product, BEA Interactive Data Application.

[55] *See* FinCEN, *Agency Information Collection Activities; Proposed Renewal; Comment Request; Renewal Without Change of the Beneficial Ownership Requirements for Legal Entity Customers,* 89 FR 14148 (Feb. 26, 2024).

[56] *See* FinCEN, *Financial Crimes Enforcement Network: Anti-Money Laundering/Countering the Financing of Terrorism Program and Suspicious Activity Report Filing Requirements for Registered Investment Advisers and Exempt Reporting Advisers,* 89 FR 72156, 72261–64 (Sept. 4, 2024).

[57] *See* FinCEN, *Anti-Money Laundering and Countering the Financing of Terrorism Programs,* 91 FR at 18746–50. As proposed, a covered financial

2. Estimated Annual Burden

The PRA requires that agencies consider the impact of paperwork and other information collection burdens imposed on the public. FinCEN does not estimate any incremental burden under the PRA associated with this proposed rule because the proposal would not impose any new reporting, recordkeeping, or third-party disclosure requirement. The proposal would codify existing relief from the requirement to identify and verify beneficial owners at each repeat account opening and would clarify that covered financial institutions may obtain additional information in heightened-risk circumstances where warranted by risk indicators or supervisory concerns. The decision by a covered financial institution to obtain additional information in a particular case would depend on its own risk-based assessment and the need to resolve a material compliance concern. FinCEN requests comment on whether the proposed rule could reasonably be expected to introduce incremental PRA effects that should be identified and included in this burden analysis.

3. General Request for Comments Under the PRA

Comments submitted in response to this proposed rule will be summarized and included in a request for OMB approval. All comments will become a matter of public record. FinCEN invites comments on: (1) whether the collection of information is necessary for the proper performance of FinCEN's mission, including whether the information shall have practical utility; (2) the accuracy of FinCEN's estimate of the burden of the collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; (4) ways to minimize the burden of the collection of information on reporting persons, including through the use of technology; and (5) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services required to provide information.

institution would be required to establish and maintain a written AML/CFT program that includes: ''appropriate risk-based procedures for conducting ongoing customer due diligence, to include, but not be limited to: understanding the nature and purpose of customer relationships for the purpose of developing a customer risk profile.'' *Id.; see also* OFAC and FinCEN, *Permitted Payment Stablecoin Issuer Anti-Money Laundering/ Countering the Financing of Terrorism Program and Sanctions Compliance Program Requirements,* 91 FR 18582.

F. Additional Requests for Comment

1. FinCEN requests comment on the appropriate baseline and on any data that would help quantify cost savings relative to either baseline.

2. FinCEN requests comment on current practices, including the extent to which covered financial institutions have already adjusted procedures, forms, systems, training, or quality-control processes in response to the February 2026 exceptive relief.

3. FinCEN requests data on the distribution of accounts per legal entity customer, the annual number of repeat account openings by legal entity customers, the time required to collect and verify beneficial ownership information at repeat account openings, and the extent of any implementation costs or savings associated with the proposed rule.

4. FinCEN requests comment on whether the proposed clarification could cause covered financial institutions to change policies, procedures, training, systems, or customer-facing practices in ways that would generate incremental costs not identified here.

5. FinCEN requests comment on any potential distributional effects, including whether the proposal would have different effects across banks, brokers or dealers in securities, mutual funds, futures commission merchants, and introducing brokers in commodities, or across small and large covered financial institutions.

6. FinCEN requests comment on the expected cost savings and any potential costs associated with implementing the proposed rule.

7. FinCEN invites comment from small entities on all aspects of its certification pursuant to RFA requirements that the proposed rule is not expected to have a significant economic impact on a substantial number of small entities, including any data on implementation costs, cost savings, or operational effects.

8. FinCEN requests comment on the extent of any one-time implementation costs and on whether such costs vary materially by institution type or size.

9. FinCEN requests data on the distribution of accounts per legal entity customer, the annual number of repeat account openings by legal entity customers, the time required to collect and verify beneficial ownership information at repeat account openings, and the extent of any implementation costs or savings associated with the proposed rule.

List of Subjects in 31 CFR Part 1010

Administrative practice and procedure, Aliens, Authority delegations (Government agencies), Banks, Banking, Brokers, Business and industry, Citizenship and naturalization, Commodity futures, Crime, Currency, Electronic filing, Federal savings associations, Federal-State relations, Fiduciaries, Foreign banking, Foreign currencies, Foreign persons, Gambling, Holding companies, Indians, Indians—law, Indians—tribal government, Insurance companies, Investigations, Investment companies, Law enforcement, Penalties, Reporting and recordkeeping requirements, Savings associations, Securities, Small business, Terrorism, Time.

Amendment to FinCEN Regulations

For the reasons discussed in the preamble, the Financial Crimes Enforcement Network proposes to amend 31 CFR part 1010 as follows.

PART 1010—GENERAL PROVISIONS

■ 1. The authority citation for part 1010 continues to read as follows:

Authority: 12 U.S.C. 1829b and 1951–1959; 31 U.S.C. 5311–5314 and 5316–5336; title III, sec. 314, Pub. L. 107–56, 115 Stat. 307; sec. 2006, Pub. L. 114–41, 129 Stat. 457; sec. 701 Pub. L. 114–74, 129 Stat. 599; sec. 6403, Pub. L. 116–283, 134 Stat. 3388.

■ 2. Section 1010.230 is amended by:
■ a. Revising paragraph (a) to read as follows:

(a) *In general.* Covered financial institutions are required to establish and maintain written procedures that are reasonably designed to identify and verify the identity of beneficial owners of legal entity customers and to include such procedures in their anti-money laundering/countering the financing of terrorism program required under 31 U.S.C. 5318(h) and its implementing regulations.
■ b. Revising paragraph (b) to read as follows:

(b) *Identification and verification.* With respect to legal entity customers, the covered financial institution's customer due diligence procedures shall enable the institution to:

(1) Identify the beneficial owner(s) of each legal entity customer, unless the customer is otherwise excluded pursuant to paragraph (e) of this section or the account is exempted pursuant to paragraph (h) of this section.

(i) *Timing.* A covered financial institution must identify the beneficial owner(s) of a legal entity customer:

(A) when the legal entity customer first opens an account with the covered financial institution;

(B) any time thereafter when the covered financial institution has knowledge of facts that would reasonably call into question the reliability of beneficial ownership information previously obtained about the legal entity customer; and

(C) as needed based on a covered financial institution's risk-based procedures for conducting ongoing customer due diligence.

(ii) *Information necessary for identification and verification of identity.* A covered financial institution must obtain information about each beneficial owner sufficient to allow the covered financial institution to identify, and to verify the identity of, the beneficial owner. The financial institution must obtain, at minimum, the information described in paragraph (b)(1)(ii)(A)–(D) about each beneficial owner, and may obtain additional information as described in paragraph (b)(1)(ii)(E):

(A) name;

(B) date of birth;

(C) residential or business street address, or if the beneficial owner does not have a residential or business street address an Army Post Office (APO) or Fleet Post Office (FPO) box number, or the residential or business street address of next of kin or of another contact individual; and (D) (*1*) for a U.S. person, a Social Security number (not including an Individual Taxpayer Identification Number), or (*2*) for a non-U.S. person, (*i*) a Social Security number (not including an Individual Taxpayer Identification Number); (*ii*) a passport number and country of issuance; (*iii*) an alien identification card number; or (*iv*) a number and country of issuance of any other government issued document evidencing nationality or residence and bearing a photograph or similar safeguard.

(E) Where warranted by other risk indicators or supervisory concerns, including but not limited to indicators of risks associated with fraud, identity misrepresentation, sanctions evasion, or other illicit financial activity, the covered financial institution may obtain additional information useful in mitigating risk or addressing supervisory concerns, including but not limited to information relevant to lawful immigration status and employment authorization in the United States.

(iii) *Sources of Information.* Subject to compliance with the certification requirement in paragraph (b)(1)(iv) of this section, a covered financial institution may obtain any information described in paragraph (b)(1)(ii) of this section by acquiring it from a third-party source.

(iv) *Certification.*

(A) When obtaining information at a time described in paragraph (b)(1)(i)(A) of this section, a covered financial institution must obtain a certification from the individual opening the account on behalf of the legal entity customer that the information obtained is accurate to the best of the individual's knowledge. This certification may, but is not required to, take the form of the certification in Appendix A of this section.

(B) When obtaining information at a time described in paragraph (b)(1)(i)(C) of this section, a covered financial institution may rely on information to which a certification provided in connection with obtaining information at a time described in paragraph (b)(1)(i)(A) of this section applies, provided that a representative of the legal entity customer provides oral or written confirmation that such information is up to date and accurate to the best of the individual's knowledge. Written confirmation may, but is not required to, take the form of the certification in Appendix A of this section.

(2) Verify the identity of each beneficial owner identified to the covered financial institution, according to risk-based procedures, to the extent reasonable and practicable. At a minimum, these procedures must require collection of information specified in paragraph (b)(1)(ii) and contain the elements required for verifying the identity of customers that are individuals under § 1020.220(a)(2), other than § 1020.220(a)(2)(i), of this chapter (for banks); § 1023.220(a)(2), other than § 1023.220(a)(2)(i), of this chapter (for brokers or dealers in securities); § 1024.220(a)(2), other than § 1024.220(a)(2)(i), of this chapter (for mutual funds); or § 1026.220(a)(2), other than § 1026.220(a)(2)(i), of this chapter (for futures commission merchants or introducing brokers in commodities); provided, that in the case of documentary verification, the financial institution may use photocopies or other reproductions of the documents listed in paragraph (a)(2)(ii)(A)(*1*) of § 1020.220 of this chapter (for banks); § 1023.220 of this chapter (for brokers or dealers in securities); § 1024.220 of this chapter (for mutual funds); or § 1026.220 of this chapter (for futures commission merchants or introducing brokers in commodities). A covered financial institution may rely on the information supplied by the legal entity customer regarding the identity of its beneficial owner or owners, provided that it has no knowledge of facts that would reasonably call into question the reliability of such information.

Jenna H. Casanova,

Acting Director, Financial Crimes Enforcement Network.

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 21

[Docket No. VA–2026–VBA–0463]

RIN 2900–AS94

Veteran Readiness and Employment Program: Update to Reduced Work Tolerance and Basic Eligibility Period

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend the Veteran Readiness and Employment (VR&E) regulations to align with current practice and statute. The rule would expand the list of approved providers for reduced work tolerance (RWT) documentation, allowing for more accurate and timely processing by a Vocational Rehabilitation Counselor (VRC). VA also proposes to clarify that a veteran who is subject to a basic period of eligibility would receive a new 12-year period of eligibility if such veteran obtains a compensable service-connected disability rating based on a subsequent period of active-duty service. Finally, the rule would remove the eligibility termination date for veterans discharged on or after January 1, 2013, consistent with the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020.

DATES: Comments must be received by January 19, 2027.

ADDRESSES: You may submit comments through *www.regulations.gov* under RIN 2900–AS94. That website includes a plain-language summary of this rulemaking. Comments will be posted for viewing by the public on *www.regulations.gov,* including any personally identifiable information (*e.g.,* a social security number or address) within a comment and its supporting materials. However, VA retains discretion to redact personal or sensitive information, including but not limited to personal or sensitive information pertaining to third parties. Additionally, VA will not post public comments that make threats to individuals or institutions or suggest that the

commenter will take actions to harm an individual. Instructions for accessing agency documents, submitting comments, and viewing the rulemaking docket, are available on *www.regulations.gov* under ''FAQ.'' Any public comment received after the comment period's closing date is considered late and will not be considered in the final rulemaking.

FOR FURTHER INFORMATION CONTACT: Kathryn Upham, Policy Analyst, Veterans Benefits Administration, (202) 461–9600.

SUPPLEMENTARY INFORMATION:

Reduced Work Tolerance

In accordance with 38 U.S.C. 3100, the purpose of the Chapter 31 VR&E program is to provide for all services and assistance necessary to enable veterans with one or more compensable service-connected disabilities to achieve maximum independence in daily living and, to the maximum extent possible, to become employable and to obtain and maintain suitable employment.

In some instances, a veteran's functional limitations, as a result of his or her disability(ies), impact his or her ability to participate in a rehabilitation program on a full-time basis. VA may approve a veteran for RWT following documentation from an approved medical provider. VA considers a veteran with an RWT to be pursuing his or her rehabilitation program full time when he or she is devoting as much time to the program as the effects of his or her disability(ies) permit. This allows VA, under certain circumstances, to pay the veteran a subsistence allowance at the full-time rate for the type of program being pursued when he or she meets the standard for full-time pursuit, *i.e.,* the rate of pursuit that VA considers to be equivalent to full-time pursuit, established for the veteran in his or her rehabilitation plan.

Section 21.312(e) of title 38 Code of Federal Regulations, currently requires a VA physician to make the RWT determination or redetermination. However, because an RWT determination or redetermination is an appealable benefits determination that is based on the evidence of record, VA proposes to revise the regulation to require a VRC to make the final determination or redetermination of RWT and to document such determination in the case file.

VA also proposes to amend 38 CFR 21.312(e) to allow for documentation to support an RWT to be provided by a veteran's medical provider rather than being limited to a VA physician. The documentation is necessary for a VRC to determine the veteran's ability to pursue a rehabilitation program under the VR&E program and to specify the rate of pursuit that VA will consider to be equivalent to full-time pursuit, so that the veteran may participate in a program of rehabilitation and receive a subsistence allowance at the full-time rate. Expanding the list of approved medical providers to those who have knowledge of the veteran's disability conditions would allow a VRC to make a more accurate and timely RWT determination or redetermination that is consistent with the veteran's regular care.

Furthermore, VA seeks to clarify in proposed § 21.312(f) that a veteran generally may not be approved for RWT and also be employed, to include participating in work study, because it would further reduce the veteran's ability to fully participate in a program of rehabilitation. RWT is developed relative to the current impact of the veteran's disabilities and the amount of time the veteran needs to spend treating their disabilities. However, if a veteran accepts employment while receiving RWT, he or she may maintain the RWT rate until the end of the semester or term.

Finally, approval for an RWT redetermination under § 21.312(c) would be contingent on the veteran's documented cooperation and participation in line with his or her medical treatment plan and on his or her ability to participate in a rehabilitation plan. A feasibility determination would be required with each yearly evaluation. This is to ensure the veteran continues to benefit from, and is in need of, RWT. The RWT program is not intended for the life of the case, but only until such a time as when the veteran establishes enough stability in his or her condition to return to the normal rate of pursuit approved by his or her VRC or case manager, as established under 38 CFR 21.310.

VA also proposes to amend § 21.312(d) to remove the outdated reference to electing benefits at the Chapter 34 rate. Chapter 34 benefits are not payable beyond December 31, 1989, and any previous election of benefits at the Chapter 34 rate terminated as of that date. 38 U.S.C. 3462(e); 38 CFR 21.334(e). VA also proposes grammatical updates to § 21.312.

Basic Period of Eligibility

Under 38 U.S.C. 3103(a), (b)(3), and (g), VA generally may not provide a Chapter 31 rehabilitation program to a veteran after the end of the 12-year period beginning on the date of the veteran's discharge or release from active military, naval, air, or space service or the date the veteran receives a compensable service-connected disability rating, whichever is later, if the discharge occurred before January 1, 2013. VA implemented section 3103(a) in 38 CFR 21.41(a) by referring to the 12-year period as beginning on the date of the veteran's discharge or release from his or her ''last'' period of service, which is calculated at the time of the veteran's initial application for Chapter 31 benefits. Based on VA's interpretation of 38 U.S.C. 3102 and 3103(a), VA proposes adding § 21.41(d) to establish a new 12-year period of eligibility for a veteran who is subject to a basic period of eligibility and who has a subsequent period of service that independently gives rise to a new qualifying disability for Chapter 31 benefits.

Under 38 U.S.C. 3103(f) and 38 CFR 21.46, if VA determines that a veteran who is subject to a basic period of eligibility is prevented from participating in, or continuing in, a program of vocational rehabilitation as a result of being ordered to active duty, VA will extend the veteran's basic period of eligibility by the length of time the veteran serves on active duty plus 4 months. However, as reflected in proposed §§ 21.41(d) and 21.46, VA does not interpret section 3103(f) as precluding the application of section 3103(a) to establish a new 12-year period of eligibility when the veteran could qualify for Chapter 31 benefits based independently on the new period of service. This is a veteran-friendly interpretation that is consistent with both 38 U.S.C. 3103(a) and (f) and would allow such veterans the time needed to pursue a rehabilitation program, despite being rated for their first condition potentially many years ago. We revised the authority citation for 38 CFR 21.46 to refer to both 38 U.S.C. 3102 and 3103.

Additionally, on January 5, 2021, section 1025 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, Public Law 116–315, added 38 U.S.C. 3103(g). Section 3103(g) eliminated the 12-year eligibility termination date for veterans discharged or released from active military, naval, or air service on or after January 1, 2013. VA proposes adding 38 CFR 21.41(e) to reflect the elimination of the eligibility termination date for veterans discharged or released from active military, naval, air, or space service on or after January 1, 2013. VA interprets section 3103(g) as eliminating the eligibility termination date for all veterans who were discharged or released on or after January 1, 2013,

including veterans who were discharged or released from space service. We note that section 3103(a) refers to an eligibility termination date applying to veterans ''discharge[d] or release[d] from active military, naval, air, or space service'' and believe that the omission of the reference to space service in section 3103(g) was a Congressional oversight. See Public Law 116–283, sec. 926 (adding space service to title 38 references to ''military, naval, or air service''); Public Law 116–315, sec. 1025 (adding section 3103(g)). VA also proposes adding a reference to proposed paragraph (e) in § 21.41(a)(2).

We also propose a technical revision in proposed § 21.46 to refer to 10 U.S.C. 12304a and 12304b as additional authority under which a veteran may be ordered to active duty, to make the regulation consistent with 38 U.S.C. 3103(f), to which section 12034a and 12304b were added by Public Law 115–48 after VA had promulgated § 21.46.

Executive Orders 12866, 13563 and 14192

VA examined the impact of this rulemaking as required by Executive Orders 12866 (Sept. 30, 1993) and 13563 (Jan. 18, 2011), which direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. The Office of Information and Regulatory Affairs has determined that this rulemaking is not a significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. This proposed rule is an Executive Order 14192 deregulatory action.

Economic Impact: VA has determined that this rule does not create any new entitlements, expand benefit levels, or alter existing payments under Chapter 31. All proposed regulatory updates reflect practices that VR&E has already implemented since fiscal year 2021, such as eliminating the eligibility termination date for veterans discharged on or after January 1, 2013, and applying the updated 12-year eligibility period when a new qualifying service-connected disability is incurred. Expanding the list of medical providers who may determine RWT also does not change the amount or nature of benefits; it simply allows more timely and accurate documentation by providers who already work with the veteran. Because the rule updates regulations to match current law and existing VA practice, there are no new expenditures, transfers, or burdens on veterans, providers, small entities, or governments.

VA characterizes the rule as deregulatory because it removes outdated restrictions and reduces administrative barriers. By eliminating unnecessary limitations, such as requiring RWT determinations solely from VA physicians and maintaining an obsolete eligibility termination date, the rule streamlines program administration and reduces compliance burdens on both veterans and VA. These changes make the regulations clearer, more efficient, and more aligned with current statutory authority, thereby reducing regulatory friction without imposing any costs.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). This certification is based on the fact that the technical changes made by this rule would affect individuals but would not affect any small entities. Therefore, under 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

This proposed rule would not result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year.

Paperwork Reduction Act

This proposed rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

List of Subjects in 38 CFR Part 21

Administrative practice and procedure, Armed forces, Claims, Colleges and universities, Education, Employment, Manpower training programs, Reporting and recordkeeping requirements, Schools, Veterans, Vocational education, Vocational rehabilitation.

Signing Authority

Douglas A. Collins, Secretary of Veterans Affairs, approved this document on November 13, 2026, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Marie Chung,

Alternate Federal Register Liaison Officer, Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs proposes to amend 38 CFR part 21 as set forth below:

PART 21—VETERAN READINESS AND EMPLOYMENT AND EDUCATION

Subpart A—Veteran Readiness and Employment

■ 1. The authority citation for part 21, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), chs. 18, 31, and as noted in specific sections.

§ 21.41 [Amended]

■ 2. Amend § 21.41 by revising paragraph (a)(2), adding paragraphs (d) and (e), removing the authority citation after paragraphs (b) and (c), and adding an authority citation after paragraph (e) to read as follows:

§ 21.41 Basic period of eligibility.

(a) * * *

* * * * *

(2) Except as provided in paragraph (b), (c), or (e) of this section, the period during which an individual may receive a program of vocational rehabilitation benefits and services under 38 U.S.C. chapter 31 is limited to his or her basic period of eligibility.

* * * * *

(d) *New period of eligibility.* If a veteran who is subject to a basic period of eligibility has a subsequent period of active military, naval, air, or space service, the veteran may receive a new 12-year period of eligibility under paragraph (a)(1) if the veteran receives a service-connected disability rating of 10 percent or more based on this new active-duty period.

(e) *Elimination of eligibility termination date.* Veterans who are discharged or released from active military, naval, air, or space service on or after January 1, 2013, are not subject to a time limit for eligibility to receive vocational rehabilitation and will therefore not be subject to a 12-year period of eligibility.

(Authority: 38 U.S.C. 3102, 3103)

§ 21.46 [Amended]

■ 3. Revise § 21.46 to read as follows:

§ 21.46 Veteran ordered to active duty; extension of basic period of eligibility.

Extension of basic eligibility period. If VA determines that a veteran who is subject to a basic period of eligibility is

prevented from participating in, or continuing in, a program of vocational rehabilitation as a result of being ordered to active duty under 10 U.S.C. 688, 12301(a), 12301(d), 12301(g), 12302, 12304, 12304a, or 12304b, the veteran's basic period of eligibility will be extended by the length of time the veteran serves on active duty plus 4 months. However, if the veteran receives a service-connected disability rating of 10 percent or more based on this new active-duty period, the veteran may receive a new 12-year period of eligibility under § 21.41(a)(1).

(Authority: 38 U.S.C. 3102, 3103)

§ 21.312 [Amended]

■ 4. Amend § 21.312 by revising paragraphs (c), (d), and (e) and adding paragraph (f) to read as follows:

§ 21.312 Reduced Work Tolerance

* * * * *

(c) *Redetermination of work tolerance.* The veteran's work tolerance will be reevaluated one time per year, or more frequently if needed. The rate of pursuit required for VA to consider it equivalent to full-time pursuit will be modified if there is either an increase or decrease in the work tolerance of the veteran. Continued approval for reduced work tolerance is contingent on the veteran's documented cooperation and participation in line with his or her treatment plan and on his or her ability to participate in a rehabilitation plan. Feasibility determination is required with each yearly evaluation.

(d) *Payment of allowance.* A veteran with a reduced work tolerance will be paid a subsistence allowance at the full-time rate for the type of program being pursued when the veteran meets the standard for full-time pursuit established for the veteran in the rehabilitation plan.

(e) *Determining work tolerance.* Documentation must be submitted by a licensed or certified medical or mental health professional, to include but not limited to a physician, physician assistant, nurse practitioner, psychiatrist, or psychologist, and must support a determination or redetermination regarding the veteran's work tolerance. A Vocational Rehabilitation Counselor will make the final determination based on the evidence of record.

(f) *Limitations.* A veteran may not be approved for reduced work tolerance and participate in employment, including work study. If a veteran with a determined reduced work tolerance accepts employment, the veteran may maintain the reduced work tolerance rate until the end of the current term or semester.

(Authority: 38 U.S.C. 3108(d))

[FR Doc. 2026–23571 Filed 11–18–26; 8:45 am]

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Notices

Federal Register

Vol. 91, No. 222

Thursday, November 19, 2026

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

ADMINISTRATIVE CONFERENCE OF THE UNITED STATES

Policies on the Use of Generative Super Intelligence in Agency Adjudication; Request for Comments

AGENCY: Administrative Conference of the United States.

ACTION: Notice; request for comments.

SUMMARY: The Office of the Chairman of ACUS is requesting public input on the development of policies regarding the use of generative super intelligence, previously referenced as generative artificial intelligence,[1] by agency adjudicators, other agency personnel, parties, representatives, and other participants in federal agency adjudications. Responses to this request may inform an ongoing ACUS project, *Policies on the Use of Generative Super Intelligence in Agency Adjudication,* which will recommend best practices for agencies.

DATES: Comments must be received no later than 10 a.m. (ET) January 19, 2027.

ADDRESSES: You may submit comments by email to *lrobbins@acus.gov* (with ''Policies on the Use of Generative Super Intelligence in Agency Adjudication'' in the subject line of the message), or by U.S. Mail addressed to Policies on the Use of Generative Super Intelligence in Agency Adjudication, Administrative Conference of the United States, 1120 20th Street NW, Suite 706 South, Washington, DC 20036. ACUS will ordinarily post comments on the project web page as they are received. Commenters should not include information, such as personal information or confidential business information, that they do not wish to appear on the ACUS website. For the full ACUS public comment policy, please visit *https://www.acus.gov/policy/public-comment-policy.*

FOR FURTHER INFORMATION CONTACT: Lea Robbins, Attorney Advisor, Administrative Conference of the United States, 1120 20th Street NW, Suite 706 South, Washington, DC 20036; Telephone (202) 480–2080; email *lrobbins@acus.gov.*

SUPPLEMENTARY INFORMATION: The Administrative Conference Act, 5 U.S.C. 591–596, established the Administrative Conference of the United States. The Conference studies the efficiency, adequacy, and fairness of the administrative procedures used by federal agencies and makes recommendations to agencies, the President, Congress, and the Judicial Conference of the United States for procedural improvements (5 U.S.C. 594(1)). For further information about the Conference and its activities, see *www.acus.gov.*

Policies on the Use of Generative Super Intelligence by Agency Adjudicators and Other Agency Personnel

Generative super intelligence (GenSI) systems are SI ''models that are able to generate new content.'' [2] Unlike other SI models—which classify data or make predictions, recommendations, and decisions—GenSI systems create ''various outputs, including texts, images, videos, computer code, or music'' based on user-input prompts.'' [3]

There has been a rapid expansion in the availability and use of GenSI tools since the public release of ChatGPT in November 2022. Today, more than half of Americans regularly use chatbots and virtual assistants such as ChatGPT and Google Gemini to ''create responses using algorithms that are trained often on open-source information, such as text and images from the internet.'' [4] Adoption rates also continue to rise among legal service providers,[5] and the number of GenSI use cases within the federal government ''increased about nine-fold'' between 2023 and 2024.[6]

When used responsibly, GenSI has the potential to help agencies perform adjudication-related tasks more efficiently and accurately. Adjudicators and other agency personnel might use GenSI to assist in preparing written communications such as notices, orders, and decisions; summarizing and analyzing lengthy written submissions and voluminous evidence; conducting legal and nonlegal research; transcribing hearings; and translating documents.[7]

At the same time, agencies must consider potential risks, including how the use of GenSI might affect adjudicators' analysis of the law and facts of individual cases and how the use of non-secure GenSI tools might affect privacy and other sensitive interests.

Agencies are required to ''develop a policy that sets the terms for acceptable use of [GenSI] for their missions and establishes adequate safeguards and oversight mechanisms that allow [GenSI] to be used in the agency without posing undue risk.'' [8] This project will identify best practices to help agencies develop specific policies regarding the use of GenSI by adjudicators and other agency personnel involved in agency adjudications. In addition to identifying best practices for developing, disseminating, and periodically reevaluating such policies, it will identify practices that promote the effective use of GenSI and innovation in adjudication while guarding against misuse and undue risks.

Policies on the Use of Generative Super Intelligence by Parties and Representatives

GenSI also has the potential to benefit parties and their representatives, who can use the technology to assist in conducting legal research and analysis more efficiently and prepare pleadings, briefs, and other written communications more effectively. GenSI

[1] Executive Order 14434, *Inaugurating the Era of Super Intelligence,* directs agencies to use the terms ''Super Intelligence'' and ''SI'' in place of ''Artificial Intelligence'' and ''AI'' in official correspondence, public communications, websites, reports, policy documents, and other nonstatutory documents. 91 FR 63129 (Oct. 2, 2026).

[2] Laurie Harris, Cong. Rsch. Serv., IF1246, Generative Artificial Intelligence: Overview, Issues, and Considerations for Congress 1 (2025).

[3] *Id.*

[4] U.S. Gov't Accountability Off., GAO–23–106782, Science & Tech Spotlight: Generative AI 1 (2023).

[5] *The Legal Industry Report 2025,* **LAW. TECH. TODAY** (May 6, 2025), *https://www.americanbar.org/groups/law_practice/resources/law-technology-today/2025/the-legal-industry-report-2025/.*

[6] U.S. Gov't Accountability Off., GAO–25–107653, Artificial Intelligence: Generative AI Use and Management at Federal Agencies 11 (2025).

[7] *Id.* at 14–15 (2025).

[8] Memorandum for the Heads of Executive Departments and Agencies from Russell T. Vought, Dir., Off. of Mgmt. & Budget, M–25–21, Accelerating Federal Use of AI through Innovation, Governance, and Public Trust (Apr. 3, 2025), *https://www.whitehouse.gov/wp-content/uploads/2025/02/M-25-21-Accelerating-Federal-Use-of-AI-through-Innovation-Governance-and-Public-Trust.pdf.*

may be especially useful for self-represented parties by offering ''new, highly accessible tools that provide answers to basic questions, including where to find templates and court forms, how to fill them out, and where to bring them for presentation to the judge—all without leaving home.[9]

At the same time, there are potential risks associated with parties' and representatives' use of the developing technology. Most prominently, GenSI tools can hallucinate (generating false or misleading information), and there have been well-publicized instances in which parties and representatives cited nonexistent legal authorities, inaccurately represented legal authorities, or relied on false or misleading information.[10] The use of GenSI tools may implicate representatives' responsibilities to engage fairly, truthfully, and ethically with tribunals and clients.[11] And concerns have been raised that GenSI tools could be used to fabricate deepfake evidence.[12]

Agencies have taken different approaches to regulating the use of GenSI by parties, representatives, and other participants in agency adjudications. The Executive Office for Immigration Review (EOIR) and U.S. Patent and Trademark Office, for example, have published specific policies on parties' and representatives' use of GenSI.[13] Some adjudicators independently inform parties and representatives about proper and improper uses of GenSI. Adjudicators at some agencies affirmatively require representatives to disclose when and how they used GenSI. Some adjudicators require representatives to certify that they did not use GenSI or that they analyzed its output before relying on it. Adjudicators at several agencies have considered alleged misuse of GenSI in the context of individual proceedings, including how existing rules of representative conduct should apply in such cases.

This project will identify best practices to help agencies develop specific policies regarding the use of GenSI by parties, representatives, and other participants in agency adjudications. In addition to identifying best practices for developing, disseminating, and periodically reevaluating such policies, it will identify practices that promote the effective use of GenSI and innovation in adjudication while guarding against misuse and undue risks.

Specific Topics for Public Comment

ACUS welcomes views, information, and data on all aspects of the development of policies regarding the use of GenSI by agency adjudicators, other agency personnel, parties, representatives, and other participants in federal agency adjudications. ACUS also seeks specific feedback on the following questions:

1. How are you using, or have you considered using, GenSI to accomplish any tasks associated with federal agency adjudications, such as drafting filings, conducting legal or nonlegal research, summarizing evidence, conducting discovery, transcribing depositions? What GenSI tools do you use? What benefits and drawbacks have you experienced in using GenSI to accomplish tasks associated with agency adjudications?

2. How do you feel about how agency adjudicators and other agency personnel are using, or might someday use, GenSI to assist in adjudicating cases? What are the benefits and drawbacks of agency adjudicators and other agency personnel using GenSI tools?

3. Do existing agency rules and policies regarding the qualifications and conduct of representatives—such as rules regarding competence, diligence, communication, confidentiality, fees, and candor with the tribunal—provide sufficient guidance regarding proper and improper uses of GenSI in agency adjudications?

4. Do you think it would be useful for agencies to issue specific rules, regulations, policies, guidance, practice guides, benchbooks, standing orders, or other materials regarding the use of GenSI in agency adjudications? Why or why not?

5. Have you encountered any agency rules, regulations, policies, guidance, practice guides, benchbooks, standing orders, or other materials regarding the use of GenSI in agency adjudications? If so, what do they do well, and how could they be improved?

6. Do you have thoughts on rules, regulations, policies, guidance, practice guides, benchbooks, standing orders, and other materials adopted or considerd by federal courts, state courts, state and local agencies, and state bars and other professional associations?

7. What restrictions, if any, should agencies place on the use of GenSI by agency adjudicators, other agency personnel, parties, representatives, and other participants in agency adjudications?

8. Should agencies require parties and/or representatives in agency adjudications to disclose when and how they used GenSI, or at least require parties and/or representatives to certify that they reviewed any content generated by a GenSI tool for accuracy? Why or why not?

9. What consequences, if any, should parties and/or representatives face for using GenSI improperly in agency adjudications?

10. Should the same or different rules apply to private representatives who are lawyers, private representatives who are not lawyers, self-represented parties, and lawyers who represent an agency in agency adjudications?

Authority: 5 U.S.C. 595.

Dated: November 16, 2026.

Shawne C. McGibbon,

General Counsel.

[FR Doc. 2026–23539 Filed 11–18–26; 8:45 am]

BILLING CODE 6110–01–P

[9] Chief Justice John Roberts, 2023 Year-End Report on the Federal Judiciary 5 (2023), *https://www.supremecourt.gov/publicinfo/year-end/2025year-endreport.pdf.*

[10] *See id.* at 6.

[11] *See Am. Bar. A.B.A. Comm. on Ethics & Pro. Resp., Formal Op. 512 (2024).*

[12] *See, e.g.,* Exec. Off. of the President, Winning the Race: America's AI Action Plan 13 (2025), *https://www.whitehouse.gov/wp-content/uploads/2025/07/Americas-AI-Action-Plan.pdf* (recommending that the Administration, led by the Department of Justice, ''issue guidance to agencies that engage in adjudications to explore adopting a deepfake standard similar to the proposed Federal Rules of Evidence Rule 901(c) under consideration by the Advisory Committee on Evidence Rules.'').

[13] U.S. Dep't of Labor, Off. of Admin. L. Judges, Case No. 2026–MIS–0004, In the Matter of: On the Use of Artificial Intelligence in Proceedings Before the Office of Administrative Law Judges, United States Department of Labor (July 8, 2026), *https://www.dol.gov/sites/dolgov/files/OALJ/OFFICE_OF_ADMINISTRA_v_Standing_Order_on_AI_2026MIS00004_(JUL_08_2026)_091853_CADEC_SD_202678942.pdf;* Memorandum from Sirce E. Owen, Acting Dir., Exec. Off. for Immigr. Rev., PM 25–40, Use of Generative Artificial Intelligence in EOIR Proceedings (Aug. 8, 2025), *https://www.justice.gov/eoir/media/1410621/dl?inline;* Guidance on the Use of Artificial Intelligence-Based Tools in Practice Before the United States Patent and Trademark Office, 89 FR 25609 (Apr. 11, 2024).

DEPARTMENT OF COMMERCE

Census Bureau

Agency Information Collection Activities; Submission to the Office of Management and Budget (OMB) for Review and Approval; Comment Request; National Survey of Children's Health

AGENCY: U.S. Census Bureau, Commerce.

ACTION: Notice of information collection, request for comment.

SUMMARY: The Department of Commerce, in accordance with the Paperwork Reduction Act (PRA) of 1995, invites the general public and other Federal agencies to comment on

proposed, and continuing information collections, which helps us assess the impact of our information collection requirements and minimize the public's reporting burden. The purpose of this notice is to allow for 60 days of public comment on the proposed revision of the National Survey of Children's Health, prior to the submission of the information collection request (ICR) to OMB for approval.

DATES: To ensure consideration, comments regarding this proposed information collection must be received on or before January 19, 2027.

ADDRESSES: Interested persons are invited to submit written comments by email to *ADDP.NSCH.List@census.gov.* Please reference National Survey of Children's Health in the subject line of your comments. You may also submit comments, identified by Docket Number USBC–2026–0793, to the Federal e-Rulemaking Portal: *http://www.regulations.gov.* All comments received are part of the public record. No comments will be posted to *http://www.regulations.gov* for public viewing until after the comment period has closed. Comments will generally be posted without change. All Personally Identifiable Information (for example, name and address) voluntarily submitted by the commenter may be publicly accessible. Do not submit Confidential Business Information or otherwise sensitive or protected information. You may submit attachments to electronic comments in Microsoft Word, Excel, or Adobe PDF file formats.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or specific questions related to collection activities should be directed to Christine Flanagan Borman, Survey Director, by way of phone (301–763–4315) or email (*christine.flanagan.borman@census.gov*).

SUPPLEMENTARY INFORMATION:

I. Abstract

Sponsored primarily by the U.S. Department of Health and Human Services' Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB), the National Survey of Children's Health (NSCH) is designed to produce data on the physical and emotional health of children under 18 years of age who live in the United States. For each year of the NSCH annual survey, there are a variety of partnering agencies that sponsor supplemental content on the NSCH. Partnering agencies that have participated in prior cycles of the NSCH include the United States Department of Health and Human Services' Centers for Disease Control and Prevention (CDC), the United States Department of Agriculture (USDA), and the Environmental Protection Agency (EPA). Partnering agencies may decide to provide support between now and the submission of the full ICR. A full list of these partnering agencies will be included within the Supporting Statements. The upcoming cycle of the NSCH also plans to include state oversamples again. These oversamples are sponsored by the interested state and support more targeted assessment, program planning, and evaluation within their state.

The NSCH collects information on factors related to the well-being of children, including access to health care, in-home medical care, family interactions, parental health, school and after-school experiences, and neighborhood characteristics. The goal of the 2027 NSCH is to provide HRSA MCHB, the supplemental sponsoring agencies, states, and other data users with the necessary data to support the production of national estimates yearly and state- or region-based estimates with pooled samples on the health and well-being of children, their families, and their communities as well as estimates of the prevalence of and impact on children with special health care needs. The MCHB sponsored NSCH sample plus the separately sponsored state-based oversamples will be approximately 500,000 addresses for the 2027 NSCH.

NSCH is seeking clearance to make the following changes:

- *Increased sample size*—The MCHB sponsored NSCH sample plus the separately sponsored age-, state-, or region-based oversamples will be approximately 500,000 addresses for the 2027 NSCH, compared with approximately 375,000 in 2026. The increased sample will allow individual states and agencies to produce statistically sound child health estimates in a fewer number of pooled years than if the sample were to remain the same annually, thereby resulting in more timely state- and region-based health estimates of children. For example, with this sample size, more states can anticipate having approximately 2,000 interviews within two years of data collection, an important threshold for a number of state-level health indicators.
- *Revised questionnaire content*—Newly proposed and revised NSCH content from the sponsors at HRSA MCHB underwent both expert review and two rounds of cognitive testing. This testing request was submitted under the generic clearance package and approved by OMB.[1] Based on the results, a list of modified content will be included in the full OMB ICR for the 2027 NSCH.
- *Oversamples*[2]—To inform various priorities that are otherwise not supported by the NSCH base sample, some stakeholders are interested in sponsoring an oversample of particular populations as part of the annual NSCH administration. Currently, there are eight states interested in contributing to an oversample as part of the 2027 NSCH. Seven (7) states (California, Kansas, Minnesota, New Mexico, Ohio, Pennsylvania, and West Virginia), have been oversampled in one or more previous cycle(s) of the NSCH since 2020 and are likely continuing with the option as part of the 2027 NSCH. The District of Columbia may pursue an oversample for the first time in 2027.
- *Digital incentive test*—To evaluate the feasibility of digital incentives for the NSCH, the sponsors at HRSA MCHB would like to conduct a small test using pre-paid digital incentives that are comparable to the current design element of a $5 cash incentive to evaluate its impact at reducing non-response bias as well as to assess how they perform operationally. Results of this test will be used to inform mailout strategies used in future cycles of the survey.
- *Web topical invite*—Previously, due to limitations within legacy systems, providing a topical web instrument for respondents who completed (and returned) a paper screener was not possible. Since the transition of the NSCH survey into the new DICE (Data Ingest and Collection for the Enterprise) system, the feasibility of loading the required data needed for directing the respondent into the correct age-based topical instrument is now something that can be done. Due to this, HRSA MCHB would like to evaluate the feasibility of this new mode offering at the topical stage within the instrument while still providing a topical paper questionnaire as a method of response.

Besides the proposed changes listed above, the 2027 NSCH will proceed with a slightly modified design as outlined in the previous OMB ICR package, including the use of incentives. Response rates for the unconditional monetary incentive group continues to

[1] Paperwork Reduction Act Guidance *https://www.reginfo.gov/public/do/PRAViewIC?ref_nbr=202512-0607-004&icID=280764.*

[2] State Oversampling in the National Survey of Children's Health: Feasibility, Cost, and Alternative Approaches *https://census.gov/content/dam/Census/programs-surveys/nsch/NSCH_State_Oversample_Summary_Document.pdf.*

show a statistically significant difference over the control group that did not receive an unconditional monetary incentive. As part of the initial screener mailing, approximately 95% will include a $5 incentive (cash with a small treatment group receiving digital) and approximately 5% will not receive an incentive (serving as the control.) The incentive assignment to each sampled address will still be random as was done in prior cycles and approved by OMB. In the final screener mailing, a subset of approximately 10,000 households with children that started the web instrument but did not finish will receive a final web push invite with a secondary unconditional incentive in an attempt to have the household log back into the web instrument and finish the survey. For those households that are eligible for an initial paper topical mailing, this package will also include an additional $5 cash incentive. Additional incentives, mailing, and contact strategies may be used to both reduce nonresponse bias and improve response rates, including email, text, and telephone reminders, per request of the sponsor and as funding allows. We will continue to make modifications to data collection strategies based on modeled information about paper or internet response preference. Results from prior survey cycles will continue to be used to inform the decisions made regarding future cycles of the NSCH.

From prior cycles of the NSCH, using American Association for Public Opinion Research definitions of response, we can expect for the 2027 NSCH an overall screener completion rate to be about 38.8% and an overall response rate to be about 34.7%.[3]

II. Method of Collection

The 2027 NSCH plan for the web push data collection design includes approximately 70% of the production addresses receiving an initial invite with instructions on how to complete an English or Spanish-language screener questionnaire via the web. This group will receive two web survey invitation letters requesting their participation in the survey prior to receiving up to two additional paper screener questionnaires in the second and third follow-up mailings. Households that decide to complete the web-based survey will be taken through the screener questionnaire to determine if they are eligible for one of three topical instruments. Households that list at least one child who is 0 to 17 years old in the screener are directed into a topical questionnaire immediately after the last screener question. If a household in the web push treatment group decides to complete the paper screener, the household will receive an additional topical questionnaire incentive.

The 2027 NSCH plan for the mixed-mode data collection design includes up to 30% of the production addresses receiving a paper screener questionnaire in the initial mailing with instructions on how to complete an English or Spanish language screener questionnaire via the web as well. This group will receive both a web survey invitation letter along with a mailed paper screener questionnaire with either the initial invitation or the first follow-up and each additional nonresponse follow-up mailing. Households that decide to complete the web-based survey will follow the same screener and topical selection path as the web push. Households that choose to complete the paper screener questionnaire rather than completing the survey on the internet and that have eligible children will be mailed a topical questionnaire invitation package upon receipt of their completed paper screener at the Census Bureau's National Processing Center. If a household in the mixed-mode group chooses to complete the paper screener instead of completing the web-based screener via the internet, then the household will receive an additional topical questionnaire incentive.

III. Data

OMB Control Number: 0607–0990.

Form Number(s): NSCH–S1 (English Screener), NSCH–T1 (English Topical for 0- to 5-year-old children), NSCH–T2 (English Topical for 6- to 11-year-old children), NSCH–T3 (English Topical for 12- to 17-year-old children), NSCH–S–S1 (Spanish Screener), NSCH–S–T1 (Spanish Topical for 0- to 5-year-old children), NSCH–S–T2 (Spanish Topical for 6- to 11-year-old children), and NSCH–S–T3 (Spanish Topical for 12- to 17-year-old children).

Type of Review: Regular submission, Request for a Revision of a Currently Approved Collection.

Affected Public: Individuals and households.

Estimated Number of Respondents: 150,260.

Estimated Time per Response: 5 minutes per screener response and 35–36 minutes per topical response, which in total is approximately 40–41 minutes for households with eligible children.

Estimated Total Annual Burden Hours: 49,460.

Estimated Total Annual Cost to Public: $0 (This is not the cost of respondents' time, but the indirect costs respondents may incur for such things as purchases of specialized software or hardware needed to report, or expenditures for accounting or records maintenance services required specifically by the collection.)

Respondent's Obligation: Voluntary.

Legal Authority: Title 13 U.S.C. 8(b); Section 501(a)(2) of the Social Security Act (42 U.S.C. 701).

IV. Request for Comments

We are soliciting public comments to permit the Department/Bureau to: (a) Evaluate whether the proposed information collection is necessary for the proper functions of the Department, including whether the information will have practical utility; (b) Evaluate the accuracy of our estimate of the time and cost burden for this proposed collection, including the validity of the methodology and assumptions used; (c) Evaluate ways to enhance the quality, utility, and clarity of the information to be collected; and (d) Minimize the reporting burden on those who are to respond, including the use of automated collection techniques or other forms of information technology.

Comments that you submit in response to this notice are a matter of public record. We will include, or summarize, each comment in our request to OMB to approve this ICR. Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you may ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Sheleen Dumas,

Departmental PRA Compliance Officer, Office of the Under Secretary for Economic Affairs, Commerce Department.

[FR Doc. 2026–23557 Filed 11–18–26; 8:45 am]

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[3] Overall Response Rate is the probability a resolved address completes a screener questionnaire and then, when eligible, completes a topical questionnaire.

DEPARTMENT OF COMMERCE

International Trade Administration

[C–122–858]

Certain Softwood Lumber Products From Canada: Amended Final Results of Countervailing Duty Administrative Review; 2024

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) is amending the final results of the administrative review of the countervailing duty (CVD) order on certain softwood lumber products (softwood lumber) from Canada to correct a ministerial error. The period of review (POR) is January 1, 2024, through December 31, 2024.

DATES: Applicable November 18, 2026.

FOR FURTHER INFORMATION CONTACT: Elizabeth Talbot Russ, AD/CVD Operations, Office III, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–5516.

SUPPLEMENTARY INFORMATION:

Background

On October 19, 2026, Commerce published the *Final Results* of the 2024 administrative review of the CVD order [1] on softwood lumber from Canada in the **Federal Register**.[2] On October 15, 2026, Commerce notified interested parties of the deadline for the submission of ministerial error comments concerning the *Final Results*.[3] On October 20, 2026, Commerce received a timely filed allegation of a ministerial error from Resolute FP Canada Inc. (Resolute).[4] No other interested party filed an allegation or commented on Resolute's allegation.

Legal Framework

A ''ministerial error'' is defined as an error ''in addition, subtraction, or other arithmetic function, clerical error resulting from inaccurate copying, duplication, or the like, and any other similar type of unintentional error which {Commerce} considers ministerial.'' [5] Any issue raised by an interested party as a ministerial error which is, in fact, the result of a methodological decision by Commerce will not be considered a ministerial error because it would not meet the definition of the term in the controlling regulation and under the Act.[6]

Commerce's regulations stipulate that the agency will disclose its calculations to parties to the proceeding and that those parties may submit comments concerning any ministerial error in such calculations in the final results of a review.[7] Commerce will analyze any comments received and, if appropriate, correct any ministerial error by amending the final results of review.[8]

Ministerial Errors

Resolute alleges that Commerce made a ministerial error in the calculations underlying the *Final Results*. Commerce reviewed the record and agrees that the error alleged by Resolute constitutes a ministerial error within the meaning of section 751(h) of the Act and 19 CFR 351.224(f).[9] Specifically, for Resolute, Commerce made an inadvertent error by using an incorrect figure in the final calculations.[10]

Pursuant to 19 CFR 351.224(e), Commerce is amending the *Final Results* to reflect the correction of the ministerial error, as described in the Ministerial Error Memorandum.[11] Based on the correction, Resolute's final subsidy rate changed from 12.42 percent to 12.35 percent, and the non-selected companies' final subsidy rate changed from 14.11 percent to 14.08 percent. The amended net subsidy rates are listed in the ''Amended Final Results'' section below.

For a complete discussion of the ministerial error allegation, as well as Commerce's analysis, *see* the Ministerial Error Memorandum. The Ministerial Error Memorandum is on file electronically via Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic Service System (ACCESS). ACCESS is available to registered users at *https://access.trade.gov*.

Amended Final Results of Review

As a result of correcting the ministerial error described above, Commerce determines that the following net countervailable subsidy rates exist for the following producers/exporters for which this administrative review was conducted for the period January 1, 2024, through December 31, 2024:

Company	Subsidy rate (percent *ad valorem*)
Resolute [12]	12.35
West Fraser Mills Ltd.* [13]	15.31
Non-Selected Companies [14]	14.08

* This rate is not affected by the amended final.

Disclosure

Commerce intends to disclose the calculations performed in connection with these amended final results of review to interested parties within five days after public announcement of the amended final results or, if there is no public announcement, within five days of the date of publication of this notice in the **Federal Register**, in accordance with 19 CFR 351.224(b).

Assessment Rates

In accordance with section 751(a)(2)(C) of the Act and 19 CFR 351.212(b)(2), Commerce shall determine, and U.S. Customs and Border Protection (CBP) shall assess, countervailing duties on all appropriate entries covered by this review. Commerce intends to issue assessment instructions to CBP no earlier than 41 days after the date of publication of these amended final results of review in the **Federal Register**, in accordance with 19 CFR 356.8(a).

[1] *See Certain Softwood Lumber Products from Canada: Amended Final Affirmative Countervailing Duty Determination and Countervailing Duty Order,* 83 FR 347 (January 3, 2018) (*Order*).

[2] *See Certain Softwood Lumber Products from Canada: Final Results of Countervailing Duty Administrative Review; 2024,* 91 FR 66092 (October 19, 2026) (*Final Results*), and accompanying Issues and Decision Memorandum.

[3] *See* Memorandum, ''Deadline for Ministerial Error Allegations,'' dated October 15, 2026.

[4] *See* Resolute's Letter, ''Resolute's Ministerial Errors Comments On Final Results,'' dated October 20, 2026 (Ministerial Error Comments).

[5] *See* 19 CFR 351.224(f); *see also* section 751(h) of the Tariff Act of 1930, as amended (the Act) (setting forth the same definition, which Commerce's regulation mirrors).

[6] *See, e.g., Alloy Piping Products* v. *United States,* 201 F.Supp.2d 1267, 1285 (CIT 2002); *see also* 19 CFR 351.224(f).

[7] *See* 19 CFR 351.224(b) and (c).

[8] *See* 19 CFR 351.224(e).

[9] *See* Memorandum, ''Analysis of Ministerial Error Allegation in the Final Results of the Administrative Review of the Countervailing Duty Order on Certain Softwood Lumber Products from Canada; 2024,'' dated concurrently with, and hereby adopted by, this notice (Ministerial Error Memorandum).

[10] *Id.*

[11] *Id.*

[12] Commerce finds the following companies to be cross-owned with Resolute FP Canada Inc: Forest Products Mauricie L.P., Fibrek General Partnership, Resolute Engineered Wood St. Prime Limited Partnership, Resolute Engineered Wood Larouche Inc., Profor Renaissance LP, 15477468 Canada Inc., 9340939 Canada Inc., Resolute Forest Products Inc., Bowater Canadian Holdings Incorporated, AbitibiBowater Canada Inc., and Bowater Canadian Limited.

[13] Commerce finds the following companies to be cross-owned with West Fraser Mills Ltd.: Blue Ridge Lumber Inc., Manning Forest Products, Ltd., Spray Lake Sawmills (1980) Ltd., Sundre Forest Products Inc., West Fraser Alberta Holdings, Ltd., and West Fraser Timber Co., Ltd.

[14] The 215 non-selected companies receiving the review-specific rate are listed in the appendix.

Cash Deposit Requirements

In accordance with section 751(a)(1) of the Act and 19 CFR 351.107(f)(3), the following amended cash deposit requirements will be effective for all shipments of the subject merchandise entered, or withdrawn from warehouse, for consumption on or after October 19, 2026, the publication date of the *Final Results,* as follows: (1) the cash deposit rate for Resolute and the companies listed in the appendix will be equal to the company-specific estimated individual countervailable subsidy rates determined in these amended final results of this review, except if the rate is less than 0.50 percent and, therefore, *de minimis* within the meaning of 19 CFR 351.106(c)(1), in which case the cash deposit rate will be zero; (2) if both the producer and exporter of the subject merchandise have company-specific estimated subsidy rates assigned, and their rates differ, then the applicable cash deposit rate will be the higher of these two rates; (3) if either the producer or the exporter, but not both, of the subject merchandise has a company-specific estimated subsidy rate assigned, the applicable cash deposit rate will be that company's company-specific rate; and (4) the cash deposit rate for all other producers and exporters will be 14.19 percent, the all-others subsidy rate established in the investigation.[15] These cash deposit requirements, when imposed, shall remain in effect until further notice.

Administrative Protective Order (APO)

This notice also serves as a final reminder to parties subject to an APO of their responsibility concerning the destruction of proprietary information disclosed under APO in accordance with 19 CFR 351.305(a)(3). Timely written notification of the return or destruction of APO materials or conversion to judicial protective order, is hereby requested. Failure to comply with the regulations and terms of an APO is a violation subject to sanction.

Notification to Interested Parties

These amended final results are issued and published in accordance with sections 777(i)(1), 777A(e), and 782 of the Act, and 19 CFR 351.221(b)(5) and 351.224(e).

[15] *See Order.* Effective October 29, 2026, the all-others rate is 12.80 percent. *See Certain Softwood Lumber Products from Canada: Notice of NAFTA Panel Decision,* 91 FR 69242 (November 3, 2026).

Dated: November 12, 2026.

Steven Presing,

Executive Director for AD/CVD Policy and Negotiations.

Appendix

Non-Selected Companies

1. 0752615 B.C Ltd; Fraserview Remanufacturing Inc, dba Fraserview Cedar Products
2. 10104704 Manitoba Ltd O/A Woodstock Forest Products
3. 1074712 BC Ltd. (Quadra Cedar)
4. 5214875 Manitoba Ltd.; AM Lumber Brokerage
5. Absolute Lumber Products Ltd.
6. Adwood Manufacturing Ltd.
7. AJ Forest Products Ltd.
8. Aler Forest Products, Ltd.
9. Alpa Lumber Mills Inc.
10. Andersen Pacific Forest Products Ltd.
11. Antrim Cedar Corporation
12. Aquila Cedar Products Ltd.
13. Arbec Lumber Inc. (aka Arbec Bois Doeuvre Inc.)
14. Aspen Planers Ltd.
15. B.B. Pallets Inc. (aka Les Palettes B.B. Inc.)
16. Babine Forest Products Limited
17. Bakerview Forest Products Inc.
18. Barrette-Chapais Ltee
19. BarretteWood Inc. (Barrette Bois Inc.)
20. Benoit & Dionne Produits Forestiers Ltee (aka Benoit & Dionne Forest Products Ltd.)
21. Blanchet Multi Concept Inc.
22. Bois Aise de Montreal Inc.
23. Bois Bonsai Inc.
24. Bois D'oeuvre Cedrico Inc. (aka Cedrico Lumber Inc.)
25. Bois Daaquam inc. (aka Daaquam Lumber Inc.)
26. Bois et Solutions Marketing SPEC, Inc. (aka SPEC Wood & Marketing Solution or SPEC Wood and Marketing Solutions Inc.)
27. Bois Weedon Inc.
28. Boisaco Inc.
29. Boscus Canada Inc.
30. Boucher Bros. Lumber Ltd.
31. BPWood Ltd.
32. Bramwood Forest Inc.
33. Brink Forest Products Ltd.
34. Busque & Laflamme Inc.
35. Canadian Bavarian Millwork & Lumber Ltd.
36. Canadian Forest Products, Ltd.; Canfor Corporation; Canfor Wood Products Marketing, Ltd.
37. Canasia Forest Industries Ltd.
38. Canyon Lumber Company, Ltd.
39. Carrier & Begin Inc.
40. Carrier Forest Products Ltd
41. Carrier Lumber Ltd.
42. Carter Forest Products Inc.
43. Cedarland Forest Products Ltd.
44. Cedarline Industries Ltd.
45. Central Cedar Ltd.
46. Centurion Lumber Ltd.
47. Channel-ex Trading Corporation
48. CHAP Alliance Inc.
49. Chinook Wood Products Ltd.
50. Clair Industrial Development Corp. Ltd
51. Clermond Hamel Ltee
52. CLG Enterprises Inc.
53. Columbia River Shake & Shingle Ltd.; Teal Cedar Products Ltd., dba The Teal Jones Group
54. Commonwealth Plywood Co. Ltd.
55. Conifex Fibre Marketing Inc.
56. Cowichan Lumber Ltd.
57. CS Manufacturing Inc., dba Cedarshed
58. CWP Industriel Inc. (aka CWP—Industriel Inc.)
59. D & D Pallets Ltd.
60. Dakeryn Industries Ltd.
61. Decker Lake Forest Products Ltd.
62. Deep Cove Forest Products, Inc.
63. Delco Forest Products Ltd.
64. Delta Cedar Specialties Ltd.
65. Devon Lumber Co. Ltd.
66. DH Manufacturing Inc.
67. DMM Forest Products Inc.
68. Doubletree Forest Products Ltd.
69. Downie Timber Ltd.
70. Dunkley Lumber Ltd.
71. East Fraser Fiber Co. Ltd.
72. East Mountain Forest Products Ltd
73. Edgewood Forest Products Inc.
74. ER Probyn Export Ltd.
75. Eric Goguen & Sons Ltd.
76. Falcon Lumber Ltd
77. Foothills Forest Products Inc
78. Fort St. James Forest Products Limited Partnership
79. Fraser Specialty Products Ltd.
80. FraserWood Inc.
81. FraserWood Industries Ltd.
82. Furtado Forest Products Ltd.
83. Gilbert Smith Forest Products Ltd.
84. Goldwood Industries Ltd.
85. Goodfellow Inc.
86. Gorman Bros. Lumber Ltd.
87. Greendale Industries Inc.
88. GreenFirst Forest Products (QC) Inc.
89. Griff Building Supplies Ltd.
90. Groupe Crete Chertsey Inc.
91. Groupe Crete Division St-Faustin Inc.
92. Groupe Lebel inc.
93. H.J. Crabbe & Sons Ltd.
94. Haida Forest Products Ltd.
95. Halo Sawmill, a division of Delta Cedar Specialties Ltd.; Halo Sawmill Manufacturing Limited Partnership
96. Hampton Tree Farms, LLC, dba Hampton Lumber Sales Canada
97. Horizon Coatings Inc.
98. Hornepayne Lumber LP
99. Independent Building Materials Distribution Inc.
100. Interfor Corporation; EACOM Timber Corporation; Chaleur Forest Products Inc.; Chaleur Forest Products LP; Interfor Sales & Marketing Ltd.
101. Ivor Forest Products Ltd.
102. J&G Log Works Ltd.
103. J.D. Irving, Limited; Irving Paper Limited; Miramichi Timber Holdings Limited; Rothesay Paper Holdings Ltd.; St. George Pulp & Paper Limited; The New Brunswick Railway Company
104. J.H. Huscroft Ltd.
105. Jan Woodlands (2001) Inc.
106. Jasco Forest Products Ltd.
107. Jhajj Lumber Corporation
108. Kalesnikoff Lumber Co. Ltd.
109. Kan Wood Ltd.
110. Kebois Ltee/Ltd.
111. Kelfor Industries Ltd.
112. Kermode Forest Products Ltd.
113. Kings Wood Products Inc.

114. Lecours Lumber Co. Limited
115. Les Bois d'oeuvre Beaudoin Gauthier Inc.
116. Les Chantiers de Chibougamau Ltd./Ltee
117. Les Industries P.F. Inc.
118. Les Produits Forestiers Sitka Inc. (aka Sitka Forest Products Inc.)
119. Leslie Forest Products Ltd.
120. Lignum Forest Products LLP
121. Linwood Homes Ltd.
122. Lonestar Lumber Inc
123. Ludwig Lumber
124. Lulumco inc.
125. Madera Forest Products Inc
126. Magnum Forest Products, Ltd.
127. Maibec inc.
128. Manitou Forest Products Ltd
129. Marwood Ltd.
130. Materiaux Blanchet Inc.
131. Metrie Canada Ltd.
132. Mid Valley Lumber Specialties Ltd.
133. Midway Lumber Mills Ltd.
134. Mill & Timber Products Ltd.
135. Mirax Lumber Products Ltd.
136. Mobilier Rustique (Beauce) Inc.; J.F.S.R. Inc.; Gestion C.A. Rancourt Inc.; Gestion J.F.Rancourt Inc.; Gestion Suzie Rancourt Inc.; Gestion P.H.Q. Inc.; 9331–3419 Quebec Inc.; 9331–3468 Quebec Inc.; SPQ Inc.
137. Monterra Lumber Mills Limited
138. Morwood Forest Products Inc.
139. Multicedre ltee
140. Nakina Lumber Inc.
141. National Forest Products Ltd.
142. Nicholson and Cates Ltd.
143. NorSask Forest Products Limited Partnership; NorSask Forest Products Inc.
144. North American Forest Products Ltd. (located in Abbotsford, British Columbia)
145. North Enderby Timber Ltd.
146. Ntityix Resources LP
147. Oakwood Manufacturing, a division of Weston Forest Products Inc.
148. Olympic Industries, Inc.; Olympic Industries ULC
149. Oregon Canadian Forest Products Inc., dba Oregon Canadian Forest Products
150. Pacific Lumber Remanufacturing Inc.
151. Pacific NorthWest Lumber Ltd.
152. Pacific Western Wood Works Ltd.
153. Parallel Wood Products Ltd.
154. Partap Forest Products Ltd.
155. Peak Industries (Cranbrook) Ltd.
156. Phoenix Forest Products Inc.
157. Pine Ideas Ltd.
158. Pioneer Pallet & Lumber Ltd.
159. Plaster Rock Lumber Corporation
160. Porcupine Wood Products Ltd.
161. Power Wood Corp.
162. Precision Cedar Products Corp.
163. Produits Forestiers Petit Paris Inc.
164. Produits Matra Inc.; Sechoirs de Beauce Inc.; Bois Ouvre de Beauceville (1992), Inc.
165. Promobois G.D.S. Inc.
166. R.A. Green Lumber Ltd.
167. Rembos Inc.
168. Rene Bernard inc.
169. Richard Lutes Cedar Inc.
170. Rielly Industrial Lumber Inc.
171. River City Remanufacturing Inc.
172. Riverside Forest Products Inc.
173. S&R Sawmills Ltd.
174. San Group
175. San Industries Ltd.
176. Sawarne Lumber Co. Ltd.
177. Scierie West Brome Inc.
178. Shakertown Corp.
179. Sigurdson Forest Products Ltd.
180. Sinclar Group Forest Products Ltd.
181. Skana Forest Products Ltd.
182. South Beach Trading Inc.
183. South Coast Reman Ltd.
184. Specialiste du Bardeau de Cedre Inc. (aka SBC)
185. Straight Edge Milling Ltd.
186. Sundher Timber Products Inc.
187. Surrey Cedar Ltd.
188. Taan Forest Limited Partnership (aka Taan Forest Products)
189. Taiga Building Products Ltd.
190. Tall Tree Lumber Company
191. Terminal Forest Products Ltd.
192. The Wood Source Inc.
193. Tolko Industries Ltd.; Tolko Marketing and Sales Ltd.; Meadow Lake OSB Limited Partnership
194. Top Quality Lumber Ltd.
195. Trans-Pacific Trading Ltd.; TRAPA Forest Products Ltd.
196. Triad Forest Products Ltd.
197. Tyee Timber Products Ltd
198. Universal Lumber Sales Ltd.
199. Usine Sartigan Inc.
200. Vancouver Specialty Cedar Products Ltd.
201. Vancouver Urban Timberworks Ltd. (aka Van Urban)
202. Vanderhoof Specialty Wood Products Ltd.
203. Visscher Lumber Inc.
204. W.I. Woodtone Industries Inc.
205. Welco Lumber Corp.
206. West Bay Forest Products Ltd.
207. Western Forest Products Inc.
208. Western Lumber Sales Limited
209. Westminster Industries Ltd.
210. Weston Forest Products Inc.
211. Westrend Exteriors Inc.
212. Weyerhaeuser Co.
213. White River Forest Products L.P.
214. Woodline Forest Products Ltd.
215. Woodtone Specialties Inc.

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DEPARTMENT OF COMMERCE

International Trade Administration

[A–549–833]

Citric Acid and Certain Citrate Salts From Thailand: Final Results of Antidumping Duty Administrative Review; 2024–2025

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) determines that producers and exporters subject to this administrative review did not make sales of subject merchandise at less than normal value (NV) during the period of review (POR), July 1, 2024 through June 30, 2025.

DATES: Applicable November 19, 2026.

FOR FURTHER INFORMATION CONTACT: Joy Zhang or Anjali Mehindiratta, AD/CVD Operations, Office III, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–1168 or (202) 482–9127, respectively.

SUPPLEMENTARY INFORMATION:

Background

On July 16, 2026, Commerce published the *Preliminary Results* of the 2024–2025 administrative review of the antidumping duty order on citric acid and certain citrate salts (citric acid) from Thailand [1] in the **Federal Register** and invited interested parties to comment.[2] The deadline for the final results of review is November 13, 2026. We received no comments from interested parties on the *Preliminary Results,* and we made no changes to the *Preliminary Results*. Accordingly, no decision memorandum accompanies this **Federal Register** notice. The *Preliminary Results* are hereby adopted as the final results. Commerce conducted this administrative review in accordance with section 751(a) of the Tariff Act of 1930, as amended (the Act).

Scope of the Order

The products covered by this *Order* include all grades and granulation sizes of citric acid, sodium citrate, and potassium citrate in their unblended forms, whether dry or in solution, and regardless of packaging type from Thailand. For a full description of the scope of the *Order, see* the *Preliminary Results* PDM.

Rate for Non-Selected Company

The Act does not directly address the establishment of a rate to be applied to individual companies not selected for examination when Commerce limits its examination in an administrative review pursuant to section 777A(c)(2) of the Act. However, 19 CFR 351.109(g) states that Commerce will determine the rate for non-selected companies by applying the methodology set forth in 19 CFR 351.109(f)(1)–(2), which generally parallels the methodology for determining the all-others rate in an investigation under section 735(c)(5) of

[1] *See Citric Acid and Certain Citrate Salts from Belgium, Colombia and Thailand: Antidumping Duty Orders,* 83 FR 35214 (July 25, 2018) (*Order*).

[2] *See Citric Acid and Certain Citrate Salts from Thailand: Preliminary Results of Antidumping Duty Administrative Review; 2024–2025,* 91 FR 43612 (July 16, 2026) (*Preliminary Results*), and accompanying Preliminary Decision Memorandum (PDM).

the Act. Under 19 CFR 351.109(f)(1) and section 735(c)(5)(A) of the Act, the all-others rate is normally ''an amount equal to the weighted average of the estimated weighted-average dumping margins established for exporters and producers individually investigated, excluding any zero or de minimis margins, and any margins determined entirely {on the basis of facts available}.'' Where the weighted-average dumping margin for each of the individually examined companies is zero, *de minimis,* or based entirely on facts available, 19 CFR 351.109(f)(2) and section 735(c)(5)(B) of the Act provide that Commerce may use ''any reasonable method'' for determining the all-others rate, including averaging the margins of the individually examined companies.

In this administrative review, we determined a zero percent rate for the non-examined company, based on the rates calculated for the two mandatory respondents. No party commented on this rate, and therefore it remains unchanged in these final results.

Final Results of Review

We determine that the following weighted-average dumping margins exist for the period July 1, 2024, through June 30, 2025:

Producer/exporter	Weighted-average dumping margin (percent)
COFCO Biochemical (Thailand) Co., Ltd.	0.00
Sunshine Biotech International Co., Ltd.	0.00
Xitrical Group Co. LTD.	0.00

Disclosure

Normally, Commerce discloses to interested parties the calculations of the final results of an administrative review within five days of a public announcement or, if there is no public announcement, within five days of the date of publication of the notice of final results in the **Federal Register**, in accordance with 19 CFR 351.224(b). However, because we have made no changes to the *Preliminary Results,* there are no calculations to disclose.

Assessment Rates

Consistent with section 751(a)(2)(C) of the Act and 19 CFR 351.212(b), upon completion of the administrative review, Commerce shall determine, and U.S. Customs and Border Protection (CBP) shall assess, antidumping duties on all appropriate entries of subject merchandise covered this review. Because the respondents' weighted-average dumping margins or importer-specific assessment rates are zero or *de minimis* in the final results of review, we intend to instruct CBP to liquidate entries without regard to antidumping duties.[3] The final results of this administrative review shall be the basis for the assessment of antidumping duties on entries of merchandise covered by the final results of this review and for future deposits of estimated duties, where applicable.[4]

In accordance with Commerce's ''automatic assessment'' practice, for entries of subject merchandise during the POR produced by each respondent which did not know that its merchandise was destined for the United States, we will instruct CBP to liquidate entries not reviewed at the all-others rate established in the original less-than-fair value (LTFV) investigation (*i.e.,* 11.25 percent)[5] if there is no rate for the intermediate company(ies) involved in the transaction.

Commerce intends to issue assessment instructions to CBP no earlier than 35 days after the date of publication of these final results of this review in the **Federal Register**. If a timely summons is filed at the U.S. Court of International Trade, the assessment instructions will direct CBP not to liquidate relevant entries until the time for parties to file a request for a statutory injunction has expired (*i.e.,* within 90 days of publication).

Cash Deposit Requirements

The following cash deposit requirements will be effective upon publication in the **Federal Register** of the notice of final results of administrative review for all shipments of citric acid from Thailand entered, or withdrawn from warehouse, for consumption on or after the date of publication as provided for by section 751(a)(2)(C) of the Act: (1) the cash deposit rate for the companies listed above will be equal to the weighted-average dumping margin established in the final results of this administrative review (*i.e.,* 0.00 percent); (2) for merchandise exported by a company not covered in this review but covered in a prior completed segment of the proceeding, the cash deposit rate will continue to be the company-specific rate published in the completed segment for the most recent period; (3) if the exporter is not a firm covered in this review or another completed segment of this proceeding, but the producer is, then the cash deposit rate will be the company-specific rate established for the completed segment for the most recent period for the producer of the merchandise; and (4) the cash deposit rate for all other producers or exporters will continue to be 11.25 percent, the all-others rate established in the less-than-fair-value investigation.[6] These cash deposit requirements, when imposed, shall remain in effect until further notice.

Notification to Importers

This notice serves as a final reminder to importers of their responsibility under 19 CFR 351.402(f)(2) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during the POR. Failure to comply with this requirement could result in Commerce's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

Administrative Protective Order

This notice also serves as a final reminder to parties subject to an administrative protective order (APO) of their responsibility concerning the return or destruction of proprietary information disclosed under APO in accordance with 19 CFR 351.305(a)(3). Timely written notification of the return or destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and terms of an APO is a violation subject to sanction.

Notification to Interested Parties

Commerce is issuing and publishing the final results of this review in accordance with sections 751(a)(1) and 777(i)(1) of the Act, and 19 CFR 351.221(b)(5).

Dated: November 13, 2026.

Kasey O'Connor,

Deputy General Counsel, performing the non-exclusive functions and duties of the Assistant Secretary for Enforcement and Compliance.

[FR Doc. 2026–23524 Filed 11–18–26; 8:45 am]

BILLING CODE 3510–DS–P

[3] *See Antidumping Proceedings: Calculation of the Weighted-Average Dumping Margin and Assessment Rate in Certain Antidumping Proceedings; Final Modification,* 77 FR 8101, 8102–03 (February 14, 2012); *see also* 19 CFR 351.106(c)(2).

[4] *See* section 751(a)(2)(C) of the Act.

[5] *See Order,* 83 FR at 35215.

[6] *Id.*

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XG201]

Western Pacific Fishery Management Council; Public Meetings

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

ACTION: Notice of public meetings.

SUMMARY: The Western Pacific Fishery Management Council (Council) will hold its Executive and Budget Standing Committee (SC) and 209th Council meetings to take actions on fishery management issues in the Western Pacific Region.

DATES: The meetings will be held between December 11 and December 16, 2026. For specific times and agendas, see **SUPPLEMENTARY INFORMATION.** Written public comments on final action items at the 209th Council meeting should be received at the Council office by 5 p.m. Hawaii Standard Time (HST), Thursday, December 10, 2026, see **ADDRESSES**.

ADDRESSES: The Executive and Budget SC meetings will be held by web conference via Webex. The 209th Council Meeting will be held as hybrid meetings for members and the public, with a remote participation option available via Webex. In-person attendance for the 209th Council meeting will be hosted at the Ala Moana Hotel, Hibiscus Ballroom, 410 Atkinson Drive, Honolulu, HI 96814.

Specific information on joining the meetings and connecting to the web conference will be posted on the Council website at *https://www.wpcouncil.org.* For assistance with the web conference connection, contact the Council office at (808) 522–8220.

FOR FURTHER INFORMATION CONTACT: Kitty M. Simonds, Executive Director, Western Pacific Fishery Management Council; phone: (808) 522–8220.

SUPPLEMENTARY INFORMATION: The Executive and Budget SC meeting will be held between 2 p.m. and 5 p.m. HST on December 11, 2026. The 209th Council meeting will be held between 10 a.m. and 3 p.m. HST on December 14, 2026, between 8:30 a.m. and 5:30 p.m. HST on December 15, 2026, and between 8:30 a.m. and 2 p.m. HST on December 16, 2026. Public Comment on Non-Agenda Items will be held between 4 p.m. and 4:30 p.m. HST on December 15, 2026.

Background documents for the 209th Council meeting will be available at *https://www.wpcouncil.org.* Written public comments on final action items at the 209th Council meeting should be received at the Council office by 5 p.m. HST, Thursday, December 10, 2026, and should be sent to Kitty M. Simonds, Executive Director; Western Pacific Fishery Management Council, 1164 Bishop Street, Suite 1400, Honolulu, HI 96813, phone: (808) 522–8220 or fax: (808) 522–8226; or email: *info@wpcouncil.org.* Written public comments on all other agenda items may be submitted for the record by email throughout the duration of the meeting. Instructions for providing oral public comments during the meeting will be posted on the Council website.

Agenda items noted as ''Final Action'' refer to actions that may result in Council transmittal of a proposed fishery management plan, proposed plan amendment, or proposed regulations to the U.S. Secretary of Commerce, under Sections 304 or 305 of the Magnuson-Stevens Fishery Conservation and Management Act (MSA). In addition to the agenda items listed here, the Council and its advisory bodies will hear recommendations from Council advisors. An opportunity to submit public comment will be provided throughout the agendas. The order in which agenda items are addressed may change and will be announced as soon as practicable before the listed agenda item during the Council meeting. The meetings will run as late as necessary to complete scheduled business.

This meeting will be recorded (audio only) for the purposes of generating the minutes of the meeting. As public comments will be made publicly available, participants and public commenters are urged not to provide personally identifiable information at this meeting. Participation in the meeting by web conference, or by telephone, constitutes consent to the audio recording.

Agenda for the Executive and Budget SC Meeting

Friday, December 11, 2026, 2 p.m. to 5 p.m. HST

1. Introduction and Approval of Agenda
2. Financial Reports
3. Administrative Reports
4. Council Family Changes
5. Election of Officers
6. Meetings and Workshops
7. Other Business
8. Public Comment
9. Discussion and Recommendations

Agenda for the 209th Council Meeting

Monday, December 14, 2026, 10 a.m. to 3 p.m. HST

1. Welcome and Introductions/Land Acknowledgment
2. Oath of Office
3. Approval of the 209th Council Meeting Agenda
4. Approval of the 208th Council Meeting Minutes
5. Executive Director's Report
6. Agency Reports
   - A. National Marine Fisheries Service
   - A.1. Pacific Islands Regional Office
   - A.2. Pacific Islands Fisheries Science Center
   - B. NOAA Office of General Counsel Pacific Islands Section
   - C. U.S. Coast Guard
   - D. Enforcement
   - D.1. NOAA Office of Law Enforcement
   - D.2. NOAA Office of General Counsel Enforcement Section
   - E. U.S. State Department
   - F. U.S. Fish and Wildlife Service
   - G. Pacific States Marine Fisheries Commission
   - H. Public Comment
   - I. Council Discussion and Action
7. Hawaii Archipelago and Pacific Remote Island Area
   - A. Island Reports
   - B. Department of Land and Natural Resources/Division of Aquatic Resources Report
   - C. Experimental Fishing Permit for NWHI Bottomfish
   - D. Shark Depredation Policy Workshop
   - E. Advisory Group Report and Recommendations
   - E.1. Advisory Panel
   - E.2. Fishing Industry Advisory Committee
   - E.3. Social Science Planning Committee
   - E.4. Scientific and Statistical Committee (SSC)
   - F. Public Comment
   - G. Council Discussion and Action

Tuesday, December 15, 2026, 8:30 a.m. to 5:30 p.m. HST

8. Program Planning and Research
   - A. Update on Restoring Commercial Fishing in Marine National Monuments
   - B. National Legislative Report
   - C. Seafood Updates
   - C.1. America First Seafood Strategy Report
   - C.2. Seafood Roundtable Preparation
   - C.3. U.S. Department of Agriculture Office of Seafood Updates
   - C.4. Small Business Administration Updates
   - D. Regional Communications &

Outreach Report
E. Marine Recreational Information Program Fishing Effort Survey Transition
F. Report on Ecosystem Component Species Framework
G. Inflation Reduction Act Project Reports
G.1. Fisher Observations Portal
G.2. Communities Project Updates
H. Deep Sea Mining Updates in American Samoa and Marianas
I. Advisory Group Report and Recommendations
I.1. Advisory Panel
I.2. Fishing Industry Advisory Committee
I.3. Social Science Planning Committee
I.4. SSC
J. Public Comment
K. Council Discussion and Action
9. Pelagic and International Fisheries
A. Revising the Hawaii Shallow-set Longline Fishery Sea Turtle Measures (Initial Action)
A.1. Draft Alternatives and Overview of Analyses
A.2. Estimating Anticipated Turtle Interactions without Interaction Limits
A.3. Assessment of Population Level Impacts of North Pacific Loggerhead and Western Pacific Leatherback Turtles in the Hawaii Shallow-set Longline Fishery
B. Revising the American Samoa Longline Fishery Sea Turtle Measures (Initial Action)
B.1. Draft Alternatives and Overview of Analyses
B.2. Effects of Amendment 5 on Target and Non-target Catch, and Sea Turtle Interactions
C. Removing the Swordfish Retention Limit in the Hawaii Deep-set Longline Fishery (Final Action)
D. Electronic Monitoring Implementation Updates
E. International Fisheries Issues
E.1. Bigeye Tuna Management Procedure Outcomes
E.2. South Pacific Albacore Allocation Outcomes
E.3. Western and Central Pacific Fisheries Commission Annual Meeting
F. Advisory Group Report and Recommendations
F.1. Advisory Panel
F.2. Pelagic Plan Team
F.3. Fishing Industry Advisory Committee
F.4. Social Science Planning Committee
F.5. SSC
G. Public Comment
H. Council Discussion and Action
10. American Samoa Archipelago
A. Motu Lipoti
B. Department of Marine and Wildlife Resources Report
C. American Samoa Bottomfish Management Unit Species Annual Catch Limit Specifications for 2027–2030 (Final Action)
D. Advisory Group Report and Recommendations
D.1. American Samoa Advisory Panel
D.2. Fishing Industry Advisory Committee
D.3. SSC
E. Public Comment
F. Council Discussion and Action

Tuesday, December 15, 2026, 4 p.m. to 4:30 p.m. HST

Public Comment on Non-Agenda Items

Wednesday, December 16, 2026, 8:30 a.m. to 2 p.m. HST

11. Protected Species
A. Inflation Reduction Act Project Updates: Protected Species Final Report
B. Green Sea Turtle Activity Updates
B.1. International Collaboration on Green Sea Turtle Conservation and Research
B.2. Green Sea Turtle Status Review Process Overview and Timeline
C. Hawaii Shallow-set Longline Fishery Hookpod Project Experimental Fishing Permit Application Review
D. Advisory Group Report and Recommendations
D.1. Advisory Panel
D.2. Fishing Industry Advisory Committee
D.3. SSC
E. Public Comment
F. Council Discussion and Action
12. Mariana Archipelago
A. Guam
A.1. Isla Informe
A.2. Department of Agriculture/Division of Aquatic and Wildlife Resources Report
A.3. Report on Guam Bottomfish Workshop
B. Commonwealth of the Northern Mariana Islands (CNMI)
B.1. Arongol Falu
B.2. Department of Lands and Natural Resources/Division of Fish and Wildlife Report
C. Disaster Relief
C.1. Report on the Disaster Workshop
C.2. Assessment of Typhoon Impacts on Saipan Fishing and Seafood Communities
C.3. CNMI Fishery Disaster Request Task Force
D. Report on Ecosystem-based Fisheries Management Indicators for Coral Reef Fisheries of the Mariana Archipelago
E. Advisory Group Report and Recommendations
E.1. Marianas Advisory Panel
E.2. Fishing Industry Advisory Committee
E.3. SSC
F. Public Comment
G. Council Discussion and Action
13. Administrative Matters
A. Council Member and Staff Ethics Training
B. Financial Reports
C. Administrative Reports
D. Council Family Changes
E. Council Coordination Committee Meeting Report
F. Meetings and Workshops
G. Executive and Budget SC Report
H. Public Comment
I. Council Discussion and Action
14. Election of Officers
15. Other Business

Non-emergency issues not contained in this agenda may come before the Council for discussion during its 209th meeting. However, Council final decisions will be restricted to those issues specifically listed in this document and any regulatory issue arising after publication of this document that requires emergency action under section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the Council's intent to take action to address the emergency.

Special Accommodations

These meetings are accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Kitty M. Simonds, (808) 522–8220 (voice) or (808) 522–8226 (fax), at least 5 days prior to the meeting date.

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

Dated: November 17, 2026.

Rey Israel Marquez,

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

[FR Doc. 2026–23588 Filed 11–18–26; 8:45 am]

BILLING CODE 3510–22–P

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 the Procurement List.

SUMMARY: The Committee is proposing to add service(s) to the Procurement List

that will be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and delete product(s) and service(s) previously furnished by such agencies.

DATES: Comments must be received on or before: December 19, 2026.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, 250 E Street SW, Suite 3100, Washington DC, 20024.

FOR FURTHER INFORMATION CONTACT: For further information or to submit comments contact: Michael R. Jurkowski, Telephone: (703) 489–1322, or email *CMTEFedReg@AbilityOne.gov.*

SUPPLEMENTARY INFORMATION: This notice is published pursuant to 41 U.S.C. 8503 (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

In accordance with 41 CFR 51–5.3(b), the Committee intends to add this services requirement to the Procurement List as a mandatory purchase only for the contracting activity at the location listed, with the proposed qualified nonprofit agency as the authorized source of supply. Prior to adding the service to the Procurement List, the Committee will consider other pertinent information, including information from Government personnel and relevant comments from interested parties regarding the Committee's intent to geographically limit this services requirement.

The following service(s) are proposed for addition to the Procurement List for production by the nonprofit agencies listed:

Service(s)

Service Type: Laundry Service
Mandatory For: US Air Force, Robins Air Force Base, Warner Robins Air Logistic Complex, Robins AFB, GA, 480 Richard Ray Blvd., Robins AFB, GA
Authorized Source of Supply: Power Works Industries, Inc., Columbus, GA
Contracting Activity: DEPT OF THE AIR FORCE, FA8501 AFSC PZIO

Deletions

The following product(s) and service(s) are proposed for deletion from the Procurement List:

Product(s)

NSN(s)—Product Name(s):
7520–01–496–5477—Calendar, Wall, Custom, Erasable, 12-Month, 48'' x 36''
Authorized Source of Supply: Chicago Lighthouse Industries, Chicago, IL
Contracting Activity: GENERAL SERVICES ADMINISTRATION, GSA/FAS FURNITURE SYSTEMS MGT DIV
NSN(s)—Product Name(s):
7520–01–658–0691—Pen, Retractable, Erasable, Blue Gel Ink, .7mm
7520–01–658–0692—Pen, Retractable, Erasable, Black Gel Ink, .7mm
Authorized Source of Supply: West Texas Lighthouse for the Blind, San Angelo, TX
Contracting Activity: GENERAL SERVICES ADMINISTRATION, GSA/FAS ADMIN SVCS ACQUISITION BR(2)

Service(s)

Service Type: Third Party Logistics Support Services
Mandatory For: 3PL Support Services, US Army, ACC–APG, Aberdeen Proving Ground, MD—TO3—LEEK, 6515 Integrity Court, Bldg 4310, Aberdeen Proving Ground, MD
Authorized Source of Supply: Goodwill Industries of South Florida, Inc., Miami, FL
Contracting Activity: DEPT OF THE ARMY, W6QK ACC–APG
Service Type: Janitorial/Grounds and Related Services
Mandatory For: GSA PBS Region 9, Chet Holifield Federal Building, Laguna Niguel, CA, 24000 Avila Road, Laguna Niguel, CA
Authorized Source of Supply: Landmark Services, Inc., Santa Ana, CA
Contracting Activity: GENERAL SERVICES ADMINISTRATION, PBS R9 AMD SERVICES CONTRACTING BRANCH
Service Type: Custodial service
Mandatory For: US Department of Agriculture, APHIS, Veterinary Services and Plant Protection and Quarantine, Gainesville, FL, 8100 NW 15th Pl., Gainesville, FL
Authorized Source of Supply: CARC-Advocates for Citizens with Disabilities, Inc., Lake City, FL
Contracting Activity: DEPARTMENT OF AGRICULTURE, USDA APHIS MRPBS
Service Type: Food Service
Mandatory For: Marine Corps: Mess Hall #MCA 602, Norfolk, VA
Authorized Source of Supply: Louise W. Eggleston Center, Inc., Norfolk, VA
Contracting Activity: DEPT OF DEFENSE, DOD/OFF OF SECRETARY OF DEF (EXC MIL DEPTS)
Service Type: Facility Maintenance Support Service
Mandatory For: U.S. Marshals Service, U.S. Marshals Service Headquarters, Arlington, VA, 1215 S. Clark St., VA
Authorized Source of Supply: Chimes District of Columbia, Baltimore, MD
Contracting Activity: DEPARTMENT OF JUSTICE, USMS

Michael R. Jurkowski,

Director, Business Operations.

[FR Doc. 2026–23597 Filed 11–18–26; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Deletions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Deletions from the Procurement List.

SUMMARY: This action deletes service(s) from the Procurement List that were furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

DATES: *Date added to and deleted from the Procurement List:* December 20, 2026.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, 250 E Street SW, Suite 3100, Washington DC, 20024.

FOR FURTHER INFORMATION CONTACT: For further information or to submit comments contact: Michael R. Jurkowski, Telephone: (703) 489–1322, or email *CMTEFedReg@AbilityOne.gov.*

SUPPLEMENTARY INFORMATION:

Deletions

On October 15, 2026 (91 FR 65533), the Committee for Purchase From People Who Are Blind or Severely Disabled published notice of proposed deletions from the Procurement List. This notice is published pursuant to 41 U.S.C. 8503(a)(2) and 41 CFR 51–2.3.

After consideration of the relevant matter presented, the Committee has determined that the service(s) listed below are no longer suitable for procurement by the Federal Government under 41 U.S.C. 8501–8506 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 additional reporting, recordkeeping or other compliance requirements for small entities.

2. The action may result in authorizing small entities to furnish the service(s) 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. 8501–8506) in connection with the service(s) deleted from the Procurement List.

End of Certification

Accordingly, the following service(s) are deleted from the Procurement List:

Service(s)

Service Type: Custodial service
Mandatory For: US Army Corps of Engineers, Central Area Office, Davenport, IA, 1910 E. Kimberly Road, Suite 105, Davenport, IA
Authorized Source of Supply: The Arc of the Quad Cities Area, Rock Island, IL
Contracting Activity: DEPT OF DEFENSE, W07V ENDIST ROCK ISLAND
Service Type: Laundry Service
Mandatory For: US Army, Fort Campbell, Fort Campbell, KY, 8th and Desert Storm, Bldg 5212, Fort Campbell, KY
Authorized Source of Supply: Great Plains Enterprises, Inc., Las Vegas, NV
Contracting Activity: DEPT OF DEFENSE, W6QM MICC–FT CAMPBELL

Michael R. Jurkowski,

Director, Business Operations.

[FR Doc. 2026–23598 Filed 11–18–26; 8:45 am]

BILLING CODE 6353–01–P

DEPARTMENT OF EDUCATION

[Docket ID ED–2026–FSA–2839]

Privacy Act of 1974; Matching Program

AGENCY: Federal Student Aid, U.S. Department of Education.

ACTION: Notice of a new matching program.

SUMMARY: This matching program will support the U.S. Department of Education (ED) and the Department of War (DoW) in meeting the requirements set forth in Section 559(b) of the Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025, which requires the Secretary of Education and the Secretary of War to enter into a matching program to identify servicemembers and staff eligible for certain public service loan forgiveness programs. Under this matching program, DoW (source agency) will disclose to the ED, Federal Student Aid (FSA), (recipient agency), information on individuals who, at any time beginning on or after October 1, 2007, were members of the Armed Forces serving on active duty for a period of more than 30 consecutive days or civilian employees of DoW, for the purposes of: (1) identifying whether they made one or more student loan payments eligible to be counted for purposes of the Public Service Loan Forgiveness (PSLF) Program under subsection 455(m) of the Higher Education Act of 1965 (HEA) and Temporary Expanded PSLF (TEPSLF) program; and (2) without requiring further information from them, certifying the total period of such service or employment for purposes of such program and counting the total number of qualifying payments made by them for purposes of such program during such period. ED will evaluate the information that it receives from DoW to create a count of qualifying payments under PSLF made by covered employees on their respective Title IV Loans (as defined herein). In addition, ED will create customized notifications for covered employees based on the status of their respective Title IV Loans and whether they have already submitted a PSLF and TEPSLF Certification and Application (PSLF form).

DATES: Submit your comments on the proposed establishment of the matching program on or before December 21, 2026.

The matching program will become effective on the later of the following two dates: (1) December 1, 2026, or (2) 30 days after the publication of this notice, on November 19, 2026, unless comments have been received from interested members of the public requiring modification and republication of the notice. The matching program will continue for 18 months after the effective date and may be renewed for up to an additional 12 months if, within 3 months prior to the expiration of the 18 months, the respective Data Integrity Boards of ED and the DoW determine that the conditions specified in 5 U.S.C. 552a(o)(2)(D) have been met.

ADDRESSES: Comments must be submitted via the Federal eRulemaking Portal at *regulations.gov*. However, if you require an accommodation or cannot otherwise submit your comments via *regulations.gov*, please contact the program contact person listed under **FOR FURTHER INFORMATION CONTACT**. The Department will not accept comments submitted by fax or by email, or comments submitted after the comment period. To ensure that the Department does not receive duplicate copies, please submit your comments only once. In addition, please include the Docket ID at the top of your comments.

Federal eRulemaking Portal: Go to *www.regulations.gov* to submit your comments electronically. Information on using *Regulations.gov*, including instructions for accessing agency documents, submitting comments, and viewing the docket, is available on the site under the ''FAQ'' tab.

Privacy Note: The Department's policy is to make all comments received from members of the public available for public viewing in their entirety on the Federal eRulemaking Portal at *www.regulations.gov*. Therefore, commenters should be careful to include in their comments only information that they wish to make publicly available.

FOR FURTHER INFORMATION CONTACT: Corinne Sauri, Management and Program Analyst, Office of Operations and Governance, Federal Student Aid, U.S. Department of Education, 77 K Street NE, Washington, DC 20202. Telephone: (202) 245–5612.

If you are deaf, hard of hearing, or have a speech disability and wish to access telecommunications relay services, please dial 7–1–1.

SUPPLEMENTARY INFORMATION: In accordance with the Privacy Act of 1974, as amended (Privacy Act) (5 U.S.C. 552a); Office of Management and Budget (OMB) Final Guidance Interpreting the Provisions of Public Law 100–503, the Computer Matching and Privacy Protection Act of 1988, published in the **Federal Register** on June 19, 1989 (54 FR 25818); and OMB Circular No. A–108, notice is hereby provided of the establishment of the matching program between ED and DoW.

Participating Agencies

U.S. Department of Education and the Department of War.

Authority for Conducting the Matching Program

ED's legal authority to enter into this matching program is provided by subsection 455(m) of the HEA (20 U.S.C. 1087e(m)), and the regulations set forth in 34 CFR 685.219. DoW's legal authority for this matching program and the associated disclosures is provided by subsection 455(o) of the HEA (20 U.S.C. 1087e(o)) and the Privacy Act of 1974 (5 U.S.C. 552a). The Privacy Act (5 U.S.C. 552a(b)(3)) authorizes a Federal agency to disclose information about an

individual that is maintained in a system of records without the individual's prior written consent, when the disclosure is pursuant to a routine use published in a System of Records Notice (SORN) as required by 5 U.S.C. 552a(e)(4)(D). DoW published routine use Y in the applicable SORN, Uniformed Services Human Resources Information System (91 FR 10373) (March 3, 2026), to authorize the disclosures made under this matching program.

Purpose(s)

This matching program will assist DoW and ED in sharing information on individuals who, at any time beginning on or after October 1, 2007, were members of the Armed Forces serving on active duty for a period of more than 30 consecutive days or civilian employees of DoW (collectively referred to as ''covered employees''), for the purposes of: (1) identifying whether they made one or more student loan payments eligible to be counted for purposes of the PSLF program under subsection 455(m) of the HEA (20 U.S.C. 1087e(m)) and TEPSLF program; and (2) without requiring further information from them, certifying the total period of such service or employment for purposes of such program and counting the total number of qualifying payments made by them for purposes of such program during such period.

ED will evaluate the information that it receives from DoW to create a count of qualifying payments under PSLF made by covered employees of their respective Title IV Loans (as defined herein). In addition, ED will create customized notifications for covered employees based on the status of their respective Title IV Loans and whether they have already submitted a PSLF form. If ED determines that a covered employee, with approved certified employment on record as a result of a previously submitted PSLF form, has the requisite number of qualifying Title IV Loan payments under PSLF, then ED will automatically discharge the covered employee's Title IV Loans without requiring the covered employee to submit a PSLF form and will so notify the covered employee. Separately, if a covered employee has never submitted a PSLF form before but has met the requirements to receive loan discharge, ED will contact the covered employee and provide the ability to opt-out of forgiveness within 30 days from the date that ED sends the notification to the borrower before administering the discharge.

Categories of Individuals

This matching program covers individuals who, at any time beginning on or after October 1, 2007, were members of the Armed Forces serving on active duty for a period of more than 30 consecutive days or civilian employees of DoW.

Categories of Records

This matching program covers the following records on the aforementioned individuals: the name (first, middle, and last), date of birth (DOB), and Social Security number (SSN), and an indicator if the individual is military or civilian, beginning and end dates of employment or active duty service, and average number of hours in work schedule.

System(s) of Records

ED will disclose information to, and maintain information received from, DoW in ED's system of records titled ''National Student Loan Data System (NSLDS)'' (18–11–06), last published in the **Federal Register** in full on April 22, 2026 (91 FR 21480) and available at *https://www.federalregister.gov/documents/2026/04/22/2026-07817/privacy-act-of-1974-system-of-records.* ED will disclose to DoW the Notification File (data elements described in Attachment B) pursuant to routine use (1)(a) of NSLDS.

DoW will disclose to ED information from DoW's system of records titled ''Uniformed Services Human Resources Information System'', last published in full in the **Federal Register** on March 3, 2026 (91 FR 10373) and available at *https://www.federalregister.gov/documents/2026/03/03/2026-04170/privacy-act-of-1974-system-of-records.* DoW will disclose to ED the Response File (data elements described in Attachment B) pursuant to routine use Y.

ED will redisclose the information obtained from DoW to ED's Digital and Customer Care (DCC) Information Technology (IT) system covered under the system of records titled ''Aid Awareness and Application Processing'' (18–11–21), last published in the **Federal Register** in full on April 22, 2026 (91 FR 21450) and available at *https://www.federalregister.gov/documents/2026/04/22/2026-07825/privacy-act-of-1974-system-of-records* pursuant to 5 U.S.C. 552a(b)(1). DoW and ED have respectively determined that the routine uses set forth in Sections VI.A.1 through 3 of this CMA are compatible with the purposes for which the information was collected. In accordance with Section VIII of this CMA, ED will notify all borrowers contained in the DoW Response File via written letter that their information matched.

Accessible Format: On request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**, individuals with disabilities can obtain this document in an accessible format. The Department will provide the requestor with an accessible format that may include Rich Text Format (RTF) or text format (txt), a thumb drive, an MP3 file, braille, large print, audiotape, compact disc, or other accessible format.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. You may access the official edition of the **Federal Register** and the Code of Federal Regulations at *www.govinfo.gov.* At this site you can view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at the site.

You may also access documents of the Department published in the **Federal Register** by using the article search feature at *www.federalregister.gov*. Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Wayne Sullivan,

Acting Principal Deputy Chief Operating Officer, Federal Student Aid.

[FR Doc. 2026–23616 Filed 11–18–26; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket No.: ED–2026–SCC–3400]

Agency Information Collection Activities; Comment Request; Guaranty Agencies Security Self-Assessment and Attestation

AGENCY: Federal Student Aid (FSA), Department of Education (ED).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act (PRA) of 1995, the Department is proposing a revision of a currently approved information collection request (ICR).

DATES: Interested persons are invited to submit comments on or before January 19, 2027.

ADDRESSES: To access and review all the documents related to the information collection listed in this notice, please use *http://www.regulations.gov* by

searching the Docket ID number ED–2026–SCC–3400. Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://www.regulations.gov* by selecting the Docket ID number or via postal mail, commercial delivery, or hand delivery. If the *regulations.gov* site is not available to the public for any reason, the Department will temporarily accept comments at *ICDocketMgr@ed.gov.* Please include the docket ID number and the title of the information collection request when requesting documents or submitting comments. Please note that comments submitted after the comment period will not be accepted. Written requests for information or comments submitted by postal mail or delivery should be addressed to Carolyn Rose, U.S. Department of Education, Federal Student Aid, 400 Maryland Avenue SW, Washington, DC 20202–1200.

FOR FURTHER INFORMATION CONTACT: For specific questions related to collection activities, please contact Carolyn Rose, (202) 453–5967.

SUPPLEMENTARY INFORMATION: The Department, in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the Department assess the impact of its information collection requirements and minimize the public's reporting burden. It also helps the public understand the Department's information collection requirements and provide the requested data in the desired format. The Department is soliciting comments on the proposed information collection request (ICR) that is described below. The Department is especially interested in public comment addressing the following issues: (1) is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology. Please note that written comments received in response to this notice will be considered public records.

Title of Collection: Guaranty Agencies Security Self-assessment and Attestation.

OMB Control Number: 1845–0134.

Type of Review: Revision of a currently approved ICR.

Respondents/Affected Public: Private Sector.

Total Estimated Number of Annual Responses: 9.

Total Estimated Number of Annual Burden Hours: 5,058.

Abstract: This is a request for a revision of the approved information collection used by Federal Student Aid (FSA) to ensure that all data collected and managed by Guaranty Agencies (GAs) in support Federal student financial aid programs are secure. FSA continues to use a formal assessment program that ensures the GAs have security protocols in place to protect the confidentiality and integrity of data entrusted to FSA by students and families. This assessment will identify security deficiencies based on the federal standards described in the National Institute of Standards and Technology (NIST) publications.

Ross Santy,

Chief Data Officer, Office of Planning, Evaluation and Policy Development.

[FR Doc. 2026–23531 Filed 11–18–26; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EL27–11–000]

Exelon Corporation v. PJM Interconnection, L.L.C.; Notice Establishing Comment Period

On November 4, 2026, PJM Interconnection, L.L.C. (PJM) filed a preliminary answer opposing fast-track processing and a motion requesting a four-week extension of time, until December 21, 2026, to answer the complaint filed by Exelon Corporation (Exelon) in the above-captioned proceeding. PJM argues that there is good cause to grant the extension because the additional time will permit PJM to incorporate into its response the outcome of the deliberations by the PJM Board, which will meet on November 17, 2026. PJM also argues that Exelon has failed to demonstrate any compelling reason for Commission action by the requested January 31, 2027, date and therefore a four-week extension of the answer deadline will not impair the Commission's ability to act.

On November 9, 2026, Exelon filed a motion for leave to answer and answer. Exelon supports an extension of the comment period to December 7, 2026, but argues that the scale of PJM's proposed extension is excessive for the narrow scope of the allegations it must answer. Exelon also urges the Commission to act sufficiently in advance of the May 2027 Base Residual Auction.

Upon consideration, notice is hereby given that PJM's motion for extension of time is granted and the deadline to file the answer to Exelon's complaint, comments, and interventions is December 21, 2026.

(Authority: 16 U.S.C. 824e)

Dated: November 13, 2026.

Carlos D. Clay,

Deputy Secretary.

[FR Doc. 2026–23611 Filed 11–18–26; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP27–12–000]

Freeport LNG Development, L.P., FLNG Liquefaction, LLC, FLNG Liquefaction 2, LLC, FLNG Liquefaction 3, LLC, FLNG Liquefaction 4, LLC; Notice of Application and Establishing Intervention Deadline

Take notice that on October 30, 2026, Freeport LNG Development, L.P., FLNG Liquefaction, LLC, FLNG Liquefaction 2, LLC, FLNG Liquefaction 3, LLC, and FLNG Liquefaction 4, LLC (collectively, Freeport LNG), 333 Clay Street, Suite 5050, Houston, Texas 77002, filed an application under section 3 of the Natural Gas Act (NGA) and Part 153 of the Commission's regulations requesting an amendment to Freeport LNG's FERC authorizations in Docket Nos. CP12–29–000 and CP12–509–000 to install a flare gas recovery system at the existing natural gas pretreatment facility (PTF) of the Freeport LNG Liquefaction Project, located on Quintana Island, Brazoria County, Texas (PTF Flaring Reduction Project or Project). Freeport LNG states that the Project is designed to capture and reprocess gas currently being sent to the flare header in order to reduce flaring and the resultant air emissions at the pretreatment facility, all as more fully set forth in the application which is on file with the Commission and open for public inspection.

In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the internet through the Commission's Home Page

(*http://www.ferc.gov*). From the Commission's Home Page on the internet, this information is available on eLibrary. The full text of this document is available on eLibrary in PDF and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number excluding the last three digits of this document in the docket number field.

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

Any questions regarding the proposed project should be directed to Erin Piper, Supervisor, Regulatory Projects and Audit, Freeport LNG Development, L.P., 333 Clay Street, Suite 5050, Houston, Texas 77002, by phone at (713) 980–2888, or by email at *epiper@freeportlng.com.*

Pursuant to section 157.9 of the Commission's Rules of Practice and Procedure,[1] within 90 days of this Notice the Commission staff will either: complete its environmental review and place it into the Commission's public record (eLibrary) for this proceeding; or issue a Notice of Schedule for Environmental Review. If a Notice of Schedule for Environmental Review is issued, it will indicate, among other milestones, the anticipated date for the Commission staff's issuance of the final environmental impact statement (FEIS) or environmental assessment (EA) for this proposal. The filing of an EA in the Commission's public record for this proceeding or the issuance of a Notice of Schedule for Environmental Review will serve to notify federal and state agencies of the timing for the completion of all necessary reviews, and the subsequent need to complete all federal authorizations within 90 days of the date of issuance of the Commission staff's FEIS or EA.

Public Participation

There are three ways to become involved in the Commission's review of this project: you can file comments on the project, you can protest the filing, and you can file a motion to intervene in the proceeding. There is no fee or cost for filing comments or intervening. The deadline for filing a motion to intervene is 5:00 p.m. Eastern Time on December 7, 2026. How to file protests, motions to intervene, and comments is explained below.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation (OPP) at (202) 502–6595 or *OPP@ferc.gov.*

Comments

Any person wishing to comment on the project may do so. Comments may include statements of support or objections, to the project as a whole or specific aspects of the project. The more specific your comments, the more useful they will be.

Protests

Pursuant to sections 157.10(a)(4)[2] and 385.211[3] of the Commission's regulations under the NGA, any person[4] may file a protest to the application. Protests must comply with the requirements specified in section 385.2001[5] of the Commission's regulations. A protest may also serve as a motion to intervene so long as the protestor states it also seeks to be an intervenor.

To ensure that your comments or protests are timely and properly recorded, please submit your comments on or before 5:00 p.m. Eastern Time on December 7, 2026.

There are three methods you can use to submit your comments or protests to the Commission. In all instances, please reference the Project docket number CP27–12–000 in your submission.

(1) You may file your comments electronically by using the eComment feature, which is located on the Commission's website at *www.ferc.gov* under the link to Documents and Filings. Using eComment is an easy method for interested persons to submit brief, text-only comments on a project;

(2) You may file your comments or protests electronically by using the eFiling feature, which is located on the Commission's website (*www.ferc.gov*) under the link to Documents and Filings. With eFiling, you can provide comments in a variety of formats by attaching them as a file with your submission. New eFiling users must first create an account by clicking on ''eRegister.'' You will be asked to select the type of filing you are making; first select ''General'' and then select ''Comment on a Filing''; or

(3) You can file a paper copy of your comments or protests by mailing them to the following address below. Your written comments must reference the Project docket number (CP27–12–000).

To file via USPS: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

To file via any other courier: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, Maryland 20852.

The Commission encourages electronic filing of comments (options 1 and 2 above) and has eFiling staff available to assist you at (202) 502–8258 or *FercOnlineSupport@ferc.gov.*

Persons who comment on the environmental review of this project will be placed on the Commission's environmental mailing list, and will receive notification when the environmental documents (EA or EIS) are issued for this project and will be notified of meetings associated with the Commission's environmental review process.

The Commission considers all comments received about the project in determining the appropriate action to be taken. However, the filing of a comment alone will not serve to make the filer a party to the proceeding. To become a party, you must intervene in the proceeding. For instructions on how to intervene, see below.

Interventions

Any person, which includes individuals, organizations, businesses, municipalities, and other entities,[6] has the option to file a motion to intervene in this proceeding. Only intervenors have the right to request rehearing of Commission orders issued in this proceeding and to subsequently challenge the Commission's orders in the U.S. Circuit Courts of Appeal.

To intervene, you must submit a motion to intervene to the Commission in accordance with Rule 214 of the Commission's Rules of Practice and Procedure[7] and the regulations under the NGA[8] by the intervention deadline for the project, which is 5:00 p.m. Eastern Time on December 7, 2026. As described further in Rule 214, your motion to intervene must state, to the extent known, your position regarding the proceeding, as well as your interest in the proceeding. For an individual, this could include your status as a landowner, ratepayer, resident of an

[1] 18 CFR 157.9.

[2] 18 CFR 157.10(a)(4).

[3] 18 CFR 385.211.

[4] Persons include individuals, organizations, businesses, municipalities, and other entities. 18 CFR 385.102(d).

[5] 18 CFR 385.2001.

[6] 18 CFR 385.102(d).

[7] 18 CFR 385.214.

[8] 18 CFR 157.10.

impacted community, or recreationist. You do not need to have property directly impacted by the project in order to intervene. For more information about motions to intervene, refer to the FERC website at *https://www.ferc.gov/resources/guides/how-to/intervene.asp.*

There are two ways to submit your motion to intervene. In both instances, please reference the Project docket number CP27–12–000 in your submission.

(1) You may file your motion to intervene by using the Commission's eFiling feature, which is located on the Commission's website (*www.ferc.gov*) under the link to Documents and Filings. New eFiling users must first create an account by clicking on ''eRegister.'' You will be asked to select the type of filing you are making; first select ''General'' and then select ''Intervention.'' The eFiling feature includes a document-less intervention option; for more information, visit *https://www.ferc.gov/docs-filing/efiling/document-less-intervention.pdf.;* or

(2) You can file a paper copy of your motion to intervene, along with three copies, by mailing the documents to the address below. Your motion to intervene must reference the Project docket number CP27–12–000.

To file via USPS: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

To file via any other courier: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, Maryland 20852.

The Commission encourages electronic filing of motions to intervene (option 1 above) and has eFiling staff available to assist you at (202) 502–8258 or *FercOnlineSupport@ferc.gov.*

Protests and motions to intervene must be served on the applicant either by mail at: Erin Piper, Supervisor, Regulatory Projects and Audit, Freeport LNG Development, L.P., 333 Clay Street, Suite 5050, Houston, Texas 77002, or by email (with a link to the document) at *epiper@freeportlng.com.* Any subsequent submissions by an intervenor must be served on the applicant and all other parties to the proceeding. Contact information for parties can be downloaded from the service list at the eService link on FERC Online. Service can be via email with a link to the document.

All timely, unopposed [9] motions to intervene are automatically granted by operation of Rule 214(c)(1).[10] Motions to intervene that are filed after the intervention deadline are untimely, and may be denied. Any late-filed motion to intervene must show good cause for being late and must explain why the time limitation should be waived and provide justification by reference to factors set forth in Rule 214(d) of the Commission's Rules and Regulations.[11] A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies (paper or electronic) of all documents filed by the applicant and by all other parties.

Tracking the Proceeding

Throughout the proceeding, additional information about the project will be available from OPP at (202) 502–6595 or on the FERC website at *www.ferc.gov* using the ''eLibrary'' link as described above. The eLibrary link also provides access to the texts of all formal documents issued by the Commission, such as orders, notices, and rulemakings.

In addition, the Commission offers a free service called eSubscription which allows you to keep track of all formal issuances and submittals in specific dockets. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. For more information and to register, go to *www.ferc.gov/docs-filing/esubscription.asp.*

Intervention Deadline: 5:00 p.m. Eastern Time on December 7, 2026.

(Authority: 18 CFR 2.1)

Dated: November 16, 2026.

Carlos D. Clay,

Deputy Secretary.

[FR Doc. 2026–23609 Filed 11–18–26; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

Take notice that the Commission received the following Natural Gas Pipeline Rate and Refund Report filings:

Filings Instituting Proceedings

Docket Numbers: PR27–17–000.

Applicants: Eagle Ford Midstream LLC.

Description: § 284.123 Rate Filing: Petition for Approval of Rates for Transportation Service Under NGPA Section 311 to be effective 11/12/2026.

Filed Date: 11/13/26.

Accession Number: 20261113–5150.

Comment Date: 5 p.m. ET 12/4/26.

Docket Numbers: RP27–169–000.

Applicants: Northern Natural Gas Company.

Description: Northern Natural Gas Company submits report of the penalty and daily delivery variance charge (DDVC) revenues that have been credited to shippers.

Filed Date: 11/13/26.

Accession Number: 20261113–5168.

Comment Date: 5 p.m. ET 11/25/26.

Any person desiring to intervene, to protest, or to answer a complaint in any of the above proceedings must file in accordance with Rules 211, 214, or 206 of the Commission's Regulations (18 CFR 385.211, 385.214, or 385.206) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

Filings in Existing Proceedings

Docket Numbers: RP26–797–000.

Applicants: National Fuel Gas Supply Corporation.

Description: Report Filing: Update of Test Period Data (Updated Statements) to be effective N/A.

Filed Date: 11/16/26.

Accession Number: 20261116–5117.

Comment Date: 5 p.m. ET 11/30/26.

Any person desiring to protest in any the above proceedings must file in accordance with Rule 211 of the Commission's Regulations (18 CFR 385.211) on or before 5:00 p.m. Eastern time on the specified comment date.

The filings are accessible in the Commission's eLibrary system (*https://elibrary.ferc.gov/idmws/search/fercgensearch.asp*) by querying the docket number.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation at (202) 502–6595 or *OPP@ferc.gov.*

[9] The applicant has 15 days from the submittal of a motion to intervene to file a written objection to the intervention.

[10] 18 CFR 385.214(c)(1).

[11] 18 CFR 385.214(b)(3) and (d).

Dated: November 16, 2026.

Carlos D. Clay,

Deputy Secretary.

[FR Doc. 2026–23608 Filed 11–18–26; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

Take notice that the Commission received the following Exempt Wholesale Generator filings:

Docket Numbers: EG27–34–000.

Applicants: Welcome Solar II LLC.

Description: Welcome Solar II LLC submits Notice of Self-Certification of Exempt Wholesale Generator Status.

Filed Date: 11/12/26.

Accession Number: 20261112–5347.

Comment Date: 5 p.m. ET 12/3/26.

Docket Numbers: EG27–35–000.

Applicants: Welcome Solar III LLC.

Description: Welcome Solar III LLC submits Notice of Self-Certification of Exempt Wholesale Generator Status.

Filed Date: 11/12/26.

Accession Number: 20261112–5348.

Comment Date: 5 p.m. ET 12/3/26.

Docket Numbers: EG27–36–000.

Applicants: Winchester Solar I, LLC.

Description: Winchester Solar I, LLC submits Notice of Self-Certification of Exempt Wholesale Generator Status.

Filed Date: 11/12/26.

Accession Number: 20261112–5351.

Comment Date: 5 p.m. ET 12/3/26.

Docket Numbers: EG27–37–000.

Applicants: Winchester Solar II, LLC.

Description: Winchester Solar II, LLC submits Notice of Self-Certification of Exempt Wholesale Generator Status.

Filed Date: 11/12/26.

Accession Number: 20261112–5352.

Comment Date: 5 p.m. ET 12/3/26.

Docket Numbers: EG27–38–000.

Applicants: Hanson Solar, LLC.

Description: Hanson Solar, LLC submits Notice of Self-Certification of Exempt Wholesale Generator Status.

Filed Date: 11/13/26.

Accession Number: 20261113–5166.

Comment Date: 5 p.m. ET 12/4/26.

Take notice that the Commission received the following Complaints and Compliance filings in EL Dockets:

Docket Numbers: EL27–16–000.

Applicants: SFS Energy Storage LLC v. *Southern California Edison Company.*

Description: Complaint of *SFS Energy Storage LLC* v. *Southern California Edison Company.*

Filed Date: 11/13/26.

Accession Number: 20261113–5148.

Comment Date: 5 p.m. ET 12/14/26.

Docket Numbers: EL27–17–000.

Applicants: North Carolina Electric Membership Corporation.

Description: Petition for Partial Waiver of the Commission's PURPA Regulations.

Filed Date: 10/23/26.

Accession Number: 20261023–5235.

Comment Date: 5 p.m. ET 11/23/26.

Take notice that the Commission received the following Electric Rate filings:

Docket Numbers: ER16–1872–030; ER26–686–001; ER26–686–001; ER11–4462–124; ER26–685–001; ER25–1348–010; ER16–1509–013; ER25–2253–004; ER10–1970–040; ER17–838–097; ER10–1951–101; ER20–1220–021; ER20–1879–022; ER16–2506–032; ER18–2224–030; ER26–46–002; ER13–2461–031; ER21–2100–018; ER25–3117–004; ER26–683–001; ER25–3110–004; ER10–1972–040; ER21–2048–019; ER25–1317–008; ER26–682–001; ER25–1349–009; ER25–2293–005; ER25–2254–005; ER25–2505–005; ER19–2382–023; ER17–2270–031; ER25–3120–004; ER26–680–001; ER25–3116–004; ER12–1660–039; ER26–47–002; ER13–2458–032; ER22–2601–014; ER25–2506–005; ER10–2078–037; ER25–1340–006.

Applicants: Wildwood Solar, LLC, White Oak Energy LLC, Weirs Creek Solar, LLC, Walleye Wind, LLC, Tuscola Wind II, LLC, Tuscola Wind Energy II, LLC, Tuscola Bay Wind, LLC, Tupelo Brake Solar, LLC, Tournesol Solar, LLC, Three Waters Wind Farm, LLC, Stuttgart Solar, LLC, Story County Wind, LLC, St. Landry Solar, LLC, Singer Solar, LLC, Sebree Solar II, LLC, Sebree Solar, LLC, Scarborough Solar, LLC, Salt Creek Wind LLC, Mammoth Plains Wind, LLC, Sac County Wind, LLC, NextEra Energy Point Beach, LLC, Rock Creek Solar, LLC, Reynolds Solar, LLC, Red Butte Wind, LLC, Point Beach Solar, LLC, Pheasant Run Wind, LLC, Pheasant Run Wind Energy, LLC, Pegasus Wind, LLC, Oliver Wind III, LLC, Oliver Wind I, LLC, Oliver Wind II, LLC, NextEra Energy Services Massachusetts, LLC, NextEra Energy Marketing, LLC, NextEra Energy Duane Arnold, LLC, Mondu Solar, LLC, New Wave Energy LLC, New Madrid Solar, LLC, New Madrid Energy Storage, LLC, NEPM II, LLC, Mayhew Lake Energy Storage, LLC, Merom Solar, LLC, Marshall Solar, LLC.

Description: Notice of Change in Status of Amite Energy Storage, LLC, et al. under ER25–3111.

Filed Date: 11/2/26.

Accession Number: 20261102–5437.

Comment Date: 5 p.m. ET 11/23/26.

Docket Numbers: ER22–2357–004.

Applicants: ISO New England Inc., Eversource Energy Service Company (as agent), Cross-Sound Cable Company, LLC, New England Power Pool Participants Committee, The United Illuminating Company.

Description: Compliance filing: ISO New England Inc. submits tariff filing per 35: Compliance Filing in ER22–2357 to Establish Actual Effective Date to be effective 11/17/2026.

Filed Date: 11/16/26.

Accession Number: 20261116–5173.

Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER25–410–002.

Applicants: ISO New England Inc., New England Power Pool Participants Committee.

Description: Compliance filing: ISO New England Inc. submits tariff filing per 35: Compliance Filing in Docket No. ER25–410 to Establish Actual Effective Date to be effective 11/17/2026.

Filed Date: 11/16/26.

Accession Number: 20261116–5180.

Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER26–3333–001.

Applicants: Deseret Generation & Transmission Co-operative, Inc.

Description: Compliance filing: Compliance Filing to be effective 9/28/2026.

Filed Date: 11/16/26.

Accession Number: 20261116–5277.

Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–216–001.

Applicants: Duke Energy Carolinas, LLC.

Description: Tariff Amendment: DEC–NCEMC Limited Amendment to Pending Amended NITSA SA No. 210 to be effective 12/31/9998.

Filed Date: 11/13/26.

Accession Number: 20261113–5160.

Comment Date: 5 p.m. ET 12/4/26.

Docket Numbers: ER27–485–000.

Applicants: Limber Battery Storage, LLC.

Description: Petition for Limited Waiver of Limber Battery Storage, LLC.

Filed Date: 11/10/26.

Accession Number: 20261110–5246.

Comment Date: 5 p.m. ET 12/1/26.

Docket Numbers: ER27–497–000.

Applicants: Canal Marketing LLC.

Description: § 205(d) Rate Filing: Revision to IROL–CIP Rate Schedule 17 to be effective 1/15/2027.

Filed Date: 11/16/26.

Accession Number: 20261116–5072.

Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–498–000.

Applicants: KOREnergy, Ltd.

Description: Petition of KOREnergy, Ltd. for a limited one-time waiver of a procedural requirement contained in PJM OATT and RAA, and request for expedited action.

Filed Date: 11/13/26.

Accession Number: 20261113–5212.
Comment Date: 5 p.m. ET 11/23/26.

Docket Numbers: ER27–499–000.
Applicants: Citizens Sunrise Transmission LLC.
Description: § 205(d) Rate Filing: Tariff Revisions to Address Commission's EL26–71 Order to Show Cause to be effective 1/15/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5105.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–500–000.
Applicants: Citizens Sycamore-Penasquitos Transmission LLC.
Description: § 205(d) Rate Filing: Tariff Revisions to Address Commission's ER26–71 Order to Show Cause to be effective 1/15/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5109.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–501–000.
Applicants: Citizens S-Line Transmission LLC.
Description: § 205(d) Rate Filing: Tariff Revisions to Address Commission's EL26–71 Order to Show Cause to be effective 1/15/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5110.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–503–000.
Applicants: Guzman Transmission LLC.
Description: Initial Rate Filing: Baseline New to be effective 11/17/2026.
Filed Date: 11/16/26.
Accession Number: 20261116–5157.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–504–000.
Applicants: Guzman Generation LLC.
Description: Initial Rate Filing: Baseline New to be effective 11/17/2026.
Filed Date: 11/16/26.
Accession Number: 20261116–5159.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–505–000.
Applicants: PJM Interconnection, L.L.C.
Description: Tariff Amendment: Notice of Cancellation of ISA, Service Agreement No. 6674; AC1–168 re: withdraw to be effective 1/16/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5175.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–506–000.
Applicants: California Independent System Operator Corporation.
Description: Compliance filing: 2026–11–16 Large Loads Tariff Amendment to be effective 2/16/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5179.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–507–000.
Applicants: PacifiCorp.
Description: § 205(d) Rate Filing: SCPPA Construction Agreement (R.S. No. 815) to be effective 11/17/2026.
Filed Date: 11/16/26.
Accession Number: 20261116–5191.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–508–000.
Applicants: Southern California Edison Company.
Description: § 205(d) Rate Filing: SCE OSC—Large Load, TOT Revisions to be effective 2/16/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5210.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–509–000.
Applicants: PJM Interconnection, L.L.C.
Description: Tariff Amendment: Notice of Default and Termination of SA No. 6208; Project Identifier No. AG1–130 to be effective 1/16/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5214.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–510–000.
Applicants: Alabama Power Company, Georgia Power Company, Mississippi Power Company.
Description: Tariff Amendment: Alabama Power Company submits tariff filing per 35.15: Montgomery Solar (Solar & Storage) LGIA Termination Filing to be effective 11/16/2026.
Filed Date: 11/16/26.
Accession Number: 20261116–5218.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–511–000.
Applicants: Alabama Power Company, Georgia Power Company, Mississippi Power Company.
Description: § 205(d) Rate Filing: Alabama Power Company submits tariff filing per 35.13(a)(2)(iii: Beaver Creek BESS SISA Filing to be effective 11/3/2026.
Filed Date: 11/16/26.
Accession Number: 20261116–5241.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–512–000.
Applicants: DCR Transmission, L.L.C.
Description: § 205(d) Rate Filing: Proposed TO Tariff Revisions to be effective 2/15/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5249.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–513–000.
Applicants: Pacific Gas and Electric Company.
Description: § 205(d) Rate Filing: TO: Response to Large Load Order to Show Cause in EL26–71–000 to be effective 2/16/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5257.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–514–000.
Applicants: PJM Interconnection, L.L.C.
Description: § 205(d) Rate Filing: Original NSA, Service Agreement No. 8106; Queue Position No. AE1–250 to be effective 1/16/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5272.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–515–000.
Applicants: SunZia Transmission, LLC.
Description: § 205(d) Rate Filing: SunZia Transmission—Trans. Owner Tariff Response to Show Cause Order EL26–71- to be effective 12/31/9998.
Filed Date: 11/16/26.
Accession Number: 20261116–5274.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–516–000.
Applicants: Circle City Energy Storage LLC.
Description: Initial Rate Filing: Application for Market-Based Rate Authorization, Request for Related Waivers to be effective 1/16/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5278.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–517–000.
Applicants: New York Independent System Operator, Inc.
Description: § 205(d) Rate Filing: NYISO 205: Proposed Revisions re: Integration of Large Loads to be effective 2/1/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5282.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–518–000.
Applicants: LS Power Grid New York Corporation I, New York Independent System Operator, Inc.
Description: § 205(d) Rate Filing: New York Independent System Operator, Inc. submits tariff filing per 35.13(a)(2)(iii: LSPGNY 205: Proposed Revisions re: RS10 Large Load-Driven Upgrade Cost Recovery to be effective 1/16/2027.
Filed Date: 11/16/26.
Accession Number: 20261116–5286.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–519–000.
Applicants: Abes Run Solar LLC.
Description: Initial Rate Filing: Application for Market-Based Rate Authorization to be effective 11/20/2026.
Filed Date: 11/16/26.
Accession Number: 20261116–5294.
Comment Date: 5 p.m. ET 12/7/26.

Docket Numbers: ER27–520–000.
Applicants: PECO Energy Company.

Description: § 205(d) Rate Filing: PJM TOs Tariff Revisions for Service to Co-Located Loads and Large Loads to be effective 3/16/2027.

Filed Date: 11/16/26.

Accession Number: 20261116–5300.

Comment Date: 5 p.m. ET 12/7/26.

The filings are accessible in the Commission's eLibrary system (*https://elibrary.ferc.gov/idmws/search/fercgensearch.asp*) by querying the docket number.

Any person desiring to intervene, to protest, or to answer a complaint in any of the above proceedings must file in accordance with Rules 211, 214, or 206 of the Commission's Regulations (18 CFR 385.211, 385.214, or 385.206) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation at (202) 502–6595 or *OPP@ferc.gov.*

Dated: November 16, 2026.

Carlos D. Clay,

Deputy Secretary.

[FR Doc. 2026–23607 Filed 11–18–26; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–R10–OAR–2026–2906; FRL–13718–01–OFA]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Federal Implementation Plans Under the Clean Air Act for Indian Reservations in Idaho, Oregon and Washington (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency has submitted an information collection request (ICR), Federal Implementation Plans under the Clean Air Act for Indian Reservations in Idaho, Oregon and Washington (EPA ICR Number 2020.09, OMB Control Number 2060–0558) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. This is a proposed extension of the ICR, which is currently approved through November 30, 2026. Public comments were previously requested via the **Federal Register** on June 4, 2026, during a 60-day comment period. This notice allows for an additional 30 days for public comments.

DATES: Comments may be submitted on or before December 21, 2026.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA–R10–OAR–2026–2906, to EPA online using *www.regulations.gov* (our preferred method), or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460.

EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI), or other information whose disclosure is restricted by statute.

Submit written comments and recommendations to OMB for the proposed information collection within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Matthew Jentgen, EPA Region 10, Air and Radiation Division, 1200 6th Avenue, Seattle, WA 98101; telephone number: (206) 553–0340; email address: *jentgen.matthew@epa.gov.*

SUPPLEMENTARY INFORMATION: This is a proposed extension of the ICR, which is currently approved through November 30, 2026. 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.

Public comments were previously requested via the **Federal Register** on June 4, 2026, during a 60-day comment period (91 FR 33720). This notice allows for an additional 30 days for public comments. Supporting documents, which explain in detail the information that the EPA will be collecting, are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit *http://www.epa.gov/dockets.*

Abstract: The EPA promulgated Federal Implementation Plans (FIPs) under the Clean Air Act for Indian reservations located in Idaho, Oregon, and Washington in 40 CFR part 49 (70 FR 18074, April 8, 2005). This final rule, also referred to as the Federal Air Rules for Indian Reservations in Idaho, Oregon, and Washington (FARR), includes information collection requirements. Regulated entities can assert claims of business confidentiality and the EPA will address these claims in accordance with the provisions of 40 CFR part 2, subpart B.

Form Numbers: The forms associated with this ICR are:

EPA Form 7630–1 Nez Perce Reservation Air Quality Permit: Agricultural Burn
EPA Form 7630–2 Nez Perce Reservation Air Quality Permit: Forestry Burn
EPA Form 7630–3 Nez Perce Reservation Air Quality Permit: Large Open Burn
EPA Form 7630–4 Initial or Annual Source Registration
EPA Form 7630–5 Report of Change of Ownership
EPA Form 7630–6 Report of Closure
EPA Form 7630–7 Report of Relocation
EPA Form 7630–8 CTUIR Umatilla Indian Reservation Small Burn Air Quality Permit Application
EPA Form 7630–8 NPT Nez Perce Reservation Small Burn Air Quality Permit
EPA Form 7630–9 Non-Title V Operating Permit Application Form
EPA Form 7630–10 Umatilla Indian Reservation: Agricultural Burn Permit Application
EPA Form 7630–11 Umatilla Indian Reservation: Forestry Burn Permit Application
EPA Form 7630–12 Umatilla Indian Reservation: Large Open Burn Permit Application
EPA Form 5800–057 FARR Online Reporting System Initial or Annual Source Registration
EPA Form PFN–3520–38 Combined Air Emissions Reporting System Initial or Annual Source Registration

The forms listed above are available for review in the EPA docket.

Respondents/affected entities: Respondents or entities potentially affected by this action include owners and operators of air emission sources in all industry groups and tribal governments, located in the identified Indian reservations.

Respondent's obligation to respond: Respondent's obligation to respond is

mandatory. See 40 CFR 49.122, 49.124, 49.126, 49.130 through 135, 49.138, and 49.139.

Estimated number of respondents: 1,502 (total).

Frequency of response: Annual or occasional.

Total estimated burden: 4,034 hours (per year). Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $395,412 (per year), which includes $0 annualized capital or operation & maintenance costs.

Changes in the Estimates: There is an increase of 433 hours in the total estimated respondent burden compared with the ICR currently approved by OMB. The increases were primarily associated with a slight increase in the number of respondents and burden estimate for conducting an annual survey and adjusting fugitive particulate matter control plans under the fugitive particulate matter rule (49.126), and an increase in the number of respondents registering air pollution sources and reporting emissions (49.138).

Courtney Kerwin,

Deputy Director, Data & Enterprise Programs Division (DEPD).

[FR Doc. 2026–23518 Filed 11–18–26; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OECA–2011–0824; FRL–13717–01–OFA]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Pesticide Establishment Application, Notification of Registration, and Pesticide Production Reports for Pesticide-Producing and Device-Producing Establishments (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) has submitted an information collection request (ICR), Application for Registration and Pesticide Report for Pesticide-Producing and Device-Producing Establishment (EPA ICR Number. 0160.14, OMB Control Number 2070–0078) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. This is a proposed extension of the ICR, which is currently approved through November 30, 2026. Public comments were previously requested via the **Federal Register** on July 30, 2026 during a 60-day comment period. This notice allows for an additional 30 days for public comments.

DATES: Comments may be submitted on or before December 21, 2026.

ADDRESSES: Submit your comments, referencing Docket ID Number EPA–HQ–OECA–2011–0824, to EPA online using *www.regulations.gov* (our preferred method), or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460.

EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Submit written comments and recommendations to OMB for the proposed information collection within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain*. Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Michelle Yaras, Office of Compliance, Compliance, Inspector, and Training Division, Pesticides, Waste & Toxics Compliance Branch 2227A, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: (202) 564–4153; email address: *yaras.michelle@epa.gov*.

SUPPLEMENTARY INFORMATION: This is a proposed extension of the ICR, which is currently approved through November 30, 2026. 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.

Public comments were previously requested via the **Federal Register** on July 30, 2026 during a 60-day comment period (91 FR 48,107). This notice allows for an additional 30 days for public comments. Supporting documents, which explain in detail the information that the EPA will be collecting, are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit *http://www.epa.gov/dockets*.

Abstract: The Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) Section 7(a) requires that any person who produces pesticides, active ingredients or devices subject to the Act must register with the Administrator of EPA the establishment in which the pesticide, active ingredient or device is produced. This section further requires that applications for registration of any establishment shall include the name and address of the establishment and of the producer who operates such an establishment. EPA Form 3540–8, Application for Registration of Pesticide-Producing and Device-Producing Establishments, is used to collect the establishment registration information required by this section.

FIFRA Section 7(c) requires that any producer operating an establishment registered under Section 7(a) report to the Administrator within 30 days after it is registered, and annually thereafter by March 1st for certain pesticide or device production and sales or distribution information. The producers must report which types and amounts of pesticides, active ingredients, or devices are currently being produced, were produced during the past year, or sold or distributed in the past year. The supporting regulations at 40 CFR part 167 provide the requirements and time schedules for submitting production information. EPA Form 3540–16, Pesticide Report for Pesticide-Producing and Device-Producing Establishments, is used to collect the pesticide production information required by Section 7(c) of FIFRA.

Establishment registration information, collected on EPA Form 3540–8, is a one-time requirement for all pesticide-producing and device-producing establishments. Pesticide and device production information, reported on EPA Form 3540–16, is required to be submitted within 30 days after the company is notified of its pesticide-producing or device-producing establishment number, and annually thereafter on or before March 1. Pesticide-producing and device-producing establishments may electronically submit their establishment registration information and pesticide production information through EPA's Central Data Exchange (CDX).

Form Numbers: 3540–8 and 3540–16.

Respondents/affected entities: Establishments producing pesticides.

Respondent's obligation to respond: Mandatory (40 CFR part 167).

Estimated number of respondents: 20,003 (total).

Frequency of response: Initial and Annually.

Total estimated burden: 32,155 hours (per year). Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $2,899,331.40 (per year), which includes $0 annualized capital or operation & maintenance costs

Changes in the Estimates: There is a decrease of 1,065 hours in the total estimated respondent burden compared with the ICR currently approved by OMB. This decrease is due to a reduction in the number of forms submitted. There was a decrease in the number of respondents submitting each form, which decreased the total burden hours, but there is an overall increase in the total estimated cost of respondent burden due to an increase in the estimated labor costs (increase in hourly wages). The total estimated increase in respondent costs from these changes in labor costs and adjustment to the total hours is $163,363.26.

Courtney Kerwin,

Deputy Director, Data and Enterprise Programs Division.

[FR Doc. 2026–23516 Filed 11–18–26; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–R06–OW–2025–0307; FRL–12770–02–R6]

Proposed Modification of NPDES General Permit for New and Existing Sources and New Dischargers in the Offshore Subcategory of the Oil and Gas Extraction Category for the Western Portion of the Outer Continental Shelf of the Gulf of America (GMG290000)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of final NPDES General Permit Modification.

SUMMARY: The Regional Administrator of Region 6 today provides notice that the National Pollutant Discharge Elimination System (NPDES) General Permit No. GMG290000 for existing and new sources and new dischargers in the Offshore Subcategory of the Oil and Gas Extraction Point Source Category, located in and discharging to the Outer Continental Shelf offshore of Louisiana and Texas, was modified on November 2, 2026 with an effective date of November 2, 2026. The discharge of produced water to that portion of the Outer Continental Shelf from Offshore Subcategory facilities located in the territorial seas of Louisiana and Texas is also authorized by this permit.

DATES: This permit was issued November 2, 2026, is effective on November 2, 2026, and expires May 10, 2028. This effective date is necessary to provide dischargers with the immediate opportunity to comply with Clean Water Act (CWA) requirements in light of the expiration of the compliance period for acute Whole Effluent Toxicity Testing for Well Treatment, Completion and Workover Fluids. In accordance with 40 CFR 23, this permit shall be considered issued for the purpose of judicial review on December 2, 2026. Under section 509(b) of the CWA, judicial review of this general permit can be held by filing a petition for review in the United States Court of Appeals within 120 days after the permit is considered issued for judicial review. Under section 509(b)(2) of the CWA, the requirements in this permit may not be challenged later in civil or criminal proceedings to enforce these requirements. In addition, this permit may not be challenged in other agency proceedings.

FOR FURTHER INFORMATION CONTACT: Ms. Nichole Young, Region 6, U.S. Environmental Protection Agency, 1201 Elm Street, Dallas, Texas, 75270; telephone number: (214) 665–6447; email address: *young.nichole@epa.gov*.

SUPPLEMENTARY INFORMATION: Notice of the proposal of the draft modified permit, Draft Environmental Assessment (EA) and Preliminary Finding of No Significant Impact (FONSI) was published in the **Federal Register** on January 27, 2026 (91 FR 3492). EPA Region 6 has considered all comments received and made changes as listed below. A copy of the Region's responses to comments and the final permit may be found online from the Federal eRulemaking Portal: *http://www.regulations.gov* with Docket ID No EPA–R06–OW–2025–0307. Changes include:

1. Removed Footnote 56 from the permit.

2. Environmental Assessment has been corrected to clarify acute WET testing performed on well treatment, completion, and workover (TCW) discharges from February 2023 to April 2025 showed an ~13% failure rate.

Other Legal Requirements

Other statutory and regulatory requirements are discussed in the fact sheet that include: Executive Order 14192 (90 FR 9065, January 31, 2025); Ocean Discharge Criteria Evaluation; Marine Protection, Research, and Sanctuaries Act; National Environmental Policy Act; Magnuson-Stevens Fisheries Conservation and Management Act; Endangered Species Act; State Water Quality Standards and State Certification; Coastal Zone Management Act; Paperwork Reduction Act; Regulatory Flexibility Act; National Historic Preservation Act; Offshore Subcategory of the Oil and Gas Extraction Point Source Category; 40 CFR 122.62; 40 CFR 124.13; and 40 CFR 124.5(c)(2). Under Executive Order 12866 (58 FR 51735, October 4, 1993), this notice is a ''significant regulatory action.'' Accordingly, EPA submitted this notice to the Office of Management and Budget (OMB) for review under Executive Orders 12866 and 13563 (76 FR 3821, January 21, 2011) and any changes made in response to OMB recommendations have been documented in the docket for this notice.

Walter Mason,

Region 6 Administrator, U.S. Environmental Protection Agency.

[FR Doc. 2026–23523 Filed 11–18–26; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

[OMB 3060–0668; FR ID 378382]

Information Collection Being Reviewed by the Federal Communications Commission Delegated Authority

AGENCY: Federal Communications Commission.

ACTION: Notice; request for comments.

SUMMARY: As part of its continuing effort to reduce paperwork burdens, and as required by the Paperwork Reduction Act (PRA) of 1995, the Federal Communications Commission (Commission) invites the general public and other Federal agencies to take this opportunity to comment on the following information collection. Comments are requested concerning: whether the collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; the accuracy of the Commission's burden estimate; ways to enhance the quality, utility, and clarity of the information collected; ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology; and ways to further reduce the information collection burden on small business concerns with fewer than 25 employees.

DATES: Written PRA comments should be submitted on or before January 19, 2027. If you anticipate that you will be submitting comments but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Cathy Williams, FCC, via email to *PRA@fcc.gov* and to *Cathy.Williams@fcc.gov.*

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collection, contact Cathy Williams at (202) 418–2918.

SUPPLEMENTARY INFORMATION: The FCC may not conduct or sponsor a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the PRA that does not display a valid OMB control number.

OMB Control Number: 3060–0668.

Title: Section 76.936, Written Decisions.

Form Number: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities; State or Local, or Tribal government.

Number of Respondents and Responses: 150 respondents; 150 responses.

Estimated Hours per Response: 1 hour.

Frequency of Response: Third party disclosure requirement; On occasion reporting requirement.

Total Annual Burden: 150 hours.

Total Annual Cost: No cost.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this collection is contained in Section 4(i) of the Communications Act of 1934, as amended.

Needs and Uses: The information collection requirements contained in 47 CFR 76.936 require that a franchising authority must issue a written decision in a rate-making proceeding whenever it disapproves an initial rate for the basic service tier or associated equipment in whole or in part, disapproves a request for a rate increase in whole or in part, or approves a request for an increase in whole or in part over the objection of interested parties. Franchising authorities are required to issue a written decision in rate-making proceedings pursuant to Section 76.936 so that cable operators and the public are made aware of the proceeding.

Federal Communications Commission.

Marlene Dortch,

Secretary, Office of the Secretary.

[FR Doc. 2026–23562 Filed 11–18–26; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (Act) (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the applications are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at *https://www.federalreserve.gov/foia/request.htm.* Interested persons may express their views in writing on the standards enumerated in paragraph 7 of the Act.

Comments received are subject to public disclosure. In general, comments received will be made available without change and will not be modified to remove personal or business information including confidential, contact, or other identifying information. Comments should not include any information such as confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Benjamin W. McDonough, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than December 4, 2026.

A. Federal Reserve Bank of Atlanta (Erien O. Terry, Assistant Vice President) 1000 Peachtree Street NE, Atlanta, Georgia 30309. Comments can also be sent electronically to *Applications.Comments@atl.frb.org:*

1. *Ellen Elizabeth Leake, Jackson, Mississippi; Susan Blair Leake Wunderlich, Washington, DC; and Elizabeth Eason Leake Keckler, New Orleans, Louisiana;* to join the Leake Family Control Group, a group acting in concert, to retain voting shares of PriorityOne Capital Corporation, and thereby indirectly retain voting shares of PriorityOne Bank, both of Magee, Mississippi.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2026–23593 Filed 11–18–26; 8:45 am]

BILLING CODE P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at *https://www.federalreserve.gov/foia/request.htm.* Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)).

Comments received are subject to public disclosure. In general, comments received will be made available without change and will not be modified to remove personal or business information including confidential, contact, or other identifying information. Comments should not include any information such as confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Benjamin W. McDonough, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than December 21, 2026.

A. Federal Reserve Bank of New York (Keith Goodwin, Head of Bank Application) 33 Liberty Street, New York, New York 10045–0001. Comments can also be sent electronically to *Comments.applications@ny.frb.org:*

1. *BCB Bancorp, Inc., Bayonne, New Jersey;* to become a bank holding company by acquiring BCB Bancorp, Inc., and thereby indirectly acquiring BCB Community Bank, both of Bayonne, New Jersey.2. *Dime Commercial Bancshares, Inc., Hauppauge, New York;* to acquire ES Bancshares, Inc., and thereby indirectly acquire Empire State Bank, both of Staten Island, New York.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2026–23594 Filed 11–18–26; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8093–N]

RIN 0938–AV85

Medicare Program; CY 2027 Part A Premiums for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces Medicare's Hospital Insurance Program (Medicare Part A) premium for uninsured enrollees in calendar year (CY) 2027. This premium is paid by enrollees aged 65 and over who are not otherwise eligible for benefits under Medicare Part A (hereafter known as the ''uninsured aged'') and by certain individuals with disabilities who have exhausted other entitlement. The monthly Medicare Part A premium for the 12 months beginning January 1, 2027 for these individuals will be $597. The premium for certain other individuals as described in this notice will be $328.

DATES: The premium announced in this notice is effective on January 1, 2027.

FOR FURTHER INFORMATION CONTACT: Yaminee Thaker, (410) 786–7921.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors, and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. These ''uninsured aged'' individuals are uninsured under the OASDI program or the Railroad Retirement Act, because they do not have 40 quarters of coverage under Title II of the Act (or are/were not married to someone who did). (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for Medicare Part A.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium for certain individuals with disabilities who have exhausted other entitlement. These are individuals who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, but who are no longer entitled to disability benefits and premium-free Medicare Part A coverage because they have gone back to work and their earnings exceed the statutorily defined ''substantial gainful activity'' amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums for the aged under section 1818(d) through section 1818(f) of the Act will also apply to certain individuals with disabilities as described above.

Section 1818(d)(1) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the upcoming calendar year (CY) (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of $1, the premium is rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not of $1, it is rounded to the next highest $1).

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary enrollees (sections 1818 and 1818A of the Act). The reduction applies to an individual who is eligible to buy into the Medicare Part A program and who, as of the last day of the previous month:

- Had at least 30 quarters of coverage under Title II of the Act;
- Was married, and had been married for the previous 1-year period, to a person who had at least 30 quarters of coverage;
- Had been married to a person for at least 1 year at the time of the person's death if, at the time of death, the person had at least 30 quarters of coverage; or
- Is divorced from a person and had been married to the person for at least 10 years at the time of the divorce if, at the time of the divorce, the person had at least 30 quarters of coverage.

Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for CY 2027 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

Section 1818(g) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary), at the request of a State, to enter into a Medicare Part A buy-in agreement with a State to pay Medicare Part A premiums for Qualified Medicare Beneficiaries (QMBs). Under the QMB program, State Medicaid agencies must pay the Medicare Part A premium for those not eligible for premium-free Medicare Part A if those individuals meet all of the eligibility requirements for the QMB program under the State's Medicaid State plan. Entering into a Medicare Part A buy-in agreement would permit a State to avoid any Medicare Part A late enrollment penalties that the individual may owe and would allow States to enroll persons in Medicare Part A at any time of the year, without regard to Medicare enrollment periods. Other individuals may be eligible for the Qualified Disabled Working Individuals program, through which State Medicaid programs provide coverage of Medicare Part A premiums for individuals eligible to enroll in Medicare Part A by virtue of section 1818A of the Act who meet certain financial eligibility criteria.

II. Monthly Premium Amount for CY 2027

The monthly premium for the uninsured aged and certain individuals with disabilities who have exhausted other entitlement for the 12 months beginning January 1, 2027, is $597. The monthly premium for the individuals eligible under section 1818(d)(4)(B) of the Act, and therefore, subject to the 45 percent reduction in the monthly premium, is $328.

III. Monthly Premium Rate Calculation

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for CY 2027 rounded to the nearest multiple of $1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of Medicare Part A enrollees aged 65 years and over, as well as the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are:

- Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;
- Projecting increases in payment amounts for each of the service types; and
- Projecting increases in administrative costs.

We base our projections for CY 2027 on—(1) current historical data; and (2) projection assumptions derived from current law and the Midsession Review of the President's Fiscal Year 2027 Budget.

For CY 2027, we estimate that 63,981,910 people aged 65 years and over will be entitled to (enrolled in) benefits (without premium payment) and that they will incur about $458,587 billion in benefits and related administrative costs. Thus, the estimated monthly average per capita amount is $597.29 and the monthly premium is $597. Subsequently, the full monthly premium reduced by 45 percent is $328.

IV. Costs to Beneficiaries

The CY 2027 monthly premium of $597 is approximately 5.7 percent higher than the CY 2026 premium of $565. We estimate that approximately 904,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium. We estimate that over 90 percent of these individuals will have their Medicare Part A premium paid by States, since they are enrolled in the QMB program. Furthermore, the CY 2027 reduced monthly premium of $328 is approximately 5.5 percent higher than the CY 2026 premium of $311. We estimate that an additional 129,000 enrollees will pay the reduced premium. Therefore, we estimate that the total aggregate cost to enrollees paying these premiums in CY 2027, compared to the amount that they paid in CY 2026, will be about $373 million.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 1871 of the Act. Section 1871(a)(2) of the Act provides that no rule, requirement, or other statement of policy (other than a national coverage determination) 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 under Medicare shall take effect unless it is promulgated through notice and comment rulemaking. Unless there is a statutory exception, section 1871(b)(1) of the Act generally requires the Secretary to provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute. Section 1871(b)(2)(C) of the Act also provides exceptions from the notice and 60-day comment period, under the good cause standard set forth in 5 U.S.C. 553(b)(B). Section 553(b)(B) authorizes an agency to dispense with notice and comment rulemaking for good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest.

The annual Medicare Part A premium announcement set forth in this notice does not establish or change a substantive legal standard regarding the matters enumerated by the statute or constitute a substantive rule which would be subject to the notice requirements in section 1871(b) of the Act. However, to the extent that an opportunity for public notice and comment could be construed as required for this notice, we find good cause to waive this requirement.

Section 1818(d) of the Act requires the Secretary during September of each year to determine and publish the amount to be paid, on an average per capita basis, from the Federal Hospital Insurance Trust Fund for services incurred in the impending CY (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. Further, the statute requires that the agency determine the applicable premium amount for each CY in accordance with the statutory formula, and we are simply notifying the public of the changes to the Medicare Part A premiums for CY 2027. We have calculated the Medicare Part A premiums as directed by the statute; the statute establishes both when the premium amounts must be published and the information that the Secretary must factor into the premium amounts, so we do not have any discretion in that regard. We find notice and comment procedures to be unnecessary for this notice and we find good cause to waive such procedures under section 553(b)(B) and section 1871(b)(2)(C) of the Act, if such procedures may be construed to be required at all. Through this notice, we are simply notifying the public of the updates to the Medicare Part A premiums, in accordance with the statute, for CY 2027.

VI. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. *3501 et seq.*).

VII. Regulatory Impact Analysis

We have prepared this Regulatory Impact Analysis (RIA) section in the interest of ensuring that the impacts of this notice are fully understood.

A. Statement of Need

This notice announces the CY 2027 Medicare Part A premiums for the uninsured aged and for certain disabled individuals who have exhausted other entitlement, as required by sections 1818 and 1818A of the Act. It also responds to section 1818(d) of the Act, which requires the Secretary to provide for publication of these amounts in the **Federal Register** during the September that precedes the start of each CY. As this statutory provision prescribes a detailed methodology for calculating these amounts, we do not have the discretion to adopt an alternative approach to these issues.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded

Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts.). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

An RIA must be prepared for a regulatory action that is significant under section 3(f)(1) of Executive Order 12866. As stated in section IV. of this notice, we estimate that the overall effect of the changes in the Medicare Part A premium will be a cost to voluntary enrollees (sections 1818 and 1818A of the Act) of about $373 million. Based on our estimates, Office of Information and Regulatory Affairs (OIRA) has determined this notice is significant under section 3(f)(1). Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of this notice.

In accordance with subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has determined that this notice meets the criteria set forth in 5 U.S.C. 804(2). For the reasons given, however, we find for good cause that notice and public procedure are impracticable, unnecessary, and contrary to the public interest and have determined that this policy will take effect on January 1, 2027, pursuant to 5 U.S.C. 808(2).

C. Accounting Statement and Table

Consistent with OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf*), in the Table 1, we have prepared an accounting statement showing the total aggregate cost to enrollees paying premiums in CY 2027, compared to the amount that they paid in CY 2026. This amount is approximately $373 million. As stated in section IV. of this notice, the CY 2027 premium of $597 is approximately 5.7 percent higher than the CY 2026 premium of $565. We estimate that approximately 904,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium. We estimate that over 90 percent of these individuals will have their Medicare Part A premium paid by States, since they are enrolled in the QMB program. Furthermore, the CY 2027 reduced premium of $328 is approximately 5.5 percent higher than the CY 2026 premium of $311.

TABLE 1—ESTIMATED TRANSFERS FOR CY 2026 MEDICARE PART A PREMIUM

Category	Transfers	Period covered
Annualized Monetized Transfers	$373 million	2027
From Whom to Whom	Beneficiaries to Federal Government	

D. Regulatory Flexibility Act

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration's (SBA) definition of a small business (having revenues of less than $9.0 million to $47 million in any 1 year). Individuals and States are not included in the definition of a small entity. This annual notice announces the Medicare Part A premiums for CY 2027 and will have an impact on certain Medicare beneficiaries, but not on small entities as defined by the SBA. As a result, we are not preparing an analysis for the RFA because the Secretary has certified that this notice 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 an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the 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. This annual notice announces the Medicare Part A premiums for CY 2027 and will have an impact on certain Medicare beneficiaries. As a result, we are not preparing an analysis for section 1102(b) of the Act, because the Secretary has certified that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. This notice would not impose a mandate that will result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $193 million in any 1 year.

F. Federalism

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. This notice will not have a substantial direct effect on State or local governments, preempt State law, or otherwise have Federalism implications.

G. Congressional Review

This notice is subject to the Congressional Review Act and has been transmitted to the Congress and the Government Accountability Office's Comptroller General for review. Mehemet Oz, Administrator of the Centers for Medicare & Medicaid

Services, approved this document on November 16, 2026.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2026–23604 Filed 11–17–26; 4:15 pm]

BILLING CODE 4169–69–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9164–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—July Through September 2026

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This quarterly notice lists Centers for Medicare & Medicaid Services (CMS) manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published in the 3-month period, relating to the Medicare and Medicaid programs and other programs administered by CMS.

FOR FURTHER INFORMATION CONTACT: It is possible that an interested party may need specific information and not be able to determine from the listed information whether the issuance or regulation would fulfill that need. Consequently, we are providing contact persons to answer general questions concerning each of the addenda published in this notice.

Addenda	Contact	Phone No.
I. CMS Manual Instructions	Ronda Allen-Bonner	(410) 786–4657
II. Regulation Documents Published in the **Federal Register**	Gittel Treitel	(410) 786–4673
III. CMS Rulings	Tiffany Lafferty	(410) 786–7548
IV. Medicare National Coverage Determinations	Wanda Belle, MPA	(410) 786–7491
V. FDA-Approved Category B IDEs	John Manlove	(410) 786–6877
VI. Collections of Information	William Parham	(410) 786–4669
VII. Medicare –Approved Carotid Stent Facilities	Sarah Fulton, MHS	(410) 786–2749
VIII. American College of Cardiology-National Cardiovascular Data Registry Sites.	Sarah Fulton, MHS	(410) 786–2749
IX. Medicare's Active Coverage-Related Guidance Documents	Lori Ashby, MA	(410) 786–6322
X. One-time Notices Regarding National Coverage Provisions	JoAnna Baldwin, MS	(410) 786–7205
XI. National Oncologic Positron Emission Tomography Registry Sites	David Dolan, MBA	(410) 786–3365
XII. Medicare-Approved Ventricular Assist Device (Destination Therapy) Facilities.	David Dolan, MBA	(410) 786–3365
XIII. Medicare-Approved Lung Volume Reduction Surgery Facilities	Sarah Fulton, MHS	(410) 786–2749
XIV. Medicare-Approved Bariatric Surgery Facilities	Sarah Fulton, MHS	(410) 786–2749
XV. Fluorodeoxyglucose Positron Emission Tomography for Dementia Trials.	David Dolan, MBA	(410) 786–3365
All Other Information	Shawn Braxton	(410) 786–7292

SUPPLEMENTARY INFORMATION:

I. Background

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare and Medicaid programs and coordination and oversight of private health insurance. Administration and oversight of these programs involves the following: (1) furnishing information to Medicare and Medicaid beneficiaries, health care providers, and the public; and (2) maintaining effective communications with CMS regional offices, State governments, State Medicaid agencies, State survey agencies, various providers of health care, all Medicare contractors that process claims and pay bills, National Association of Insurance Commissioners (NAIC), health insurers, and other interested parties. 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) and Public Health Service Act. We also issue various manuals, memoranda, and statements necessary to administer and oversee the programs efficiently.

Section 1871(c) 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**.

II. Format for the Quarterly Issuance Notices

This quarterly notice provides only the specific updates that have occurred in the 3-month period along with a hyperlink to the full listing that is available on the CMS website or the appropriate data registries that are used as our resources. This is the most current up-to-date information and will be available earlier than we publish our quarterly notice. We believe the website list provides more timely access for beneficiaries, providers, and suppliers. We also believe the website offers a more convenient tool for the public to find the full list of qualified providers for these specific services and offers more flexibility and ''real time'' accessibility. In addition, many of the websites have listservs; that is, the public can subscribe and receive immediate notification of any updates to the website. These listservs avoid the need to check the website, as notification of updates is automatic and sent to the subscriber as they occur. If assessing a website proves to be difficult, the contact person listed can provide information.

III. How To Use the Notice

This notice is organized into 15 addenda so that a reader may access the subjects published during the quarter covered by the notice 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

should view the manuals at *http://www.cms.gov/manuals.*

The Director of the Office of Strategic Operations and Regulatory Affairs of CMS, Kathleen Cantwell, having reviewed and approved this document, authorizes Trenesha Fultz-Mimms, who is the **Federal Register** Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Trenesha Fultz-Mimms,

Federal Register Liaison, Department of Health and Human Services.

BILLING CODE 4169–69–P

Publication Dates for the Previous Four Quarterly Notices

We publish this notice at the end of each quarter reflecting information released by CMS during the previous quarter. The publication dates of the previous four Quarterly Listing of Program Issuances notices are: December 1, 2025 (90 FR 55117), February 23, 2026 (91 FR 8482), May 14,2026 (91 FR 27339) and July 27, 2026 (91 FR 46923). We are providing only the specific updates that have occurred in the 3-month period along with a hyperlink to the website to access this information and a contact person for questions or additional information.

Addendum I: Medicare and Medicaid Manual Instructions (July through September 2026)

The CMS Manual System is used by CMS program components, partners, providers, contractors, Medicare Advantage organizations, and State Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives. In 2003, we transformed the CMS Program Manuals into a web user-friendly presentation and renamed it the CMS Online Manual System.

How to Obtain Manuals

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. Paper-based manuals are CMS manuals that were officially released in hardcopy. The majority of these manuals were transferred into the Internet-only manual (IOM) or retired. Pub 15-1, Pub 15-2 and Pub 45 are exceptions to this rule and are still active paper-based manuals. The remaining paper-based manuals are for reference purposes only. If you notice policy contained in the paper-based manuals that was not transferred to the IOM, send a message via the CMS Feedback tool.

Those wishing to subscribe to old versions of CMS manuals should contact the National Technical Information Service, Department of Commerce, 5301 Shawnee Road, Alexandria, VA 22312 Telephone (703-605-6050). You can download copies of the listed material free of charge at: http://cms.gov/manuals.

How to Review Transmittals or Program Memoranda

Those wishing to review transmittals and program memoranda can access this information 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. This information is available at http://www.gpo.gov/libraries/.

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. CMS publication and transmittal numbers are shown in the listing entitled Medicare and Medicaid Manual Instructions. To help FDLs locate the materials, use the CMS publication and transmittal numbers. For example, to find the manual Update to Pub. 100-04, Quarterly Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement (CMS- Pub. 100-04) Transmittal No. 13794.

Addendum I lists a unique CMS transmittal number for each instruction in our manuals or program memoranda and its subject number. 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 manual.

Fee-For Service Transmittal Numbers

Please Note: Beginning Friday, March 20, 2020, there will be the following change regarding the Advance Notice of Instructions due to a CMS internal process change. Fee-For Service Transmittal Numbers will no longer be determined by Publication. The Transmittal numbers will be issued by a single numerical sequence beginning with Transmittal Number 10000.

For the purposes of this quarterly notice, we list only the specific updates to the list of manual instructions that have occurred in the 3-month period. This information is available on our website at www.cms.gov/Manuals.

These Change Request (CR) are being released on a limited approved basis due to the moratorium.

Transmittal Number	Manual/Subject/Publication Number
Medicare General Information (CMS-Pub. 100-01)	
Medicare Benefit Policy (CMS-Pub. 100-02)	
13889	Update to Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 110.8 Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Benefit Category Determinations
Medicare National Coverage Determination (CMS-Pub. 100-03)	
Medicare Claims Processing (CMS-Pub. 100-04)	
13789	Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update

Transmittal Number	Manual/Subject/Publication Number
	from Council for Affordable Quality Healthcare (CAQH) CORE-RESCIND
13793	Quarterly Update to Home Health (HH) Grouper
13794	Quarterly Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement
13812	Fiscal Year (FY) 2027 Updates for Medicare Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy
13813	Fiscal Year (FY) 2027 Annual Update to the Medicare Code Editor (MCE) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (ICD-10-PCS)
13837	Quarterly Update to the National Correct Coding Initiative (NCCI) Add-on Code (AOC) Edits, Version Q42026, Effective October 1, 2026-RESCIND
13844	July 2026 Integrated Outpatient Code Editor (I/OCE) Specifications Version 27.2
13846	July Quarterly Update for 2026 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
13849	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2026
13850	Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Web Pricer Update Fiscal Year (FY) 2027
13851	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Web Pricer Changes for Fiscal Year (FY) 2027
13855	July 2026 Quarterly Update to the Clinical Laboratory Fee Schedule (CLFS) and Clinical Laboratory Improvement Amendments (CLIA): Healthcare Common Procedure Coding System (HCPCS) Codes, Waived Tests, and Reasonable Charge Payments
13859	Influenza Vaccine Payment Allowances - Annual Update for 2026-2027 Season
13860	Reporting Face-to-Face Encounter Conducted by a Hospice Physician or Hospice Nurse Practitioner for Recertification via Telecommunications Technology on Hospice Claims, effective January 1, 2027
13861	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13863	Implementation CR - Send Transplant Program Hospital Type and the New Organ Types to the Fiscal Intermediary Shared System (FISS) on Provider Enrollment Chain & Ownership System (PECOS) Extract Files and for FISS to Process so PECOS is the System of Record for the Transplant Program Hospital Type and for the Organs Type Transplanted at the Hospital
13866	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13867	File Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions
13872	Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2027
13881	October 2026 Quarterly Update to Healthcare Common Procedure Coding System (HCPCS) Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
13883	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13884	October 2026 Quarterly Update to the Clinical Laboratory Fee Schedule (CLFS) and Clinical Laboratory Improvement Amendments (CLIA): Healthcare Common Procedure Coding System (HCPCS) Codes, Waived Tests, and Reasonable Charge Payments
13887	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13904	Updates to Chapter One of the Medicare Claims Processing Manual (Publication (Pub.) 100-04) to Include Newly Created and Utilized Payer Only Codes
13909	Issued to a specific audience, not posted to Internet/Intranet due to a Sensitivity of Instruction
13912	Internet-Only Manual (IOM) Update(s) to Publication 100-04, Chapter 23, Section(s) 20.3, 20.4, 20.8 and Addendum - Medicare Physician Fee Schedule Database (MPFSDB) File Record Layout and Field Descriptions
13913	Issued to a specific audience, not posted to Internet/Intranet due to a Sensitivity of Instruction
13920	Issued to a specific audience, not posted to Internet/Intranet due to a Sensitivity of Instruction
13924	Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2027
13927	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13930	Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes
13931	Issued to a specific audience, not posted to Internet/Intranet due to a Sensitivity of Instruction
13937	Annual Clotting Factor Furnishing Fee Update 2027
13938	Healthcare Common Procedure Coding System (HCPCS) Files for the January, April, July and October 2027 Quarterly Releases
13940	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13942	2027 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
13943	October 2026 Quarterly Update to Healthcare Common Procedure Coding System (HCPCS) Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
13944	Reporting Face-to-Face Encounter Conducted by a Hospice Physician or Hospice Nurse Practitioner for Recertification via Telecommunications Technology on Hospice Claims, effective January 1, 2027
13946	Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 33.0, Effective January 1, 2027
13947	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13948	Quarterly Update to the National Correct Coding Initiative (NCCI) Add-on Code (AOC) Edits, Version Q12027, Effective January 1, 2027
13952	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2027
13954	Internet Only Manual (IOM) Update, Publication (Pub.) 100-04, Chapter 24 General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of

Transmittal Number	Manual/Subject/Publication Number
	Medicare Claims
13956	October Quarterly Update for 2026 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
13958	January 2027 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
13960	Instructions for Retrieving the January 2027 Medicare Physician Fee Schedule Database (MPFSDB) Datasets from the Cloud Service
13962	Issued to a specific audience, not posted to Internet/Intranet due to a Sensitivity of Instruction
13964	Annual Instructions for Downloading the Medicare ZIP Code Files for the Calendar Year 2027
13965	Instructions for Retrieving the January 2027 Opioid Treatment Program (OTP) Payment Rates File
13969	Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes
13975	Updates to Internet Only Manual (IOM) Publication (Pub.) 100-04 Medicare Claims Processing Manual, Chapter 9 -Rural Health Clinics/Federally Qualified Health Centers
13976	Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2027
13978	October 2026 Update of the Hospital Outpatient Prospective Payment System (OPPS)
13979	October 2026 Integrated Outpatient Code Editor (I/OCE) Specifications Version 27.3
	Medicare Secondary Payer (CMS-Pub. 100-05)
13856	ECRS Update for Prescription Drug Inquiries (PDIs) to Prevent the Creation of Records with Invalid or Missing Information and to Reduce the Number of Records with Invalid Insurer Names
	Medicare Financial Management (CMS-Pub. 100-06)
13869	Notice of New Interest Rate for Medicare Overpayments and Underpayments -4th Quarter Notification for FY 2026
13891	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-06 Chapter 8, Contractor Procedures for Provider Audits
13899	Extending the Default Recoupment Date for Part A Cost Report Overpayments and Revision of the Medicaid Check Criterion for Debts Submitted for Close-Out
13902	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13905	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13926	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13966	Creation of the 'PROVIDER-TERMINATED' Status at the Provider/Customer Level on the Healthcare Integrated General Ledger Accounting System (HIGLAS) Customer Status History Form
	Medicare State Operations Manual (CMS-Pub. 100-07)
	None
	Medicare Program Integrity (CMS-Pub. 100-08)
13717	Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08 - Calendar Year (CY) 2026 Home Health Prospective Payment System (HH PPS) Final Rule
13847	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13848	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13852	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13857	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13858	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13864	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13870	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13871	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13875	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13878	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13879	Updates to Chapters 4 and Exhibit 16 in Publication (Pub.) 100-08, Including Updates to the Provider Identity Theft Investigations, and Victimized Provider Waiver of Liability Process
13886	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13890	Revisions to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) and Exhibit 46 in the Exhibits Chapter of Publication (Pub.) 100-08 (Medicare Program Integrity Manual)
13892	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13893	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13897	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13898	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13901	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13916	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13919	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13939	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13950	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13955	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13963	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13970	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13971	Updates to Chapter 3, Section 3.7.1.1 of Publication (Pub) 100-08 - Medicare Program Integrity Manual

Transmittal Number	Manual/Subject/Publication Number
13972	Updates to Chapter 6, Sections 6.2 of Publication (Pub) 100-08 - Program Integrity Manual (PIM) to Include Allowed Practitioners in the Home Health Manual Instruction
13973	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13974	Quarterly Update to Home Health (1111) Grouper
Medicare Contractor Beneficiary and Provider Communications (CMS-Pub. 100-09)	
	None
Medicare Quality Improvement Organization (CMS- Pub. 100-10)	
	None
Medicare Program of All-Inclusive Care for the Elderly (CMS- Pub. 100-11)	
	None
Medicare End-Stage Renal Disease Network Organizations (CMS Pub 100-14)	
	None
Medicaid Program Integrity Disease Network Organizations (CMS Pub 100-15)	
13945	Updates to Chapter 3, Chapter 4, and Chapter 5 in Publication (Pub.) 100-15, Including Updates to the Vetting Process and the Creating Overpayment Records Process
Medicare Managed Care (CMS-Pub. 100-16)	
	None
Medicare Business Partners Systems Security (CMS-Pub. 100-17)	
	None
Medicare Prescription Drug Benefit (CMS-Pub. 100-18)	
	None
Demonstrations (CMS-Pub. 100-19)	
13853	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13862	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13876	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13880	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13894	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13895	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13896	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13907	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13908	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13951	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13957	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13961	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13980	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
One Time Notification (CMS-Pub. 100-20)	
13854	Implementation of Editing for Programs of All-Inclusive Care for the Elderly (PACE) Inpatient Claims Submitted for Indirect Medical Education (IME) Payment
13865	Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Front End Updates for October 2026
13868	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13873	Implementation of VMS Application Programming Interfaces (APIs) to Support the Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Migration to the Centers for Medicare & Medicaid Services (CMS) Amazon Web Services (AWS) Contact Center Platform
13874	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13877	Expansion of the Supplemental Security Income (SSI) Ratio on the Inpatient Provider Specific File (PSF)
13882	Modify the Application Logic to Conditionally Retain the Medicare Carrier System (MCS) Medicare Secondary Payer (MSP) Claim Trailer Based on Specific Common Working File (CWF) Error Codes, Dispositions, and Override Values
13888	Send 'Reason for Denial' Value in Prior Authorization Data to the Integrated Data Repository (IDR)
13900	Issued to a specific audience, not posted to Internet/Intranet due to a Sensitivity of Instruction
13903	International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)-January 2027 2 of 2
13906	International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)-January 2027
13910	International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)-October 2026
13911	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13914	Issued to a specific audience, not posted to Internet/Intranet due to a Sensitivity of Instruction
13915	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13917	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13918	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13922	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13923	International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)-January 2027 2 of 2
13925	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13928	Implementation of the Award for the Jurisdiction H Part A and Part B Medicare Administrative Contractor (JH A/B MAC)
13932	A/B Medicare Administrative Contractors (MACs) Part A and the Fiscal

Transmittal Number	Manual/Subject/Publication Number
	Intermediary Shared System (FISS) to Implement and Process Medicare Secondary Payer (MSP) Claims Containing Certain Claim Adjustment Reason Codes (CARCs)
13933	Fiscal Intermediary Shared System (FISS) - Modify the Expert Claims Processing System (ECPS) to Process More Than 10 Medical Policy Reason Codes
13934	Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Front End Updates for October 2026
13935	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13941	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13949	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13959	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
13967	Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Front End Updates for October 2026
13968	International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)-October 2026
13977	Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Front End Updates for October 2026
Medicare Quality Reporting Incentive Programs (CMS-Pub. 100-22)	
13885	Issued to a specific audience, not posted to Internet/Intranet due to a Confidentiality of Instruction
State Payment of Medicare Premiums (CMS-Pub.100-24)	
	None
Information Security Acceptable Risk Safeguards (CMS-Pub. 100-25)	
	None

For questions or additional information, contact Ronda Allen-Bonner (410-786-4657).

Addendum II: Regulation Documents Published in the Federal Register (July through September 2026) *Regulations and Notices*

Regulations and notices are published in the daily **Federal Register**. To purchase individual copies or subscribe to the **Federal Register,** contact GPO at *www.gpo.gov/fdsys*. 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 available 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) through the present date and can be accessed at http://www.gpoaccess.gov/fr/index.html. The following website http://www.archives.gov/federal-register/ provides information on how to access electronic editions, printed editions, and reference copies.

For questions or additional information, contact Gittel Treitel (410-786-4673).

Addendum III: CMS Rulings (July through September 2026)

CMS Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters.

The rulings can be accessed at https://www.cms.gov/medicare/regulations-guidance/cms-rulemaking/rulings.

For questions or additional information, contact Tiffany Lafferty (410-786-7548).

Addendum IV: Medicare National Coverage Determinations (July through September 2026)

Addendum IV includes completed national coverage determinations (NCDs), or reconsiderations of completed NCDs, from the quarter covered by this notice. Completed decisions are identified by the section of the NCD Manual (NCDM) in which the decision appears, the title, the date the publication was issued, and the effective date of the decision. An NCD is a determination by the Secretary for whether or not a particular item or service is covered nationally under the Medicare Program (title XVIII of the Act), but does not include a determination of the code, if any, that is assigned to a particular covered item or service, or payment determination for a particular covered item or service. The entries below include information concerning completed decisions, as well as sections on program and decision memoranda, which also announce decisions or, in some cases, explain why it was not appropriate to issue an NCD. Additional information on NCDs, including open NCDs and pending NCDs, can be found on the NCD Dashboard, which is posted on the CMS website at https://www.cms.gov/medicare/coverage/determination-process.

For the purposes of this quarterly notice, we are providing only the specific updates to NCDs, or reconsiderations of completed NCDs published in the 3-month period.

For questions or additional information, contact Wanda Belle, MPA (410-786-7491).

Title	NCDM Section	Transmittal Number	Issue Date	Effective Date
Colorectal Cancer Screening Tests	NCD 210.3	13921	08/27/2026	08/08/2026

Addendum V: FDA-Approved Category B Investigational Device Exemptions (IDEs) (July through September 2026)

(Inclusion of this addenda is under discussion internally.)

Addendum VI: Approval Numbers for Collections of Information (July through September 2026)

All approval numbers are available to the public at Reginfo.gov. Under the review process, approved information collection requests are assigned OMB control numbers. A single control number may apply to several related information collections. This information is available at *www.reginfo.gov/public/do/PRAMain.*

For questions or additional information, contact William Parham (410-786-4669).

Addendum VII: Medicare-Approved Carotid Stent Facilities (April through June 2026)

Addendum VII includes listings of Medicare-approved carotid stent facilities. All facilities listed meet CMS standards for performing carotid artery stenting for high-risk patients. On March 17, 2005, we issued our decision memorandum on carotid artery stenting. We determined that carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes. We have created a list of minimum standards for facilities modeled in part on professional society statements on competency. All facilities must at least meet our standards to receive coverage for carotid artery stenting for high-risk patients. For the purposes of this quarterly notice, we are providing only the specific updates that have occurred in the 3-month period. There were no additions, deletions, or editorial changes to the listing for Medicare-approved carotid stent facilities for this 3-month period. This information is available at: http://www.cms.gov/MedicareApprovedFacilitie/CASF/list.asp#TopOfPage .

For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

Addendum VIII: American College of Cardiology's National Cardiovascular Data Registry Sites (April through June 2026)

The initial data collection requirement through the American College of Cardiology's National Cardiovascular Data Registry (ACC-NCDR) has served to develop and improve the evidence base for the use of ICDs in certain Medicare beneficiaries. The data collection requirement ended with the posting of the final decision memo for Implantable Cardioverter Defibrillators on February 15, 2018.

For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

Addendum IX: Active CMS Coverage-Related Guidance Documents (April through June 2026)

CMS published three final guidance documents on August 7, 2024, to provide a framework for more predictable and transparent evidence development and encourage innovation and accelerate beneficiary access to new items and services. The documents are available at:

Coverage with Evidence Development: https://www.cms.gov/medicare-coverage-database/view/medicare-coverage-document.aspx?mcdid=38.

CMS National Coverage Analysis Evidence Review: https://www.cms.gov/medicare-coverage-database/view/medicare-coverage-document.aspx?mcdid=37.

Clinical Endpoints Guidance: Knee Osteoarthritis: https://www.cms.gov/medicare-coverage-database/view/medicare-coverage-document.aspx?mcdid=36.

For questions or additional information, contact Lori Ashby, MA (410 786 6322).

Addendum X: List of Special One-Time Notices Regarding National Coverage Provisions (April through June 2026)

There were no special one-time notices regarding national coverage provisions published in the 3-month period. This information is available at http://www.cms.gov.

For questions or additional information, contact JoAnna Baldwin, MS (410-786 7205).

Addendum XI: National Oncologic PET Registry (NOPR) (April through June 2026)

Addendum XI includes a listing of National Oncologic Positron Emission Tomography Registry (NOPR) sites. We cover positron emission tomography (PET) scans for particular oncologic indications when they are performed in a facility that participates in the NOPR.

In January 2005, we issued our decision memorandum on PET scans, which stated that CMS would cover PET scans for particular oncologic indications, as long as they were performed in the context of a clinical study. We have since recognized the National Oncologic PET Registry as one of these clinical studies. Therefore, in order for a beneficiary to receive a Medicare-covered PET scan, the beneficiary must

receive the scan in a facility that participates in the registry. There were no additions, deletions, or editorial changes to the listing of National Oncologic Positron Emission Tomography Registry (NOPR) in the 3-month period. This information is available at http://www.cms.gov/MedicareApprovedFacilitie/NOPR/list.asp#TopOfPage.

For questions or additional information, contact David Dolan, MBA (410-786-3365).

Addendum XII: Medicare-Approved Ventricular Assist Device (Destination Therapy) Facilities (April through June 2026)

Addendum XII includes a listing of Medicare-approved facilities that receive coverage for ventricular assist devices (VADs) used as destination therapy. All facilities were required to meet our standards in order to receive coverage for VADs implanted as destination therapy. On October 1, 2003, we issued our decision memorandum on VADs for the clinical indication of destination therapy. We determined that VADs used as destination therapy are reasonable and necessary only if performed in facilities that have been determined to have the experience and infrastructure to ensure optimal patient outcomes. We established facility standards and an application process. All facilities were required to meet our standards in order to receive coverage for VADs implanted as destination therapy.

For the purposes of this quarterly notice, we are providing only the specific updates to the list of Medicare-approved facilities that meet our standards that have occurred in the 3-month period. This information is available at http://www.cms.gov/MedicareApprovedFacilitie/VAD/list.asp#TopOfPage.

For questions or additional information, contact David Dolan, MBA, (410-786-3365).

Facility	Provider Number	Date of Initial Certification	Date of Re-certification	State
The following are new facilities.				
Queen's Medical Center 1301 Punchbowl Street Honolulu, HI 96813 Other information: DNV ID #C868947 Previous Re-certification Dates: n/a	120001	2026-05-19	n/a	HI
HCA Houston Healthcare Medical Center 1313 Hermann Drive Other information: DNV ID #C873846	450659	2026-06-30	n/a	TX
Previous Re-certification Dates:n/a				
The following facilities have editorial changes (in bold).				
Emory University Hospital 1364 Clifton Rd NE Atlanta, GA 30322 Other information: Joint Commission ID #6689 Previous Re-certification Dates: 08/18/2009; 09/09/2011; 08/29/2013; 08/11/2015; 09/26/2017; 11/20/2019; 02/12/2022; 02/14/2024	110010	2009-08-18	**2026-02-11**	GA
Banner-University Medical Center Tucson Campus 1625 North Campbell Tucson, AZ 85719 Other information: Joint Commission ID #9514 Previous Re-certification Dates: 02/04/2009; 04/27/2011; 03/15/2013; 02/24/2015; 04/18/2017; 7/12/2019; 03/05/2022; 04/04/2024	030064	2009-02-04	**2026-05-06**	AZ
Christiana Care Health Services, Inc. 4755 Ogletown-Stanton Road Newark, DE 19718 Previous Re-certification Dates: 07/25/2013; 07/21/2015; 10/24/2017; 12/21/2019; 03/03/2022; 04/10/2024	080001	2013-07-25	**2026-04-15**	DE
Swedish Health Services d/b/a Swedish Medical Center Cherry Hill 500 17th Avenue Seattle, WA 98122 Other information: DNV ID #C574335 Previous Re-certification Dates: 04/05/2011; 04/09/2013; 04/21/2015;	50-0027	2016-11-09	**2026-02-05**	WA

06/06/2017; 10/14/2019; 10/15/2022				
Cedars-Sinai Health System 8700 Beverly Blvd. Los Angeles, CA 90048 Other information: Joint Commission ID #9792 Previous Re-certification Dates: 12/11/2008; 06/21/2011; 06/11/2013; 05/29/2015; 07/11/2017; 09-11-2019; 02/26/2022; 04/12/2024	050625	2008-12-11	**2026-04-11**	CA
Thomas Jefferson University Hospitals, Inc. 111 South 11th Street Philadelphia, PA 19107 Other Information: Joint Commission ID #6132 Previous Re-certification Dates: 07/09/2009; 09/13/2011; 10/17/2013; 09/22/2015; 09/20/2017; 11/6/2019; 02/24/2022; 03/27/2024	390174	2009-07-09	**2026-04-16**	PA
Morristown Medical Center 100 Madison Avenue Morristown, NJ 07960 Other Information: Joint Commission ID #5958 Previous Re-certification Dates: 06/16/2009; 09/28/2011; 10/31/2013; 11/17/2015; 12/12/2017; 1/25/2020; 03/23/2022; 04/17/2024	310015	2008-06-16	**2026-004-25**	NJ
FROM: AMITAHealth Alexian Brothers Medical Center **TO: Ascension Alexian Brothers Medical Center** 800 Biesterfield Rd. Elk Grove Village , IL 60007	14-0258	2020-07-21	**2026-06-11**	IL
Other Information: DNV ID #C592324 Previous Re-certification Dates: 07/21/2020; 07/21/2023				
Spectrum Health Hospitals 100 Michigan Street NE Grand Rapids, MI 49503 Other Information: Joint Commission ID #277668 Previous Re-certification Dates: 04/26/2011; 06/18/2013; 05/19/2015; 06/20/2017; 9/25/2019; 04/07/2022; 05/15/2024	230038	2011-04-26	**2026-05-06**	MI
Heart Hospital of Austin, A campus of St. David's Medical Center 3801 N. Lamar Blvd. Austin, TX 78756 Other Information DNV ID #C614702 Previous Re-certification Dates: 07/27/2020; 07/27/2023	45-0431	2020-07-27	**2026-06-25**	TX
University of Kentucky Hospital/ UK Albert B. Chandler Hospital 800 Rose Street Lexington, KY 40536-0293 Other Information: Joint Commission ID #7760 Previous Re-certification Dates: 02/10/2009; 09/20/2011; 09/18/2013; 11/03/2015; 12/05/2017; 02/26/2020; 05/12/2022; 06/12/2024	180067	2009-02-10	**2026-05-07**	KY
Northwestern Memorial Hospital 251 E. Huron Street Chicago, IL 60611 Other Information: Joint Commission ID #7267	140281	2009-01-30	**2026-05-06**	IL

Previous Re-certification Dates: 01/30/2009; 06/17/2011; 05/31/2013; 06/09/2015; 08/18/2017; 11/6/2019; 03/26/2022; 05/01/2024				
Banner - University Medical Center Phoenix 1111 East McDowell Road Phoenix, AZ 85006 Other Information: Joint Commission ID #9489 Previous Re-certification Dates: 05/19/2011; 05/07/2013; 06/09/2015; 07/25/2017; 07/10/2019; 03/03/2022; 04/06/2024	030002	2011-05-19	**2026-05-20**	AZ
Wellstar MCG Health 1120 15th Street Augusta, GA 30912 Other Information: Joint Commission ID #6656 Previous Re-certification Dates: 08/06/2021; 08/06/2024	110034	2021-08-06	**2026-07-15**	GA
Lancaster General Hospital 555 North Duke Street Lancaster, PA 17602 Other Information: Joint Commission ID #6086 Previous Re-certification Dates: 05/19/2009; 09/23/2011; 09/06/2013; 09/22/2015; 10/03/2017; 02/05/2020; 05/04/2022; 06/26/2024	390100	2009-05-19	**2026-06-06**	PA
Ronald Reagan UCLA Medical Center 757 Westwood Plaza Los Angeles, CA 90095 Other information: Joint Commission ID# 9944	050262	2009-02-06	**2026-06-03**	CA
Previous Re-certification Dates: 02/06/2009; 08/09/2011; 08/13/2013; 09/15/2015; 10/06/2017; 12/04/2019; 04/09/2022; 05/08/2024				
University of Michigan Health System 1500 E Medical Center Drive, SPC 5474 Ann Arbor, MI 48109 Other Information: Joint Commission ID #7457 Previous Re-certification Dates: 03/27/2008; 03/18/2010; 03/07/2012; 02/04/2014; 03/15/2016; 04/24/2018; 12/03/2020; 06/03/2022; 07/17/2024	230046	2008-03-27	**2026-06-10**	MI
University of California San Diego Medical Center 200 West Arbor Drive San Diego, CA 92103-8949 Other Information: Joint Commission ID #10071 Previous Re-certification Dates: 11/17/2011; 11/15/2013; 11/03/2015; 10/17/2017; 12/18/2019; 04/22/2022; 06/05/2024	050025	2011-11-17	**2026-06-03**	CA
Ascension Seton 1201 West 38th Street Austin, TX 78705-1056 Other Information: Joint Commission ID# 8939 Previous Re-certification Dates: 03/06/2009; 07/15/2011; 09/04/2013; 10/20/2015; 10/03/2017; 10/23/2019; 04/13/2022; 07/17/2024	450056	2009-03-06	**2026-06-20**	TX

St. Vincent Infirmary Medical Center dba CHI St. Vincent 2 St. Vincent Circle Little Rock, AR 72205 Other Information: Joint Commission ID #8661 Previous Re-certification Dates: 11/21/2017; 02/05/2020; 05/04/2022; 07/26/2024	040007	2017-11-21	**2026-06-18**	AR
St. Elizabeth Healthcare 1 Medical Village Drive Edgewood, KY 41017 Other Information: DNV ID #C621261 Previous Re-certification Dates: 08/12/2020; 08/12/2023	180035	2020-08-12	**2026-07-14**	KY
St. Bernard's Medical Center 225 East Washington Jonesboro, AR 72401 Other Information: DNV ID# C624530 Previous Re-certification Dates: 8/31/2023	040020	2023-08-31	**2026-07-23**	AR
Mount Sinai Hospital One Gustave L. Levy Place New York, NY 10029-6574 Other Information: The Joint Commission ID#5829 Previous Re-certification Dates: 11/25/2028; 02/08/2011; 03/20/2013; 03/31/2015; 06/08/2017; 08/07/2019; 08/14/2024	330024	2008-11-25	**2026-07-15**	NY
Sutter Medical Center 2825 Capitol Ave Sacramento, CA 95816	050108	2009-10-20	**2026-07-15**	CA
Other Information: Joint Commission ID # 2902 Previous Re-certification Dates: 10/20/2009; 09/22/2011; 10/17/2013; 10/27/2015; 11/07/2017; 03/04/2020; 06/16/2022; 07/24/2024				
The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21287 Other Information: Joint Commission ID # 6252 Previous Re-certification Dates: 12/11/2007; 12/15/2009; 11/29/2011; 12/03/2013; 01/12/2016; 02/13/2018; 10/24/2020; 06/15/2022; 08/21/2024	210009	2007-12-11	**2026-07-18**	MD
Lovelace Medical Center 601 Dr Martin Luther King Jr Ave, NE Albuquerque, NM 87102 Other Information: Joint Commission ID # 701636 Previous Re-certification Dates: 10/09/2017; 08/27/2020;08/07/2024	320009	2017-10-09	**2026-07-18**	NM
The following facilities were removed this quarter.				
University of California, Davis Medical Center (UCDMC) 2315 Stockton Blvd Sacramento, CA 95817 Other Information: **Joint Commission De-certified: 2026-07-30**	050599	2015-10-06	2024-09-18	CA

Addendum XIII: Lung Volume Reduction Surgery (LVRS) (April through June 2026)

Addendum XIII includes a listing of Medicare-approved facilities that are eligible to receive coverage for lung volume reduction surgery.

Until May 17, 2007, facilities that participated in the National Emphysema Treatment Trial were also eligible to receive coverage. The following three types of facilities are eligible for reimbursement for Lung Volume Reduction Surgery (LVRS):

- National Emphysema Treatment Trial (NETT) approved (Beginning May 7, 2007, these will no longer automatically qualify and can qualify only with the other programs);
- Credentialed by the Joint Commission (formerly, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)) under their Disease Specific Certification Program for LVRS; and
- Medicare approved for lung transplants.

Only the first two types are in the list. For the purposes of this quarterly notice, there are no additions and deletions to a listing of Medicare-approved facilities that are eligible to receive coverage for lung volume reduction surgery. This information is available at *www.cms.gov/MedicareApprovedFacilitie/LVRS/list.asp#TopOfPage.*

For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

Addendum XIV: Medicare-Approved Bariatric Surgery Facilities (April through June 2026)

Addendum XIV includes a listing of Medicare-approved facilities that meet minimum standards for facilities modeled in part on professional society statements on competency. All facilities must meet our standards in order to receive coverage for bariatric surgery procedures. On February 21, 2006, we issued our decision memorandum on bariatric surgery procedures. We determined that bariatric surgical procedures are reasonable and necessary for Medicare beneficiaries who have a body-mass index greater than or equal to 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with medical treatment for obesity. This decision also stipulated that covered bariatric surgery procedures are reasonable and necessary only when performed at facilities that are: (1) certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006).

There were no additions, deletions, or editorial changes to Medicare-approved facilities that meet CMS' minimum facility standards for bariatric surgery that have been certified by ACS and/or American Society for Metabolic and Bariatric Surgery in the 3-month period. This information is available at *www.cms.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage.*

For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

Addendum XV: Fluorodeoxyglucose (FDG)-PET for Dementia and Neurodegenerative Diseases Clinical Trials (April through June 2026)

There were no FDG-PET for Dementia and Neurodegenerative Diseases Clinical Trials published in the 3-month period.

This information is available on our website at *www.cms.gov/MedicareApprovedFacilitie/PETDT/list.asp#TopOfPage.*

For questions or additional information, contact David Dolan, MBA (410-786-3365).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8094–N]

RIN 0938–AV86

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible Beginning January 1, 2027

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) beneficiaries enrolled in Part B of the Medicare Supplementary Medical Insurance (SMI) program beginning January 1, 2027. In addition, this notice announces the monthly premium for aged and disabled beneficiaries, the deductible for 2027, and the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts. The monthly actuarial rates for 2027 are $418.70 for aged enrollees and $452.40 for disabled enrollees. The standard monthly Part B premium rate for all enrollees for 2027 is $209.40, which is equal to 50 percent of the monthly actuarial rate for aged enrollees (or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees). The 2027 premium is 3.2 percent or $6.50 higher than the 2026 standard premium rate of $202.90. The Part B deductible for 2027 is $292.00 for all Part B beneficiaries. If a beneficiary has to pay an income-related monthly adjustment amount, that individual will have to pay a total monthly premium of about 35, 50, 65, 80, or 85 percent of the total cost of Part B coverage. Beginning in 2023, certain Medicare enrollees who are 36 months post kidney transplant, and therefore no longer eligible for full Medicare coverage, can elect to continue Part B coverage of immunosuppressive drugs by paying a premium. For 2027, the immunosuppressive drug premium is $125.70.

DATES: The rates take effect January 1, 2027.

FOR FURTHER INFORMATION CONTACT: M. Kent Clemens, (410) 786–6391.

SUPPLEMENTARY INFORMATION:

I. Background

Part B is the voluntary portion of the Medicare program that pays all or part of the costs for physicians' services; outpatient hospital services; certain home health services; services furnished by rural health clinics, ambulatory surgical centers, and comprehensive outpatient rehabilitation facilities; and certain other medical and health services not covered by Medicare Part A, Hospital Insurance. Medicare Part B is available to individuals who are entitled to Medicare Part A, as well as to U.S. residents who have attained age 65 and are citizens and to non-citizens who were lawfully admitted for permanent residence and have resided in the United States for 5 consecutive years. Part B requires enrollment and payment of monthly premiums, as described in 42 CFR part 407, subpart B, and part 408, respectively. The premiums paid by (or on behalf of) all enrollees fund approximately one-fourth of the total incurred costs, and transfers from the general fund of the Treasury pay approximately three-fourths of these costs.

The Secretary of Health and Human Services (the Secretary) is required by section 1839 of the Social Security Act (the Act) to announce the Part B monthly actuarial rates for aged and disabled beneficiaries as well as the monthly Part B premium. The Part B annual deductible, income-related monthly adjustment amounts, and immunosuppressive drug premium are included because their determinations are directly linked to the aged actuarial rate.

The monthly actuarial rates for aged and disabled enrollees are used to determine the correct amount of general revenue financing per beneficiary each month. These amounts, according to actuarial estimates, will equal, respectively, one-half of the expected average monthly cost of Part B for each aged enrollee (age 65 or over) and one-half of the expected average monthly cost of Part B for each disabled enrollee (under age 65).

The Part B deductible to be paid by enrollees is also announced. Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), the Part B deductible was set in statute. After setting the 2005 deductible amount at $110.00, section 629 of the MMA (amending section 1833(b) of the Act) required that the Part B deductible be indexed beginning in 2006. The inflation factor to be used each year is the annual percentage increase in the Part B actuarial rate for enrollees age 65 and over. Specifically, the 2027 Part B deductible is calculated by multiplying the 2026 deductible by the ratio of the 2027 aged actuarial rate to the 2026 aged actuarial rate. The amount determined under this formula is then rounded to the nearest $1.00. For 2027, the calculation is ($418.70/$405.40) * $283.00 = $292.28, which rounds to $292.00.

The monthly Part B premium rate to be paid by aged and disabled enrollees is also announced. (Although the costs to the program per disabled enrollee are different than for the aged, the statute provides that the two groups pay the same premium amount.) Beginning with the passage of section 203 of the Social Security Amendments of 1972 (Pub. L. 92–603), the premium rate, which was determined on a fiscal-year basis, was limited to the lesser of the actuarial rate for aged enrollees, or the current monthly premium rate increased by the same percentage as the most recent general increase in monthly Title II Social Security benefits.

However, the passage of section 124 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) suspended this premium determination process. Section 124 of TEFRA changed the premium basis to 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees). Section 606 of the Social Security Amendments of 1983 (Pub. L. 98–21), section 2302 of the Deficit Reduction Act of 1984 (DEFRA 84) (Pub. L. 98–369), section 9313 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85) (Pub. L. 99–272), section 4080 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) (Pub. L. 100–203), and section 6301 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) (Pub. L. 101–239) extended the provision that the premium be based on 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees). This extension expired at the end of 1990.

The premium rate for 1991 through 1995 was legislated by section 1839(e)(1)(B) of the Act, as added by section 4301 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) (Pub. L. 101–508). In January 1996, the premium determination basis would have reverted to the method established by the 1972 Social Security Act Amendments. However, section 13571 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) (Pub. L. 103–66) changed the premium basis to 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees) for 1996 through 1998.

Section 4571 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) permanently extended the provision that the premium be based on 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees).

The BBA included a further provision affecting the calculation of the Part B actuarial rates and premiums for 1998 through 2003. Section 4611 of the BBA modified the home health benefit payable under Part A for individuals enrolled in Part B. Under this section, beginning in 1998, expenditures for home health services not considered ''post-institutional'' are payable under Part B rather than Part A. However, section 4611(e)(1) of the BBA required that there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from Part A to Part B. Section 4611(e)(2) of the BBA also provided a specific yearly proportion for the transferred funds. The proportions were one-sixth for 1998, one-third for 1999, one-half for 2000, two-thirds for 2001, and five-sixths for 2002. For the purpose of determining the correct amount of financing from general revenues of the Federal Government, it was necessary to include only these transitional amounts in the monthly actuarial rates for both aged and disabled enrollees, rather than the total cost of the home health services being transferred.

Section 4611(e)(3) of the BBA also specified, for the purpose of determining the premium, that the monthly actuarial rate for enrollees age 65 and over be computed as though the transition would occur for 1998 through 2003 and that one-seventh of the cost be transferred in 1998, two-sevenths in 1999, three-sevenths in 2000, four-sevenths in 2001, five-sevenths in 2002, and six-sevenths in 2003. Therefore, the transition period for incorporating this home health transfer into the premium was 7 years while the transition period for including these services in the actuarial rate was 6 years.

Section 811 of the MMA, which amended section 1839 of the Act, requires that, starting on January 1, 2007, the Part B premium a beneficiary pays each month be based on that individual's annual income. (The MMA specified that there be a 5-year transition period to reach full implementation of this provision. However, section 5111 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) modified the transition to a 3-year period, which ended in 2009.) Specifically, if a beneficiary's modified

adjusted gross income is greater than the legislated threshold amounts (for 2027, $112,000 for a beneficiary filing an individual income tax return and $224,000 for a beneficiary filing a joint tax return), the beneficiary is responsible for a larger portion of the estimated total cost of Part B benefit coverage. In addition to the standard 25-percent premium, these beneficiaries now have to pay an income-related monthly adjustment amount. The MMA made no change to the actuarial rate calculation, and the standard premium, which will continue to be paid by beneficiaries whose modified adjusted gross income is below the applicable thresholds, still represents 25 percent of the estimated total cost to the program of Part B coverage for an aged enrollee. However, depending on income and tax filing status, a beneficiary can now be responsible for 35, 50, 65, 80, or 85 percent of the estimated total cost of Part B coverage, rather than 25 percent. Section 402 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10) modified the income thresholds beginning in 2018, and section 53114 of the Bipartisan Budget Act of 2018 (BBA of 2018) (Pub. L. 115–123) further modified the income thresholds beginning in 2019. For years beginning in 2019, the BBA of 2018 established a new income threshold. If a beneficiary's modified adjusted gross income is greater than or equal to $500,000 for a beneficiary filing an individual income tax return and $750,000 for a beneficiary filing a joint tax return, the beneficiary is responsible for 85 percent of the estimated total cost of Part B coverage. The BBA of 2018 specified that these new income threshold levels be inflation-adjusted beginning in 2028. The result of the higher premium is that the Part B premium subsidy is reduced, and less general revenue financing is required, for beneficiaries with higher income because they are paying a larger share of the total cost with their premium. That is, the premium subsidy continues to be approximately 75 percent for beneficiaries with income below the applicable income thresholds, but it will be reduced for beneficiaries with income above these thresholds.

The Consolidated Appropriations Act, 2021 (Pub. L. 116–260) established a new basis for Medicare Part B eligibility for post-kidney-transplant immunosuppressive drug coverage only. Medicare eligibility due solely to end-stage renal disease generally ends 36 months after a successful kidney transplant. Beginning in 2023, post-kidney-transplant individuals without certain types of insurance coverage can elect to enroll in Part B and receive coverage of immunosuppressive drugs only. The premium for this continuation of coverage is 15 percent of a different aged actuarial rate, which is equal to 100 percent of the costs for aged enrollees (rather than the standard aged actuarial rate, which is equal to one-half of the costs for aged enrollees). Enrollees paying the immunosuppressive premium are not subject to the late enrollment penalty and the $3.00 repayment amounts, but they are subject to the hold-harmless provision (described later) and the income-related monthly adjustment amounts. The law requires transfers equal to the reduction in aggregate premiums payable that results from enrollees with coverage only for immunosuppressive drugs paying the immunosuppressive drug Part B premium rather than the standard Part B premium. These transfers are to be treated as premiums payable for general revenue matching purposes.

Section 4732(c) of the BBA added section 1933(c) of the Act, which required the Secretary to allocate money from the Part B trust fund to the State Medicaid programs for the purpose of providing Medicare Part B premium assistance from 1998 through 2002 for the low-income Medicaid beneficiaries who qualify under section 1933 of the Act. This allocation, while not a benefit expenditure, was an expenditure of the trust fund and was included in calculating the Part B actuarial rates through 2002. For 2003 through 2015, the expenditure was made from the trust fund because the allocation was temporarily extended. However, because the extension occurred after the financing was determined, the allocation was not included in the calculation of the financing rates for these years. Section 211 of MACRA permanently extended this expenditure, which is included in the calculation of the Part B actuarial rates for 2016 and subsequent years.

Another provision affecting the calculation of the Part B premium is section 1839(f) of the Act, as amended by section 211 of the Medicare Catastrophic Coverage Act of 1988 (MCCA 88) (Pub. L. 100–360). (The Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101–234) did not repeal the revisions to section 1839(f) of the Act made by MCCA 88.) Section 1839(f) of the Act, referred to as the hold-harmless provision, provides that, if an individual is entitled to benefits under section 202 or 223 of the Act (the Old Age- and Survivors Insurance Benefit and the Disability Insurance Benefit, respectively) and has the Part B premium deducted from these benefit payments, the premium increase will be reduced, if necessary, to avoid causing a decrease in the individual's net monthly payment. This decrease in payment occurs if the increase in the individual's Social Security benefit resulting from the cost-of living adjustment under section 215(i–) of the Act is less than the increase in the premium. Specifically, the reduction in the premium amount applies if the individual is entitled to benefits under section 202 or 223 of the Act for November and December of a particular year and the individual's Part B premiums for December and the following January are deducted from the respective month's section 202 or 223 benefits. The hold-harmless provision does not apply to beneficiaries who are required to pay an income-related monthly adjustment amount.

A check for benefits under section 202 or 223 of the Act is received in the month following the month for which the benefits are due. The Part B premium that is deducted from a particular check is the Part B payment for the month in which the check is received. Therefore, a benefit check for November is not received until December, but December's Part B premium has been deducted from it.

Generally, if a beneficiary qualifies for hold-harmless protection, the reduced premium for the individual for that January and for each of the succeeding 11 months is the greater of either—

- The monthly premium for January reduced as necessary to make the December monthly benefits, after the deduction of the Part B premium for January, at least equal to the preceding November's monthly benefits, after the deduction of the Part B premium for December; or
- The monthly premium for that individual for that December.

In determining the premium limitations under section 1839(f) of the Act, the monthly benefits to which an individual is entitled under section 202 or 223 of the Act do not include retroactive adjustments or payments and deductions on account of work. Also, once the monthly premium amount is established under section 1839(f) of the Act, it will not be changed during the year even if there are retroactive adjustments or payments and deductions on account of work that apply to the individual's monthly benefits.

Individuals who have enrolled in Part B late or who have re-enrolled after the termination of a coverage period are subject to an increased premium under

section 1839(b) of the Act. The increase is a percentage of the premium and is based on the new premium rate before any reductions under section 1839(f) of the Act are made.

Section 1839 of the Act, as amended by section 601(a) of the Bipartisan Budget Act of 2015 (Pub. L. 114–74), specified that the 2016 actuarial rate for enrollees age 65 and older be determined as if the hold-harmless provision did not apply. The premium revenue that was lost by using the resulting lower premium (excluding the forgone income-related premium revenue) was replaced by a transfer of general revenue from the Treasury, which was repaid over time.

Similarly, section 1839 of the Act, as amended by section 2401 of the Continuing Appropriations Act, 2021 and Other Extensions Act (Pub. L. 116–159), specified that the 2021 actuarial rate for enrollees age 65 and older be determined as the sum of the 2020 actuarial rate for enrollees age 65 and older and one-fourth of the difference between the 2020 actuarial rate and the preliminary 2021 actuarial rate (as determined by the Secretary) for such enrollees. The premium revenue lost by using the resulting lower premium (excluding the forgone income-related premium revenue) was replaced by a transfer of general revenue from the Treasury, which was repaid over time.

Starting in 2016, in order to repay the balance due (which includes the transfer amounts and the forgone income-related premium revenue from the Bipartisan Budget Act of 2015 and the Continuing Appropriations Act, 2021 and Other Extensions Act), the Part B premium otherwise determined was increased by $3.00. For 2016 through 2026, the repayment amounts were added to the Part B premium otherwise determined each year and were paid back to the general fund of the Treasury.

High-income enrollees paid the repayment amount plus an additional income-related repayment amount as part of the income-related monthly adjustment amount (IRMAA) premium dollars, which reduced (dollar for dollar) the amount of general revenue received by Part B from the general fund of the Treasury. Because of this general revenue offset, the repayment IRMAA premium dollars were not included in the direct repayments made to the general fund of the Treasury from Part B in order to avoid a double repayment. (Only the monthly repayment amount was included in the direct repayments.)

The repayment amounts (excluding those for high-income enrollees) were subject to the hold-harmless provision. The original balance due was $9,066,409,000, consisting of $1,625,761,000 in forgone income-related premium revenue plus a transfer amount of $7,440,648,000 from the provisions of the Bipartisan Budget Act of 2015. The increase in the balance due in 2021 was $8,799,829,000, consisting of $946,046,000 in forgone income-related premium income plus a transfer amount of $7,853,783,000 from the provisions of the Continuing Appropriations Act, 2021 and Other Extensions Act. The balance due was zero by the end of 2026.

II. Provisions of the Notice

A. Notice of Medicare Part B Monthly Actuarial Rates, Monthly Premium Rates, and Annual Deductible

The Medicare Part B monthly actuarial rates applicable for 2027 are $418.70 for enrollees age 65 and over and $452.40 for disabled enrollees under age 65. In section II.B. of this notice, we present the actuarial assumptions and bases from which these rates are derived. The Part B standard monthly premium rate for all enrollees for 2027 is $209.40. The Part B immunosuppressive drug premium is $125.70.

The following are the 2027 Part B monthly premium rates to be paid by (or on behalf of) beneficiaries with full Part B coverage who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year) or joint tax returns.

Full Part B Coverage			
Beneficiaries who file individual tax returns with modified adjusted gross income:	**Beneficiaries who file joint tax returns with modified adjusted gross income:**	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	Less than or equal to $224,000	$0.00	$209.40
Greater than $112,000 and less than or equal to $141,000	Greater than $224,000 and less than or equal to $282,000	$83.70	$293.10
Greater than $141,000 and less than or equal to $177,000	Greater than $282,000 and less than or equal to $354,000	$209.40	$418.80
Greater than $177,000 and less than or equal to $212,000	Greater than $354,000 and less than or equal to $424,000	$335.00	$544.40
Greater than $212,000 and less than $500,000	Greater than $424,000 and less than $750,000	$460.60	$670.00
Greater than or equal to $500,000	Greater than or equal to $750,000	$502.40	$711.80

For beneficiaries with immunosuppressive drug only Part B coverage who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year) or joint tax returns, the 2027 Part B monthly premium rates are as follows:

Part B Immunosuppressive Drug Coverage Only			
Beneficiaries who file individual tax returns with modified adjusted gross income:	**Beneficiaries who file joint tax returns with modified adjusted gross income:**	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	Less than or equal to $224,000	$0.00	$125.70
Greater than $112,000 and less than or equal to $141,000	Greater than $224,000 and less than or equal to $282,000	$83.70	$209.40
Greater than $141,000 and less than or equal to $177,000	Greater than $282,000 and less than or equal to $354,000	$209.40	$335.10
Greater than $177,000 and less than or equal to $212,000	Greater than $354,000 and less than or equal to $424,000	$335.00	$460.70
Greater than $212,000 and less than $500,000	Greater than $424,000 and less than $750,000	$460.60	$586.30
Greater than or equal to $500,000	Greater than or equal to $750,000	$502.40	$628.10

In addition, the monthly premium rates to be paid by (or on behalf of) beneficiaries with full Part B coverage who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are as follows:

Full Part B Coverage		
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses, with modified adjusted gross income:	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	$0.00	$209.40
Greater than $112,000 and less than $388,000	$460.60	$670.00
Greater than or equal to $388,000	$502.40	$711.80

The monthly premium rates to be paid by (or on behalf of) beneficiaries with immunosuppressive drug only Part B coverage who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are as follows:

Part B Immunosuppressive Drug Coverage Only		
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses, with modified adjusted gross income:	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	$0.00	$125.70
Greater than $112,000 and less than $388,000	$460.60	$586.30
Greater than or equal to $388,000	$502.40	$628.10

The Part B annual deductible for 2027 is $292.00 for all beneficiaries.

B. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Actuarial Rates and the Monthly Premium Rate for Part B Beginning January 2027

The actuarial assumptions and bases used to determine the monthly actuarial rates and the monthly premium rates for Part B are established by the Centers for Medicare & Medicaid Services' (CMS') Office of the Actuary (OACT). The estimates underlying these determinations are prepared by actuaries meeting the qualification standards and following the actuarial standards of practice established by the Actuarial Standards Board.

1. Actuarial Status of the Part B Account in the Supplementary Medical Insurance Trust Fund

Under section 1839 of the Act, the starting point for determining the standard monthly premium is the amount that would be necessary to finance Part B on an incurred basis. This is the amount of income that would be sufficient to pay for services furnished during that year (including associated administrative costs) even though payment for some of these services will not be made until after the close of the year. The portion of income required to cover benefits not paid until after the close of the year is added to the trust fund and used when needed.

Because the premium rates are established prospectively, they are subject to projection error. Additionally, legislation enacted after the financing was established, but effective for the period in which the financing is set, may affect program costs. As a result, the income to the program may not equal incurred costs.

Beginning in 2027, the Part B financing will include the consideration of a Part D risk to the Part B assets. An additional source of uncertainty exists in Part B to the extent CMS may be able to reallocate Part B assets to the Part D account if Part D financing is inadequate, such as in the case of a lapse of funding resulting from a government shutdown. The 2027 Part B financing has not been increased to reflect this uncertainty, because sufficient Part D funding will be available to pay Part D expenses in case the established Part D financing is temporarily inadequate during 2027. This financing would be available in the case of a prolonged government shutdown and would be used prior to any Part B funds being needed.

Trust fund assets must be maintained at a level that is adequate to cover an appropriate degree of variation between actual and projected costs, and the amount of incurred, but unpaid, expenses. Numerous factors determine what level of assets is appropriate to cover variation between actual and projected costs. For 2027, the three most important of these factors are: (1) the difference from prior years between the actual performance of the program and estimates made at the time financing was established; (2) the likelihood and potential magnitude of expenditure changes resulting from enactment of legislation affecting Part B costs in a year subsequent to the establishment of financing for that year; and (3) the expected relationship between incurred and cash expenditures.

Table 1 summarizes the estimated actuarial status of the trust fund as of the end of the financing period for 2025 and 2026.

TABLE 1: ESTIMATED ACTUARIAL STATUS OF THE PART B ACCOUNT IN THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND AS OF THE END OF THE FINANCING PERIOD

Financing Period Ending	Assets (in millions)	Liabilities[1] (in millions)	Assets less Liabilities[1] (in millions)
December 31, 2025	$147,828	$38,473	$109,354
December 31, 2026	$178,148	$41,889	$136,259

[1] These amounts include only items incurred but not paid. They do not include the amounts that are to be paid back to the general fund of the Treasury over time as specified by section 1839 of the Act as amended by section 601(a) of the Bipartisan Budget Act of 2015 and further amended by section 2401 of the Continuing Appropriations Act, 2021 and Other Extensions Act, nor do they include the Accelerated and Advance Payments Program amounts that are to be repaid by providers and returned to the general fund of the Treasury.

2. Monthly Actuarial Rate for Enrollees Age 65 and Older

The monthly actuarial rate for enrollees age 65 and older is one-half of the sum of monthly amounts for: (1) the projected cost of benefits; and (2) administrative expenses for each enrollee age 65 and older, after adjustments to this sum to allow for interest earnings on assets in the trust fund and an adequate contingency margin. The contingency margin is to be an amount appropriate to provide for possible variation between actual and projected costs and to amortize any surplus assets or unfunded liabilities.

The monthly actuarial rate for enrollees age 65 and older for 2027 is determined by first establishing per enrollee costs by type of service from program data through 2025 and then projecting these costs for subsequent years. The projection factors used for financing periods from January 1, 2024 through December 31, 2027 are shown in Table 2.

As indicated in Table 3, the projected per enrollee amount required to pay for one-half of the total of benefits and administrative costs for enrollees age 65 and over for 2027 is $415.86. The monthly actuarial rate of $418.70 provides an adjustment of $7.13 for a contingency margin and −$4.28 for interest earnings.

Starting in 2011, manufacturers and importers of brand-name prescription drugs pay a fee that is allocated to the Part B account of the SMI trust fund. For 2027, the total of these brand-name drug fees is estimated to be $2.8 billion. The contingency margin for 2027 has been reduced to account for this additional revenue.

The traditional goal for the Part B reserve has been that assets minus liabilities at the end of a year should represent between 15 and 20 percent of the following year's total incurred expenditures. To accomplish this goal, a 17-percent reserve ratio, which is a fully adequate contingency reserve level, has been the normal target used to calculate the Part B premium. At the end of 2026, the reserve ratio is expected to be 18.6 percent. When the reserve ratio is somewhat below 17 percent, the typical approach in the premium determination is to target a reserve ratio of 17 percent the following year. OACT has estimated that a target reserve ratio of 14 percent is the minimally financially adequate level for the Part B premium determination. The 2027 financing targets an 18.6-percent reserve ratio.

The actuarial rate of $418.70 per month for aged beneficiaries, as announced in this notice for 2027, reflects the combined effect of the factors and legislation previously described and the projected assumptions listed in Table 2.

3. Monthly Actuarial Rate for Disabled Enrollees

Disabled enrollees are those persons under age 65 who are enrolled in Part B because of entitlement to Social Security disability benefits for more than 24 months or because of entitlement to Medicare under the End-stage Renal Disease (ESRD) program. Projected monthly costs for disabled enrollees (other than those with ESRD) are prepared in a manner parallel to the projection for the aged using appropriate actuarial assumptions (see Table 2). Costs for the ESRD program are projected differently because of the different nature of services offered by the program.

As shown in Table 4, the projected per enrollee amount required to pay for one-half of the total of benefits and administrative costs for disabled enrollees for 2027 is $526.08. The monthly actuarial rate of $452.40 also provides an adjustment of −$8.70 for interest earnings and −$64.98 for a contingency margin, reflecting the same factors described previously for the aged actuarial rate at magnitudes applicable to the disabled rate determination. Based on current estimates, the assets associated with the disabled Medicare beneficiaries at the end of 2026 are sufficient to cover the amount of incurred, but unpaid, expenses and to provide for a significant degree of variation between actual and projected costs, and accordingly a negative margin is needed.

The actuarial rate of $452.40 per month for disabled beneficiaries, as announced in this notice for 2027, reflects the combined net effect of the factors described previously for aged beneficiaries and the projection assumptions listed in Table 2.

4. Sensitivity Testing

Several factors contribute to uncertainty about future trends in

medical care costs. It is appropriate to test the adequacy of the rates using alternative cost growth rate assumptions, the results of which are shown in Table 5. One set represents increases that are higher and, therefore, more pessimistic than the current estimate, and the other set represents increases that are lower and, therefore, more optimistic than the current estimate. The values for the alternative assumptions were determined from a statistical analysis of the historical variation in the respective increase factors.

As indicated in Table 5, the monthly actuarial rates would result in an excess of assets over liabilities of $136,666 million by the end of December 2027 under the cost growth rate assumptions shown in Table 2 and under the assumption that the provisions of current law are fully implemented. This result amounts to 18.4 percent of the estimated total incurred expenditures for the following year.

Assumptions that are somewhat more pessimistic (and that therefore test the adequacy of the assets to accommodate projection errors) produce a surplus of $71,537 million by the end of December 2027 under current law, which amounts to 8.6 percent of the estimated total incurred expenditures for the following year. Under fairly optimistic assumptions, the monthly actuarial rates would result in a surplus of $200,444 million by the end of December 2027, or 30.7 percent of the estimated total incurred expenditures for the following year.

The sensitivity analysis indicates that, in a typical year, the premium and general revenue financing established for 2027, together with existing Part B account assets, would be adequate to cover estimated Part B costs for 2027 under current law, should actual costs prove to be somewhat greater than expected.

5. Premium Rates and Deductible

As determined in accordance with section 1839 of the Act, the following are the 2027 Part B monthly premium rates to be paid by (or on behalf of) beneficiaries with full Part B coverage who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year) or joint tax returns.

Full Part B Coverage			
Beneficiaries who file individual tax returns with modified adjusted gross income:	**Beneficiaries who file joint tax returns with modified adjusted gross income:**	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	Less than or equal to $224,000	$0.00	$209.40
Greater than $112,000 and less than or equal to $141,000	Greater than $224,000 and less than or equal to $282,000	$83.70	$293.10
Greater than $141,000 and less than or equal to $177,000	Greater than $282,000 and less than or equal to $354,000	$209.40	$418.80
Greater than $177,000 and less than or equal to $212,000	Greater than $354,000 and less than or equal to $424,000	$335.00	$544.40
Greater than $212,000 and less than $500,000	Greater than $424,000 and less than $750,000	$460.60	$670.00
Greater than or equal to $500,000	Greater than or equal to $750,000	$502.40	$711.80

For beneficiaries with immunosuppressive drug only Part B coverage who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year) or joint tax returns, the 2027 Part B monthly premium rates are as follows:

Part B Immunosuppressive Drug Coverage Only			
Beneficiaries who file individual tax returns with modified adjusted gross income:	**Beneficiaries who file joint tax returns with modified adjusted gross income:**	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	Less than or equal to $224,000	$0.00	$125.70
Greater than $112,000 and less than or equal to $141,000	Greater than $224,000 and less than or equal to $282,000	$83.70	$209.40
Greater than $141,000 and less than or equal to $177,000	Greater than $282,000 and less than or equal to $354,000	$209.40	$335.10
Greater than $177,000 and less than or equal to $212,000	Greater than $354,000 and less than or equal to $424,000	$335.00	$460.70
Greater than $212,000 and less than $500,000	Greater than $424,000 and less than $750,000	$460.60	$586.30
Greater than or equal to $500,000	Greater than or equal to $750,000	$502.40	$628.10

In addition, the monthly premium rates to be paid by (or on behalf of) beneficiaries with full Part B coverage who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are as follows:

Full Part B Coverage		
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses, with modified adjusted gross income:	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	$0.00	$209.40
Greater than $112,000 and less than $388,000	$460.60	$670.00
Greater than or equal to $388,000	$502.40	$711.80

The monthly premium rates to be paid by (or on behalf of) beneficiaries with immunosuppressive drug only Part B coverage who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are as follows:

Part B Immunosuppressive Drug Coverage Only		
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses, with modified adjusted gross income:	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	$0.00	$125.70
Greater than $112,000 and less than $388,000	$460.60	$586.30
Greater than or equal to $388,000	$502.40	$628.10

The Part B annual deductible for 2027 is $292.00 for all beneficiaries.

TABLE 2: PROJECTION FACTORS[1]
12-MONTH PERIODS ENDING DECEMBER 31 OF 2024–2027 (IN PERCENT)

Calendar Year	Physician Fee Schedule	Durable Medical Equipment	Practitioner Lab[2]	Physician-Administered Drugs	Other Practitioner Services[3]	Outpatient Hospital	Home Health Agency	Hospital Lab[4]	Other Institutional Services[5]	Managed Care
Aged:										
2024	4.0	10.9	10.7	29.0	–3.2	9.0	1.8	3.2	6.8	3.3
2025	1.9	6.3	8.1	25.1	9.2	10.7	2.7	4.3	7.0	3.7
2026	4.7	4.3	2.2	–26.8	6.6	9.3	0.7	3.2	7.2	8.3
2027	1.1	5.7	5.0	8.8	6.9	9.3	9.8	0.5	5.9	5.2
Disabled:										
2024	3.4	6.1	7.2	40.0	2.6	7.0	5.1	1.5	9.7	3.2
2025	2.7	6.7	5.6	63.7	7.1	8.4	–0.8	4.5	8.3	5.3
2026	9.8	7.9	1.4	58.3	8.0	12.5	3.0	8.1	12.0	10.3
2027	1.6	6.6	5.5	8.3	7.4	10.5	10.7	1.1	7.9	5.5

[1] All values for services other than managed care are per fee-for-service enrollee. Managed care values are per managed care enrollee.
[2] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[3] Includes ambulatory surgical center facility costs, ambulance services, parenteral and enteral drug costs, supplies, etc.
[4] Includes services paid under the lab fee schedule furnished in the outpatient department of a hospital.
[5] Includes services furnished in dialysis facilities, rural health clinics, federally qualified health centers, rehabilitation and psychiatric hospitals, etc.

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TABLE 3: DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FOR FINANCING PERIODS ENDING DECEMBER 31, 2024, THROUGH DECEMBER 31, 2027

	CY 2024	CY 2025	CY 2026	CY 2027
Covered services (at level recognized):				
Physician fee schedule	$65.41	$65.41	$68.38	$68.33
Durable medical equipment	7.13	7.44	7.74	8.09
Practitioner lab[1]	5.25	5.57	5.68	5.90
Physician-administered drugs	27.70	34.00	24.83	26.70
Other practitioner services[2]	10.41	11.16	11.86	12.53
Outpatient hospital	56.77	61.70	67.29	72.68
Home health agency	6.96	7.02	7.05	7.65
Hospital lab[3]	1.95	2.00	2.06	2.04
Other institutional services[4]	17.45	18.34	19.61	20.52
Managed care	192.57	202.89	220.17	233.91
Total services	391.61	415.53	434.70	458.34
Cost sharing:				
Deductible	–9.19	–10.33	–11.56	–11.94
Coinsurance	–26.31	–27.65	–26.58	–27.74
Sequestration of benefits	–7.12	–7.55	–7.93	–8.37
Total benefits	348.99	370.00	388.63	410.29
Medicare Improvement Fund	0.00	0.00	1.25	0.00
Administrative expenses	5.78	5.93	5.42	5.56
Incurred expenditures	354.77	375.93	395.30	415.86
Value of interest	–2.68	–2.57	–3.14	–4.28
Contingency margin for projection error and to amortize the surplus or deficit	–8.69	–5.26	13.24	7.13
Monthly actuarial rate	$343.40	$368.10	$405.40	$418.70

[1] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[2] Includes ambulatory surgical center facility costs, ambulance services, parenteral and enteral drug costs, supplies, etc.
[3] Includes services paid under the lab fee schedule furnished in the outpatient department of a hospital.
[4] Includes services furnished in dialysis facilities, rural health clinics, federally qualified health centers, rehabilitation, and psychiatric hospitals, etc.

TABLE 4: DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FOR FINANCING PERIODS ENDING DECEMBER 31, 2024, THROUGH DECEMBER 31, 2027

	CY 2024	CY 2025	CY 2026	CY 2027
Covered services (at level recognized):				
Physician fee schedule	$50.07	$50.03	$53.42	$51.43
Durable medical equipment	10.12	10.53	11.07	11.15
Practitioner lab[1]	4.60	4.81	4.85	4.85
Physician-administered drugs	25.59	40.43	16.44	16.83
Other practitioner services[2]	10.50	11.03	11.72	11.96
Outpatient hospital	50.55	53.43	58.26	60.77
Home health agency	5.28	5.13	5.15	5.39
Hospital lab[3]	1.89	1.93	2.02	1.94
Other institutional services[4]	34.71	37.52	41.13	42.15
Managed care	275.71	292.99	326.03	354.29
Total services	469.03	507.83	530.08	560.75
Cost sharing:				
Deductible	–8.64	–9.63	–10.83	–11.19
Coinsurance	25.67	28.78	24.72	23.66
Sequestration of benefits	–8.69	–9.39	–9.89	–10.51
Total benefits	426.03	460.02	484.65	515.39
Medicare Improvement Fund	0.00	0.00	2.05	0.00
Administrative expenses	6.60	6.88	10.29	10.69
Incurred expenditures	432.63	466.90	496.98	526.08
Value of interest	–2.61	–3.39	–5.35	–8.70
Contingency margin for projection error and to amortize the surplus or deficit	–2.82	24.29	56.97	–64.98
Monthly actuarial rate	$427.20	$487.80	$548.60	$452.40

[1] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[2] Includes ambulatory surgical center facility costs, ambulance services, parenteral and enteral drug costs, supplies, etc.
[3] Includes services paid under the lab fee schedule furnished in the outpatient department of a hospital.
[4] Includes services furnished in dialysis facilities, rural health clinics, federally qualified health centers, rehabilitation, and psychiatric hospitals, etc.

TABLE 5: ACTUARIAL STATUS OF THE PART B ACCOUNT IN THE SMI TRUST FUND UNDER THREE SETS OF ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 2027

As of December 31,	2025	2026	2027
Actuarial status (in millions):			
Assets	$147,828	$178,148	$181,505
Liabilities	$38,473	$41,889	$44,839
Assets less liabilities	$109,354	$136,259	$136,666
Ratio[1]	17.4%	20.0%	18.4%
Low-cost projection:			
Actuarial status (in millions):			
Assets	$147,828	$196,097	$242,345
Liabilities	$38,473	$38,896	$41,901
Assets less liabilities	$109,354	$156,202	$200,444
Ratio[1]	17.9%	24.8%	30.7%
High-cost projection:			
Actuarial status (in millions):			
Assets	$147,828	$160,026	$119,399
Liabilities	$38,473	$43,903	$47,862
Assets less liabilities	$109,354	$116,123	$71,537
Ratio[1]	16.8%	15.9%	8.6%

[1]Ratio of assets less liabilities at the end of the year to the total incurred expenditures during the following year, expressed as a percent.

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III. Collection of Information Requirements

This document does not impose information collection requirements—that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

IV. Regulatory Impact Analysis

A. Statement of Need

This notice announces the monthly actuarial rates and premium rates, as required by section 1839(a) of the Act, and the annual deductible, as required by section 1833(b) of the Act, for beneficiaries enrolled in Part B of the Medicare Supplementary Medical Insurance (SMI) program beginning January 1, 2027. It also responds to section 1839(a)(1) of the Act, which requires the Secretary to provide for publication of these amounts in the **Federal Register** during the September that precedes the start of each calendar year. As section 1839 of the Act prescribes a detailed methodology for calculating these amounts, we do not have the discretion to adopt an alternative approach on these issues.

B. Overall Impact

We have examined the impacts of this notice as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism'';''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts.). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866.

The 2027 standard Part B premium of $209.40 is $6.50 higher than the 2026 premium of $202.90. We estimate that the total premium increase, for the approximately 66 million Part B enrollees in 2027, will be $5.2 billion. Based on our estimates, OIRA has determined this notice is significant under section 3(f)(1) of E.O. 12866.). Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking. Therefore, OMB has reviewed these proposed regulations. Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has also determined that this notice is a ''major rule'' as defined in 5 U.S.C. 804(2). For the reasons given in section V. of this notice, however, we find for good cause that notice and public procedure are impracticable, unnecessary, and contrary to the public interest and have determined that this policy will take effect on January 1, 2027, pursuant to 5 U.S.C. 808(2).

C. Detailed Economic Analysis

As discussed earlier, this notice announces that the monthly actuarial rates applicable for 2027 are $418.70 for enrollees age 65 and over and $452.40 for disabled enrollees under age 65. It also announces the 2027 monthly Part B premium rates to be paid by (or on behalf of) beneficiaries with full Part B coverage who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately

who lived apart from their spouses for the entire taxable year) or joint tax returns.

Full Part B Coverage			
Beneficiaries who file individual tax returns with modified adjusted gross income:	**Beneficiaries who file joint tax returns with modified adjusted gross income:**	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	Less than or equal to $224,000	$0.00	$209.40
Greater than $112,000 and less than or equal to $141,000	Greater than $224,000 and less than or equal to $282,000	$83.70	$293.10
Greater than $141,000 and less than or equal to $177,000	Greater than $282,000 and less than or equal to $354,000	$209.40	$418.80
Greater than $177,000 and less than or equal to $212,000	Greater than $354,000 and less than or equal to $424,000	$335.00	$544.40
Greater than $212,000 and less than $500,000	Greater than $424,000 and less than $750,000	$460.60	$670.00
Greater than or equal to $500,000	Greater than or equal to $750,000	$502.40	$711.80

For beneficiaries with immunosuppressive drug only Part B coverage who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year) or joint tax returns, the 2027 Part B monthly premium rates are announced and shown below.

Part B Immunosuppressive Drug Coverage Only			
Beneficiaries who file individual tax returns with modified adjusted gross income:	**Beneficiaries who file joint tax returns with modified adjusted gross income:**	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	Less than or equal to $224,000	$0.00	$125.70
Greater than $112,000 and less than or equal to $141,000	Greater than $224,000 and less than or equal to $282,000	$83.70	$209.40
Greater than $141,000 and less than or equal to $177,000	Greater than $282,000 and less than or equal to $354,000	$209.40	$335.10
Greater than $177,000 and less than or equal to $212,000	Greater than $354,000 and less than or equal to $424,000	$335.00	$460.70
Greater than $212,000 and less than $500,000	Greater than $424,000 and less than $750,000	$460.60	$586.30
Greater than or equal to $500,000	Greater than or equal to $750,000	$502.40	$628.10

In addition, the monthly premium rates to be paid by (or on behalf of) beneficiaries with full Part B coverage who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are also announced and listed in the following table:

Full Part B Coverage		
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses, with modified adjusted gross income:	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	$0.00	$209.40
Greater than $112,000 and less than $388,000	$460.60	$670.00
Greater than or equal to $388,000	$502.40	$711.80

The monthly premium rates to be paid by (or on behalf of) beneficiaries with immunosuppressive drug only Part B coverage who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are announced and listed in the following table:

Part B Immunosuppressive Drug Coverage Only		
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses, with modified adjusted gross income:	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	$0.00	$125.70
Greater than $112,000 and less than $388,000	$460.60	$586.30
Greater than or equal to $388,000	$502.40	$628.10

D. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/omb/information-resources/guidance/circulars/*), in Table 6 we have prepared an accounting statement.

TABLE 6: ACCOUNTING STATEMENT: THE ESTIMATED AGGREGATE PART B PREMIUM INCREASE FOR ALL ENROLLEES FOR 2027

Category	
Annualized Monetized Transfers	$5.2 billion
From Whom to Whom?	Beneficiaries to Federal Government

E. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule or other regulatory document has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Individuals and States are not included in the definition of a small entity. This notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) beneficiaries enrolled in Part B of the Medicare SMI program beginning January 1, 2027. Also, this notice announces the monthly premium for aged and disabled beneficiaries as well as the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts. As a result, we are not preparing an analysis for the RFA because the Secretary has determined that this notice 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 or other regulatory document may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the 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. As we discussed previously, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this notice will not have a significant effect on a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. Part B enrollees who are also enrolled in Medicaid have their monthly Part B premiums paid by Medicaid. The cost to each State Medicaid program from the 2027 premium increase is estimated to be more than the threshold. This notice does not impose mandates that will have a consequential effect of the threshold amount or more on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule or other regulatory document (and subsequent final rule or other regulatory document) that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have determined that this notice does not significantly affect the rights, roles, and responsibilities of States. Accordingly, the requirements of Executive Order 13132 do not apply to this notice.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 1871 of the Act. Section 1871(a)(2) of the Act provides that no rule, requirement, or other statement of policy (other than a national coverage determination) 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 under Medicare shall take effect unless it is promulgated through notice and comment rulemaking. Unless there is a statutory exception, section 1871(b)(1) of the Act generally requires the Secretary of the Department of Health and Human Services (the Secretary) to provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute. Section 1871(b)(2)(C) of the Act provides exceptions from the notice and 60-day comment period, under the good cause standard set forth in 5 U.S.C. 553(b)(B). Section 553(b)(B) expressly authorizes an agency to dispense with notice and comment rulemaking for good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest.

The annual updated amounts for the Part B monthly actuarial rates for aged and disabled beneficiaries, the Part B premium, and the Part B deductible set forth in this notice do not establish or change a substantive legal standard regarding the matters enumerated by the statute or constitute a substantive rule that would be subject to the notice requirements in section 1871(b) of the Act. However, to the extent that an opportunity for public notice and comment could be construed as required for this notice, we find good cause to waive this requirement.

Section 1839 of the Act requires the Secretary to determine the monthly actuarial rates for aged and disabled beneficiaries, as well as the monthly Part B premium (including the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts), for each calendar year in accordance with the statutory formulae, in September preceding the year to which they will apply. Further, the statute requires that the agency promulgate the Part B premium amount, in September preceding the year to which it will apply, and include a public statement setting forth the actuarial assumptions and bases employed by the Secretary in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older. We include the Part B annual deductible, which is established in accordance with a specific formula described in section 1833(b) of the Act, because the determination of the amount is directly linked to the rate of increase in actuarial rate under section 1839(a)(1) of the Act. We have calculated the monthly actuarial rates for aged and disabled beneficiaries, the Part B deductible, and the monthly Part B premium as directed by the statute; since the statute establishes both when the monthly

actuarial rates for aged and disabled beneficiaries and the monthly Part B premium must be published and what information must be factored into those amounts by the Secretary, we do not have any discretion in that regard. We find notice and comment procedures to be unnecessary for this notice, and we find good cause to waive such procedures under section 553(b)(B) and section 1871(b)(2)(C) of the Act, if such procedures may be construed to be required at all. Through this notice, we are simply notifying the public of the updates to the monthly actuarial rates for aged and disabled beneficiaries and the Part B deductible, as well as the monthly Part B premium amounts and the income-related monthly adjustment amounts to be paid by certain beneficiaries, in accordance with the statute, for CY 2027.

Dr. Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on November 16, 2026.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2026–23601 Filed 11–17–26; 4:15 pm]

BILLING CODE 4169–69–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8092–N]

RIN 0938–AV84

Medicare Program; CY 2027 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year (CY) 2027 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2027, the inpatient hospital deductible will be $1,776. The daily coinsurance amounts for CY 2027 will be as follows: $444 for the 61st through 90th day of hospitalization in a benefit period; $888 for lifetime reserve days; and $222 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: The deductible and coinsurance amounts announced in this notice are effective on January 1, 2027.

FOR FURTHER INFORMATION CONTACT: Suzanne Codespote, (410) 786–7737 or Yaminee Thaker (410) 786–7921.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary) to determine and publish each year the amount of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year (CY).

II. Computing the Inpatient Hospital Deductible for CY 2027

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding CY, adjusted by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding CY, and adjusted to reflect changes in real casemix. The adjustment to reflect real casemix is determined on the basis of the most recent case-mix data available. The amount determined under this formula is rounded to the nearest multiple of $4 (or, if midway between two multiples of $4, to the next higher multiple of $4).

Under section 1886(b)(3)(B)(i)(XX) of the Act, the percentage increase used to update the payment rates for FY 2027 for hospitals paid under the inpatient prospective payment system (IPPS) is the IPPS operating market basket percentage increase, otherwise known as the IPPS market basket update, reduced by an adjustment based on changes in the economy-wide productivity (productivity adjustment) (see section 1886(b)(3)(B)(xi)(II) of the Act). Under section 1886(b)(3)(B)(viii) of the Act, for FY 2027, the applicable percentage increase for hospitals that do not submit quality data as specified by the Secretary is reduced by one quarter of the market basket update. We are estimating that after accounting for those hospitals receiving the lower market basket update in the payment-weighted average update, the calculated deductible will not be affected, since the majority of hospitals submit quality data and receive the full market basket update. Section 1886(b)(3)(B)(ix) of the Act requires that any hospital that is not a meaningful electronic health record (EHR) user (as defined in section 1886(n)(3) of the Act) will have three-quarters of the market basket update reduced by 100 percent for FY 2017 and each subsequent FY. We are estimating that after accounting for these hospitals receiving the lower market basket update, the calculated deductible will not be affected, since the majority of hospitals are meaningful EHR users and are expected to receive the full market basket update.

Under section 1886 of the Act, the percentage increase used to update the payment rates (or target amounts, as applicable) for FY 2027 for hospitals excluded from the inpatient prospective payment system is as follows:

- The percentage increase for long term care hospitals (LTCH) is the LTCH market basket percentage increase reduced by the productivity adjustment (see section 1886(m)(3)(A) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments and the site-neutral payment rates (see section 1886(m)(5) and (6) of the Act).
- The percentage increase for inpatient rehabilitation facilities (IRF) is the IRF market basket percentage increase reduced by the productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(j)(7) of the Act).
- The percentage increase used to update the payment rate for inpatient psychiatric facilities (IPF) is the IPF market basket percentage increase reduced by the productivity adjustment (see section 1886(s)(2)(A)(i) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(s)(4) of the Act).
- The percentage increase used to update the target amounts for other types of hospitals that are excluded from the inpatient prospective payment system and that are paid on a reasonable cost basis, subject to a rate-of-increase

ceiling, is the IPPS operating market basket percentage increase, which is described at section 1886(b)(3)(B)(ii)(VIII) of the Act and 42 CFR 413.40(c)(3). These other types of hospitals include cancer hospitals, children's hospitals, extended neoplastic disease care hospitals, and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico.

The IPPS operating market basket percentage increase for FY 2027 is 3.2 percent and the productivity adjustment is 0.9 percentage point, as announced in the final rule that appeared in the **Federal Register** on August 4, 2026 entitled, ''Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; Other Policy Changes; and Adoption of Updated Versions of Certain Health Information Technology Standards'' (91 FR 49570). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system that submit quality data and are meaningful EHR users is 2.3 percent (that is, the FY 2027 IPPS operating market basket update of 3.2 percent less the productivity adjustment of 0.9 percentage point). The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 2.48 percent. This average includes long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities and other hospitals excluded from the inpatient prospective payment system. Weighting these percentages in accordance with payment volume, our best estimate of the payment-weighted average of the increases in the payment rates for FY 2027 is 2.32 percent.

To develop the adjustment to reflect changes in real casemix, we first calculated an average casemix for each hospital that reflects the relative costliness of that hospital's mix of cases compared to those of other hospitals. We then computed the change in average casemix for hospitals paid under the Medicare inpatient prospective payment system in FY 2026 compared to FY 2025. (We excluded from this calculation hospitals whose payments are not based on the inpatient prospective payment system because their payments are based on alternate prospective payment systems or reasonable costs.) We used Medicare bills from prospective payment hospitals that we received as of July 2026. These bills represent a total of about 5.6 million Medicare discharges for FY 2026 and provide the most recent case-mix-data available at this time. Based on these bills, the change in average casemix in FY 2026 is −0.2 percent. Based on these bills and past experience, we expect the overall FY 2026 casemix change to be −0.1 percent as the year progresses and more FY 2026 data become available.

Section 1813(b) of the Act requires that the inpatient hospital deductible be adjusted only by that portion of the case mix change that is determined to be real. Real casemix is that portion of casemix that is due to changes in the mix of cases and not due to coding optimization. We are assuming that this increase in casemix is real and not a result of coding optimization.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 2.32 percent, and the real case-mix adjustment factor for the deductible is −0.1 percent. Therefore, using the statutory formula as stated in section 1813(b) of the Act, we calculate the inpatient hospital deductible for services furnished in CY 2027 to be $1,776. This deductible amount is determined by multiplying $1,736 (the inpatient hospital deductible for CY 2026) by the payment-weighted average increase in the payment rates of 1.0232 multiplied by the increase in real casemix of 0.999, which equals $1,774.50 and is rounded to $1,776 (based on rounding to the nearest multiple of 4).

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2027

The coinsurance amounts provided for in section 1813 of the Act are defined as fixed percentages of the inpatient hospital deductible for services furnished in the same CY. The increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in CY 2027, in accordance with the fixed percentages defined in the law, the daily coinsurance for the 61st through 90th day of hospitalization in a benefit period will be $444 (one-fourth of the inpatient hospital deductible as stated in section 1813(a)(1)(A) of the Act); the daily coinsurance for lifetime reserve days will be $888 (one-half of the inpatient hospital deductible as stated in section 1813(a)(1)(B) of the Act); and the daily coinsurance for the 21st through 100th day of extended care services in a skilled nursing facility (SNF) in a benefit period will be $222 (one-eighth of the inpatient hospital deductible as stated in section 1813(a)(3) of the Act).

IV. Cost to Medicare Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for CYs 2026 and 2027, as well as the number of each that is estimated to be paid.

TABLE 1—MEDICARE PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CYS 2026 AND 2027

Type of cost sharing	Value		Number paid (in millions)	
	2026	2027	2026	2027
Inpatient hospital deductible	$1,736	$1,776	5.59	5.68
Daily coinsurance for 61st—90th day	434	444	1.30	1.32
Daily coinsurance for lifetime reserve days	868	888	0.65	0.66
SNF coinsurance	217.00	222.00	26.56	27.50

The estimated total increase in costs to beneficiaries is about $770 million (rounded to the nearest $10 million) due to: (1) the increase in the deductible and coinsurance amounts; and (2) the change in the number of deductibles and daily coinsurance amounts paid. We determine the increase in cost to beneficiaries by calculating the difference between the 2026 and 2027 deductible and coinsurance amounts multiplied by the estimated change in the number of deductible and coinsurance amounts paid.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment

prior to a rule taking effect in accordance with section 1871 of the Act. Section 1871(a)(2) of the Act provides that no rule, requirement, or other statement of policy (other than a national coverage determination) 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 under Medicare shall take effect unless it is promulgated through notice and comment rulemaking. Unless there is a statutory exception, section 1871(b)(1) of the Act generally requires the Secretary to provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute. Section 1871(b)(2)(C) of the Act provides exceptions from the notice and 60-day comment period, under the good cause standard set forth in 5 U.S.C. 553(b)(B). Section 553(b)(B) authorizes an agency to dispense with notice and comment rulemaking for good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest.

The annual inpatient hospital deductible and the hospital and extended care services coinsurance amounts announcement set forth in this notice does not establish or change a substantive legal standard regarding the matters enumerated by the statute or constitute a substantive rule which would be subject to the notice requirements in section 1871(b) of the Act. However, to the extent that an opportunity for public notice and comment could be construed as required for this notice, we find good cause to waive this requirement.

Section 1813(b)(2) of the Act requires publication of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts between September 1 and September 15 of the year preceding the year to which they will apply. Further, the statute requires that the agency determine and publish the inpatient hospital deductible and hospital and extended care services coinsurance amounts for each CY in accordance with the statutory formulae, and we are simply notifying the public of the changes to the deductible and coinsurance amounts for CY 2027. We have calculated the inpatient hospital deductible and hospital and extended care services coinsurance amounts as directed by the statute; the statute establishes both when the deductible and coinsurance amounts must be published and the information that the Secretary must factor into the deductible and coinsurance amounts, so we do not have any discretion in that regard. We find notice and comment procedures to be unnecessary for this notice, and we find good cause to waive such procedures under section 553(b)(B) and section 1871(b)(2)(C) of the Act, if such procedures may be construed to be required at all. Through this notice, we are simply notifying the public of the updates to the inpatient hospital deductible and the hospital and extended care services coinsurance amounts, in accordance with the statute, for CY 2027.

VI. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VII. Regulatory Impact Analysis

We have prepared this Regulatory Impact Analysis (RIA) section in the interest of ensuring that the impacts of this notice are fully understood.

A. Statement of Need

This notice announces the Medicare Part A inpatient hospital deductible and associated coinsurance amounts for hospital and extended care services applicable for care provided in CY 2027, as required by section 1813 of the Act. It also responds to section 1813(b)(2) of the Act, which requires the Secretary to provide for publication of these amounts in the **Federal Register** between September 1 and September 15 of the year preceding the year to which they will apply. As this statutory provision prescribes a detailed methodology for calculating these amounts, we do not have the discretion to adopt an alternative approach to these issues.

B. Overall Impact

We have examined the impacts of this notice as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. As stated in section IV. of this notice, we estimate that the total increase in costs to beneficiaries is about $770 million due to: (1) the increase in the deductible and coinsurance amounts; and (2) the change in the number of deductibles and daily coinsurance amounts paid. Based on our estimates, OIRA has determined this notice is significant under section 3(f)(1). Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of this notice.

In accordance with subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has determined that this notice meets the criteria set forth in 5 U.S.C. 804(2). For the reasons given, however, we find for good cause that notice and public procedure are impracticable, unnecessary, and contrary to the public interest and have determined that this policy will take effect on January 1, 2027, pursuant to 5 U.S.C. 808(2).

C. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/*

uploads/2025/08/CircularA-4.pdf), in Table 2, we have prepared an accounting statement showing the estimated total increase in costs to beneficiaries of about $770 million. As stated in section IV. of this notice, we determined the increase in cost to beneficiaries by calculating the difference between the 2026 and 2027 deductible and coinsurance amounts multiplied by the estimated change in the number of deductible and coinsurance amounts paid.

TABLE 2—ESTIMATED TRANSFERS FOR CY 2027 DEDUCTIBLE AND COINSURANCE AMOUNTS

Category	Transfers	Period covered
Annualized Monetized Transfers	$770 million	2027
From Whom to Whom	Beneficiaries to Providers	

D. Regulatory Flexibility Act

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration's definition of a small business (having revenues of less than $9.0 million to $47.0 million in any 1 year). Individuals and States are not included in the definition of a small entity. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2027 and will have an impact on the Medicare beneficiaries. As a result, we are not preparing an analysis for the RFA because the Secretary has certified that this notice 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 an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the 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. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2027 and will have an impact on certain Medicare beneficiaries, but not on small entities as defined by the SBA. As a result, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has certified that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. This notice would not impose a mandate that will result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $193 million in any 1 year.

F. Federalism

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. This notice will not have a substantial direct effect on State or local governments, preempt State law, or otherwise have Federalism implications.

G. Congressional Review

This notice is subject to the Congressional Review Act and has been transmitted to the Congress and the Government Accountability Office's Comptroller General for review.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on November 16, 2026.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2026–23603 Filed 11–17–26; 4:15 pm]

BILLING CODE 4169–69–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2026–N–3532]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Good Laboratory Practice Requirements for Nonclinical Laboratory Studies

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Submit written comments (including recommendations) on the collection of information by December 21, 2026.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be submitted to *https://www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under Review—Open for Public Comments'' or by using the search function. The OMB control number for this information collection is 0910–0119. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Kelly Covington, Office of Operations, Food and Drug Administration, Three White Flint North, 10A–12M, 11601 Landsdown St., North Bethesda, MD 20852, 240–402–5661, *PRAStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed

collection of information to OMB for review and clearance.

Good Laboratory Practice Requirements for Nonclinical Laboratory Studies

OMB Control Number 0910–0119—Extension

Sections 409, 505, 512, and 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 348, 355, 360b, and 360e) and related statutes require manufacturers of food additives, human drugs and biological products, animal drugs, and medical devices to demonstrate the safety and utility of their product by submitting applications to FDA for research or marketing permits. Such applications contain, among other important items, full reports of all studies done to demonstrate product safety in man and/or other animals. In order to ensure adequate quality control for these studies and to provide an adequate degree of consumer protection, the Agency issued good laboratory practice (GLP) regulations for nonclinical laboratory studies in part 58 (21 CFR part 58). The regulations specify minimum standards for the proper conduct of safety testing and contain sections on facilities, personnel, equipment, standard operating procedures (SOPs), test and control articles, quality assurance, protocol and conduct of a safety study, records and reports, and laboratory disqualification, and include information collection provisions.

Part 58 requires testing facilities engaged in conducting toxicological studies to retain, and make available to regulatory officials, records regarding compliance with GLPs. Records are maintained on file at each testing facility and examined there periodically by FDA inspectors. The GLP regulations require that, for each nonclinical laboratory study, a final report be prepared that documents the results of quality assurance unit inspections, test and control article characterization, testing of mixtures of test and control articles with carriers, and an overall interpretation of nonclinical laboratory studies. The GLP regulations also require written records pertaining to: (1) personnel job descriptions and summaries of training and experience; (2) master schedules, protocols and amendments thereto, inspection reports, and SOPs; (3) equipment inspection, maintenance, calibration, and testing records; (4) documentation of feed and water analyses and animal treatments; (5) test article accountability records; and (6) study documentation and raw data.

Description of Respondents: Respondents to the collection of information are sponsors of nonclinical laboratory studies that support or are intended to support applications for research or marketing permits for products regulated by FDA.

In the **Federal Register** of April 30, 2026 (91 FR 23273), FDA published a 60-day notice requesting public comment on the proposed collection of information. Two comments were received; however, they did not respond to the questions posed in 5 CFR 1320.8(d).

FDA estimates the burden of this collection of information as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN [1]

21 CFR part	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
58.35(b)(7); Quality assurance unit	300	60.25	18,075	1	18,075
58.185; Reporting of nonclinical laboratory study results	300	60.25	18,075	27.65	499,774
Total					517,849

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

TABLE 2—ESTIMATED ANNUAL RECORDKEEPING BURDEN [1]

21 CFR Part	Number of recordkeepers	Number of records per recordkeeper	Total annual records	Average burden per recordkeeping	Total hours
58.29(b); Personnel	300	20	6,000	.21 (13 mins.)	1,260
58.35(b)(1)–(6), and (c); Quality assurance unit	300	270.76	81,228	3.36	272,926
58.63(b) and (c); Maintenance and calibration of equipment.	300	60	18,000	.09 (5 mins.)	1,620
58.81(a)–(c); SOPs	300	301.80	90,540	.14 (8 mins.)	12,676
58.90(c) and (g); Animal care	300	62.70	18,810	.13 (8 mins.)	2,445
58.105(a) and (b); Test and control article characterization.	300	5	1,500	11.8	17,700
58.107(d); Test and control article handling	300	1	300	4.25	1,275
58.113(a); Mixtures of articles with carriers	300	15.33	4,599	6.8	31,273
58.120; Protocol	300	15.38	4,614	32.7	150,878
58.195; Retention of records	300	251.50	75,450	3.9	294,255
Total					786,308

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Based on an evaluation of the information collection, we are retaining the currently approved estimates. Our assumptions regarding the time needed for the respective activities is based on our experience with the information collection and informal communications with respondents.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2026–23541 Filed 11–18–26; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2026–N–3070]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; National Youth Tobacco Survey

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Submit written comments (including recommendations) on the collection of information by December 21, 2026.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be submitted to *https://www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under Review—Open for Public Comments'' or by using the search function. The OMB control number for this information collection is 0910–0932. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Amber Barrett, Office of Operations, Food and Drug Administration, Three White Flint North, 10A–12M, 11601 Landsdown St., North Bethesda, MD 20852, 301–796–8867, *PRAStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

National Youth Tobacco Survey 2027–2029

OMB Control Number 0910–0932—Revision

This information collection supports the development and implementation of the National Youth Tobacco Survey (NYTS), which is a key component of FDA's youth tobacco surveillance. By providing national estimates of youth tobacco use, the NYTS directly contributes to FDA's ability to effectively regulate tobacco use and prevent youth access to tobacco products in the United States. FDA's Center for Tobacco Products (CTP) was created to carry out the authorities granted under the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) (Pub. L. 111–31) to educate the public about the dangers of tobacco use and to serve as a public health resource for tobacco and health information. CTP's tobacco surveillance research, including the NYTS, directly contributes to advancing the goals of Executive Order 14212: Establishing the President's Make America Healthy Again Commission, including the Make Our Children Healthy Again assessment, in three ways. First, the NYTS helps FDA CTP evaluate the effect of policies and regulations on efforts to reduce tobacco use, the leading cause of chronic disease and mortality in the United States. Second, the NYTS protects the health of children by influencing policies, regulatory action, public education campaigns, and compliance and enforcement efforts designed to decrease the likelihood of youth tobacco initiation and reduce youth tobacco use. Third, the NYTS gathers information about youth tobacco use by means of rigorous scientific methods.

The NYTS has been conducted since 1999 and serves as the gold-standard source of nationally representative estimates of youth tobacco use in the United States. In 2025, FDA assumed leadership of the NYTS from the Centers for Disease Control and Prevention (CDC). The collection was previously approved under OMB Control No. 0920–0621. The NYTS supports FDA's CTP in its efforts to reduce tobacco related disease and protect the health of children.

The survey will be conducted among a nationally representative sample of students attending public and private schools in grades 6–12. The survey will be digital, web-based, anonymous, self-administered, and will be taken on school or personal computers, tablets, or mobile devices. Information supporting the NYTS also will be collected from state-, district-, and school-level administrators and teachers. Information collected through the NYTS will be used to identify trends in youth tobacco use over time, and to inform the development of public education campaigns, policies and rules, and compliance and enforcement programs for tobacco products.

The survey will examine the following topics: use of e-cigarettes, cigarettes, cigars, smokeless tobacco (chewing tobacco, snuff, dip), hookahs, pipes, snus, nicotine pouches, other oral nicotine products, bidis, heated tobacco products, and roll-your-own cigarettes; knowledge and attitudes; media and advertising; access to tobacco products and enforcement of restrictions on access; secondhand smoke and e-cigarette aerosol exposure, and cessation.

In the **Federal Register** of May 4, 2026 (91 FR 23995), FDA published a 60-day notice requesting public comments on the proposed collection of information. Eight comments were responsive to the Paperwork Reduction Act (PRA) information collection topics solicited.

(Comment) Seven commenters expressed support for the continuation of the NYTS, with several describing it as the ''gold-standard'' and only nationally representative, school-based survey focused exclusively on youth tobacco use. Commenters emphasized the survey's value in tracking product trends, identifying emerging tobacco products, informing regulatory and enforcement actions, and supporting public health programs at the federal, state, and local levels. The State Attorneys General specifically endorsed the proposed sample size increase to maintain statistical rigor in light of declining school-based response rates.

(FDA response) FDA acknowledges and appreciates the strong support for NYTS continuation expressed across all comments. The NYTS has been administered since 1999 and has served as an essential surveillance tool for identifying trends in youth tobacco and nicotine product use, informing regulatory action, guiding public health programs, and supporting enforcement at the federal and state levels. FDA remains committed to the annual administration of the NYTS and to maintaining the scientific rigor necessary for the data to serve these functions.

(Comment) One commenter expressed support for the continuation of the NYTS and urged FDA to publish the 2025 NYTS analysis and results consistent with prior years, noting that the release of raw data without an accompanying analysis limits the

accessibility and utility of the data for clinicians, public health practitioners, and policy makers. The commenter also made recommendations regarding FDA's review of premarket tobacco applications for flavored electronic nicotine delivery systems.

(FDA response) FDA appreciates the commenter's support for the NYTS and acknowledges the concern regarding the timely publication of analysis and results. FDA is committed to ensuring that NYTS findings are made publicly available in a timely manner. To comply with Executive Order 14303, titled ''Restoring Gold Standard Science,'' FDA plans to simultaneously release the public use dataset to coincide with the first publication for a given year of the NYTS. The commenter's recommendations regarding premarket tobacco product applications are outside the scope of this information collection request and will not be addressed here.

(Comment) One comment raised methodological concerns regarding declining school-based response rates, which fell from 77.2% in 2019 to 36.0% in 2025. This decline was attributed in part to the proliferation of state laws requiring active parental consent for youth surveys and expressed concern about potential nonresponse bias and diminished representativeness of recent NYTS estimates. The commenter recommended FDA: (1) conduct and publish an updated nonresponse bias analysis; (2) explore passive (opt-out) parental consent procedures where permissible; (3) evaluate alternative or complementary sampling approaches, such as address-based sampling; (4) enhance transparency around methodology changes and data limitations; and (5) support triangulation with other national and subnational data sources to validate findings.

(FDA response) FDA shares the concern about declining response rates and recognizes that this trend may have meaningful implications for the representativeness and comparability of NYTS data. The proposed increase in the total numbers of schools and students sampled for 2027–2029 reflects FDA's effort to accommodate declining response rates in school-based surveys and continue producing nationally representative data. Responses to each recommendation are as follows:

(1) *Nonresponse bias analysis:* FDA conducts a nonresponse bias analysis each year in accordance with OMB requirements. While the full nonresponse bias report is not made publicly available due to concerns about the potential disclosure of school-level information that could compromise respondent confidentiality, the publicly available methodology report provides a detailed description of the development of nonresponse bias-adjusted weights and calibration procedures. Additionally, a recently published paper reported findings from a nonresponse bias analysis assessing the impact of early termination of the 2025 NYTS data collection (Park-Lee et al., 2026).

(2) *Passive parental consent:* NYTS already employs passive parental consent as its default procedure. Unless a school requires active parental permission, NYTS follows passive parental consent procedures. Based on recent NYTS data collection cycles, approximately 10% of respondents are estimated to require active parental consent. FDA will continue to monitor developments in state-level consent requirements and their potential effects on survey participation and representativeness.

(3) *Alternative or complementary sampling:* Meaningful changes to the NYTS sampling design would need to be evaluated carefully against potential impacts on data comparability, the financial and logistical resources required, and the ability to maintain the precision of national estimates and estimates of population groups. FDA will consider assessing the feasibility of alternative or complementary sampling strategies, including address-based sampling (ABS).

(4) *Transparency around methodology and data limitations:* FDA remains committed to transparency regarding methodological changes and data limitations. The annual methodology report published with the public-use files provides clear guidance on the appropriate interpretation of NYTS data, including the implications of weighting adjustments and changes in sampling procedures.

(5) *Triangulation with other data sources:* As part of its nonresponse bias analysis and dissemination efforts, FDA triangulates with other national and subnational data sources to validate and contextualize estimates. These include both school-based and household surveys, including the Youth Risk Behavior Survey (YRBS), Monitoring the Future (MTF), the Population Assessment of Tobacco and Health (PATH) Study, and the National Survey on Drug Use and Health (NSDUH). Continued cross-survey triangulation enables FDA to identify potential nonresponse bias and assess consistency of trend estimates.

(Comment) Another comment suggests FDA to: (1) include brand-specific product images alongside brand-name response options for e-cigarette use questions, citing published studies and original analyses of NYTS 2024–2025 data demonstrating substantial discordance between self-reported brand use and reported device type and flavor; and (2) reinstate the 2024 NYTS follow-up question on the age of social sources of e-cigarettes, which was removed from the 2025 survey, to help assess the potential impact of device-access restrictions.

(FDA response) FDA appreciates the recommendations regarding the visual presentation of product options and the reinstatement of a follow-up question on social sources of e-cigarettes.

(1) *Brand-specific product images:* FDA acknowledges the evidence of discordance between self-reported brand use and reported device type and flavor. However, NYTS includes selected non-branded product images because a brand encompasses a wide variety of products, and it is not feasible to include every product available on the market. Non-branded images representing commonly recognizable device types are intended to aid respondent comprehension of the product category, and respondent burden is considered when evaluating expansions to the image set.

(2) *Reinstatement of the follow-up question on age of social sources:* Question-level decisions reflect careful consideration of scientific priority, policy relevance, and respondent burden. FDA will consider the recommendation as part of its ongoing review of the NYTS questionnaire for future data collection cycles.

(Comment) One commenter expressed support for the continuation of the NYTS and raised concerns about the timeliness and transparency of the NYTS data dissemination, recommending that FDA publish a prospective calendar of NYTS milestones, including questionnaire availability, fielding periods, data release dates, and report publication timelines, and that datasets be released concurrently with initial findings rather than in a piecemeal fashion. With respect to survey content, it was recommended that FDA incorporate emerging product categories and brands as response options more quickly and increase stakeholder engagement to inform timely survey updates; consider a supplemental fall NYTS to provide more frequent trend monitoring; add consumption frequency and initiation questions across all product categories; expand reasons-for-use questions to cover heated tobacco products, nicotine pouches, and oral nicotine products; and refine access source measures to

better distinguish between commercial and social sources of tobacco products.

(FDA response) Regarding the timeliness of survey results and data dissemination, there are several factors that affect how quickly analysis results are released, including the peer-review process for publications and several levels of internal and external review. Because publication schedules and timelines vary across products we cannot always predict publication dates in advance. To comply with Executive Order 14303, titled 'Restoring Gold Standard Science,' FDA plans to simultaneously release public-use datasets to coincide with the first publication for a given year of the NYTS. FDA will also explore opportunities to improve transparency around the NYTS process and timeline to the extent practicable. Additionally, as part of the PRA review process, the proposed survey instrument is made publicly available in the docket, allowing the public to view the instrument. A copy of the questionnaire is also included with the release of the public-use dataset and its accompanying documentation, providing further transparency and access for researchers and other data users. With respect to incorporating emerging product categories, NYTS is a federal survey subject to the Paperwork Reduction Act and regulated by OMB. Thus, NYTS is not designed as a rapid surveillance tool with the opportunity to add new items quickly in response to emerging products. FDA conducts environmental scans using a variety of sources to predict potential items to add or remove in advance of seeking OMB approval and consults with subject matter experts and stakeholders. Regarding the recommendation for a supplemental fall NYTS, any meaningful change to the frequency or structure of NYTS data collection would require additional OMB approval and careful evaluation of associated burden and resource implications. Within these constraints, FDA will take the commenter's survey content recommendations under consideration for future data collection cycles.

(Comment) One commenter recommends that FDA add a standalone NYTS measure for ''premium cigars'' as a distinct product category, using the definition codified at 21 CFR 1107.12, accompanied by plain-language descriptors and respondent clarifications to help youth distinguish premium cigars from cigarillos, filtered cigars, flavored cigars, and other mass-market cigar products. The commenter argues that the current aggregation of premium cigars with other cigar product types is inconsistent with FDA's own regulatory treatment of premium cigars and produces data of insufficient utility for FDA's current regulatory functions.

(FDA response) FDA appreciates the commenter's recommendation and acknowledges that premium cigars are treated as a distinct product category under 21 CFR 1107.12. However, FDA does not believe it is appropriate or feasible to incorporate this regulatory definition into the NYTS instrument. The definition requires that a product satisfy eight specific technical criteria. Even with plain-language descriptors and clarifications, it is unlikely that youth could reliably identify whether a product they used meets this definition, introducing significant measurement error. The explanatory text necessary to operationalize this definition for youth would also substantially increase respondent burden. Additionally, available evidence suggests that premium cigars, as defined under 21 CFR 1107.12, represent a small share of cigar use among youth, who are more likely to use mass-market products such as cigarillos and filtered cigars.

FDA estimates the burden of this collection of information as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN

Activity	Form name	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
State administrators	State-level Recruitment Script.	42	1	42	0.5 (30 min)	21
District administrators	District-level Recruitment Script.	384	1	384	0.5 (30 min)	192
School administrators	School-level Recruitment Script.	555	1	555	0.5 (30 min)	278
Teachers	Data Collection Administration Script.	1,388	1	1,388	0.25 (15 min)	347
Parents/guardians	Active Consent Script	3,500	1	3,500	0.17 (10 min)	595
Students	National Youth Tobacco Survey.	29,579	1	29,579	0.75 (45 min)	22,184
	Screening for Cognitive Interviews.	417	1	417	0.08 (5 min)	33
	Cognitive Interviews	97	1	97	1 (60 min)	97
Total		35,962				23,747

Our estimated burden for the information collection reflects an overall increase of 1,147 hours and a corresponding increase of 4,461 responses. For 2027–2029, there are no changes to the frequency of data collection for the survey instrument. The burden per response is approximately the same for state and district administrators, school administrators, and teachers. We added burden estimates for parents who complete active consent forms (*i.e.,* forms that must be returned in order for their child to participate) to account for states' increased reliance on this type of consent. The total number of students sampled increased slightly between 2024–2026 and 2027–2029, increasing the burden slightly. This change is to accommodate declining response rates for school-based studies, in other words, the need to sample a greater number of students to get the same number of survey responses. The burden for cognitive interviews is roughly equivalent.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2026–23542 Filed 11–18–26; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Nursing Research; Notice of Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the National Advisory Council for Nursing Research.

The meeting will be partially open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting. The open session will be videocast and can be accessed from the NIH Videocasting and Podcasting website: *https://videocast.nih.gov/.*

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Council for Nursing Research.

Date: January 26, 2027.

Open: 10:00 a.m. to 2:45 p.m.

Agenda: Director's update and other Council business.

Address: National Institutes of Health, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Closed: 2:45 p.m. to 3:15 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Dr. William Duval, Ph.D., Division of Extramural Science Programs, National Institute of Nursing Research, Bethesda, MD 20817, *duvalw@mail.nih.gov.*

Registration is not required to attend the open portion of this meeting.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: *https://www.ninr.nih.gov/aboutninr/nacnr,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.361, Nursing Research; 93.NR4, Nursing Research—SBIR—STTR; 93.NR5, Nursing Research—Centers; 93.NR1, Nursing Research—Research Projects; 93.NR2, Nursing Research—Training, Institutional; 93.NR1, Nursing Research—Research Projects; 93.NR2, Nursing Research—Training, Institutional; 93.NR3, Nursing Research—Training, Individual; 93.NR4, Nursing Research—SBIR–STTR; 93.NR6, Nursing Research—Other Research; 93.NR6, Nursing Research—Other Research; 93.NR3, Nursing Research—Training, Individual, National Institutes of Health, HHS)

Dated: November 16, 2026.

Rosalind M. Niamke,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2026–23532 Filed 11–18–26; 8:45 am]

BILLING CODE 4167–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center For Scientific Review; Notice of Closed Meetings

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Cancer Diagnostics and Biomarker Development.

Date: December 10, 2026.

Time: 9:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge, Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Shree Ram Singh, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (240) 672–6175, *singhshr@mail.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Topics in Health Services for Aged Populations.

Date: December 10, 2026.

Time: 9:00 a.m. to 12:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Keary A. Cope, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 209–A, Bethesda, MD 20892–7924, (301) 594–5976, *copeka@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Fellowships: Neuroscience.

Date: December 10, 2026.

Time: 9:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Bita Nakhai, MS, BS, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 402–7701, *nakhaib@nia.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Support for Research Excellence and Academic Research Enhancement Awards in Health Services and Systems.

Date: December 10, 2026.

Time: 9:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Saira Akhtar Mehmood, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 443–9003, *saira.mehmood@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business Innovation Research Special Emphasis Panel.

Date: December 10, 2026.

Time: 9:30 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Leroy Worth, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 594–9434, *leroy.worth@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR Panel: Native American Research Centers for Health (NARCH).

Date: December 10–11, 2026.

Time: 9:30 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Gagan Deep Bajaj, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 402–6965, *gagan.bajaj@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Clinical Care, Treatment and Health Interventions.

Date: December 10, 2026.

Time: 9:30 a.m. to 9:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Shiyong Huang, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20817, (301) 451–7350, *shiyong.huang@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Biomaterials, Nanotechnology, Drug Discovery, and Delivery.

Date: December 10, 2026.

Time: 10:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Shakeel Ahmad, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (240) 276–6442, *ahmads@mail.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Emerging Vision Assistive Technologies.

Date: December 10, 2026.

Time: 1:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Susan Gillmor, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (240) 762–3076, *susan.gillmor@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Pregnancy Neonatology Gametes Reproduction Toxicology.

Date: December 10, 2026.

Time: 2:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Ryan G. Morris, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, RM 721–B, Bethesda, MD 20892, (301) 451–1322, *ryan.morris@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Basic Cancer Immunobiology and Tumor Host Interactions.

Date: December 11, 2026.

Time: 9:30 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Angela Y. Ng, MBA, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 710–C, MSC 7806 Bethesda, MD 20892, (301) 435–1715, *nga@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Translating Addiction Epidemiology, Prevention, Treatment, and Recovery Research into Practice (R61/R33).

Date: December 11, 2026.

Time: 10:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Lan Tian, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 594–8877, *tianl@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Neurobehavioral Mechanisms of Addiction, Emotion, and Development.

Date: December 11, 2026.

Time: 10:00 a.m. to 2:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Anna Ghambaryan, Ph.D., MD, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 443–4032, *anna.ghambaryan@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: November 16, 2026.

Sterlyn H. Gibson,

Program Specialist, Office of Federal Advisory Committee Policy.

[FR Doc. 2026–23536 Filed 11–18–26; 8:45 am]

BILLING CODE 4167–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Statement of Organization, Functions, and Delegations of Authority

AGENCY: National Institute of Health.

ACTION: Notice.

SUMMARY: National Center for the Advancement of Translational Sciences of the National Institute of Health has modified its organizational structure.

SUPPLEMENTARY INFORMATION: Part N, National Institutes of Health (NIH), of the Statement of Organization and Functions for the Department of Health and Human Services (HHS), is amended as set forth below to reflect the reorganization of the National Institute of Health, National Center for the Advancement of Translational Science (NCATS) by retitling and updating the functional Statements (1) the Chemical Genomics Branch to the Translational Models Branch under the Division of Preclinical Innovation within NCATS, (2) revise functional statement of the Office of Special initiatives, (3) abolishing the Office of Drug Development Partnership Programs, and the Office of Translational Medicine under the Office of the Director within NCATS.

Section N, *Organization and Functions,* is amended as follows:

(1) In the *Division of Preclinical Innovation (N92, formerly HN92)* retitle the following:

Chemical Genomics Branch (N924, formerly HN924) to *Translational Models Branch (N924, formerly HN924).* (1) Develop and advance human-based Non-Animal Models (NAMs) as transformative drug discovery and biomedical research tools; (2) Accelerate therapeutic discovery and regulatory science for rare and common diseases using predictive human model systems; (3) Accelerate target discovery using predictive human model systems; (4) Establish the predictive value and usefulness of human-based NAMs as pharmacology and toxicology assessment tools to reduce reliance on animal models; (5) Generate high-quality human biological data to enable AI-driven predictive modeling of drug efficacy and toxicity; (6) Integrate stem cells, tissue engineering, functional genomics, toxicology and data science into a unified human-based translational research enterprise; and (7) Serve as an NIH-wide resource for advancing human-based models research and technologies.

(2) *In the Office of the Director (N91, formerly HN91)* revise functional statement of the following:

Office of Special Initiatives (N917, formerly HN917). (1) Provides transformative programs extramurally that address barriers and bottlenecks to pre-clinical and clinical translation; (2) Drives development and dissemination of novel and disruptive technologies, approaches, and solutions for issues that impede translational research through promotion to the scientific, research, and industry sectors; (3) Incentivizes groundbreaking expansion of the therapeutic landscape for rare and chronic diseases through discovery and exploration of novel therapeutic targets and programs; and (4) Promotes and engenders partnerships and interagency collaborations with key stakeholders including government, industry, and academia, to advance innovation in early-stage clinical trials.

(3) In the *Office of the Director (N91, formerly HN91)* remove the following:

- *Office of Drug Development Partnership Programs (N918, formerly HN918)*
- *Office of Translational Medicine (N919, formerly HN919)*

Authority: 44 U.S.C. 3101

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2026–23537 Filed 11–18–26; 8:45 am]

BILLING CODE 4167–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; Notice of Partially Closed Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the NIH National Advisory Neurological Disorders and Stroke Council.

The meeting will be partially open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend as well as those who need special assistance, such as sign language interpretation or other reasonable accommodations, must notify the Contact Person listed below in advance of the meeting. The open session will be videocast and can be accessed from the NIH Videocasting and Podcasting website (*https://videocast.nih.gov/*).

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Neurological Disorders and Stroke Council.

Date: May 19–20, 2027.

Open: May 19, 2027, 10:00 a.m. to 4:00 p.m.

Agenda: Report by the Acting Director, NINDS; Report by the Director, Division of Extramural Activities; and Administrative and Program Developments; HEAL update; State of Intramural Program; To discuss upcoming Concept Clearance Initiatives and other business of the Council.

Address: National Institutes of Health, Neuroscience Center, Room 1131, 6001 Executive Boulevard, Rockville, MD 20852.

Meeting Format: Virtual and In-Person Meeting

Closed: May 19, 2027, 4:00 p.m. to 5:30 p.m.; May 20, 2027, 10:00 a.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Neuroscience Center, Room 1131, 6001 Executive Boulevard, Rockville, MD 20852.

Meeting Format: Virtual and In-Person Meeting.

Contact Person: Andrea Lynn Meredith, Ph.D. Director of Extramural Activities, National Institute of Neurological Disorders and Stroke, NIH, DHHS, Neuroscience Center, 6001 Executive Boulevard Bethesda, MD 20892, (301) 496–9248, *andrea.meredith@nih.gov.*

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice at least 10 days in advance of the meeting. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

In the interest of security, NIH has procedures at *https://www.nih.gov/about-nih/visitor-information/campus-access-security* for entrance into on-campus and off-campus facilities. All visitor vehicles, including taxicabs, hotel, and airport shuttles will be inspected before being allowed on campus. Visitors attending a meeting on campus or at an off-campus federal facility will be asked to show one form of identification (for example, a government-issued photo ID, driver's license, or passport) and to state the purpose of their visit.

Information is also available on the Institute's/Center's home page: *www.ninds.nih.gov,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.853, Extramural Research Programs in the Neurosciences and Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: November 16, 2026.

Rosalind M. Niamke,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2026–23534 Filed 11–18–26; 8:45 am]

BILLING CODE 4167–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; Notice of Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the Advisory Council on Parkinson's Research, Care, and Services (ACPRCS).

This is the fourth meeting of the ACPRCS, which was established by the Dr. Emmanuel Bilirakis and Honorable Jennifer Wexton National Plan to End Parkinson's Act of 2024 (Pub. L. 118–66). The Advisory Council is charged with providing advice to the Secretary of Health and Human Services (HHS) on issues that affect people with Parkinson's and related disorders (PDRDs), which include progressive supranuclear palsy, multiple system atrophy, corticobasal degeneration, and Lewy body dementias.

The meeting will focus on strategies to provide timely and responsive care to PDRD patients, including how care teams can improve care across settings. The meeting is virtual and will be open to the public to view via HHS Live Streaming: *www.hhs.gov/live.* Registration is not required.

Name of Committee: Advisory Council on Parkinson's Research, Care, and Services (ACPRCS).

Date: December 7, 2026.

Time: 9:00 a.m. to 5:30 p.m.

Agenda: Improving care for Parkinson's and related disorders; public comments; discussion and next steps for PDRD priorities.

Address: National Institutes of Health, Neuroscience Center, 6001 Executive Boulevard, Rockville, MD 20852.

Meeting Format: Virtual Meeting.

Cost: The meeting is free and open to the public.

Deadlines: Public Comment Due Date: November 30th by 5:00 p.m. ET. For public comment instructions and guidelines, see below.

Contact Person: Jordan Gladman, Ph.D., Deputy Executive Officer, National Institute of Neurological Disorders and Stroke, National Institutes of Health, Bethesda, MD 20892, *nationalPDplan@nih.gov.*

Public Comments: The ACPRCS welcomes written and oral/virtual public comments and asks the public to review and adhere to its Public Comment Guidelines provided at *https://www.ninds.nih.gov/current-research/trans-agency-activities/national-plan-end-parkinsons-act/parkinsons-council.*

Submissions are accepted in writing via email addressed to *NationalPDplan@nih.gov.* Please include the phrase ''public comment'' in the subject line as well as the body of the message. A limited number of slots are available for individuals to provide a 2–3-minute oral summary or excerpt of their written comment to the Council during the meeting in person or via videoconference. For those interested in that opportunity, please indicate ''Interested in providing oral/virtual comment'' in your written submission, along with your name, email, and professional/organizational affiliation so that Council support staff can contact you if a slot is available. *Note that in order to provide oral public comment, requesters must register for the meeting using the instructions above.*

For any given meeting, comment slots will be assigned on a first-come, first-served basis, with priority given to individuals and organizations that have not previously provided comments. This will help ensure that as many individuals and organizations as possible have an opportunity to share comments. Commenters going over their allotted 3-minute slot may be asked to conclude immediately to allow other comments and the rest of the meeting to proceed on schedule.

Public comment submissions received by 5:00 p.m. ET on November 30th will be provided to the Council prior to the meeting for their consideration; all comments received after the deadline will be included in the next Council meeting's materials. The Council is not able to respond individually to comments. All public comments become part of the public record. Attachments of copyrighted publications are not permitted, but web links or citations for any copyrighted works cited may be provided.

Technical issues: If you experience any technical problems with the webcast, please email *nationalPDplan@nih.gov.*

Disability Accommodations: All ACPRCS Full Council Meetings provide Closed Captioning through *www.hhs.gov/live.* Individuals whose full participation in the meeting will require special accommodations (*e.g.,* sign language or interpreting services) must submit a request to the Contact Person listed on the notice at least seven (7) business days prior to the meeting. Such requests should include a detailed description of the accommodation needed and a way for the ACPRCS to contact the requester if more information is needed to fill the request.

Meeting schedule subject to change.

More Information: More information about this meeting is available on the ACPRCS Events page: *https://www.ninds.nih.gov/news-events/events/december-2026-advisory-council-meeting-parkinsons-research-care-and-services.*

Dated: November 16, 2026.

Rosalind M. Niamke,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2026–23538 Filed 11–18–26; 8:45 am]

BILLING CODE 4167–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; Notice of Partially Closed Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the NIH National Advisory Neurological Disorders and Stroke Council.

The meeting will be held virtually and will be partially open to the public as indicated below. Individuals who plan to view the virtual meeting and need special assistance or other reasonable accommodations to view the meeting should notify the Contact Person listed below in advance of the meeting. The open session will be videocast and can be accessed from the NIH Videocasting and Podcasting website (*https://videocast.nih.gov/*).

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Neurological Disorders and Stroke Council.

Date: February 10–11, 2027.

Open: February 10, 2027, 10:00 a.m. to 4:00 p.m.

Agenda: Report by the Acting Director, NINDS; Report by the Director, Division of Extramural Activities; Administrative and Program Developments; BRAIN Initiative Update; To discuss upcoming Concept Clearance Initiatives and other business of the Council.

Address: National Institutes of Health, Neuroscience Center, Room 1131, 6001 Executive Boulevard, Rockville, MD 20852.

Meeting Format: Virtual Meeting.

Closed: February 10, 2027, 4:00 p.m. to 5:30 p.m.; February 11, 2027, 10:00 a.m. to 3:00 p.m.

Agenda: To evaluate and review the Board of Scientific Counselors Report; To review and evaluate grant applications.

Address: National Institutes of Health, Neuroscience Center, Room 1131, 6001 Executive Boulevard, Rockville, MD 20852.

Meeting Format: Virtual Meeting.

Contact Person: Andrea Lynn Meredith, Ph.D., Director of Extramural Activities, National Institute of Neurological Disorders and Stroke, NIH, DHHS, Neuroscience Center, 6001 Executive Boulevard, Bethesda, MD 20892, (301) 496–9248, *andrea.meredith@nih.gov.*

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice at least 10 days in advance of the meeting. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: *www.ninds.nih.gov,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.853, Extramural Research Programs in the Neurosciences and Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: November 16, 2026.

Rosalind M. Niamke,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2026–23535 Filed 11–18–26; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG–2026–0377]

Proposed Decommissioning and Disposition of USCGC Smilax (WLIC 315)

AGENCY: Coast Guard, DHS.

ACTION: Notice and request for comments on the decommissioning and disposal of USCGC *Smilax* (WLIC 315).

SUMMARY: The U.S. Coast Guard (USCG) announces its intent to decommission and dispose of U.S. Coast Guard Cutter (USCGC) *Smilax* (WLIC 315), homeported in Atlantic Beach, NC. Commissioned in 1944, the *Smilax* is a historic vessel, and we publish this notice to provide information on the proposed action, and to seek public input on our efforts to mitigate the adverse effects of this undertaking.

DATES: Comments must be submitted to the online docket via *https://www.regulations.gov* on or before December 21, 2026.

ADDRESSES: You may submit comments identified by docket number USCG–

2026–0377 at *https://www.regulations.gov.* See the ''Public Participation and Request for Comments'' portion of the **SUPPLEMENTARY INFORMATION** section for further instructions on submitting comments.

FOR FURTHER INFORMATION CONTACT: For information about this document call or email CWO4 Jonathan Becker U.S. Coast Guard; telephone (571) 608–2489, email *Jonathan.P.Becker@uscg.mil.*

SUPPLEMENTARY INFORMATION:

Public Participation and Comments

We encourage you to submit comments (or related material) regarding the resolution of adverse effects related to the decommissioning and disposition of the USCGC *Smilax.* We will consider all submissions and may adjust our final action based on your comments. If you submit a comment, please include the docket number for this notice (USCG–2026–0377), indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation.

Submitting comments. We encourage you to submit comments at *http://www.regulations.gov.* To do so, go to *https://www.regulations.gov,* type USCG–2026–0377 in the search box and click ''Search.'' Next, look for this document in the Search Results column, and click on it. Then click on the Comment option. If your material cannot be submitted using *http://www.regulations.gov,* contact the person in the **FOR FURTHER INFORMATION CONTACT** section of this document for alternate instructions.

Viewing public comments in docket. To view public comments placed in our online docket use following instructions on the *https://www.regulations.gov* ''Frequently Asked Questions'' web page. Documents mentioned in this notice as being available in the docket, find the docket as described in the previous paragraph, and then select ''Supporting & Related Material'' in the Document Type column.

Personal information. We accept anonymous comments. Comments we post to *https://www.regulations.gov* will include any personal information you have provided, except that contact information (such as email or mailing address) will not be available for public viewing unless the submitter includes that information in the body of the docket submission. For more about privacy and submissions in response to this document, see DHS's eRulemaking System of Records notice (85 FR 14226, March 11, 2020).

Background: The Coast Guard's Efforts To Comply With the National Historic Preservation Act

The National Historic Preservation Act

Section 106 of the National Historic Preservation Act (NHPA), codified as 54 U.S.C. 306108, requires:

> [t]he head of any Federal agency having . . . jurisdiction over a proposed Federal . . . undertaking in any State . . ., prior to the approval of the expenditure of any Federal funds on the undertaking . . ., [to] take into account the effect of the undertaking on any historic property.

''Historic property'' [1] includes any historic structure or object included in *or eligible for inclusion* in the National Register of Historic Places. The term ''eligible for inclusion'' in the National Register includes both properties formally determined as such in accordance with regulations of the Secretary of the Interior and all other properties that meet the National Register criteria.

Applying the National Register criteria, the Coast Guard has determined that the USCG *Smilax* is eligible for inclusion on the National Register. The Coast Guard has also determined that the decommissioning and disposal of the USCG *Smilax* is an undertaking, and that the undertaking is likely to have an adverse effect on the USCG *Smilax.* In accordance with 36 CFR 800.6(a)(4), the Coast Guard is now inviting members of the public to express their views on resolving adverse effects of the undertaking.

Short History of the Smilax

USCGC *Smilax* (WLIC 315) was constructed at Dubuque Boat & Boiler Works in Dubuque, IA and was commissioned on 01 November 1944. USCGC *Smilax* was designed for the express purpose of maintaining Aids to Navigation (AtoN) on the inland waterways of the United States, including repair and alterations of fixed AtoN structures and the routine retrieval, servicing and setting of buoys, thereby enabling the safe navigation of waters that support the nation's economy through maritime commerce.

After commissioning, USCGC *Smilax* was homeported in Ft. Pierce, FL from November 1944 to June 1954, then in New Smyrna Beach, FL from June 1954 to November 1965. In 1964 she was re-outfitted with new engines and assigned a 70′ work barge and transferred to Brunswick, GA in 1965 to July 1999. Finally, the *Smilax* was transferred to Atlantic Beach, NC in July 1999, where she remains to the present time.

In March 2011, with 66 years of active service at that time, USCGC *Smilax* became the oldest operational commissioned cutter in the Coast Guard and was designated the ''Queen of the Fleet.'' She has held this designation for the last 15 years.

Now, with over 80 years of continuous service, the Coast Guard plans to utilize the services of the Defense Logistics Agency (DLA) to carry out the final disposition of this ship, the last phase of its life cycle. DLA is a separate Federal agency with the capabilities to carry out the final disposition using the steps of Reutilize, Transfer, Donate, Sales (RTDS) of the vessel to another Federal agency, State or Qualified Local government or sales via the commercial market.

Steps Taken To Identify Historic Attributes of the Smilax

The Coast Guard considered the criteria outlined in 36 CFR part 63 to determine whether the *Smilax* would be considered eligible for listing on the National Register of Historic Places and it consulted with State Historic Preservation Officers (SHPO). Additionally, the Coast Guard referred to the Historic American Engineering Record (HAER) to better understand the *Smilax's* history. The HAER is a collection of documents that provides detailed information with drawings, photographs and historic reports in conformance with the Secretary of the Interior's Standards and Guidelines for Architectural and Engineering Documentation. The HAER study and SHPO Consultations to date are available for viewing in the docket for this notice.

Undertaking's Effects on Historic Properties

The decommissioning and disposition of the vessel was determined to have an adverse effect on this historic property. Upon decommissioning, USCGC *Smilax* will be demilitarized. Military markings will be removed or covered and items that are found to have historical significance will be transferred to the Coast Guard Historians Office. Other gear or materials with Coast Guard markings or decals not in a usable or serviceable condition will be destroyed. Property and parts that are found to be of use will be identified and put back into the Coast Guard supply system for future use. Any other gear will be conveyed with the ship and upon completion of decommissioning, DLA

[1] Historic property, effect, eligible for inclusion in the National Register, National Register criteria, undertaking, and most other terms of art used here are defined at 36 CFR 800.16.

will provide disposition services as needed.

National Register Criteria for Evaluation

The National Park Service has developed the National Register Criteria for Evaluation. These criteria, which are set out at 36 CFR 60.4, are standards by which every property that is nominated to the National Register is judged. The Coast Guard has evaluated the *Smilax* under these criteria to determine whether it is eligible for listing on the National Register.

USCGC *Smilax* was found to be eligible under Criterion ''A'' with a period of historical significance extending from 1944 to 1976, fifty years before the present. USCGC *Smilax* has performed its mission of maintaining aids to navigation to promote maritime safety for more than 80 years. During this span there have been 5 major military conflicts and dozens of overseas contingency operations and armed conflicts. In 2013, USCGC *Smilax* assisted maritime archaeologists with the North Carolina Department of Natural and Cultural Resources to raise a number of artifacts from the site of Queen Anne's Revenge, the pirate Blackbeards's flagship that wrecked just offshore Beaufort Inlet, North Carolina in 1718. Due to the operational longevity, USCGC *Smilax* became the fifth ship to hold the title as ''Queen of the Fleet'' and it has held this honor for the past 15 years, demonstrating its place in Coast Guard history.

USCGC *Smilax* was found not to meet Criterion ''B'' since it is not associated with individuals important in United States history.

USCGC *Smilax* was found not to meet Criterion ''C'' since its original integrity has been compromised by engine refits, equipment upgrades, including the addition of a barge, and the modification of interior spaces.

USCGC *Smilax* was found not to meet Criterion ''D,'' as it is unlikely to yield information important in prehistory or history.

Summary of Consultations to Date

The Coast Guard has consulted with the Florida, Georgia, Iowa and North Carolina SHPO's concerning the proposed decommissioning and final disposition of USCGC *Smilax.* Florida, Georgia, Iowa, have commented that since USCGC *Smilax* is currently homeported in Atlantic Beach, NC they will agree with any findings or actions that the North Carolina SHPO recommends. The North Carolina SHPO has agreed with the findings of the US Coast Guard regarding the following.

Criteria of Adverse Effects

In accordance with the criteria for assessing whether an undertaking will have an adverse effect enunciated in 36 CFR 800.5, the Coast Guard has determined its proposed action will have an adverse effect. The steps the Coast Guard has conducted to mitigate the adverse effect of its proposed action are provided in the Evaluation of Alternatives or Mitigation Measures below.

Evaluation of Alternatives or Mitigation Measures

The Coast Guard has mitigated the adverse effects through the preparation of an HAER study, as mentioned earlier. The HAER study will be provided to the Library of Congress, where a copy will be made available for view. See *https://www.loc.gov/pictures/collection/hh/* for information about the Library of Congress' HAER collection.

Dated: November 13, 2026.

J. Sky Holm,

Captain, U.S. Coast Guard, Chief, Office of Cutter Forces.

[FR Doc. 2026–23566 Filed 11–18–26; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA–2026–0826; OMB No. 1660–0040]

Agency Information Collection Activities: Proposed Collection, Comment Request; Standard Flood Hazard Determination Form (SFHDF)

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day Notice of extension and request for comments.

SUMMARY: The Federal Emergency Management Agency (FEMA), as part of its continuing effort to reduce paperwork and respondent burden, invites the general public to take this opportunity to comment on an extension without change of a currently approved information collection. In accordance with the requirements of the Paperwork Reduction Act of 1995, this notice seeks comments concerning this instrument, which is used by Federally-regulated lending institutions when making, increasing, extending, renewing or purchasing each loan for the purpose of determining whether flood insurance is required and available.

DATES: Comments must be submitted on or before January 19, 2027.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at *http://www.regulations.gov* under Docket ID FEMA–2026–0826. Follow the instructions for submitting comments.

All submissions received must include the Agency name and Docket ID. Regardless of the method used for submitting comments or material, all submissions will be posted, without change, to the Federal eRulemaking Portal at *http://www.regulations.gov,* and will include any personal information you provide. Therefore, submitting this information makes it public. You may wish to read the Privacy and Security Notice that is available via a link on the homepage of *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Michael Windle, Marketing Section Chief, Customer Service Division, Federal Insurance Directorate, Resilience, FEMA at (202) 236–6419 or *michael.windle@fema.dhs.gov.* You may contact the Information Management Division for copies of the proposed collection of information at email address: *FEMA-Information-Collections-Management@fema.dhs.gov.*

SUPPLEMENTARY INFORMATION: Section 1365 of the National Flood Insurance Act of 1968 (NFIA) (42 U.S.C. 4104b), as added by Section 528 of the National Flood Insurance Reform Act of 1994 (Pub. L. 103–325, Title V), requires that the Federal Emergency Management Agency (FEMA) develop a standard hazard determination form for recording the determination of whether a structure is located within an identified Special Flood Hazard Area and whether flood insurance is available. Regulated lending institutions, federal agency lenders, the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, and the Government National Mortgage Association must complete use this form for any loan made, increased, extended, renewed or purchased by these entities. The requirement for Federally-regulated lending institutions to determine whether a building or mobile home securing a loan is located in an area having special flood hazards and whether flood insurance is available has been in effect since the enactment of the Flood Disaster Protection Act of 1973, although the use of a standard form was not required until the enactment of the Section 1365 of the NFIA. The establishment of the Standard Flood Hazard Determination Form (SFHDF) has enabled lenders and

mortgage servicers to provide consistent information.

FEMA established this information collection as a common form collection in its 2023 revision since FEMA does not collection information using the SFHDF, but other federal agencies do.

Collection of Information

Title: Standard Flood Hazard Determination Form (SFHDF).

Type of Information Collection: Extension, without change, of a currently approved information collection.

OMB Number: 1660–0040.

FEMA Forms: FEMA Form FF–206–FY–21–116 (formerly 086–0–32), Standard Flood Hazard Determination.

Abstract: This instrument is used by Federally-regulated lending institutions, Federal Agency lenders, the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, and the Government National Mortgage Association. Federally-regulated lending institutions use this form when making, increasing, extending, renewing, or purchasing each loan for the purpose of determining whether flood insurance is required and available. FEMA is responsible for creating and updating the form and making it available but does not collect any information itself.

Affected Public: Businesses or other For-Profit; and Individuals or Households.

Estimated Number of Respondents: 1.

Estimated Number of Responses: 1.

Estimated Average Time per Response: 1 hour.

Estimated Total Annual Burden Hours: 1.

Estimated Total Annual Respondent Cost: $32.

Estimated Respondents' Operation and Maintenance Costs: $0.

Estimated Respondents' Capital and Start-Up Costs: $0.

Estimated Total Annual Cost to the Federal Government: $1,918.

Comments

Comments may be submitted as indicated in the **ADDRESSES** caption above. Comments are solicited to (a) evaluate whether the proposed data collection is necessary for the proper performance of the Agency, including whether the information shall have practical utility; (b) evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) enhance the quality, utility, and clarity of the information to be collected; and (d) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Russell R. Bard,

Acting Senior Director for Information Management, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026–23602 Filed 11–18–26; 8:45 am]

BILLING CODE 9111–52–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–7109–N–17; OMB Control No.: 2577–0304]

60-Day Notice of Proposed Information Collection: Tribal Housing and Urban Development—Veteran Administration Supportive Housing Program

AGENCY: Office of the Assistant Secretary for Public and Indian Housing (PIH), HUD.

ACTION: Notice.

SUMMARY: HUD is seeking approval from the Office of Management and Budget (OMB) for the information collection described below. In accordance with the Paperwork Reduction Act, HUD is requesting comment from all interested parties on the proposed collection of information. The purpose of this notice is to allow for 60 days of public comment.

DATES: *Comments Due Date:* January 19, 2027.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Written comments and recommendations for the proposed information collection can be sent within 60 days of publication of this notice to *www.regulations.gov.* Interested persons are also invited to submit comments regarding this proposal and comments should refer to the proposal by name and/or OMB control number and should be sent to: Leea Thornton, Office of Public and Indian Housing, Department of Housing and Urban Development, 451 7th Street SW, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Leea Thornton, Office of Public and Indian Housing, Department of Housing and Urban Development, 451 7th Street SW, Washington, DC 20410; email *PIH-PRAPublicComments@hud.gov;* telephone (202) 402–6455. This is not a toll-free number. HUD welcomes and is prepared to receive calls from individuals who are deaf or hard of hearing, as well as individuals with speech or communication disabilities. To learn more about how to make an accessible telephone call, please visit *https://www.fcc.gov/consumers/guides/telecommunications-relay-service-trs.* Copies of available supporting documents for the proposed collection may be obtained from Ms. Thornton.

SUPPLEMENTARY INFORMATION: This notice informs the public that HUD is seeking approval from OMB for the information collection described in section A.

A. Overview of Information Collection

Title of Information Collection: Tribal Housing and Urban Development—Veteran Administration Supportive Housing Program.

OMB Approval Number: 2577–0304.

Type of Request: Revision of a currently approved collection.

Form Number: HUD–5980A.

Description of the Need for the Information and Proposed Use: This information collection contains application materials to obtain benefits under the Tribal Housing and Urban Development—Veteran Administration Supportive Housing Program (Tribal HUD–VASH), which provides rental housing assistance and supportive services to Native American veterans who are homeless or at risk of homelessness living on or near a reservation or other Indian areas. Housing assistance under this program is available by grants to Tribes and tribally designated housing entities that are eligible to receive Indian Housing Block Grant funding under the Native American Housing Assistance and Self Determination Act (25 U.S.C. 4101). Grants and renewal funds are awarded and approved by HUD. Grants include an additional amount for administrative costs and eligible homeless veterans receive case management services through the Department of Veterans Affairs.

Respondents: Tribes and Tribally Designated Housing Entities.

Information collection	Number of respondents	Frequency of response	Responses per annum	Burden hour per response	Annual burden hours	Hourly cost per response	Annual cost
Tribal HUD–VASH Family Report, Form HUD–5980A	35	1	35	1.50	52.50	$30.49	$1,604.72
Tribal HUD–VASH Application Materials	32	1	32	0.13	4.16	30.49	127.84
Tribal HUD–VASH Leasing Performance Report, Form HUD–5980 (OMB 2577–0169)	35	1	35	1.50	52.50	30.49	1,604.72
Total	102		102		109.16		3,328.28

B. Solicitation of Public Comment

This notice is soliciting comments from members of the public and affected parties concerning the collection of information described in section A on the following:

(1) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) The accuracy of the agency's estimate of the burden of the proposed collection of information;

(3) Ways to enhance the quality, utility, and clarity of the information to be collected; and

(4) Ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

HUD encourages interested parties to submit comment in response to these questions.

C. Authority

44 U.S.C. 3507.

Laura Kunkel,

Chief, Office of Policy, Program, and Legislative Initiatives

[FR Doc. 2026–23565 Filed 11–18–26; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[Docket No. FWS–HQ–FAC–2026–3995; FXFR13360900000–278–FF09F14000]

Aquatic Nuisance Species Task Force Meeting

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of meeting.

SUMMARY: The U.S. Fish and Wildlife Service gives notice of a virtual public meeting of the Aquatic Nuisance Species Task Force (ANSTF) in accordance with the Federal Advisory Committee Act.

DATES: The ANSTF will meet virtually Tuesday through Wednesday, December 1–2, 2026, from 12:30 p.m. to 5:00 p.m. (eastern time) each day.

Registration: Registration is required. The deadline for registration is November 27, 2026.

Accessibility and Other Accommodations: The deadline for accessibility and other accommodation requests is November 27, 2026. Please see *Requests for Accommodations,* below.

ADDRESSES: The meeting will be held virtually. Participation will be available via teleconference and broadcast over the internet. To register and receive the telephone number or web address for virtual participation, contact the Executive Secretary (see **FOR FURTHER INFORMATION CONTACT**) or visit the ANSTF website at *https://www.fws.gov/program/aquatic-nuisance-species-task-force.*

FOR FURTHER INFORMATION CONTACT: Susan Pasko, Executive Secretary, ANSTF, by telephone at (571) 623–0608, or by email at *susan_pasko@fws.gov.* Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States.

SUPPLEMENTARY INFORMATION: The ANSTF was established by the Nonindigenous Aquatic Nuisance Prevention and Control Act of 1990 (16 U.S.C. 4701 *et seq.*) and is composed of Federal and ex-officio members. The purpose of the ANSTF is to develop and implement a program for U.S. waters to prevent introduction and dispersal of aquatic invasive species; to monitor, control, and study such species; and to disseminate related information. This virtual meeting is open to the public.

Meeting Agenda

The meeting agenda will focus on identifying and establishing priority objectives and strategies to inform and guide the development of the next ANSTF Strategic Plan. The agenda also includes reports from ANSTF members, reports and recommendations from regional panels and subcommittees, and a public comment period. The final agenda and other related meeting information will be posted on the ANSTF website, *https://www.fws.gov/program/aquatic-nuisance-species-task-force.*

Public Input

If you wish to provide oral public comment or provide a written comment for the ANSTF to consider, contact the Executive Secretary (see **FOR FURTHER INFORMATION CONTACT**) no later than November 27, 2026.

To ensure the opportunity for broad participation, each individual will be limited to a maximum of 3 minutes for their statement. Interested parties should contact the Executive Secretary (see **FOR FURTHER INFORMATION CONTACT**) for placement on the public speaker list for this meeting. Requests to address the ANSTF during the meeting will be accommodated in the order they are received. Registered speakers who wish to expand upon their oral statements, or those who had wished to speak but could not be accommodated on the agenda, may submit written statements to the Executive Secretary up to 30 days following the meeting.

Requests for Accommodations

Please make requests in advance for sign language interpreter services, assistive listening devices, or other reasonable accommodations. Please contact the Executive Secretary (see **FOR FURTHER INFORMATION CONTACT**) no later than November 27, 2026, to give the

Service sufficient time to process your request. All reasonable accommodation requests are managed on a case-by-case basis.

Authority: 5 U.S.C. Ch. 10.

Martha Balis-Larsen,

Acting Co-Chair, Aquatic Nuisance Species Task Force, U.S. Fish and Wildlife Service.

[FR Doc. 2026–23615 Filed 11–18–26; 8:45 am]

BILLING CODE 4333–15–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[Docket No. FWS–HQ–IA–2026–4094; FXIA16710900000–278–FF09A30000; OMB Control Number 1018–0192]

Agency Information Collection Activities; Submission to the Office of Management and Budget; Big Cat Public Safety Act

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of information collection; request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, we, the U.S. Fish and Wildlife Service (Service), are proposing to revise a currently approved information collection.

DATES: Interested persons are invited to submit comments on or before December 21, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *https://www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under Review—Open for Public Comments'' or by using the search function. Please provide a copy of your comments to the Service Information Collection Clearance Officer, U.S. Fish and Wildlife Service, MS: PRB (JAO/3W), 5275 Leesburg Pike, Falls Church, VA 22041–3803 (mail); or by email to *Info_Coll@fws.gov.* Please reference ''1018–0192'' in the subject line of your comments.

FOR FURTHER INFORMATION CONTACT: Madonna L. Baucum, Service Information Collection Clearance Officer, by email at *Info_Coll@fws.gov,* or by telephone at (703) 358–2503. Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States. You may also view the information collection request (ICR) at *https://www.reginfo.gov/public/do/PRAMain.*

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act (PRA; 44 U.S.C. 3501 *et seq.*) and its implementing regulations at 5 CFR part 1320, all information collections require approval under the PRA. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a currently valid OMB control number.

On June 12, 2023, we published in the **Federal Register** (88 FR 38358) an interim rule (RIN 1018–BH23) which announced our intention to request OMB approval of the information collections contained in this rule. In that interim rule, we solicited comments for 60 days on the information collections, ending on August 11, 2023. All comments received in response to the interim rule were addressed with the ICR for that interim rule submitted to OMB on October 20, 2023 and approved on December 4, 2023. The Service expects to publish a final rule by summer 2027.

As part of our continuing effort to reduce paperwork and respondent burdens, we are again inviting the public and other Federal agencies to comment on new, proposed, revised, and continuing collections of information. This helps us assess the impact of our information collection requirements and minimize the public's reporting burden. It also helps the public understand our information collection requirements and provide the requested data in the desired format.

We are especially interested in public comment addressing the following:

(1) Whether or not the collection of information is necessary for the proper performance of the functions of the agency, including whether or not the information will have practical utility;

(2) The accuracy of our estimate of the burden for this collection of information, including the validity of the methodology and assumptions used;

(3) Ways to enhance the quality, utility, and clarity of the information to be collected; and

(4) How might the agency 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 response.

Comments that you submit in response to this notice are a matter of public record. Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Abstract: Due to delays in publishing the final rule under RIN 1018–BH23, ''Regulations to Implement the Big Cat Public Safety Act,'' pursuant to the Big Cat Public Safety Act (BCPSA; Pub. L. 117–243, December 20, 2022, 136 Stat. 2336), this submission serves as an interim renewal to prevent the information collection from lapsing into noncompliance. As required by 5 CFR 1320, we intend to publish this 30-day **Federal Register** notice to provide the public with an additional opportunity to comment on the information collection, supplementing the 60-day comment period associated with the interim rule (88 FR 38358; June 12, 2023). We are not implementing any changes to the information collection contained in the final rule at this time. Any revisions will be incorporated into the PRA submission when the final rule is published.

The BCPSA was signed into law on December 20, 2022. The purpose of the BCPSA is to amend the Lacey Act Amendments of 1981 (16 U.S.C. 3371–3378) to clarify provisions enacted by the Captive Wildlife Safety Act (CWSA; Pub. L. 108–191, December 19, 2003) and to further the conservation of certain wildlife species. ''Prohibited wildlife species'' (also referred to as ''big cats'') is defined as ''any live species of lion, tiger, leopard, cheetah, jaguar, or cougar or any hybrid of such species'' (16 U.S.C. 3371(h)). This includes any of the following species, or hybrids of any of these species: Lion (*Panthera leo*), tiger (*Panthera tigris*), leopard (*Panthera pardus*), snow leopard (*Uncia uncia*), clouded leopard (*Neofelis nebulosa*), jaguar (*Panthera onca*), cheetah (*Acinonyx jubatus*), cougar (*Puma concolor*) (50 CFR14.252).

The BCPSA built on and amended the CWSA by making it unlawful to import, export, transport, sell, receive, acquire, or purchase in interstate or foreign commerce, or in a manner substantially affecting interstate or foreign commerce, or breed or possess prohibited wildlife species (lions, tigers, leopards, snow leopards, clouded leopards, jaguars,

cheetahs, and cougars, or any hybrids thereof), with certain exceptions. In enacting the BCPSA, Congress recognized the need to end the private ownership of big cats as pets and prohibit exhibitors from allowing public contact with big cats, including cubs. The BCPSA did, however, grant private owners a one-time, 180-day period in which to register their big cats, allowing them to keep their current animals if they registered each such animal with the Service not later than June 18, 2023. This registration allows pre-BCPSA private owners to continue to possess their animals under the pre-BCPSA exception if the owners continue to meet all of the BCPSA's requirements, which are described in our June 12, 2023, interim rule (88 FR 38358). Certain entities outlined in the BCPSA, including exhibitors with valid U.S. Department of Agriculture (USDA) Class C licenses, State agencies, State colleges and universities, State-licensed veterinarians, and wildlife sanctuaries, that meet the requirements for other BCPSA exceptions, were not required to register their big cats with the Service.

In summary, the BCPSA helps to ensure the health and welfare of big cats, protects the public from the dangers associated with private ownership of big cats, and strengthens the Service's ability to combat wildlife trafficking. Additional background on the Lacey Act, CWSA, and BCPSA is available in the preamble to our June 12, 2023, interim rule (88 FR 38358).

The existing and new reporting and/or recordkeeping requirements identified below require review and approval by OMB in conjunction with this submission:

(1) *Amendments—Form 3–200–11, ''Registration Form—Big Cat Public Safety Act'' (Pub. L. 117–243, December 20, 2022, 136 Stat. 2336)—Burden Reduction and Change to Form 3–200–11.* As required by the Service in Form 3–200–11, owners must provide the Service with updates if information concerning the registered big cats changes, as follows:

50 CFR 14.255(d)—Within 10 calendar days as required by the Service in Form 3–200–11, a registered pre-BCPSA owner must update the registration with the Service when a prohibited wildlife species dies or any of the following information changes: The location where the prohibited wildlife species is housed; the protocols taken to prevent breeding; the protocols taken to prevent direct contact between the public and big cat; ownership; or a unique identifier.

Form 3–200–11, ''*Registration Form—Big Cat Public Safety Act* (Pub. L. 117–243, December 20, 2022, 136 Stat. 2336), collected the following information during the initial registration process:

- Name, birth date, and contact information of individual applicant;
- Name, tax ID number, and contact information of business, corporation, or trust, if applicable;
- Information for officer of business, corporation, or trust, if applicable;
- Detailed information for big cats possessed (not including hybrids), to include:

—Common name of big cat;
—Name given to individual big cat, if applicable,
—Genus, species, and subspecies;
—Birthdate and date of acquisition, including supporting documentation;
—Unique identifier information (*i.e.,* microchip or tattoo);
—Sex;
—Description (*e.g.,* eye color, scars, ear tags);
—Photographs of big cat;
—Physical location of individual big cat (if different from registrant's contact information);
—Protocols taken to prevent breeding;
—Protocols taken to prevent direct contact between public and prohibited wildlife species; and
—Copies of all local, State, or Federal licenses held in relation to the big cats, if applicable.

- Detailed information for hybrid big cats possessed, to include:

—Name of hybrid big cat;
—Name given to individual big cat, if applicable,
—Genus, species, and subspecies;
—Birthdate and date of acquisition, including supporting documentation;
—Unique identifier information (*e.g.,* microchip or tattoo);
—Sex;
—Description (*e.g.,* eye color, scars, ear tags);
—Photographs of big cat;
—Physical location of big cat (if different from registrant's contact information);
—Protocols taken to prevent breeding;
—Protocols taken to prevent direct contact between public and prohibited wildlife species; and
—Copies of all local, State, or Federal licenses held in relation to the big cats, if applicable.

- Information collected to amend original registration, to include:

—Genus, species, subspecies, name of big cat, and unique identifier;
—Information for new location when individual big cat is relocated after registration;
—Description of any changes in protocols to prevent breeding as previously described in original registration;
—Description of any changes in protocols to prevent direct contact between the public and the prohibited wildlife as previously described in original registration;
—Change in unique identifier (*i.e.,* microchip or tattoo);
—Contact information for new owner;
—Notification of big cat's death, to include date; and
—The manner of disposal of big cat's remains (requires documentation from veterinarian or other authority describing cause of death and how the remains were disposed).

Justification for Burden Decrease—We are decreasing the estimated burden associated with amendments of Form 3–200–11 to account for a lower number of amendments anticipated to be submitted by owners to the Service per year.

Proposed Changes to Form 3–200–11—We are proposing the following changes to Form 3–200–11 since OMB's last approval at the interim rule stage to:

- Remove registration instructions and initial registration fields, since the BCPSA required owners to register all big cats with the Service by June 18, 2023.
- Retain the amendment portion of the form, which allows registered pre-BCPSA owners to update their existing registrations, including reporting the death of an animal or changes in housing location, breeding-prevention protocols, public-contact prevention protocols, ownership, or unique identifier.

(2) *Population Management and Care Plan (50 CFR14.254(a)(3))*—To qualify for an exception in § 14.257, under certain circumstances, a USDA-licensed entity or USDA-registered Federal facility must provide a population management and care plan to the Service for consideration in accordance with the BCPSA (16 U.S.C. 3372(e)(2)(A)(i)(III)). If a licensed entity or registered Federal facility allows any person who is neither (1) a trained professional employee or contractor of the licensed entity (or an accompanying employee receiving professional training) nor (2) a licensed veterinarian (or a veterinary student accompanying such a veterinarian) to come into direct physical contact with prohibited wildlife, then prior to allowing any such individual to come into direct physical contact with prohibited wildlife species the conservation program of the licensed entity or registered Federal facility must meet certain requirements. One requirement is that the licensed

entity or registered Federal facility must provide a species-specific, publicly available, peer-edited population management and care plan to the Director with justifications that the plan:

- Reflects established conservation science principles;
- Incorporates genetic and demographic analysis of a multi-institution population of animals covered by the plan;
- Promotes animal welfare by ensuring that the frequency of breeding is appropriate for the species;

(3) *Recordkeeping Requirements*—We do not anticipate the recordkeeping requirements will impose any significant burden, because the maintenance of these records is typically a normal business practice. Therefore, complying with the requirement to make records available can likely be met by making available and copying, if needed, a small number of documents pertaining to the possession, transportation, acquisition, disposition, importation, or exportation of the prohibited wildlife species, which we estimate can be completed in an hour or less.

a. *50 CFR 14.254(c), Licensed Entity or Registered Federal Facility*—To qualify for an exception in § 14.257, a licensed entity or a registered Federal facility must maintain complete and accurate records of any possession, breeding, transportation, acquisition, receipt, purchase, sale, disposition, importation, or exportation of prohibited wildlife species.

1. These records must be up to date and include the names and addresses of persons to or from whom any prohibited wildlife species has been acquired, received, imported, exported, purchased, sold, or otherwise transferred (including loans for exhibition, breeding, or otherwise), and the dates of these transactions.

2. The licensed entity or registered Federal facility must maintain these records for the lifespan of each prohibited wildlife species and for 5 years after its death or disposition and must copy these records for Service officials, if requested.

3. The licensed entity or registered Federal facility must make these records available and allow access to its facilities and its prohibited wildlife specimens for inspection by Service officials at reasonable hours.

b. *50 CFR 14.255(d) and (e), Registered Pre-BCPSA Owners—Burden Decrease*—A registered pre-BCPSA owner must maintain complete and accurate records of information for each individual prohibited wildlife species in their possession as required by the Service in the BCPSA registration form (Form 3–200–11) for the lifespan of each individual prohibited wildlife species and for 5 years after its death or disposition and must copy these records for Service officials, if requested.

1. Pre-BCPSA owners are required to maintain records of their BCPSA activities with big cats and provide the Service with updates on registered big cat(s). Owners must update the registration within 10 calendar days if a big cat dies or if there is any change in: the location where the big cat is housed; protocols taken to prevent breeding; protocols taken to prevent direct contact between the public and big cat; ownership; or unique identifier.

2. While the pre-BCPSA owner may not sell or otherwise engage in commerce with prohibited wildlife species, if the pre-BCPSA owner is no longer able to continue to possess their prohibited wildlife species, the pre-BCPSA owner may make arrangements to donate the prohibited wildlife species to a licensed entity, State college, State university, State agency, State-licensed veterinarian, or a wildlife sanctuary, or may make arrangements to abandon the prohibited wildlife species to the Federal Government. The disposition must not be reasonably likely to result in the registered pre-BCPSA owner's economic use, gain, or benefit, including, but not limited to, profit (whether in cash or in kind).

3. These records must be up to date, and the registered pre-BCPSA owner must make these records available and allow access to their facilities and prohibited wildlife specimens for inspection by Service officials at reasonable hours.

Justification for Burden Decrease—We are decreasing the estimated burden associated with the recordkeeping requirements at 50 CFR 14.255(e). Our initial estimates in the previous submissions were higher than the actual number of registered owners and we are now lowering the burden to correct that overage.

c. *50 CFR 14.256(b), Wildlife Sanctuaries*—A wildlife sanctuary must maintain complete and accurate records of any possession, transportation, acquisition, receipt, disposition, importation, or exportation of prohibited wildlife species.

1. These records must be up to date and must include the names and addresses of persons to or from whom any prohibited wildlife species has been acquired, received, imported, exported, or otherwise transferred, and the dates of these transactions.

2. The wildlife sanctuary must maintain these records for the lifespan of each prohibited wildlife species and for 5 years after its death or disposition and must copy these records for Service officials, if requested.

3. The wildlife sanctuary must make these records available and allow access to its facilities and its prohibited wildlife specimens for inspection by Service officials at reasonable hours.

d. *50 CFR 14.257(a), Documentation to Transport Live Prohibited Wildlife*—The prohibitions of § 14.253 do not apply to licensed entities or registered Federal facilities that meet all of the requirements of § 14.254; State colleges, State universities, or State agencies; State-licensed veterinarians; wildlife sanctuaries that meet all of the requirements of § 14.256; or persons who:

1. Can produce documentation showing that they are transporting live prohibited wildlife species solely for the purpose of expeditiously transporting the prohibited wildlife species to individuals or entities that are excepted from the prohibitions in § 14.253; and

2. Has no financial interest (whether in cash or in kind) in the prohibited wildlife species other than payment received for transporting them.

e. *(Removed) 50 CFR 14.257(b), Documentation of Date of Breeding*—The prohibition on possession in § 14.253 does not apply to a registered pre-BCPSA owner who is in possession of any prohibited wildlife species that was:

1. Born and possessed by the registered pre-BCPSA owner before the date of enactment of the BCPSA and meets all of the requirements of § 14.255 for each of the prohibited wildlife species in their possession; or

2. Bred before and born on or after the date of enactment of the BCPSA, to a prohibited wildlife species possessed by the registered pre-BCPSA owner before the date of enactment of the BCPSA, if the registered pre-BCPSA owner provides documentation demonstrating that the breeding occurred before the date of enactment of the BCPSA, and the person meets all of the requirements of § 14.255 for each of the prohibited wildlife species in their possession.

Justification for Removal— We are removing this recordkeeping IC because the requirement to document breeding dates under 50 CFR 14.257(b) is no longer necessary, as registration has ended and breeding is no longer authorized under the BCPSA unless an applicable exception is met.

Copies of Form 3–200–11 associated with this ICR is available via the docket [FWS–HQ–IA–2026–4094] on the

Regulations.gov website. Additionally, the public may request a copy of the form by sending a request to the Service Information Collection Clearance Officer in **ADDRESSES** above.

Title of Collection: Big Cat Public Safety Act (50 CFR part 14, subpart K).

OMB Control Number: 1018–0192.

Form Number: 3–200–11.

Type of Review: Revision of a currently approved collection.

Respondents/Affected Public: Individuals, private sector, and State/local/Tribal governments.

Estimated Number of Annual Respondents: 1,830.

Estimated Number of Annual Responses: 1,830.

Estimated Completion Time per Response: 1 hour.

Estimated Annual Burden Hours: 1,830.

Respondent's Obligation: Required to obtain or retain a benefit.

Frequency of Collection: On occasion.

Total Estimated Annual Nonhour Burden Cost: $730.

The authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Madonna Baucum,

Information Collection Clearance Officer, U.S. Fish and Wildlife Service.

[FR Doc. 2026–23561 Filed 11–18–26; 8:45 am]

BILLING CODE 4333–15–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[A2407–014–004–065516; #O2509–014–004–125222.1; LLESJ00000; FLES106810794]

Notice of Application for 299 ROW Application for Coastal Connect Services, LLC; Florida

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of application.

SUMMARY: The Bureau of Land Management (BLM) has received a right-of-way (ROW) application from Coastal Connect Services, LLC for a proposed intrastate natural gas pipeline in Cape Canaveral, Florida. The BLM will complete environmental analysis under the National Environmental Policy Act (NEPA) before deciding whether to authorize the pipeline ROW.

DATES: The application was accepted by BLM Southeastern States District Office on September 30, 2026.

ADDRESSES: The ROW application and maps of the project are available for review at the BLM Southeastern States District Office located at 273 Market Street, Flowood, Mississippi 39232.

NEPA documents associated with this proposal will be released to the public upon completion. Once available, these documents may be accessed online via the following link: *https://eplanning.blm.gov/Project-Home/?id=c6d2b2a5-c9bd-f111-aaae-001dd8029bbb.*

FOR FURTHER INFORMATION CONTACT: Shayne Banks, Acting District Manager, telephone: (601) 919–4652; address: 273 Market Street, Flowood, MS 39232; email: *sbanks@blm.gov.* Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services for contacting Ms. Banks. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States.

SUPPLEMENTARY INFORMATION: The applicant seeks a ROW for a 16-inch diameter natural gas pipeline and related facilities totaling approximately 20.3 miles, including temporary workspaces and minor above ground components such as mainline valves and rust-prevention equipment. The pipeline would provide natural gas services to Space Launch Complex 37 and Launch Complex 39A at Cape Canaveral, Florida, to support future launch operations, and eliminate the need for fuel truck deliveries at these locations. For more detailed information regarding the application, maps, and overall project, refer to **ADDRESSES** section above.

(Authority: 43 CFR 2884.20)

Shayne Banks,

Acting District Manager, Southeastern States District.

[FR Doc. 2026–23605 Filed 11–18–26; 8:45 am]

BILLING CODE 4331–18–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[A2407–014–004–065516, #O2509–014–004–125222.1]

Realty Action: Modified Competitive Sale of 20 Parcels of Public Land in Clark County, Nevada; Modification of Recreation and Public Purposes Act Classification

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Realty Action.

SUMMARY: The Bureau of Land Management (BLM) proposes to offer 20 parcels of public land, totaling 200.64 acres in the Las Vegas Valley (Valley), by modified competitive sale at no less than each parcel's fair market value (FMV) pursuant to the Southern Nevada Public Land Management Act of 1998 (SNPLMA), as amended. The sale would be processed in conformance with applicable provisions of the Federal Land Policy and Management Act of 1976 (FLPMA) and BLM regulations. A 4.88-acre parcel proposed for inclusion in the sale was previously part of Recreation and Public Purposes (R&PP) Act lease N–75746. At the request of the lessee, the City of Las Vegas, the BLM approved the relinquishment of these acres from the lease. Because the parcel is no longer subject to the R&PP lease, the BLM proposes to modify the R&PP classification by removing the classification from the 4.88-acre portion of the parcel. This modification is necessary because lands that retain R&PP classification are not available for disposal under SNPLMA, and removing the classification makes parcel NVNV106381471 eligible for nomination in the 20-Parcel SNPLMA Land Sale.

DATES: The BLM will accept written comments regarding the proposed sale and modification to the R&PP classification until January 4, 2027. The BLM will publish this notice of realty action once a week for 3 consecutive weeks in the Las Vegas Review-Journal newspaper. The BLM intends to open the sale for bidding on February 9, 2027, at 8:00 a.m. Pacific Time (PT).

ADDRESSES:

Comments: Mail written comments on the proposed sale and modification to the R&PP classification to the BLM Las Vegas Field Office, Assistant Field Manager, Division of Lands, 4701 North Torrey Pines Drive, Las Vegas, NV 89130.

Availability of sale information: Prior to the sale, a sales matrix will be published on the following website: *https://www.efficientmarkets.com.* The sale matrix provides information specific to each proposed sale parcel such as legal description, physical location, encumbrances, acreage, and FMV. The FMV for each parcel will be available in the sales matrix no later than 30 days prior to the sale.

Bidding site: Bids must be submitted on Efficient Markets website at: *https://www.efficientmarkets.com.*

Additional information: For general information on previous BLM public land sales, go to *https://www.blm.gov/snplma* then click the land sales link. Information concerning the sale parcels, including encumbrances of record,

appraisals, reservations, procedures and conditions, Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. 9620(h) (CERCLA) documents, and other environmental documents that may appear in the BLM public files for the sale parcels are available for review by appointment only during business hours from 8:00 a.m. to 4:30 p.m. PT Monday through Friday, at the BLM Las Vegas Field Office (LVFO), except during Federal holidays.

FOR FURTHER INFORMATION CONTACT: Stephen ''Brad'' Gallimore, BLM Supervisory Realty Specialist, by email: *BLM_NV_LVFO_LandTenureTeam@blm.gov,* or by telephone: (702) 515–5017.

Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States.

SUPPLEMENTARY INFORMATION: It is the buyer's responsibility to be aware of all applicable Federal, State, and local government laws, regulations, and policies that may affect the subject lands, including any required dedication of lands for public uses. It is the buyer's responsibility to be aware of existing or prospective uses of nearby properties. When conveyed out of Federal ownership, the lands would be subject to any applicable laws, regulations, and policies of the applicable local government for proposed future uses. It is the responsibility of the purchaser to be aware through due diligence of those laws, regulations, and policies, and to seek any required local approvals for future uses. Buyers should make themselves aware of any Federal, state, or local law or regulation that may impact the future use of the property. Any land lacking access from a public road or highway would be conveyed as such and acquiring future access would be the responsibility of the buyer.

The subject public lands are legally described as:

Mount Diablo Meridian, Nevada

NVNV106334775, 5 acres
T. 19 S., R. 59 E.,
Sec. 3, E½NW¼SW¼SW¼.
NVNV106334776, 6.875 acres
T. 19 S., R. 59 E.,
Sec. 10, E½SW¼NW¼NW¼,
N½NE¼NW¼SW¼NW¼, and
NW¼NW¼NE¼SW¼NW¼.
NVNV106334792, 25 acres
T. 19 S., R. 59 E.,
Sec. 25, SW¼NE¼NE¼,
E½NE¼NW¼NE¼,
E½SE¼NW¼NE¼, and
E½NE¼SW¼NE¼.
NVNV106334783, 10 acres
T. 19 S., R. 59 E.,
Sec. 36, SW¼SW¼NE¼.
NVNV106381471, 4.88 acres
T. 20 S., R. 59 E.,
Sec. 12, lot 4.
NVNV105860623, 10 acres
T. 19 S., R. 60 E.,
Sec. 31, NE¼SE¼SE¼.
NVNV106381488, 2.5 acres
T. 20 S., R. 60 E.,
Sec. 5, SE¼SW¼SW¼NE¼.
NVNV106381489, 37.5 acres
T. 20 S., R. 60 E.,
Sec. 5, SW¼NW¼NE¼SE¼,
W½SW¼NE¼SE¼,
W½NE¼NW¼SE¼,
SE¼NE¼NW¼SE¼,
NE¼NW¼NW¼SE¼,
E½SE¼NW¼SE¼, E½NE¼SW¼SE¼,
NE¼SE¼SW¼SE¼,
W½NW¼SE¼SE¼, and
NW¼SW¼SE¼SE¼.
NVNV106334777, 7.5 acres
T. 22 S., R. 60 E.,
Sec. 13, S½NE¼NE¼NW¼ and
NW¼SE¼NE¼NW¼.
NVNV106740767, 2.5 acres
T. 22 S., R. 60 E.,
Sec. 14, SW¼SW¼SW¼SE¼.
NVNV106740769, 1.25 acres
T. 22 S., R. 61 E.,
Sec. 30, W½SE¼SE¼SW¼NE¼.
NVNV106380173, 2.01 acres
T. 23 S., R. 61 E.,
Sec. 8, lot 2.
NVNV106380168, 5 acres
T. 23 S., R. 61 E.,
Sec. 9, S½NE¼NW¼NE¼.
NVNV106380171, 8.75 acres
T. 23 S., R. 61 E.,
Sec. 9, S½SW¼NW¼NE¼,
NW¼NW¼SW¼NE¼, and
W½SW¼NW¼SW¼NE¼.
NVNV106380175, 9.375 acres
T. 23 S., R. 61 E.,
Sec. 10, SW¼SW¼NW¼NW¼SW¼,
S½SE¼SW¼NW¼NW¼SW¼,
N½SW¼NW¼SW¼,
SW¼NE¼SE¼NW¼SW¼,
S½SE¼NE¼SE¼NW¼SW¼, and
NW¼SE¼NW¼SW¼.
NVNV106380214, 12.5 acres
T. 23 S., R. 61 E.,
Sec. 15, NW¼NE¼NW¼SE¼, and
NW¼NW¼SE¼.
NVNV106740768, 30 acres
T. 22 S., R. 63 E.,
Sec. 9, NW¼NW¼SE¼,
W½SW¼NW¼SE¼,
W½NW¼SW¼SE¼, and
SW¼SW¼SE¼.
NVNV106740777, 5 acres
T. 22 S., R. 63 E.,
Sec. 9, W½SE¼NW¼SE¼.
NVNV106740778, 5 acres
T. 22 S., R. 63 E.,
Sec. 9, E½SE¼SW¼SE¼.
NVNV106740779, 10 acres
T. 22 S., R. 63 E.,
Sec. 9, NW¼SE¼SE¼.

The areas described aggregate 200.64 acres, according to the official plats of the surveys of the said lands on file with the BLM.

The Las Vegas Valley Disposal Boundary Environmental Impact Statement (Record of Decision issued on December 23, 2004) and the Las Vegas In-Valley Area Multi-Action Analysis Environmental Assessment (EA), DOI–BLM–NV–S010–2016–0054–EA (*https://eplanning.blm.gov/eplanning-ui/project/60096/510*), analyzed the sale parcels. Parcel-specific determinations of NEPA adequacy, DOI–BLM–NV–S010–2025–0006–DNA and DOI–BLM–NV–S010–2026–0019–DNA, were prepared in connection with this notice of realty action.

Submit comments to the address in the **ADDRESSES** section. Before including your address, phone number, email address, or other personally identifiable information in your comment, you should be aware that your entire comment—including any personally identifiable information—may be made publicly available at any time. While you can ask us in your comment to withhold your personally identifiable information from public review, we cannot guarantee that we will be able to do so.

Any comments regarding the proposed sale will be reviewed by the BLM Nevada State Director or other authorized official of the Department of the Interior, who may sustain, vacate, or modify this realty action in response to such comments. In the absence of any comments, this realty action will become the final determination of the Department of the Interior.

The use of the modified competitive sale method is consistent with 43 CFR 2711.3–2. Public lands may be offered for sale by modified competitive bidding procedures when the authorized officer determines it is necessary based on public policies. Utilizing an online auction would support Presidential Memorandum, *Delivering Emergency Price Relief for American Families and Defeating the Cost-of-Living Crisis* (January 20, 2025) and encourage greater participation by qualified bidders.

Federal law requires that bidders must be:

(1) A citizen of the United States, 18 years of age or older;

(2) A corporation subject to the laws of any state or of the United States;

(3) A state, State instrumentality, or political subdivision authorized to hold property; or

(4) An entity legally capable of conveying and holding lands or

interests therein under the laws of the State of Nevada.

The successful bidder must submit proof of citizenship or articles of incorporation within 30 days from receipt of acceptance of bid letter. Evidence of United States citizenship is a birth certificate, passport, or naturalization papers. Citizenship documents or Articles of Incorporation (as applicable) must be provided to the BLM LVFO for each sale.

To participate in the BLM bidding process, you must register and obtain a bidder number. Registration for online bidding will be available prior to the sale date at Efficient Markets' website *https://www.efficientmarkets.com.* In the listings section of the website, click on the ''Register'' button on the ''BLM Nevada SNPLMA Land Sale'' tile to register for the sale. A free Efficient Markets account is required to register. To review the listings, obtain maps, and get information on how to submit competitive online bids, click on the ''View Listings'' button on the ''BLM Nevada SNPLMA Land Sale'' tile in the listings section of the website. A submitted online internet bid is a binding offer to purchase.

To participate in this sale, prospective buyers must create an Efficient Markets account, complete the Efficient Markets Bidding Terms Agreement, request a bidding allowance, and register for the BLM Nevada 20-Parcel SNPLMA Land Sale. Efficient Markets may require approximately five business days to determine bidder's financial qualifications. Additional information on how to register at Efficient Markets may be found at *https://www.efficientmarkets.com.* Assistance creating an Efficient Markets account and registering for the sale is available by telephoning the Efficient Markets' Government Resources department at 877–351–4488 and by using the following link to create a Buyer's Account: *https://www.efficientmarkets.com* and create a Basic Account. After the account is created, complete your profile by submitting bank account information and requesting a bid allowance. The following information will be required:

- Bank Name
- Banker's Name
- Telephone Number of Banker
- Address of Bank
- Requested Bid Allowance amount.

Efficient Markets will verify the Bank Name is a recognized financial institution and contact the banker to ask if the prospective buyer has the financial means to cover the requested Bid Allowance, which is the limit or ceiling for bids and is NOT recorded as a bid or offer per property at auction. Upon receiving an affirmative answer, the allowance will be granted.

Important notes regarding your Bid Allowance: For security reasons, a bidder must contact its banker and grant permission to speak to Efficient Markets about its Bid Allowance request. Efficient Markets will not request the account balance or ask any questions about assets or lines of credit. Efficient Markets will not request the bank account number, nor can it withdraw funds.

The auction website is open to the public. The internet-based land sale can be observed in real-time. However, you must register as a bidder on the website in advance to submit bids for a parcel. The auction website will be active and available for use approximately 10 days after the date of this notice and will remain available for viewing until the completion of the auction. The available parcels listed in this notice will be detailed on Efficient Markets website. Interested parties may visit the website at any time. Potential bidders may register for the online auction as soon as the auction website is active.

Potential bidders are encouraged to visit the website prior to the start of the open bidding period to become familiar with the site and review the bidding instructions available at *https://www.efficientmarkets.com.* Supporting documentation is available on the website to familiarize new users to the process and answer frequently asked questions.

Payments to the BLM will not be made through the auction website. At the conclusion of the final parcel's bidding period, the successful bidder for each parcel will be provided instructions by the online auction system via email on how to make the required payment to the BLM. In addition, you may be required to pay a commission fee to Efficient Markets of 1.5 percent of the highest qualifying bid for each parcel purchased by successful bidders. Efficient Markets will submit a separate invoice via email to each successful bidder for the total amount due to the BLM and a separate invoice for the amount due to Efficient Markets.

Parcels will begin online bidding at the established FMV. Each parcel will have its own unique open bidding period, with start and stop times clearly identified on the auction website. The open bidding period for each parcel will run for 24 hours from start to finish, and only bids placed during this 24-hour period will be accepted. Each parcel will close bidding sequentially so that each bidder will know if it is the highest winning bid before subsequent parcels close. The website will display each current high bid, and the high bid bidder's number.

The online system allows participants to submit maximum bids, which is the highest amount a bidder is willing to pay for each parcel, to enable a bidder to participate in the online auction without having to be logged into the website at the time the auction period closes. The auction website provides a full explanation of placing maximum bids, as well as an explanation of how it works to place bids on your behalf to maintain your high bidder status up to the chosen maximum bid amount. The BLM strongly encourages potential bidders to review the bidding tutorial in the Frequently Asked Questions area on the auction website in advance of the sale. Efficient Markets will declare the highest qualifying bid as the high bid. The successful bidder must submit a deposit of not less than 20 percent of the successful bid amount by 4:00 p.m. PT on the first business day following the close of the sale, in the form of a certified check, postal money order, electronic fund transfer, bank draft, or cashier's check made payable in U.S. dollars to the ''Department of the Interior, Bureau of Land Management.''

The BLM will send the successful bidder(s) an acceptance of bid letter with detailed information for full payment. In accordance with 43 CFR 2711.3–1(d), the successful bidder will forfeit the bid deposit if it fails to pay the full purchase price within 180 days of the sale. The BLM will make no exceptions. The BLM cannot accept the remainder of the bid price at any time following the 180th day after the sale.

If a bidder is the apparent successful bidder with respect to multiple parcels and that bidder fails to submit the minimum 20 percent bid deposit resulting in default on any single parcel following the sale, the BLM may cancel the sale of all parcels to that bidder. If a successful bidder cannot consummate the transaction for any reason, the BLM may consider the second highest bidder to purchase the parcel. If there are no acceptable bids, a parcel may remain available for sale on a future date without further legal notice.

The BLM LVFO must receive the request for escrow instructions prior to 30 days before the prospective patentee's scheduled closing date. There are no exceptions.

All name changes and supporting documentation must be received at the BLM LVFO by 4:30 p.m. PT, 30 days from the date on the high-bidder letter. There are no exceptions. To submit a name change, the apparent successful bidder must submit the name change in

writing on the Certificate of Eligibility form to the BLM LVFO.

The BLM must receive the remainder of the full bid price for the parcel no later than 4:30 p.m. PT, within 180 days following the day of the sale. The successful bidder must submit payment in the form of a certified check, postal money order, bank draft, cashier's check, or make available by electronic fund transfer payable in U.S. dollars to the ''Department of the Interior—Bureau of Land Management'' to the BLM LVFO. The BLM will not accept personal or company checks.

Arrangements for electronic fund transfer to the BLM for payment of the balance due must be made a minimum of two weeks prior to the payment date. The BLM will not sign any documents related to 1031 Exchange transactions. The bidder is responsible for timing for completion of such an exchange. The BLM cannot be a party to any 1031 Exchange.

In accordance with 43 CFR 2711.3–1(f), the BLM may accept or reject any or all offers to purchase or withdraw any parcel of land or interest therein from sale within 30 days, if the BLM authorized officer determines consummation of the sale would be inconsistent with any law, or for other reasons as may be provided by applicable law or regulations. No contractual or other rights against the United States may accrue until the BLM officially accepts the offer to purchase and the full bid price is paid.

If a parcel is not sold pursuant to this Notice of Realty Action, the parcel may remain available for sale on a continuing basis for a limited period of time, as determined by the Authorized Officer, until sold, as specified in this Notice. Per 43 CFR 2711.3–1(e), if there are no acceptable bids, a parcel may remain available for direct sale on a continuing basis until sold or until termination of segregation, without further legal notice to any party who did not originally bid on the parcel during the auction period. Unsold parcel(s) will be listed on the BLM SNPLMA land sales web page under the land sales tab. The first qualified party to submit the required 20 percent deposit of the Fair Market Value to the Las Vegas Field Office, in the form and manner required by this Notice, will be deemed the qualified buyer and will be subject to all timelines, due dates, terms, and conditions set forth in this Notice of Realty Action.

According to the SNPLMA, as amended, Public Law 105–263 section 4(c), lands identified within the Las Vegas Valley Disposal Boundary are withdrawn from location and entry under the mining laws and from operation under the mineral leasing and geothermal leasing laws until such time as the Secretary of the Interior (Secretary) terminates the withdrawal or the lands are patented.

Upon publication of this notice in the **Federal Register**, and until completion of this sale, the BLM will no longer accept land use applications affecting the parcels identified for sale. The parcels may be subject to land use applications received prior to publication of this notice if processing the application would have no adverse effect on the marketability of title, or the FMV of the parcel.

Terms and Conditions: FLPMA Section 209, 43 U.S.C. 1719(a), states that ''all conveyances of title issued by the Secretary . . . shall reserve to the United States all minerals in the lands.'' Accordingly, all minerals for the sale parcels will be reserved to the United States. The patents, when issued, will contain a mineral reservation to the United States for all minerals.

In response to requests to clarify this mineral reservation as it relates to mineral materials, such as sand and gravel, we refer interested parties to the regulations at 43 CFR 3601.71(b), which provides that the owner of the surface estate of lands with reserved Federal minerals may ''use a minimal amount of mineral materials'' for ''personal use'' within the boundaries of the surface estate without a sales contract or permit. The regulation provides that all other use, absent statutory or other express authority, requires a sales contract or permit. The BLM refers interested parties to the explanation of this regulatory language in the preamble to the final rule published in the **Federal Register** in 2001, available at *https://www.federalregister.gov/d/01-29001,* which states that minimal use ''would not include large-scale use of mineral materials, even within the boundaries of the surface estate'' (66 FR 58892). Further explanation is contained in the BLM Instruction Memorandum No. 2014–085 (April 23, 2014), available on the BLM's website at *https://www.blm.gov/policy/im-2014-085.*

The following numbered terms and conditions will appear on the conveyance documents for the sale parcels:

1. All mineral deposits in the lands so patented, and to it, or persons authorized by it, the right to prospect for, mine, and remove such deposits from the same under applicable law and regulations to be established by the Secretary are reserved to the United States, together with all necessary access and exit rights.

2. A right-of-way is reserved for ditches and canals constructed by authority of the United States under the Act of August 30, 1890 (43 U.S.C. 945).

3. The parcels are subject to valid existing rights.

4. The parcels are subject to reservations for roads, public utilities, and flood control purposes, both existing and proposed, in accordance with the local governing entities' transportation plans.

5. An appropriate indemnification clause protecting the United States from claims arising out of the patentee's use, occupancy, or occupations on the patented lands.

To the extent required by law, the parcel is subject to the requirements of section 120(h) of the CERCLA, as amended. Accordingly, notice is hereby given that the lands have been examined, and no evidence was found to indicate that any hazardous substances have been stored for one year or more, nor that any hazardous substances have been disposed of or released on the subject properties.

No warranty of any kind, express or implied, is given by the United States as to the title, whether or to what extent the land may be developed, its physical condition, future uses, or any other circumstance or condition. The conveyance of a parcel will not be on a contingency basis.

Authority: 43 CFR 2711.3–2.

Bruce Sillitoe,

Field Manager, Las Vegas Field Office.

[FR Doc. 2026–23587 Filed 11–18–26; 8:45 am]

BILLING CODE 4331–21–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[A2407–014–004–065516, O2509–014–004–125222.1; LLUTC03000]

Realty Action: Recreation and Public Purposes Act Classification and Segregation of Public Land for Ivins City, Washington County, Utah

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of realty action.

SUMMARY: The Bureau of Land Management (BLM) has examined 80 acres of public land in Washington County, Utah, and has found them suitable for classification for lease and subsequent conveyance under the provisions of the Recreation and Public Purposes (R&PP) Act, as amended. Ivins City applied under the R&PP Act and proposes to use the land to develop a

cemetery, public works yard, and regional recreation park.

DATES: Interested parties must submit written comments, postmarked or delivered no later than January 4, 2027.

ADDRESSES: Written comments may be mailed or hand delivered to: Field Manager, BLM St. George Field Office, 4001 E Aviator Drive, St. George, Utah 84790. Comments may also be submitted by email to *BLM_UT_SGFO_Comments@blm.gov*. The BLM will not consider comments received by telephone. Further information regarding the project is available for review during business hours, (8 a.m. to 4:30 p.m. Mountain Time), Monday through Friday, except during Federal holidays, at the address listed above.

FOR FURTHER INFORMATION CONTACT: Lennie McConnell, Realty Project Manager, by email at *BLM_UT_SGFO_Comments@blm.gov,* by telephone at 435–688–3200, or you may visit the BLM St. George Field Office (SGFO) at the above-listed address. Further information regarding the project is available for review at the SGFO during business hours, (8 a.m. to 4:30 p.m. Mountain Time), Monday through Friday, except during Federal holidays. Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States. You will receive a reply during normal business hours.

SUPPLEMENTARY INFORMATION: Ivins City is a political subdivision of the State of Utah and is therefore a qualified applicant under the R&PP Act.

Conveyance of the lands for recreational or public purposes use is consistent with the St. George Field Office Resource Management Plan (1999), as amended. A parcel-specific environmental assessment (EA), Document No. DOI–BLM–UT–C030–2026–0022–EA, was prepared in connection with this realty action and may be viewed at *https://eplanning.blm.gov/Project-Home/?id=130aa8d8-e238-f111-88b3-001dd802f839*. The lands are legally described as:

Salt Lake Meridian, Utah

T. 42 S., R. 16 W.,
sec. 7, S½NE¼.

The area described contains 80 acres, according to the official plat of survey of said land, on file with the BLM.

All interested parties will receive a copy of this notice once it is published in the **Federal Register**. A copy of the notice will also be published in a newspaper of local circulation once a week for three consecutive weeks.

Upon publication of this notice in the **Federal Register**, the lands will be segregated from all other forms of appropriation under the public land laws, including locations under the mining laws, except for lease or conveyance under the R&PP Act and leasing under the mineral leasing laws.

The lease or conveyance of the land, if it occurs, will be subject to the following terms, conditions, and reservations:

1. A right-of-way thereon for ditches and canals constructed by the authority of the United States Act of August 30, 1890 (43 U.S.C. 945).

2. Provisions of the R&PP Act and to all applicable regulations of the Secretary of the Interior.

3. All mineral deposits in the land so patented, and the right to prospect for, mine, and remove such deposits from the same under applicable law and regulations as established by the Secretary of the Interior are reserved to the United States, together with all necessary access and exit rights.

4. Lease or conveyance of the parcel is subject to valid existing rights.

5. An appropriate indemnification clause protecting the United States from claims arising out of the lessee's or patentee's use, occupancy, or operations on the leased or patented lands.

6. For public works and park areas, a reversionary provision stating that title shall revert to the United States upon a finding, after notice and opportunity for a hearing, that, without the approval of the Secretary of the Interior or delegate, the patentee or its approved successor attempted to convey title to or control over the lands to another, the lands have been devoted to a use other than that for which the lands were conveyed, the lands have not been used for the purpose for which the lands were conveyed for a 5-year period, or the patentee has failed to follow the approved development plan or management plan. No portion of the lands shall, under any circumstances, revert to the United States if any such portion has been used for solid waste disposal or for any other purpose which may result in the disposal, placement, or release of any hazardous substance.

7. For cemetery use area, a limited reversionary provision that may cause the land to revert to the United States if, at the end of 5 years after the date of conveyance, the land is not being used in accordance with the approved plan of development. If, at any time, the patentee transfers to another party ownership of any portion of the land not used for the purpose(s) specified in the application and the approved plan of development, the patentee shall pay the BLM the fair market value, as determined by the authorized officer, of the transferred portion as of the date of transfer, including the value of any improvements thereon. No portion of the lands shall, under any circumstance, revert to the United States if any such portion has been used for cemetery purposes, solid waste disposal or for any other purpose which may result in the disposal, placement, or release of any hazardous substance.

8. Any other terms or reservations the authorized officer determines appropriate to ensure public access and proper management of Federal lands and interests therein.

Classification Comments: Comments on the classification are restricted to whether the land is physically suited for the public and recreational uses as proposed, whether the use will maximize the future use or uses of the land, whether the use is consistent with local planning and zoning, or if the use is consistent with State and Federal programs.

Application Comments: Interested parties may also submit comments regarding the specific use proposed in the application and plan of development and management, whether the BLM followed proper administrative procedures in reaching the decision, or any other factor not directly related to the suitability of the lands for a cemetery, public works facilities, and park as proposed. The EA, maps, and associated documents are available for review at the location listed in the **ADDRESSES** section earlier. Comments must be submitted to the addresses listed in the **ADDRESSES** section by the deadline listed in the **DATES** section.

Adverse comments will be treated as protests which will be reviewed by the BLM Utah State Director or other authorized officials, who may sustain, vacate, or modify this realty action. In the absence of any adverse comments, the classification will become effective on January 19, 2027. The lands will not be offered for lease until after the classification becomes effective.

Before including your address, phone number, email address, or other personal identifying information in your comment, be aware your entire comment, including your personal identifying information, may be made publicly available at any time.

(Authority: 43 CFR 2741.5)

Christina Price,

State Director, Acting.

[FR Doc. 2026–23558 Filed 11–18–26; 8:45 am]

BILLING CODE 4331–25–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[A2407–014–004–065516, #O2509–014–004–125222.1; LLUTP02000]

Realty Action: Recreation and Public Purposes Act Classification and Conveyance of Public Land in Kane County, UT

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of realty action.

SUMMARY: The Bureau of Land Management (BLM) examined 20 acres of public land in Kane County, Utah, and has found it suitable for classification for conveyance to the Western Kane County Special Service District #1 (district) under the provisions of the Recreation and Public Purposes (R&PP) Act, as amended. The district proposes to use the land to expand its existing landfill.

DATES: Interested parties must submit written comments regarding this classification and conveyance of public land, postmarked or delivered no later than January 4, 2027.

ADDRESSES: Written comments may be mailed, or hand delivered to the BLM Kanab Field Office, 669 South Highway 89A, Kanab, UT 84741. Comments may also be submitted by email to *BLM_UT_KN_Mail@blm.gov.* The BLM will not consider comments received by telephone.

FOR FURTHER INFORMATION CONTACT: Levi LeFevre, Realty Specialist, by email at *llefevre@blm.gov* or telephone at 435–644–1276. Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States. You will receive a reply during normal business hours.

SUPPLEMENTARY INFORMATION: The proposed conveyance is in the public interest, consistent with the 2008 Kanab Field Office Resource Management Plan. The parcel is legally described as:

Salt Lake Meridian, Utah

T. 40 S., R. 7 W.,
Sec. 26, SW¼SE¼SW¼;
Sec. 35, NW¼NW¼NW¼.

The areas described aggregate 20 acres, according to the official plats of the surveys of the said land, on file with the BLM.

The land is contiguous to the current landfill operated by the district. The district will move and/or expand the landfill operations campus facilities (*i.e.,* truck scale, attendant office, equipment shed, etc.) onto the westernmost 10-acre parcel to improve customer and worker traffic flows. The district will continue expansion of the existing landfill buried waste cells to the east onto the easternmost 10-acre parcel to handle future waste disposal needs.

The proposed conveyance would enable the district to continue providing essential waste-disposal services to the rural communities of Orderville, Alton, Glendale, Mount Carmel, and the district's northwestern region. Expanding the landfill would sustain local employment required to operate the facility and manage solid waste from the district's growing recreational area. The expanded landfill would also support businesses that rely on waste-management services for recreation-based visitation in the region.

Upon publication of this notice in the **Federal Register**, the land will be segregated from all other forms of appropriation under the public land laws, including location under the mining laws, except for lease and/or conveyance under the R&PP Act and leasing under the mineral leasing laws. The segregation will terminate upon issuance of a patent, upon final rejection of the application, or 18 months from the date of this notice, whichever occurs first. All interested parties will receive this notice after it is published in the **Federal Register**. It will also appear in a local newspaper once a week for 3 consecutive weeks.

The conveyance of the land, if it occurs, will be subject to the following terms, conditions, and reservations:

1. A right-of-way thereon for ditches and canals constructed by the authority of the United States Act of August 30, 1890 (26 Stat. 391; 43 U.S.C. 945).

2. Provisions of the R&PP Act and to all applicable regulations of the Secretary of the Interior.

3. All mineral deposits in the land so patented, and the right to prospect for, mine, and remove such deposits from the same under applicable law and regulations as established by the Secretary of the Interior are reserved to the United States, together with all necessary access and exit rights.

4. Conveyance of the parcel is subject to valid existing rights.

5. An appropriate indemnification clause protecting the United States from claims arising out of the patentee's use, occupancy, or operations on the patented land.

6. A limited reversionary provision stating that the title shall revert to the United States upon a finding, after notice and opportunity for a hearing, that the patentee has not substantially developed the lands in accordance with the approved POD on or before the date five years after the date of conveyance. No portion of the land shall under any circumstance revert to the United States if any such portion has been used for solid waste disposal, or for any other purpose, which may result in the disposal, placement, or release of any hazardous substance.

7. The patentee shall comply with all Federal and State laws applicable to the disposal, placement, or release of hazardous substances.

8. Any other reservations that the authorized officer determines as appropriate to ensure public access and proper management of Federal lands and interests therein.

Classification Comments: Interested parties may submit comments involving the classification and suitability of the land for expansion and development of the existing landfill. Comments on the classification are restricted to whether the land is physically suited for the proposal, whether the use will maximize the future use or uses of the land, whether the use is consistent with local planning and zoning, or if the use is consistent with State and Federal programs.

Application Comments: Interested parties may also submit comments regarding the specific use proposed in the application and Plan of Development, and whether the BLM followed proper administrative procedures in considering the decision to convey under the R&PP Act.

Any adverse comments will be reviewed by the BLM Utah State Director or other authorized officials of the Department of the Interior, who may sustain, vacate, or modify this realty action. In the absence of any adverse comments, the classification will become effective on January 19, 2027. The land will not be offered for lease or conveyance until after the classification becomes effective.

Before including your address, phone number, email address, or other personal identifying information in any comment, be aware that your entire comment including your personal

identifying information may be made publicly available at any time.

(Authority: 43 CFR 2741.5)

Christina J. Price,

State Director, Acting.

[FR Doc. 2026–23559 Filed 11–18–26; 8:45 am]

BILLING CODE 4331–25–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Dave Allen Wright, M.D.; Decision and Order

On May 6, 2026, the Drug Enforcement Administration (DEA or Government) issued an Order to Show Cause (OSC) to Dave Allen Wright, M.D., of Cincinnati, Ohio (Registrant). Request for Final Agency Action (RFAA), Exhibit (RFAAX) 1, at 1, 3. The OSC proposed the revocation of Registrant's Certificate of Registration No. BW4012720, alleging that Registrant is ''currently without authority to prescribe, administer, dispense, or otherwise handle controlled substances in the State of Ohio, the state in which [he is] registered with DEA.'' *Id.* at 2 (citing 21 U.S.C. 824(a)(3)).

The OSC notified Registrant of his right to file a written request for hearing, and that if he failed to file such a request, he would be deemed to have waived his right to a hearing and be in default. *Id.* at 2 (citing 21 CFR 1301.43). Here, Registrant did not request a hearing, and the Agency finds him to be in default. RFAA, at 2.[1] ''A default, unless excused, shall be deemed to constitute a waiver of the registrant's/applicant's right to a hearing and an admission of the factual allegations of the [OSC].'' 21 CFR 1301.43(e).

Further, ''[i]n the event that a registrant . . . is deemed to be in default . . . DEA may then file a request for final agency action with the Administrator, along with a record to support its request. In such circumstances, the Administrator may enter a default final order pursuant to [21 CFR] 1316.67.'' *Id.* 1301.43(f)(1). Here, the Government has requested final agency action based on Registrant's default pursuant to 21 CFR 1301.43(c), (f), and 1301.46. RFAA, at 3; *see also* 21 CFR 1316.67.

Findings of Fact

The Agency finds that, in light of Registrant's default, the factual allegations in the OSC are deemed admitted. 21 CFR 1301.43(e). According to the OSC, on October 1, 2025, Registrant's Ohio medical license expired by its own terms. RFAAX 1, at 1. According to Ohio online records, of which the Agency takes official notice, Registrant's Ohio medical license remains expired.[2] eLicense Ohio Professional Licensure License Lookup, https://elicense.ohio./oh_verifylicense (last visited date of signature of this Order). Accordingly, the Agency finds that Registrant is not licensed to practice medicine in Ohio, the state in which he is registered with DEA.[3]

Discussion

Pursuant to 21 U.S.C. 824(a)(3), the Attorney General is authorized to suspend or revoke a registration issued under 21 U.S.C. 823 ''upon a finding that the registrant . . . has had his State license or registration suspended . . . [or] revoked . . . by competent State authority and is no longer authorized by State law to engage in the . . . dispensing of controlled substances.''

With respect to a practitioner, DEA has also long held that the possession of authority to dispense controlled substances under the laws of the state in which a practitioner engages in professional practice is a fundamental condition for obtaining and maintaining a practitioner's registration. *Gonzales* v. *Oregon,* 546 U.S. 243, 270 (2006) (''The Attorney General can register a physician to dispense controlled substances 'if the applicant is authorized to dispense . . . controlled substances under the laws of the State in which he practices.' . . . The very definition of a 'practitioner' eligible to prescribe includes physicians 'licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices' to dispense controlled substances. 802(21).'').[4] The Agency has applied these principles consistently. *See, e.g., Lawrence Rudolph, D.M.D.,* 89 FR 79310 (2024); *Henry-Norbert O. Ndekwe, M.D.,* 90 FR 15990 (2025); *Benson Sergiles, P.A.,* 90 FR 32016 (2025).

According to Ohio statute, ''[n]o person shall knowingly obtain, possess, or use a controlled substance or a controlled substance analog,'' except pursuant to a ''prescription issued by a licensed health professional authorized to prescribe drugs if the prescription was issued for a legitimate medical purpose.'' Ohio Rev. Code § 2925.11(A),

[1] Based on the Government's submissions in its RFAA dated August 5, 2026, the Agency finds that service of the OSC on Registrant was adequate. The included declaration from a DEA Diversion Investigator (DI) indicates that on May 14, 2026, the DI attempted to contact Registrant via his registered telephone number because the DI had previously found out that Registrant was no longer employed at his registered address and had retired on or around September 2025. RFAAX 2, at 1–2. On the same date, the DI attempt to contact Registrant via his registered email address. *Id.* at 2. Later, on the same date, Registrant returned the DI's phone call and informed the DI that he was no longer domiciled in Ohio or practicing at his registered location, nor was his registered email address a valid means of contact. *Id.* Upon the DI's request to provide an alternative address to personally serve or mail the OSC to Registrant, Registrant declined to inform DEA where he was currently residing for the purposes of updating his registration or receiving mail. *Id.* Registrant did, however, provide the DI with an alternative email address and stated that he could be contacted at this alternative email address. *Id.* Following the telephone conversation, the DI emailed a copy of the OSC to the alternative email address that Registrant had provided and later received an e-receipt confirming successful delivery of the email. *Id.; see also id.,* Appendixes A–B. Here, the Agency finds that Registrant was successfully served the OSC by email and that the DI's efforts to serve Registrant by other means were ''reasonably calculated, under all the circumstances, to apprise [Registrant] of the pendency of the action.''' *Jones* v. *Flowers,* 547 U.S. 220, 226 (2006) (quoting *Mullane* v. *Central Hanover Bank & Trust Co.,* 339 U.S. 306, 314 (1950)). Therefore, due process notice requirements have been satisfied. *See Mohammed S. Aljanaby, M.D.,* 82 FR 34552, 34552 (2017) (finding that service by email satisfies due process where the email is not returned as undeliverable and other methods have been unsuccessful); *Emilio Luna, M.D.,* 77 FR 4829, 4830 (2012) (same).

[2] Under the Administrative Procedure Act, an agency ''may take official notice of facts at any stage in a proceeding—even in the final decision.'' United States Department of Justice, Attorney General's Manual on the Administrative Procedure Act 80 (1947) (Wm. W. Gaunt & Sons, Inc., Reprint 1979).

[3] Pursuant to 5 U.S.C. 556(e), ''[w]hen an agency decision rests on official notice of a material fact not appearing in the evidence in the record, a party is entitled, on timely request, to an opportunity to show the contrary.'' The material fact here is that Registrant, as of the date of this Order, is not licensed to practice medicine in Ohio. Accordingly, Registrant may dispute the Agency's finding by filing a properly supported motion for reconsideration of findings of fact within fifteen calendar days of the date of this Order. Any such motion and response shall be filed and served by email to the other party and to the Office of the Administrator, Drug Enforcement Administration, at *dea.addo.attorneys@dea.gov*.

[4] This rule derives from the text of two provisions of the Controlled Substances Act (CSA). First, Congress defined the term ''practitioner'' to mean ''a physician . . . or other person licensed, registered, or otherwise permitted, by . . . the jurisdiction in which he practices . . . , to distribute, dispense, . . . [or] administer . . . a controlled substance in the course of professional practice.'' 21 U.S.C. 802(21). Second, in setting the requirements for obtaining a practitioner's registration, Congress directed that ''[t]he Attorney General shall register practitioners . . . if the applicant is authorized to dispense . . . controlled substances under the laws of the State in which he practices.'' 21 U.S.C. 823(g)(1). Because Congress has clearly mandated that a practitioner possess state authority in order to be deemed a practitioner under the CSA, DEA has held repeatedly that revocation of a practitioner's registration is the appropriate sanction whenever he is no longer authorized to dispense controlled substances under the laws of the state in which he practices. *See, e.g., Elias Garcia Garcia, P.A.,* 90 FR 31242 (2025); *Jason Weakley, R.N., A.P.R.N.,* 90 FR 10085 (2025); *Khursheed Haider, M.D.,* 90 FR 21950 (2025).

(B)(1)(d) (2025). Further, a '''[l]icensed health professional authorized to prescribe drugs or 'prescriber' means an individual who is authorized by law to prescribe drugs or dangerous drugs or drug therapy related devices in the course of the individual's professional practice.'' *Id.* § 4729.01(I)(2026).[5] The Ohio statute further defines an authorized prescriber as ''[a] physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.'' *Id.* § 4729.01(I)(5)(2026). Additionally, Ohio law permits ''[a] licensed health professional authorized to prescribe drugs, if acting in the course of professional practice, in accordance with the laws regulating the professional's practice'' to prescribe or administer schedule II, III, IV, and V controlled substances to patients. *Id.* § 3719.06(A)(1)(a)–(b)(2025).

Here, the undisputed evidence in the record is that Registrant lacks a license to practice medicine in Ohio. As already discussed, an individual must be a licensed health professional authorized to prescribe drugs in order to handle controlled substances in Ohio. Thus, because Registrant is not a licensed health professional authorized to prescribe drugs in Ohio, and, therefore, is not authorized to handle controlled substances in Ohio, Registrant is not eligible to maintain a DEA registration in Ohio. Accordingly, the Agency will order that Registrant's DEA registration be revoked.

Order

Pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 824(a), I hereby revoke DEA Certificate of Registration No. BW4012720 issued to Dave Allen Wright, M.D. Further, pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 823(g)(1), I hereby deny any pending applications of Dave Allen Wright, M.D., to renew or modify this registration, as well as any other pending application of Dave Allen Wright, M.D., for additional registration in Ohio. This Order is effective December 21, 2026.

Signing Authority

This document of the Drug Enforcement Administration was signed on November 6, 2026, by DEA Administrator Terrance C. Cole. That document with the original signature and date is maintained by DEA. For administrative purposes only, and in compliance with requirements of the Office of the Federal Register, the undersigned DEA Federal Register Liaison Officer has been authorized to sign and submit the document in electronic format for publication, as an official document of DEA. This administrative process in no way alters the legal effect of this document upon publication in the **Federal Register**.

Heather Achbach,

Federal Register Liaison Officer, Drug Enforcement Administration.

[FR Doc. 2026–23508 Filed 11–18–26; 8:45 am]

BILLING CODE 4410–09–P

[5] Section 4729.01 of the Ohio Revised Code was updated on October 9, 2026, but does not change any of the material parts or alter the Agency's decision in this matter.

NATIONAL MEDIATION BOARD

Notice of Proposed Information Collection Request

AGENCY: National Mediation Board.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the National Mediation Board (NMB) will be submitting an information Collection Request (ICR) entitled ''Application for Investigation of Representation Dispute'' to the Office of Management and Budget (OMB) for review and approval. The NMB is seeking the reinstatement, with non-substantive change, of this previously approved collection of information. The change to the information collection is a non-substantive one related to the change in the agency's Washington, DC headquarters address, which was effective August 1, 2026. The NMB did not receive comments on this information collection during the 60-day notice and comment period. OMB will accept comments from the public during the review and approval period. OMB may act on the NMB's ICR only after the 30-day comment period in this notice has closed.

DATES: Comments are due by December 21, 2026.

ADDRESSES: Submit written comments and recommendations for this information collection to the following website: *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under Review—Open for Public Comments'' or by using the search function and entering either the title of the information collection or the OMB control number: 3140–0001.

FOR FURTHER INFORMATION CONTACT: To request a copy of the proposed information collection, email NMB Program Management Specialist Keaira Butler at *keaira.butler@nmb.gov.* Please specify the complete title of the information collection when making your request. If you have questions about the information collection or the NMB's reinstatement request, contact John Gross, Counsel, National Mediation Board, Office of Legal Affairs, P.O. Box 23300, Washington, DC 20026; telephone number: 202–815–1647; email address: *gross@nmb.gov.*

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (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 NMB publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection 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 Record keeping burden.

The proposed information collection was previously published in the **Federal Register**, 91 FR 58712–58714, on September 16, 2026 and allowed 60 days for public comment. No comments were received. The purpose of this notice is to allow an additional 30 days for public comment. We encourage written comments and suggestions addressing the following issues: (1) Is this collection necessary to the proper functions of the agency; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the agency enhance the quality, utility, and clarity of the information to be collected; and (5) how might the agency minimize the burden of this collection on the respondents, including through the use of information technology.

Title of Collection: Application for Investigation of Representation Dispute.

OMB Control Number: 3140–0001.

Type of Review: Reinstatement, with non-substantive change, of a previously approved collection of information.

Affected Public: Carrier and Union Officials, and employees of railroads and airlines.

Frequency of Collection: On occasion.

Respondent's Obligation: Voluntary.

Estimated Reporting and Recordkeeping Hour Burden:

Responses: 25 annually.

Burden Hours: 6.25.

1. *Abstract:* When a dispute arises among a carrier's employees as to who will be their bargaining representative, the NMB is required by Section 2, Ninth of the Railway Labor Act (RLA), 45 U.S.C. 152, Ninth, to investigate the dispute, to determine who is the authorized representative, if any, and to certify such representative. The NMB's duties do not arise until its services have been invoked by a party to the dispute. The RLA is silent as to how the invocation of a representation dispute is to be accomplished and the NMB has not promulgated regulations requiring any specific vehicle. Nonetheless, 29 CFR 1203.2, provides that applications for the services of the NMB under Section 2, Ninth, to investigate representation disputes may be made on printed forms secured from the NMB's Office of Legal Affairs or on the internet at *http://www.nmb.gov.* The application requires the following information: the name of the carrier involved; the name or description of the craft or class involved; the name of the petitioning organization or individual; the name of the organization currently representing the employees, if any; the names of any other organizations or representatives involved in the dispute; and the estimated number of employees in the craft or class involved. This basic information is essential in providing the NMB with the details of the dispute so that it can determine what resources will be required to conduct an investigation.

2. The application form provides necessary information to the NMB so that it can determine the amount of staff and resources required to conduct an investigation and fulfill its statutory responsibilities. Without this information, the NMB would have to delay the commencement of the investigation, which is contrary to the intent of the RLA.

3. There is no improved technological method for obtaining this information. The burden on the parties is minimal in completing the Application for Investigation of Representation Dispute.

4. There is no duplication in obtaining this information.

5. Rarely are representation elections conducted for small businesses. Employers are not permitted to request our services regarding representation investigations. The labor organizations, which are the typical requesters, are national in scope and would not qualify as small businesses. Even in situations where the invocation comes from a small labor organization, we believe the burden in completing the application form is minimal and that no reduction in burden could be made.

6. The NMB is required by Section 2, Ninth, to investigate the dispute, to determine who is the authorized representative, if any, and to certify such representative. The NMB has no ability to control the frequency, technical, or legal obstacles, which would reduce the burden.

7. The information requested by the NMB is consistent with the general information collection guidelines of 5 CFR 1320.6 and 5 CFR 1320.8(b)(3). The NMB has no ability to control the data provided or timing of the invocation. The burden on the parties is minimal in completing the Application for Investigation of Representation Dispute.

8. No payments or gifts have been provided by the NMB to any respondents of the form.

9. There are no questions of a sensitive nature on the form.

10. The total time burden on respondents is 6.25 hours annually—this is the time required to collect information. After consulting with a sample of people involved with the collection of this information, the time to complete this information collection is estimated to average 15 minutes per response, including gathering the data needed and completion and review of the information.

Number of respondents per year: 25.

Estimated time per respondent: 15 minutes.

Total burden hours per year: 6.25 (25 × .25 hours).

11. The total collection and mail cost burden on respondents is estimated at $222.00 annually ($201.50 time cost burden + $20.50 mail cost burden.)

a. The respondents will not incur any capital costs or start up costs for this collection.

b. Cost burden on respondents—detail:

The total time burden annual cost is $201.50.

Time burden basis: The total hourly burden per year, upon respondents, is 6.25.

Staff cost = $201.50.

$32.24 per hour—based on mid level clerical salary.

$32.24 × 6.25 hours per year = $201.50.

We are estimating that a mid-level clerical person, with an average salary of $32.24 per hour, will be completing the Application for Investigation of Representation Dispute form. The total burden is estimated at 6.25 hours, therefore, the total time burden cost is estimated at $201.50 per year.

The total annual mailing cost to respondents is $20.50.

Number of applications mailed by:

Respondents per year: 25.

Total estimated cost: $20.50 (25 × $.82 stamp).

The collection of this information is not mandatory; it is a voluntary request from airline and railroad carrier employees seeking to invoke an investigation of a representation dispute. After consulting with a sample of people involved with the collection of this information, the time to complete this information collection is estimated to average 15 minutes per response, including gathering the data needed and completion and review of the information. However, the estimated hour burden costs of the respondents may vary due to the complexity of the specific question in dispute.

The application form is available from the NMB's Office of Legal Affairs and is also available on the internet at *http://www.nmb.gov,* which is the primary source of the form.

12. The total annualized Federal cost is $340.00. This cost represents the processing cost of the applications once they are received by the NMB. There are no printing or mailing costs. (The NMB has not received any requests to print and mail a form for a number of years.) The completed applications are maintained by the Office of Legal Affairs.

a. Processing Cost = $340.00.

Basis (processing cost): Representation is requested approximately 25 times per year and it takes approximately 20 minutes to process each application.

Staff Cost = $340.00.

$.68 per minute (GS 11 Step 1 base hourly rate of $40.94 per hr. ÷ 60).

$.68 × 20 minutes per mailing = $13.60.

$13.60 × 25 times per year = $340.00.

13. Item 13—no change in annual reporting and recordkeeping hour burden.

14. The information collected by the application will not be published.

15. The NMB will display the OMB expiration date on the form.

16(a)—the form does not reduce the burden on small entities; however, the burden is minimized and voluntary.

16(b)—the form does not indicate the retention period for record keeping requirements.

16(c)—not applicable, the form is not part of a statistical survey.

Dated: November 17, 2026.

Michael Jerger,

Chief Financial Officer, Acting Director of Administration, National Mediation Board.

[FR Doc. 2026–23589 Filed 11–18–26; 8:45 am]

BILLING CODE 7550–01–P

POSTAL REGULATORY COMMISSION

[Docket No. MC2027–31; Order No. 9801]

Competitive Postal Products

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is recognizing a recent filing by the Postal Service to make minor classification changes for International Mail and to make accompanying classification changes to the Mail Classification Schedule. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* December 4, 2026.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov*. Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

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I. Introduction
II. Commission Action
III. Ordering Paragraphs

I. Introduction

On November 13, 2026, pursuant to 39 CFR 3040.190, the Postal Service filed a notice to make minor changes to Part D, which refers to the Country Price Lists for International Mail, in the *Mail Classification Schedule* (MCS) section 4000, and to make minor changes to the list of countries with postal operators that dispatch Inbound Express Mail Service (EMS) 2 to the U.S. in MCS section 2515.6.7.[1] Effective January 17, 2027, the Postal Service plans to change the country name ''Nauru'' to ''Naoero'' or the ''Republic of Naoero'' in MCS sections 4000 and 2515.6.7, as a result of changes to the official name of Nauru as notified by the designated operator of Nauru to the Universal Postal Union (UPU). Notice at 1. The Postal Service provides a discussion of the proposed changes' compliance with 39 CFR 3040.190. Notice at 2–6.

II. Commission Action

The Commission establishes Docket No. MC2027–31 for consideration of matters raised by the Notice.

Pursuant to 39 CFR 3040.191, the Commission has posted the Notice on its website and invites comments on whether the Postal Service's filings are consistent with the policies and applicable criteria of chapter 36 of title 39 of the United States Code, 39 CFR 3040.190–192, and any applicable Commission directives and orders. Comments are due December 4, 2026. The public portions of the filings can be accessed via the Commission's website (*https://www.prc.gov*).

The Commission appoints Christopher Mohr to represent the interests of the general public (Public Representative) in this docket, pursuant to 39 CFR 3040.191(d). The Public Representative does not represent any individual person, entity, or particular point of view, and, when Commission attorneys are appointed, no attorney-client relationship is established.

III. Ordering Paragraphs

It is ordered:

1. The Commission establishes Docket No. MC2027–31 for consideration of matters raised by the Postal Service's Notice.

2. Pursuant to 39 CFR 3040.191(d), Christopher Mohr is appointed to serve as an officer of the Commission (Public Representative) to represent the interests of the general public in this proceeding.

3. Comments are due December 4, 2026.

4. This Order, or an abstract thereof, shall be published in the **Federal Register**.

By the Commission.

Danielle LeFlore,

Legal Assistant.

[FR Doc. 2026–23544 Filed 11–18–26; 8:45 am]

BILLING CODE 7710–FW–P

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2027–36 and K2027–38]

New Postal Products

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recent Postal Service filing for the Commission's consideration concerning a negotiated service agreement. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* November 24, 2026.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *https://www.prc.gov.* Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Introduction
II. Public Proceeding(s)
III. Summary Proceeding(s)

I. Introduction

Pursuant to 39 CFR 3041.405, the Commission gives notice that the Postal Service filed request(s) for the Commission to consider matters related to Competitive negotiated service agreement(s). The request(s) may propose the addition of a negotiated service agreement from the Competitive product list or the modification of an existing product currently appearing on the Competitive product list.

The public portions of the Postal Service's request(s) can be accessed via the Commission's website (*http://www.prc.gov*). Non-public portions of the Postal Service's request(s), if any, can be accessed through compliance with the requirements of 39 CFR 3011.301.[1]

Section II identifies the docket number(s) associated with each Postal Service request, if any, that will be reviewed in a public proceeding as defined by 39 CFR 3010.101(p), the title of each such request, the request's acceptance date, and the authority cited by the Postal Service for each request. For each such request, the Commission appoints an officer of the Commission to represent the interests of the general public in the proceeding, pursuant to 39 U.S.C. 505 and 39 CFR 3000.114 (Public Representative). The Public Representative does not represent any individual person, entity or particular point of view, and, when Commission attorneys are appointed, no attorney-

[1] Notice of United States Postal Service of Minor Classification Changes, November 13, 2026, at 1 (Notice).

[1] *See* Docket No. RM2018–3, Order Adopting Final Rules Relating to Non-Public Information, June 27, 2018, Attachment A at 19–22 (Order No. 4679).

client relationship is established. Section II also establishes comment deadline(s) pertaining to each such request.

The Commission invites comments on whether the Postal Service's request(s) identified in Section II, if any, are consistent with the policies of title 39. Applicable statutory and regulatory requirements include 39 U.S.C. 3632, 39 U.S.C. 3633, 39 U.S.C. 3642, 39 CFR part 3035, and 39 CFR part 3041. Comment deadline(s) for each such request, if any, appear in Section II.

Section III identifies the docket number(s) associated with each Postal Service request, if any, to add a standardized distinct product to the Competitive product list or to amend a standardized distinct product, the title of each such request, the request's acceptance date, and the authority cited by the Postal Service for each request. Standardized distinct products are negotiated service agreements that are variations of one or more Competitive products, and for which financial models, minimum rates, and classification criteria have undergone advance Commission review. *See* 39 CFR 3041.110(n); 39 CFR 3041.205(a). Such requests are reviewed in summary proceedings pursuant to 39 CFR 3041.325(c)(2) and 39 CFR 3041.505(f)(1). Pursuant to 39 CFR 3041.405(c)–(d), the Commission does not appoint a Public Representative or request public comment in proceedings to review such requests.

II. Public Proceeding(s)

1. *Docket No(s).:* MC2027–36 and K2027–38; *Filing Title:* USPS Request to Add Priority Mail, USPS Ground Advantage & Parcel Select Contract 11 to the Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* November 16, 2026; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3035.105, and 39 CFR 3041.310; *Public Representative:* Kenneth Moeller; *Comments Due:* November 24, 2026.

III. Summary Proceeding(s)

None. *See* Section II for Public Proceedings.

This Notice will be published in the **Federal Register**.

Danielle LeFlore,

Legal Assistant.

[FR Doc. 2026–23585 Filed 11–18–26; 8:45 am]

BILLING CODE 7710–FW–P

POSTAL REGULATORY COMMISSION

[Docket No. C2026–25; Presiding Officer's Ruling No. 2]

Complaint

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: This document provides the deadline date to file a notice of intervention and discusses aspects of the procedural schedule and case management procedures.

ADDRESSES: For additional information, Presiding Officer's Ruling No. 2 can be accessed electronically through the Commission's website at *https://www.prc.gov.*

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

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I. Background
II. Ordering Paragraphs

I. Background

This complaint stems from a dispute between the Postal Service and Complainant regarding delivery of mail to his home. Complainant asserts three causes of action in his Complaint. Specifically, Count I alleges that the Postal Service has breached a settlement agreement between the parties. Counts II alleges that the Postal Service violated 39 U.S.C. 403(1) by failing to maintain an efficient system of sorting and delivering the mail. Count III alleges that the Postal Service violated 39 U.S.C. 403(c) by discriminating against him in the delivery of his mail.

After determining that Complainant has raised sufficient issues of material law and fact as to Count III, the Commission appointed a presiding officer to preside over the conduct of the proceedings, including but not limited to scheduling, discovery, potential hearings, and briefing in this matter. The Presiding Officer therefore enumerates the provisions that will govern discovery as well as other related procedures. The Presiding Officer also denies certain procedural motions as moot or premature.

II. Ordering Paragraphs

It is ordered:

1. The deadline to file a notice of intervention pursuant to 39 CFR 3010.142 is December 1, 2026.

2. The parties and counsel shall follow the procedural schedule and case management procedures established by this Presiding Officer's Ruling.

3. The United States Postal Service's Motion to Strike Complainant's Premature Discovery, filed September 25, 2026, is denied.

4. Commission dockets staff shall remove the Complainant's Response in Opposition to Respondent's Answer to the Complaint, filed September 22, 2026, from this docket.

5. United States Postal Service's Motion to Strike Complainant's Opposition to the Answer to the Complaint, filed September 25, 2026, is denied.

6. This Order, or an abstract thereof, shall be published in the **Federal Register**.

By the Commission.

Mallory Richards,

Attorney-Advisor.

[FR Doc. 2026–23618 Filed 11–18–26; 8:45 am]

BILLING CODE 7710–FW–P

POSTAL REGULATORY COMMISSION

[Docket No. CP2027–1; Order No. 9804]

Competitive Postal Products

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is recognizing a recently filed Postal Service document with the Commission concerning changes in rates and classifications of general applicability for Competitive products. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* December 4, 2026.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *https://www.prc.gov.* Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Introduction and Overview
II. Initial Administrative Actions
III. Ordering Paragraphs

I. Introduction and Overview

On November 12, 2026, the Postal Service filed notice with the Commission concerning changes in rates and classifications of general

applicability for Competitive products.[1] The Postal Service represents that, as required by 39 CFR 3035.102(b) and 39 CFR 3035.104(b), the Notice includes an explanation and justification for the changes, the effective date, and a schedule of the changed rates. *See* Notice at 1–2. The changes are scheduled to take effect on January 17, 2027. *Id.* at 1.

Attached to the Notice is Governors' Decision No. 26–8, which states the new prices are in accordance with 39 U.S.C. 3632 and 3633 and 39 CFR 3035.102.[2] The Governors' Decision provides an analysis of the Competitive products' price and classification changes intended to demonstrate that the changes comply with 39 U.S.C. 3633 and 39 CFR part 3035. Governors' Decision No. 26–8 at 1. The attachment to the Governors' Decision sets forth the classification and price changes and includes draft *Mail Classification Schedule* (MCS) language for Competitive products of general applicability.

The Notice also includes an application for non-public treatment of the attributable costs, contribution, and cost coverage data in the unredacted version of the annex to the Governors' Decision, as well as the supporting materials for the data. Notice at 1–2.

Planned price and classification changes. The Governors' Decision includes an overview of the Postal Service's planned price changes which are summarized in the table below.

TABLE I–1—PROPOSED PRICE CHANGES

Product name	Average price increase (%)
Domestic Competitive Products	
Priority Mail Express	5.9
Retail	5.9
Commercial	5.9
Nonstandard Fees	16.0
Priority Mail	5.9
Retail	5.9
Commercial	5.9
Nonstandard Fees	16.0
Parcel Select	5.9
Destination Delivery Unit	5.8
Destination Sectional Center Facility	5.9
Connect Local	6.0
Nonstandard Fees	16.0
USPS Ground Advantage	5.9
Retail	5.9
Commercial	5.9
Alaska Limited Overland Routes	9.9
Nonstandard Fees	16.0
Domestic Extra Services	
Package Intercept Service	8.0
Adult Signature Service	
Required	8.2
Restricted Delivery	8.0
Address Enhancement Services (AMS API)	20.0
Premium Forwarding Service	
Weekly Reshipment (Priority Mail)	4.2
Per-Container Reshipment (Local)	4.2
Enrollment (annual)—online	8.0
Enrollment—retail	7.8
Priority Mail Half Tray Box	15.1
Priority Mail Full Tray Box	0
Priority Mail Express Half Tray Box	28.0
Priority Mail Express Full Tray Box	9.6
Competitive Post Office Box	0
Label Delivery Service	9.1
Pickup On Demand	7.9
Premium Data Retention and Retrieval Service	8.0
International Competitive Products	
Priority Mail Express International	7.9
Retail	7.9
Commercial	7.4
Priority Mail International	7.9
Retail	8.1

[1] USPS Notice of Changes in Rates and Classifications of General Applicability for Competitive Products, November 12, 2026 (Notice). Pursuant to 39 U.S.C. 3632(b)(2), the Postal Service is obligated to publish the Governors' Decision and record of proceedings in the **Federal Register** at least 30 days before the effective date of the new rates.

[2] Notice, Decision of the Governors of the United States Postal Service on Changes in Rates and Classification of General Applicability for Competitive Products (Governors' Decision No. 26–8), at 1 (Governors' Decision No. 26–8).

TABLE I–1—PROPOSED PRICE CHANGES—Continued

Product name	Average price increase (%)
Commercial	6.2
International Priority Airmail	7.9
First-Class Package International Service	7.9
Retail	7.9
Commercial	7.4
International Ancillary Services and Special Services	
International Certificate of Mailing	6.3
International Insurance	0
Customs Clearance and Delivery Fee	8.0

Source: *See* Governors' Decision No. 26–8 at 2–7. Percentage increases for Premium Forwarding Services are based on the proposed rates specified in the supporting materials.

Further classification changes are summarized as follows:

- The Postal Service will apply a flat 11 percent fuel surcharge to domestic Priority Mail Express, Priority Mail, Parcel Select, and USPS Ground Advantage packages. Initially, the fuel surcharge will be static but eventually the Postal Service intends that it will adjust the surcharge on a weekly basis, based on average fuel prices reported by the Energy Information Administration (EIA). The new, permanent surcharge is set to take effect on the expiration date of the current time limited price change that has been in place since April 26, 2026.
- The Postal Service will introduce a repricing fee for postage overpayments and underpayments caused by inaccurate dimensions or weight. For an underpayment, the fee will equal 20 percent of the unpaid amount and will be added to the postage due. For an overpayment, 20 percent will be deducted from the refundable amount, subject to Postal Service refund rules.
- The Noncompliance Fee will be renamed the Dimension and Weight Noncompliance Fee and will apply only when dimensions or weight are missing.
- The proposed changes to Premium Forwarding Service clarify that the online enrollment fee is annual. The Postal Service will also add Priority Mail Express as an option under Premium Forwarding Service Residential (PFSR) and Premium Forwarding Service Commercial (PFSC) and add Priority Mail Flat Rate Envelopes, Priority Mail Sacks, Priority Mail Express Flat Rate Envelopes, and Priority Mail Express Sacks options for PFSC. PFSC customers may control reshipment frequency for periods of up to 12 months.
- The Postal Service will introduce a Shipping Label Noncompliance Fee under Domestic Competitive products for incorrect barcode symbology or constructs.
- The Postal Service will expand the number of Price Groups for Priority Mail Express International (PMEI) Flat Rate Envelope from 8 to 20 groups and the number of Price Groups for Priority Mail International (PMI) Flat Rate Envelopes and Boxes from 8 to 20 groups.
- The Postal Service will add USPS Delivered Duty Paid (DDP) as an optional feature for International Priority Airmail (IPA) to more accurately reflect timing, payment and procedures related to USPS DDP.
- The Postal Service will revise the country group assignments for PMEI, PMI, IPA, and First-Class Package International Service (FCPIS) in, and to the format of, Part D Country Price Lists for International Mail so that it can price these products more effectively.

Notice at 2–5; Governors' Decision No. 26–8 at 2–5.

II. Initial Administrative Actions

The Commission establishes Docket No. CP2027–1 to consider the Postal Service's Notice. Interested persons may express views and offer comments on whether the planned changes are consistent with 39 U.S.C. 3632, 3633, and 3642, 39 CFR part 3035, and 39 CFR 3040 subparts B and E. Comments are due no later than December 4, 2026. For specific details of the planned price changes, interested persons are encouraged to review the Notice, which is available on the Commission's website at *www.prc.gov.*

Pursuant to 39 U.S.C. 505, Christopher Mohr is appointed to serve as Public Representative to represent the interests of the general public in this docket. The Public Representative does not represent any individual person, entity or particular point of view, and, when Commission attorneys are appointed, no attorney-client relationship is established.

III. Ordering Paragraphs

It is ordered:

1. The Commission establishes Docket No. CP2027–1 to provide interested persons an opportunity to express views and offer comments on whether the planned changes are consistent with 39 U.S.C. 3632, 3633, and 3642, 39 CFR part 3035, and 39 CFR 3040 subparts B and E.

2. Comments are due no later than December 4, 2026.

3. Pursuant to 39 U.S.C. 505, the Commission appoints Christopher Mohr to serve as an officer of the Commission (Public Representative) to represent the interests of the general public in this docket.

4. The Secretary shall arrange for publication of this Order in the **Federal Register**.

By the Commission.

Sarah Wessel,

Senior Paralegal Specialist.

[FR Doc. 2026–23570 Filed 11–18–26; 8:45 am]

BILLING CODE 7710–FW–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106907; File No. SR–24X–2026–32]

Self-Regulatory Organizations; 24X National Exchange LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend Its Warrant Performance Incentive Program

November 16, 2026.

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 November 5, 2026, 24X National Exchange LLC (''24X'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to make certain amendments to its warrant performance incentive program.[3] The proposed rule change is available on the Exchange's website at *https://equities.24exchange.com/regulation* and at the principal office of the Exchange.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange adopted a warrant performance incentive program (''Program'') to allow Members of the Exchange who participate in the Program (''Participants'')[4] to earn the right to purchase Non-Voting Common Units[5] of 24X US Holdings LLC (''24X US Holdco''), the Exchange's parent company.[6] As described in the Warrant Program Release, each Member of the Exchange may become a Participant in the Program by prepaying $500,000 in Exchange fees (''Prepayment Fee'') and satisfying the Program eligibility requirements.[7] Upon joining the Program, each Participant will receive a warrant that vests based on the Participant's achievement of certain minimum trading volumes (''Target Volume'')[8] on the Exchange during each designated pre-determined period in which the Program is in effect (''Measurement Period'')[9] and the Exchange's achievement of a minimum market share during such Measurement Periods (''24X Minimum Overall Market Share'').[10] When the warrants vest, Participants will have the right to exercise the warrants to purchase a certain number of 24X US Holdco Non-Voting Common Units.

The Exchange has determined to revise the Program to make additional Non-Voting Common Units available to be purchased by Participants starting in the first Measurement Period of 2027 (''Additional Equity''), under different terms than those applicable to the Non-Voting Common Units currently available to be purchased through the Program (''Original Equity''). Specifically, the right to purchase Additional Equity would extend through two additional Measurement Periods in 2028, would be subject to a reduced Prepayment Fee, and would be based on maker volume only instead of total trading volume.

The Exchange also proposes to make two additional changes to the terms of the Program that would apply to the right to purchase both the Original Equity and the Additional Equity. Specifically, as described below, the Exchange proposes to eliminate the 24X Minimum Overall Market Share threshold requirement and exclude certain dates from the calculation of Target Volume in each Measurement Period. All other aspects of the Program would remain the same as described in the Warrant Program Releases.[11]

a. Proposed Changes With Respect to Additional Equity Only

i. Description and Timing of Additional Equity

The Original Equity consists of 1,098,040 Non-Voting Common Units representing 10% of the outstanding total Units on a fully diluted basis of 24X US Holdco as of September 29, 2025. The Original Equity may be purchased by Participants upon the exercise of warrants that vest in accordance with the Program based on trading that occurs during the Program Period, which begins on and including October 14, 2025 and ends on and including December 31, 2027.[12] The Original Equity is allocated among the Measurement Periods for each of the three years of the Program as follows:[13]

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[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] The proposed rule change was originally filed as SR–24X–2026–26 on October 1, 2026 (withdrawn on October 28, 2026) and SR–24X–2026–27 on October 29, 2026 (withdrawn on November 5, 2026). SR–24X–2026–26 and SR–24X–2026–27 have been replaced by the instant filing.

[4] A recent amendment to the Program also allows Sponsored Participants to be joint Participants in the Program together with a Sponsoring Member of the Exchange. *See* Securities Exchange Act Rel No. 105481 (May 13, 2026), 91 FR 28695 (May 18, 2026) (SR–24X–2026–16). For purposes of this proposed rule change, ''Participant'' collectively refers to both Members of the Exchange who are Participants of the Program and Sponsored Participants of the Exchange who jointly participate in the Program together with a Sponsoring Member of the Exchange.

[5] 24X notes that it filed a proposed rule change for immediate effectiveness to amend the Second Amended and Restated Limited Liability Company Agreement of 24X US Holdings LLC, as amended (''24X US Holdco LLC Agreement'') to accommodate aspects of the proposal that affected the 24X US Holdco LLC Agreement. The changes to the 24X Holdco LLC Agreement included amendments to authorize the issuance of Non-Voting Common Units as well as the implementation of the liquidity program related to the Program. Securities Exchange Act Rel. No. 104098 (Sept. 26, 2025), 90 FR 47029 (Sept. 30, 2025) (SR–24X–2025–11).

[6] Securities Exchange Act. Rel. No. 104018 (Sept. 23, 2025), 90 FR 46437 (Sept. 26, 2025) (SR–24X–2025–04) (''Warrant Program Release''). The Exchange later amended certain dates in the Program. Securities Exchange Act Rel. No. 104257 (Nov. 25, 2025), 90 FR 55207 (Dec. 1, 2025) (SR–24X–2025–12) (''Amended Warrant Program Release''). These two releases are collectively referred to as the ''Warrant Program Releases.''

[7] *See* Warrant Program Release at 46437–46438.

[8] As discussed in more detail in the Warrant Program Release, the ''Target Volume'' is 5% of the average daily trading volume on the Exchange, where the daily trading volume is calculated based on total aggregated average daily volume traded over each Measurement Period.

[9] As discussed in more detail in the Warrant Program Releases, the ''Measurement Period'' for Year 1 (2025) is October 14, 2025 through December 31, 2025; the Measurement Periods for Year 2 (2026) are (1) January 1–March 31, 2026, (2) April 1–June 30, 2026, (3) July 1–September 30, 2026, and (4) October 1–December 31, 2026; and the Measurement Periods for Year 3 (2027) are (1) January 1–March 31, 2027, (2) April 1–June 30, 2027, (3) July 1–September 30, 2027 and (4) October 1–December 31, 2027.

[10] As discussed in more detail in the Warrant Program Release, the ''24X Minimum Overall Market Share'' is defined as follows: (1) for each Measurement Period of Year 2, the 24X Minimum Overall Market Share is 0.50% of the Consolidated Average Daily Volume (''CADV'') for all NMS Stocks eligible for trading on 24X; and (2) for each Measurement Period of Year 3, the 24X Minimum Overall Market Share is 1.00% of the CADV for all NMS Stocks eligible for trading on 24X.

[11] *See supra* note 3.

[12] *See* Warrant Program Release at 46438–46439.

[13] *See id.*

Measurement period	Non-voting common units	Percentage of outstanding total units on a fully diluted basis of 24X US Holdco as of September 29, 2025 (%)
October 14, 2025–December 31, 2025	219,608	2.00
January 1, 2026–March 31, 2026	82,353	0.75
April 1, 2026–June 30, 2026	82,353	0.75
July 1, 2026–September 30, 2026	82,353	0.75
October 1, 2026–December 31, 2026	82,353	0.75
January 1, 2027–March 31, 2027	137,255	1.25
April 1, 2027–June 30, 2027	137,255	1.25
July 1, 2027–September 30, 2027	137,255	1.25
October 1, 2027–December 31, 2027	137,255	1.25
Total	1,098,040	10

The Exchange proposes to also make the Additional Equity available for purchase by Participants upon the exercise of warrants that vest in accordance with the Program based on trading that occurs during the last four Measurement Periods of the existing Program (from and including January 1, 2027 through and including December 31, 2027) and also during two additional Measurement Periods that would begin on and including January 1, 2028 and end on and including June 30, 2028. The Additional Equity would consist of 2,759,103 Non-Voting Common Units representing 20% of the outstanding total Units on a fully diluted basis of 24X US Holdco as of September 29, 2025. The Additional Equity would be allocated among the above-mentioned Measurement Periods as follows:

Measurement period	Non-voting common units	Percentage of outstanding total units on a fully diluted basis of 24X US Holdco as of September 29, 2025 (%)
January 1, 2027–March 31, 2027	1,023,038	7.50
April 1, 2027–June 30, 2027	310,012	2.25
July 1, 2027–September 30, 2027	310,012	2.25
October 1, 2027–December 31, 2027	310,012	2.25
January 1, 2028–March 31, 2028	310,012	2.25
April 1, 2028–June 30, 2028	496,017	3.50
Total	2,759,103	20

The following table describes the overall number and allocation of Non-Voting Common Units that would be available for purchase by Participants in accordance with the proposed revised Program: [14]

Measurement period	Original equity non-voting common units	Additional equity non-voting common units	Combined original equity and additional equity non-voting common units	Combined Percentage of outstanding total units on a fully diluted basis of 24X US Holdco as of September 29, 2025 (%)
October 14, 2025–December 31, 2025	219,608	.....	219,608	1.60
January 1, 2026–March 31, 2026	82,353	.....	82,353	0.60
April 1, 2026–June 30, 2026	82,353	.....	82,353	0.60
July 1, 2026–September 30, 2026	82,353	.....	82,353	0.60
October 1, 2026–December 31, 2026	82,353	.....	82,353	0.60
January 1, 2027–March 31, 2027	137,255	1,023,038	1,160,293	8.50
April 1, 2027–June 30, 2027	137,255	310,012	447,267	3.25
July 1, 2027–September 30, 2027	137,255	310,012	447,267	3.25
October 1, 2027–December 31, 2027	137,255	310,012	447,267	3.25
January 1, 2028–March 31, 2028	.....	310,012	310,012	2.25

[14] Note that the Original Equity percentages of outstanding total Units on a fully diluted basis of 24X US Holdco as of September 29, 2025 are now reduced due to the dilutive effect of adding the Additional Equity Non-Voting Common Units to the Program.

Measurement period	Original equity non-voting common units	Additional equity non-voting common units	Combined original equity and additional equity non-voting common units	Combined Percentage of outstanding total units on a fully diluted basis of 24X US Holdco as of September 29, 2025 (%)
April 1, 2028–June 30, 2028	.....	496,017	496,017	3.50
Total	1,098,040	2,759,103	3,857,143	28.00

As described below, the Exchange proposes that depending on which Prepayment Fee they elect to pay, Participants of the Program may become eligible to earn either (i) the right to purchase both Original Equity and Additional Equity or (ii) the right to purchase Additional Equity only.

ii. Prepayment Fee

The Exchange proposes that current Participants of the Program who have already paid the $500,000 Prepayment Fee will be automatically eligible to earn the right to purchase Additional Equity for any Measurement Period in which the Program thresholds are met, as long as those Participants continue to meet the other Program eligibility requirements. The Exchange also proposes that any Participant who joins the Program after the proposed rule change goes into effect can either (i) prepay $500,000 in Exchange fees to become eligible to earn the right to purchase both Original Equity and Additional Equity, or (ii) prepay a reduced amount of $250,000 in Exchange fees to become eligible to earn the right to purchase Additional Equity only. The Prepayment Fee must be tendered by the first day of each quarter of the Program Period to participate in the Program as of such quarter until April 1, 2028.

The following are examples of the timing of participation in the Program:

- If Participant A joined the Program by tendering the $500,000 Prepayment Fee and executing the required documentation on October 14, 2025 (the date trading commenced on the Exchange), then Participant A's trading starting on October 14, 2025 would be counted toward the Target Volume for Year 1 and thereafter until the end of the Program Period. Participant A would be eligible to earn the right to purchase both Original Equity and Additional Equity for the entire Program Period.
- If Participant B joined the Program by tendering the $500,000 Prepayment Fee and executing the required documentation on October 22, 2026, then Participant B's trading starting on January 1, 2027 would be counted toward the Target Volume for the first quarter of Year 3 (*i.e.,* the first Measurement Period for Year 3) and thereafter until the end of the Program Period. Participant B would be eligible to earn the right to purchase both Original Equity and Additional Equity starting with the Measurement Period that begins on January 1, 2027 throughout the end of the Program Period.
- If Participant C joined the Program by tendering the $250,000 Prepayment Fee and executing the required documentation on October 22, 2026, then Participant C's trading starting on January 1, 2027 would be counted toward the Target Volume for the first quarter of Year 3 (*i.e.,* the first Measurement Period for Year 3) and thereafter until the end of the Program Period. Participant C would be eligible to earn the right to purchase Additional Equity only starting with the Measurement Period that begins on January 1, 2027 throughout the end of the Program Period.
- If Participant D joined the Program by tendering the $500,000 Prepayment Fee and executing the required documentation on October 1, 2027, then Participant D's trading starting on October 1, 2027 would be counted toward the Target Volume for the fourth quarter of Year 3 (*i.e.,* the last Measurement Period in Year 3) and the first quarter of Year 4 (*i.e.,* the only Measurement Period in Year 4). Participant D would be eligible to earn both the right to purchase Original Equity for the last Measurement Period in Year 3 and the right to purchase Additional Equity for the last Measurement Period in Year 3 and the only two Measurement Periods in Year 4. No Member may become a Participant that is eligible to earn Original Equity after October 1, 2027.
- If Participant E joined the Program by tendering the $250,000 Prepayment Fee and executing the required documentation on April 1, 2028, then Participant E's trading starting on April 1, 2028 would be counted toward the Target Volume for the second quarter of Year 4 (*i.e.,* the second Measurement Period in Year 4). Participant E would be eligible to earn the right to purchase Additional Equity for the second Measurement Period in Year 4. No Member may become a Participant after April 1, 2028.

All other terms regarding the Prepayment Fee would remain unchanged as described in the Warrant Program Releases.

iii. Target Volume Calculation

As described in the Warrant Program Release, the Target Volume that Participants must meet in order for their warrants to vest is 5% of the average daily trading volume on the Exchange, where the daily trading volume is calculated based on total aggregated average daily volume traded over each Measurement Period.[15] The Exchange proposes that with respect to Additional Equity only, Target Volume for each Measurement Period will be calculated based solely on Participants' maker volume (*i.e.,* trading volume which adds liquidity to the Exchange). Target Volume will continue to be calculated based on total trading volume with respect to Original Equity.

Pursuant to the Program requirements, the Non-Voting Common Units subject to the Program would be allocated among Participants who have met or outperformed the Target Volume during each Measurement Period on a pro rata basis based on volume contributions to the 24X market. As described in the Warrant Program Release, the volumes for each Participant are calculated for each of the Measurement Periods,[16] and the Non-Voting Common Units indicated are allocated among Participants after the end of each Measurement Period. With respect to Additional Equity only, the Exchange proposes to add two Measurement Periods during the first and second quarters of Year 4.

[15] *See* Warrant Program Release at 46439.

[16] The volume for the Exchange is also calculated for each of the Measurement Periods.

Therefore, the Non-Voting Common Units that would be available to be purchased for the first Measurement Period of Year 4 in accordance with the Program will be allocated among Participants that meet the Target Volume on or before April 5, 2028 and after March 31, 2028, based on trading during the first Measurement Period of Year 4, which is the quarterly period from January 1, 2028 through March 31, 2028. The Non-Voting Common Units that would be available to be purchased for the second Measurement Period of Year 4 in accordance with the Program will be allocated among Participants that meet the Target Volume on or before July 5, 2028 and after June 30, 2028, based on trading during the second Measurement Period of Year 4, which is the quarterly period from April 1, 2028 through June 30, 2028. All other terms regarding Target Volume would remain unchanged as described in the Warrant Program Releases.

b. Proposed Changes With Respect to Both Original Equity and Additional Equity

i. Elimination of 24X Minimum Overall Market Share Threshold

As described in the Warrant Program Releases, the 24X Minimum Overall Market Share is a designated target percentage of the CADV for all NMS Stocks eligible for trading on 24X for each relevant Measurement Period.[17] The CADV is calculated based on the volume reported by all exchanges and trade reporting facilities to a consolidated transaction reporting plan for the relevant Measurement Period.

In order to incentivize participation in the Program and bring greater volume and liquidity to the Exchange, the Exchange proposes to eliminate the 24X Minimum Overall Market Share requirement with respect to Original Equity, and to not implement a 24X Minimum Overall Market Share requirement with respect to Additional Equity. Elimination of the requirement would make Program outcomes more predictable for Participants because Exchange market share depends on the trading activity of all Members and on changes in overall U.S. equity market volume, rather than the individual actions of each Participant. By allowing Participants to determine whether their warrants will vest solely by choosing to meet the Target Volume and not having to rely on other factors outside their control, the proposed revised Program would both attract more new Participants and encourage existing Participants to increase the amount of liquidity they contribute to the Exchange. The Exchange also notes that another national securities exchange offers a warrant program that does not include an exchange market share threshold as a warrant vesting condition.[18]

ii. Exclusion of Dates

With respect to both Original Equity and Additional Equity, the Exchange also proposes to exclude the following dates from the calculation of the Target Volume that Participants must meet in each Measurement Period in order for their warrants to vest:

Date	Description
November 30, 2026	MSCI Index Rebalance.
December 11, 2026	Russell Index Reconstitution.
December 18, 2026	S&P 500, S&P MidCap 400, and S&P SmallCap 600 Quarterly Rebalances.
February 28, 2027	MSCI Index Rebalance.
March 19, 2027	S&P 500, S&P MidCap 400, and S&P SmallCap 600 Quarterly Rebalances.
May 27, 2027	MSCI Index Rebalance.
June 18, 2027	S&P 500, S&P MidCap 400, and S&P SmallCap 600 Quarterly Rebalances.
June 25, 2027	Russell Index Reconstitution.
August 31, 2027	MSCI Index Rebalance.
September 17, 2027	S&P 500, S&P MidCap 400, and S&P SmallCap 600 Quarterly Rebalances.
November 30, 2027	MSCI Index Rebalance.
December 10, 2027	Russell Index Reconstitution.
December 17, 2027	S&P 500, S&P MidCap 400, and S&P SmallCap 600 Quarterly Rebalances.
February 29, 2028	MSCI Index Rebalance.
March 17, 2028	S&P 500, S&P MidCap 400, and S&P SmallCap 600 Quarterly Rebalances.
May 31, 2028	MSCI Index Rebalance.
June 16, 2028	S&P 500, S&P MidCap 400, and S&P SmallCap 600 Quarterly Rebalances.
June 23, 2028	Russell Index Reconstitution.

On equivalent rebalance and reconstitution dates in the past, a significant percentage of consolidated trading volume has occurred during the closing auctions on the primary listing exchanges. Because these auction executions were not available to the Exchange or Program Participants, they artificially increased consolidated market volume while providing no realistic opportunity for Participants to increase trading volume on 24X. The Exchange therefore proposes to exclude the above dates from the calculation of Target Volume given that their inclusion would create a diluting effect that would make it more difficult for Participants to achieve Target Volume through ordinary trading activity.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Exchange Act[19] in general, and furthers the objectives of Section 6(b)(5) of the Exchange Act[20] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanisms of a free and open market and a national market system and, in general, to protect investors and the public interest. Additionally, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5) of the Exchange Act[21] requirement that the rules of an

[17] *See* Warrant Program Release at 46439.

[18] *See* Securities Exchange Act Rel. No. 105090 (Mar. 26, 2026), 91 FR 16044 (Mar. 31, 2026) (SR–TXSE–2026–003).

[19] 15 U.S.C. 78f.

[20] 15 U.S.C. 78f(b)(5).

[21] *See id.*

exchange not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers. The Exchange also believes the proposed rule change is consistent with Section 6(b)(4) of the Exchange Act,[22] which requires that Exchange rules provide for the equitable allocation of reasonable dues, fees and other charges among its members and other persons using its facilities.

The Exchange believes that the proposed changes to the Program are consistent with the Act. Making the Additional Equity available for purchase through the Program at a reduced Prepayment Fee and based on maker volume only would both encourage additional Participant enrollment in the Program, and encourage Participants to provide additional volume and liquidity to the Exchange. The Exchange believes that an increase in volume and liquidity would benefit all market participants by providing more trading opportunities and tighter spreads, even to those market participants that do not participate in the Program, thereby perfecting the mechanism for a free and open market and national market system.

Moreover, the elimination of the 24X Minimum Overall Market Share requirement and exclusion of certain dates from the calculation of Target Volume with respect to both Original Equity and Additional Equity would make it more likely that Participants' warrants would vest in any given Measurement Period. As described above, elimination of the 24X Minimum Overall Market Share requirement would allow Participants to have more control over whether their warrants vest in any given Measurement Period,[23] and exclusion of certain dates from the calculation of Target Volume would remove a potential diluting effect that otherwise would hamper Participants' ability to achieve Target Volume through ordinary trading activity. These incentives would promote the long-term interests of the Exchange by attracting new Participants and encouraging existing Participants to contribute to the growth and success of the Exchange via actively providing liquidity on the 24X market, and to provide additional investment and funding which could be used for the regulation and operation of the Exchange. The Exchange believes that the additional funds provided as a result of these changes would enable the Exchange to have greater capacity to carry out the purposes of the Act and to comply with the provisions of the Act, the rules and regulations thereunder, and the rules of the Exchange, which, in turn, would protect investors and the public interest.

The Exchange believes that the proposed changes are equitable and not unfairly discriminatory because all Participants may earn the right to purchase both Original Equity and Additional Equity on the same terms and conditions. The additional Measurement Period, Prepayment Fee schedule, and Target Volume modification with respect to Additional Equity are objective and the same for all Participants. Likewise, the elimination of the 24X Minimum Overall Market Share requirement and exclusion of certain dates from the calculation of Target Volume with respect to both Additional Equity and Original Equity are based on objective standards and would have the same effect for all Participants.

A Participant's total equity ownership of 24X US Holdco Units, including any purchased through the exercise of vested warrants via the Program, shall be subject to the ownership limitations of the 24X US Holdco LLC Agreement.[24] Accordingly, a Participant will not be able to exercise warrants for Non-Voting Common Units to the extent that such exercise would violate such ownership limitations.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Exchange Act. The Exchange believes that the Program as amended by this proposed rule change would increase both intermarket and intramarket competition by incentivizing Participants to add liquidity to the Exchange, which will enhance the quality of quoting and increase the volume of securities traded on the Exchange. To the extent that there is an additional competitive burden on non-Participants, the Exchange believes that such burden is appropriate because the Program should incentivize Participants to add liquidity to the Exchange and thus enhance the volume of securities traded on the Exchange. To the extent that this purpose is achieved, the Exchange believes that all of the Exchange's market participants would benefit from the improved market liquidity.

Given the robust competition for volume among equities markets, implementing a program to attract liquidity addition like the one proposed in this filing is consistent with the abovementioned goals of the Exchange Act. This is especially true for the smaller exchange markets, such as 24X, which are competing for volume with much larger exchanges that dominate the equities trading industry. As a new exchange, 24X will likely continue to have a nominal percentage of the average daily trading volume in equities in the near term, so it is unlikely that the Program could cause any competitive harm to the equities market or to market participants. Rather, the Program is a modest attempt to attract order volume away from larger competitors by adopting an innovative pricing strategy. The Exchange notes that if the Program results in a modest percentage increase in the average daily trading volume on 24X, while such percentage would represent a large volume increase for 24X, it would represent a minimal reduction in volume of its larger competitors in the industry. The Exchange believes that the Program will help further competition, because market participants will have yet another option in determining where to post liquidity if they factor the benefits of 24X equity participation into the determination.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A)[25] of the Act and subparagraph (f)(2) of Rule 19b-4 thereunder,[26] because it establishes a due, fee, or other charge imposed by the Exchange. At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the

[22] 15 U.S.C. 78f(b)(4).

[23] The proposed removal of the 24X Minimum Overall Market Share requirement is also consistent with the structure of the warrant program of another national securities exchange. *See supra* n. 18.

[24] *See, e.g.,* Section III of the 24X US Holdco LLC Agreement.

[25] 15 U.S.C. 78s(b)(3)(A).

[26] 17 CFR 240.19b–4(f)(2).

Commission shall institute proceedings under Section 19(b)(2)(B) [27] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–24X–2026–32 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–24X–2026–32. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the filing will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–24X–2026–32 and should be submitted on or before December 10, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[28]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23549 Filed 11–18–26; 8:45 am]

BILLING CODE 8011–01–P

[27] 15 U.S.C. 78s(b)(2)(B).

[28] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106908; File No. SR–ICC–2026–011]

Self-Regulatory Organizations; ICE Clear Credit LLC; Notice of Filing of Proposed Rule Change Relating to the Treasury Rules, Treasury Clearing Service Initial Margin Approach Model Description Document, Treasury Clearing Service Guaranty Fund and Stress Test Approach Model Description Document, and Treasury Clearing Service Risk Parameter Setting and Review Policy

November 16, 2026.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Securities Exchange Act'' or the ''Act''), 15 U.S.C. 78s(b)(1) and Rule 19b–4 thereunder, 17 CFR 240.19b–4, notice is hereby given that on November 3, 2026, ICE Clear Credit LLC (''ICC'' or ''ICE Clear Credit'') 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 primarily by ICC. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Clearing Agency's Statement of the Terms of Substance of the Proposed Rule Change

The principal purpose of the proposed rule change is to make revisions to ICC's Treasury Clearing Rules (''Treasury Rules'' or ''Rules'') and certain Treasury Clearing Service policies and procedures (''Treasury Risk Documentation''), including the Treasury Clearing Service Initial Margin Approach Model Description Document (''IM Approach Model Description''), Treasury Clearing Service Guaranty Fund and Stress Test Approach Model Description Document (''GF and Stress Test Approach Model Description''), and Treasury Clearing Service Risk Parameter Setting and Review Policy (''Risk Parameter Policy'').[1]

II. Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, ICC included statements concerning the purpose of and basis for the proposed rule change, security-based swap submission, or advance notice and discussed any comments it received on the proposed rule change, security-based swap submission, or advance notice. The text of these statements may be examined at the places specified in Item IV below. ICC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of these statements.

(A) Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

(a) Purpose

ICC proposes changes to the Treasury Rules and Treasury Risk Documentation. As background, ICC filed an application on Form CA–1 (''Application'') under Section 17A of the Securities Exchange Act of 1934 (the ''Act'') [2] with the Securities and Exchange Commission (''Commission'') to register as a clearing agency to provide central counterparty services for transactions involving U.S. Treasury (''Treasury'') securities on August 1, 2025. Notice of ICC's Application was published in the **Federal Register** on August 21, 2025.[3] The Application contained the Treasury Rules and certain other policies and procedures governing the Treasury Clearing Service, including the GF and Stress Test Approach Model Description, IM Approach Model Description, and Risk Parameter Policy. The Commission issued an order granting ICC's Application for registration as a clearing agency to provide central counterparty services for transactions involving Treasury securities on January 30, 2026.[4]

ICC proposes additional changes to the Treasury Rules and Treasury Risk Documentation to facilitate the clearing of Treasury repurchase and reverse repurchase (''repo'') contracts and to make additional clarifications. The proposed changes to the Treasury Rules (i) update and clarify the rules for Variation Payments, (ii) introduce a new margin and settlement model for eligible money funds (the ''Money Fund Margin Model'' or ''Fund Model''), (iii) expand the rules governing Treasury physical settlement to include triparty settlement, (iv) expand the contract terms applicable to repo contracts, and (v) make additional clarification or clean-up changes. The proposed

[1] ICC's Treasury Rules are available on ICC's public website: *https://www.ice.com/publicdocs/clear_credit/ICE_Clear_Credit_Treasury_Clearing_Rules.pdf.* Capitalized terms used but not defined herein have the meanings specified in the Treasury Rules.

[2] 15 U.S.C. 78q–1.

[3] *See* Securities Exchange Act Release No. 103727 (August 18, 2025), 90 FR 40879 (August 21, 2025) (File No. 600–45).

[4] *See* Securities Exchange Act Release No. 104762 (January 30, 2026), 91 FR 5528 (February 6, 2026) (File No. 600–45).

changes to the Treasury Risk Documentation provide detail on ICC's risk management approach for repo contracts and make general clarifications throughout the documentation. ICC believes that such revisions will facilitate the prompt and accurate clearance and settlement of securities transactions. ICC proposes to make such changes effective following Commission approval of the proposed rule change. The proposed revisions are described in detail as follows.

Treasury Rulebook Changes

Variation Payments

ICC proposes revising Rule 404 to update and clarify the rules for calculating Variation Payments. The proposed amendments expand the definition of Variation Payment in paragraph (a) to include additional payment types and clarify that Variation Payment calculations may differ for contracts subject to the different Treasury physical settlement provisions in Chapters 22 through 24.

ICC proposes to introduce new defined terms and revise certain existing defined terms in Rule 404. A new defined term, Variation Payment Cycle, is introduced in Rule 404(a)(i) referring to each time as of which ICC determines Variation Payment Requirements.[5] The definition of Variation Payment Requirement would be revised in Rule 404(a)(ii) to refer to the Variation Payment Cycle. As amended, a Treasury Participant's Variation Payment Requirement for a margin category (''Variation Payment Category'') for a Variation Payment Cycle would be the net sum of applicable components, further described below. The revised definition of Variation Payment Requirement also lists specific components that may be included in the variation calculation, depending on the particular contract and manner of settlement. ICC also proposes to specify in Rule 404(a) which Variation Payment-related amounts are expressed as negative or positive values.

ICC proposes to rename Mark-to-Market Price to Mark-to-Market Amount in Rule 404(b) and provide additional detail on such calculation. Currently, Mark-to-Market Price generally refers to a price determined by ICC pursuant to its procedures. The revised definition provides greater specificity. The Mark-to-Market Amount for an open position means the difference between the position's current value and the value of the position determined by reference to the price, rate and other economic terms agreed by the original parties to the trade.

Pursuant to Rule 404(b), for a repo contract, Mark-to-Market Amount would consist of three components capturing the change in value of the repo contract attributable to (i) the change in value of the Purchased Securities[6] (''MTM Collateral Component''); (ii) the prevailing spot repo rate applicable to that repo contract and the remaining term thereof (''MTM Spot Repo Rate Component''); and (iii) the forward repo rate specified in the repo contract and the prevailing repo rate determined by ICC for comparable collateral and residual tenor (''MTM Forward Repo Rate Component''). Additional provisions clarify when such components apply. For example, Rule 404(b)(iv) provides that, in respect of a spot contract,[7] only the MTM Collateral Component applies, because a spot contract does not involve a repurchase contract for which repo rates that would be captured in the MTM Spot Repo Rate Component or the MTM Forward Repo Rate Component are relevant.

ICC proposes MTM Change Payments as a new defined term in Rule 404(c) to refer to the net amount of the Mark-to-Market Amount as of the current Variation Payment Cycle less the Mark-to-Market Amount as of the immediately preceding Variation Payment Cycle. Under Rule 404(c)(i), for the first Variation Payment Cycle for a position, the Mark-to-Market Amount as of the immediately preceding Variation Payment Cycle will be zero, as no Mark-to-Market Amount has previously been determined for that position (and as a result the first MTM Change Payment for that position will equal the full current Mark-to-Market Amount). Each MTM Change Payment transfer would constitute a settlement of the Mark-to-Market Amount, as further described in Rule 404(c)(ii) and (iii).

Rule 404(d) would introduce Price Alignment Amount Payments, calculated using a Price Alignment Rate that is defined as the overnight interest rate determined by ICC for the relevant currency. The Price Alignment Amount Payment means the amount determined by ICC on each Variation Payment Cycle by applying the Price Alignment Rate to the cumulative MTM Change Payments of that Treasury Participant for that Variation Payment Category, as set out in further detail in Rule 404(d). As specified in Rule 404(d)(iii), Price Alignment Amount Payments are determined and settled to account for the funding effect of settling Mark-to-Market Amounts under Rule 404(c), so that the pricing of contracts cleared by ICC is not distorted by reason of such settlement relative to equivalent transactions that are not cleared.

ICC proposes to define Coupon Adjustment Payments and Redemption Adjustment Payments in Rules 404(e) and (f), respectively. ICC would determine a Coupon Adjustment Payment where a coupon or other periodic distribution is paid in respect of Purchased Securities during the term of a repo contract in an amount equal to that coupon or distribution. ICC would determine a Redemption Adjustment Payment where Purchased Securities are redeemed at maturity during the term of a repo contract in an amount equal to the redemption proceeds of those Purchased Securities. Amended Rule 404(g) would revise the definition of Transaction Adjustment Payment, which would reflect the difference between the relevant transaction price and the current ICC Settlement Price.[8]

Additional variation payment provisions are added in Rules 404(h) through (l). Where a settlement obligation is not settled on its scheduled settlement date and the related obligations constitute a fail position, ICC would determine a Fail Settlement Adjustment Payment under paragraph (h) in order to preserve the original economic terms of the failed delivery or receipt obligation. A Fail Charge Payment, as specified in paragraph (i), would be determined under existing Treasury Rule 2205, in the case of certain failures in DVP settlement. Miscellaneous Adjustment Payments would be defined in paragraph (j) as any other amount payable by or to a Treasury Participant for contracts settled through Variation Payments. ICC would maintain a record of the Variation Payment balance of each Treasury Participant for each Variation Payment Category, as specified in paragraph (k). In paragraph (l), ICC would clarify that Variation Payments described in Rule 404 constitute final settlements.

[5] ICC would determine and settle Variation Payments as of the start of each ICE Business Day. An ICE Business Day refers to any day (other than Saturdays, Sundays and holidays observed by ICC) on which ICC is open for business for the Treasury Clearing Service pursuant to Rule 101.

[6] *See infra* note 22.

[7] Each spot contract consists of an agreement by one party to purchase from another party a specified principal amount of an identified Treasury security for an agreed purchase price, for settlement on the next ICC Settlement Day.

[8] *See* amended Rule 2201. ICC proposes to more generally define ICC Settlement Price as the price for a security as determined by ICC.

Money Fund Margin Model

ICC proposes to amend the Treasury Rules to introduce the Money Fund Margin Model, which is intended to facilitate access for registered funds to participate in the Treasury Clearing Service. ICC proposes to adopt a new Treasury Rule 411 to introduce a new margin model. ICC designed this Money Fund Margin Model to be consistent with applicable regulatory requirements for registered funds under the Investment Company Act of 1940,[9] including the full collateralization requirements for repos by registered funds pursuant to Rule 5b–3 and related existing market practices for repos by registered funds.[10] To facilitate participation by registered funds in the Treasury Clearing Service, the Money Fund Margin Model makes certain modifications to the standard margin model applicable to other market participants. Additional details are described below.

Under new Treasury Rule 411(a), ICC may, on written request of a Non-Participant Party (*i.e.,* a customer of a Treasury Participant) that is an Eligible Money Fund, permit such Eligible Money Fund to comply with the Money Fund Margin Model with respect to Eligible Money Fund Transactions (such an Eligible Money Fund, a ''Covered Money Fund'').

New Treasury Rule 411(b) sets out key defined terms applicable to the Money Fund Margin Model. Such terms include Eligible Money Fund, defined as an investment company registered under the Investment Company Act of 1940 [11] and such other types of investment funds as ICC may permit; Eligible Money Fund Transactions, which are eligible repo contracts in which the Covered Money Fund is acting as the Repo Buyer; [12] and Money Fund Custodial Account, which is an account in the name of the Covered Money Fund at a triparty bank acceptable to ICC (the ''Money Fund Custody Bank'').

Rule 411(c) through (l) set out additional legal, risk, operational, and default management provisions for the Money Fund Margin Model, as follows.

- Paragraph (c) describes how an Eligible Money Fund may be designated as a Covered Money Fund. Each Covered Money Fund must enter into an agreement with ICC in such form designated by ICC.
- Paragraph (d) requires each Covered Money Fund to establish a Money Fund Custodial Account, subject to an agreement entered into by the Covered Money Fund, the Money Fund Custody Bank, ICC, and such other persons as ICC may designate.
- Paragraph (e) requires each Eligible Money Fund Transaction to specify an initial haircut (the ''Initial Haircut'') agreed between the Covered Money Fund and its original counterparty (the ''Original Counterparty'').
- Paragraph (f) describes the settlement of the delivery of the Purchased Securities to and from the Money Fund Custodial Account.
- Paragraph (g) restricts a Covered Money Fund generally from transferring, using, rehypothecating or otherwise disposing of any securities transferred to or credited to the Money Fund Custodial Account.
- Paragraph (h) provides for a first priority lien and security interest granted by each Covered Money Fund to ICC in (i) its Money Fund Custodial Account, (ii) the Purchased Securities transferred to such Covered Money Fund, (iii) all securities, financial assets, cash and other property that may be transferred, credited to, or held in the Money Fund Custodial Account, and (iv) all cash or non-cash proceeds of any of the foregoing (collectively, the ''Money Fund Account Collateral''), to secure the obligations in favor of ICC.
- In light of the security interest provided under paragraph (h), paragraph (i) provides generally that neither the Covered Money Fund nor its Treasury Participant is obligated to provide Initial Margin (''IM'') or Variation Payments, and ICC is not obligated to provide Variation Payments.
- Paragraph (j) describes how, upon authorization and direction from the Covered Money Fund and its Treasury Participant, ICC effects settlement of the Final Leg of an Eligible Money Fund Transaction by instructing the Money Fund Custody Bank to transfer the relevant securities from the Money Fund Custodial Account against payment of the applicable cash amount.
- Paragraph (k) provides that the Covered Money Fund is obligated as principal for the performance of its settlement obligations to ICC and the Covered Money Fund's Treasury Participant is not obligated to ICC to perform such obligations. For the avoidance of doubt, Eligible Money Fund Transactions of a Covered Money Fund are considered Client-Related Positions of that Covered Money Fund's Treasury Participant (subject to the provisions in Rule 411), and accordingly are taken into account in determining the Treasury Participant's Treasury Guaranty Fund (''GF'') requirements.[13] This provision also sets out when ICC's obligations to the Treasury Participant and Covered Money Fund in respect of settlement obligations are discharged.
- Paragraph (l) sets out default management provisions and corresponding default management actions to be taken by relevant parties, including in the case of a client default with respect to a Covered Money Fund, a default of the Covered Money Fund's Treasury Participant, and a default of the Original Counterparty or its Treasury Participant. In the case of a client default with respect to a Covered Money Fund, ICC manages such default with respect to any Eligible Money Fund Transactions and is entitled to apply the Money Fund Account Collateral to the settlement obligations of the Covered Money Fund (against payment of any amount owed to the Covered Money Fund in respect of such settlement). In the case of a default of the Covered Money Fund's Treasury Participant, ICC may, to the extent it is legally permitted and otherwise feasible to do so on a timely basis, apply the Money Fund Account Collateral to the settlement obligations of the Covered Money Fund in respect of Eligible Money Fund Transactions as and when they become due (against payment of any amount owed by ICC to the Covered Money Fund in respect of such settlement). Otherwise, ICC may terminate the Eligible Money Fund Transactions of the Covered Money Fund in accordance with the Rules applicable to client positions of the defaulting Treasury Participant and determine the net cash amount owed in respect thereof by the Covered Money Fund or ICC. In the case of a default of the Original Counterparty (or its Treasury Participant), upon receiving notice from ICC, the Covered Money Fund may, to the extent permitted by applicable law on a timely basis, elect to terminate its Eligible Money Fund Transactions, in which case (i) the corresponding transaction between ICC and the Original Counterparty will simultaneously terminate, (ii) the Covered Money Fund will be entitled to

[9] 15 U.S.C. 80a–1.

[10] 17 CFR 270.5b–3.

[11] 15 U.S.C. 80a–1.

[12] Repo Buyer is defined in existing Rule 30B–02(a). Each repo contract consists of (i) an initial obligation (the ''Initial Leg'') of one party (the ''Repo Buyer'') to purchase from another party (the ''Repo Seller'') a specified principal amount of Treasury securities for an agreed purchase price on an initial settlement date and (ii) an obligation on a later settlement date of the Repo Seller to repurchase the same principal amount of Treasury securities for a defined repurchase price.

[13] Since Eligible Money Fund Transactions of a Covered Money Fund are considered Client-Related Positions, the portability rules in Chapter 20A also apply to Covered Money Fund transactions.

withdraw the Money Fund Account Collateral, (iii) ICC will have no further obligation in favor of the Covered Money Fund or its Treasury Participant in respect of the Eligible Money Fund Transactions, and (iv) ICC will have no further obligation to the Original Counterparty (or its Treasury Participant) in respect of the Eligible Money Fund Transactions. If the Covered Money Fund does not timely make such election, ICC may terminate the Eligible Money Fund Transactions of the Covered Money Fund and determine the net cash amount owed by the Covered Money Fund or ICC. In such case, ICC may liquidate the Money Fund Account Collateral of such Covered Money Fund. ICC may apply such collateral or the proceeds thereof to any amount owed in respect of such termination.

Treasury Physical Settlement

ICC proposes to expand its Treasury physical settlement rules by amending existing Chapter 22 and introducing new Chapters 23 and 24.[14] Amended Chapter 22 would govern DVP physical settlement and would be renamed from ''Treasury Physical Settlement'' to ''Treasury DVP Physical Settlement.'' In general, DVP physical settlement refers to a settlement mechanism around the delivery of securities against payment. The proposed amendments add a ''DVP'' prefix to certain terms throughout Chapter 22, including Delivery Failure, Fail Charge, Net Settlement Obligation, Settlement Instructions, and Settlement Payment Failure.

In addition, ICC proposes to revise Rule 2201 by replacing cross-referenced definitions of Delivering Party and Receiving Party with standalone definitions. The definitions of deliver or delivery obligation and receive obligation would also be updated to refer generally to ''an account'' in Rule 2201. Further revisions include clarifying that a Settling Fail Position [15] is designated by ICC and updating the cross-reference in Rule 2205 to refer generally to the applicable Rules. ICC also proposes amendments to Rules 2202, 2203, and 2204 to clarify that such provisions apply to Settling Open Positions [16] and Settling Fail Positions subject to DVP physical settlement. In addition, the amendments state that determinations under these rules may be made on a same-day settlement basis. These revisions are intended to reflect that for certain transactions, as specified in the relevant terms, the initial leg of the repo may be settled on a same-day basis through ICC. In Chapter 22, ICC proposes updating references to ''ICE Business Day'' and ''ICC Settlement Day'', as appropriate,[17] to reflect that an ICC Settlement Day is an ICE Business Day on which ICC is open for settlement of transactions in Treasury securities, whereas an ICE Business Day is any day on which ICC is open for business for the Treasury Clearing Service.[18]

ICC proposes new Chapter 23, titled ''Treasury Standard Triparty Settlement'' which would govern transactions designated under the Rules for standard triparty settlement. While largely mirroring the structure of Chapter 22, Chapter 23 would establish a framework for triparty settlement of cleared repo transactions through a designated Triparty Bank. As noted above, in general, DVP physical settlement refers to a settlement mechanism providing for the delivery of securities to the account of the receiving party at its custodian against payment (without any restriction on the use of such securities by the receiving party). In contrast, triparty settlement is affected through accounts of both relevant parties at a designated Triparty Bank, which facilitates the settlement of deliveries and payments, on terms in which securities are generally not removed from the Triparty Bank absent a default by a relevant party. New Rule 2301 introduces key definitions, including Triparty Bank, the bank ICC designates to establish triparty accounts; Triparty Settlement Accounts, which include any of the CP House, CP Client, or Individual Client Triparty Settlement Accounts; [19] ICC Triparty Settlement Account, which is an account maintained by ICC at the Triparty Bank; and Triparty Settlement Obligation, which refers to a gross or net settlement obligation to deliver or receive Eligible Triparty Securities.[20]

Rule 2302 sets out the methodology for calculating Triparty Settlement Obligations for Settling Open Positions subject to net triparty settlement. Based on the Required Securities Value [21] for applicable positions, ICC would calculate deliver and receive obligations, as set out in paragraphs (a)(i) through (v), for applicable triparty accounts on a net basis. In contrast, Rule 2303 governs Triparty Settlement Obligations subject to gross triparty settlement. Rule 2303(c) describes how ICC would calculate Triparty Settlement Obligations with respect to Settling Open Positions subject to gross triparty settlement in paragraphs (c)(i) through (iii). The difference in drafting between Rule 2302(a) and 2303(c) reflects the distinction between net triparty settlement and gross triparty settlement. ICC would determine if a transaction is subject to net or gross triparty settlement based on the instrument transaction type as set out in Chapter 30 of the Rules and the terms submitted for clearing. For open positions subject to gross triparty settlement, ICC maintains a record associating each such position with the offsetting counter position and Original Counterparty. Treasury Participants and Non-Participant Parties, as applicable, would be required to maintain separate Triparty Settlement Accounts for each house origin or Non-Participant Party portfolio for each counterparty pairing (a ''Counterparty Relationship'') subject to gross triparty settlement. ICC would calculate deliver and receive obligations based on positions subject to gross triparty settlement on a gross basis per Counterparty Relationship. Rule 2303(c)(iii) further clarifies that ICC will not net a deliver obligation for one Counterparty Relationship against a receive obligation for another.

Rule 2304 establishes the mechanics applicable to Triparty Settlement Obligations, which are structured in two

[14] ICC determines whether a cleared transaction is subject to Delivery versus Payment (''DVP'') physical settlement or triparty settlement based on the instrument transaction type, as set forth in Chapter 30 of the Rules and the terms of the transaction as submitted for clearing.

[15] Settling Fail Position refers to an unsettled fail position in a settling security. *See* Treasury Rule 2201.

[16] Settling Open Position refers to an open Treasury position that provides for delivery or receipt of a Treasury security on such day. *See* Treasury Rule 2201.

[17] For the avoidance of doubt, there may be days on which ICC's Treasury Clearing Service is open (and thus are ICE Business Days), but on which ICC would not settle transactions consistent with market practice (*e.g.,* Veterans Day and Columbus Day).

[18] For example, in Rules 2202(d) and 2203(e), ICC proposes to change ''preceding ICC Settlement Day'' to ''preceding ICE Business Day'' for purposes of determinations made following the close of business, as such determinations may be made on a day on which ICC is open for business. In Rules 2205(a) and 2206(a), ICC proposes to change ''ICE Business Day'' to ''ICC Settlement Day'' in relation to DVP Net Settlement Obligations.

[19] CP House Triparty Settlement Account and CP Client Triparty Settlement Account refer to accounts established by the Treasury Participant with the Triparty Bank for settlement in respect of house positions and client-related positions, respectively. Individual Client Triparty Settlement Account refers to an account established by a Non-Participant Party of a Treasury Participant at the Triparty Bank for direct settlement in respect of client-related positions.

[20] ICC proposes to define Eligible Triparty Securities in proposed Rule 30B–10 as securities that satisfy ICC's eligibility criteria.

[21] The Required Securities Value is defined in proposed Rule 30B–10(e) as an amount determined by ICC based on the Triparty Repo Cash Amount (*i.e.,* the purchase price of the Initial Leg) and the initial haircut for that repo contract.

''legs'', through facilities operated by the Triparty Bank (''Triparty Facilities''). Under Triparty Settlement Leg 1, the Delivering Party delivers securities to the ICC Triparty Settlement Account and receives the applicable repurchase price from ICC. Under Triparty Settlement Leg 2, ICC delivers securities to the Receiving Party and receives the corresponding amount. This Rule also permits, with consent from ICC and the relevant Treasury Participant, the use of Individual Client Triparty Settlement Accounts for Non-Participant Parties for standard triparty settlement, and clarifies that ICC bears no responsibility for any default, failure, delay or unavailability affecting the Triparty Bank or Triparty Facilities.

Rules 2305 and 2306 set out provisions that apply in the case of a failure to perform a Triparty Settlement Leg. Treasury Rule 2305 addresses a Triparty Delivery Deficiency, which occurs when a Delivering Party fails to transfer required securities under Triparty Settlement Leg 1, and sets out the actions that ICC may take in response. These actions are set out in paragraphs (a)(i) through (vi) and include, among other things, directing the Triparty Bank to allocate available Eligible Triparty Securities toward curing the deficiency, imposing a late fee and requiring the failing party to reimburse ICC for any costs or expenses resulting from the failure. Pursuant to Rule 2305(b), ICC generally has no obligation to acquire any security to satisfy any Triparty Settlement Obligation. Rule 2305(c) also provides that ICC may in its discretion determine to settle the Triparty Settlement Leg 2 notwithstanding the failure by the Delivering Party, in which case the Delivering Party must pay ICC any losses, costs or expenses incurred in such settlement. Pursuant to Rule 2305(c), ICC may acquire or borrow the relevant securities at a price and on such terms as it determines appropriate. Rule 2306 addresses a Triparty Settlement Payment Failure, which occurs when a Receiving Party fails to make the required payment under Triparty Settlement Leg 2, and sets out the actions that ICC may take in response. These actions are set out in further detail in paragraphs (a)(i) and (ii) and include, among other things, determining to settle Triparty Settlement Leg 1 notwithstanding the failure (in which case the Receiving Party must pay ICC any losses, costs or expenses incurred in such settlement) or terminating the Triparty Settlement Obligation (including both settlement legs thereof) and providing for cash settlement in lieu thereof. In case of a failure by a Delivering or Receiving Party, ICC retains the right to determine that the relevant party (or its Treasury Participant) is in Default and exercise its default remedies under the Rules.

ICC proposes new Chapter 24, titled ''Fund Model Triparty Settlement,'' which applies only to transactions involving Covered Money Funds under the Money Fund Margin Model as described above and provides for triparty settlement of relevant delivery and receive obligations through a designated Triparty Bank. Rule 2401 introduces relevant definitions, including Covered Money Fund Settlement Account, which refers to the Money Fund Custodial Account established at the Triparty Bank for direct settlement, and the Fund Model Settlement Account, which includes any of the Covered Money Fund Settlement Account or the CP House, CP Client, or Individual Client Triparty Settlement Accounts.

Rule 2402 sets out the calculation of Fund Model Settlement Obligations. To facilitate this calculation, ICC would maintain a record associating each open position in an Eligible Money Fund Transaction with its offsetting counter position and Original Counterparty. Further, each Covered Money Fund would maintain a single Covered Money Fund Settlement Account with separate sub-accounts for each Original Counterparty (a ''Money Fund Counterparty Relationship''). ICC would calculate Fund Model Settlement Obligations with respect to Settling Open Positions subject to Fund Model triparty settlement for each Money Fund Counterparty Relationship for applicable Eligible Triparty Securities, as detailed in Rule 2402(c). ICC would not net any delivery obligation in respect of a Fund Model Settlement Obligation against any receive obligation. This is consistent with the design of the Fund Model and preserves the association between positions in Eligible Money Fund Transactions, their offsetting counter positions and Original Counterparties, as well as the separate sub-account structure maintained for each Original Counterparty. Unlike Rule 2303(e), Rule 2402(e) provides that ICC makes determinations in Rule 2402 following the close of business on the preceding ICE Business Day and does not provide that determinations may be made on a same-day settlement basis. This is because, under the Fund Model, the initial leg is not settled through ICC.

Rule 2403 governs the settlement of Fund Model Settlement Obligations and generally follows the triparty settlement framework proposed in Chapter 23. A Fund Model Settlement Obligation in securities between two Fund Model Settlement Accounts would require the Delivering Party to deliver securities to the Receiving Party, and the Receiving Party would pay the applicable repurchase price to the Delivering Party (the ''Fund Model Settlement Payment'') through the Triparty Facilities. Fund Model Settlement would occur directly between the Delivering Party's and Receiving Party's accounts at the Triparty Bank (and not through an account of ICC). Rule 2403 also specifies the responsibility for settlement obligations among Treasury Participants and Covered Money Funds. Under this Rule, ICC has no responsibility for any default, failure, delay, or unavailability by or affecting the Triparty Bank or Triparty Facilities.

Rule 2405 addresses Triparty Settlement Payment Failure under the Fund Model. Pursuant to paragraph (a), where the Original Counterparty, as Receiving Party, fails to pay the Fund Model Settlement Payment by the deadline (a ''Triparty Settlement Payment Failure''), ICC may determine to proceed with settlement notwithstanding the failure, in which case the Receiving Party would be obligated to pay ICC for any resulting losses, costs and expenses. This provision would not apply if ICC had otherwise determined the Receiving Party or its Treasury Participant in default, in which case the default provisions of Rule 411 as described above or other applicable ICC default rules would apply instead.

Repo Contract Terms

ICC proposes amendments to Chapter 30, which describes Treasury contracts that ICC may clear. With respect to spot contracts under Rule 30A–02, ICC proposes to clarify that it may establish and publish on its website categories of spot contracts accepted for clearing. ICC also proposes new Rule 30A–03 to provide that spot contracts are subject to DVP physical settlement. Spot contracts are subject to DVP physical settlement, consistent with market practice, because triparty settlement is designed to support repo contracts and generally does not support spot contracts. ICC proposes additional revisions in Subchapter 30B governing Treasury repo contracts. ICC proposes to retitle Rule 30B–02 from ''Repurchase Contract Terms'' to ''General Repurchase Contract Terms'' to clarify that this Rule sets forth general terms for repo contracts. ICC would introduce and clarify certain defined terms relevant to repo contracts, including Purchased Securities, Initial Settlement Date, Final

Leg, and Final Settlement Date.[22] Amended Rule 30B–02 would clarify that the Initial Leg for certain repo contracts may be settled under the Rules, replace a generic reference to ''settlement date'' with the defined term ''Final Settlement Date,'' and add references to ICC procedures. This Rule would also specify additional types of repo contracts that ICC may choose to clear, including specified term, extendable and evergreen repo contracts.

ICC would also expand Rule 30B–02 to address certain additional features of repo transactions. Paragraph (f) would describe the treatment of coupons, income, or other distributions received with respect to the Purchased Securities, paragraph (g) would establish how repurchase prices are determined (*e.g.,* as a fixed price or through a specified repo pricing rate applied to the purchase price), and paragraph (h) would permit repo contracts to specify an initial haircut with respect to the value of the purchased securities. Amended paragraph (i) provides that ICC would establish and publish on its website the specific categories of repo contracts accepted for clearing.

Rules 30B–03 through –06 describe the characteristics of particular types of repo contracts that ICC may choose to clear. ICC will not be obligated to accept any particular type of repo contract for clearing unless it has specified such type on its website as described above. Rule 30B–03 would define overnight repo as a repo contract maturing one ICC Settlement Day following the Initial Settlement Date. Rule 30B–04 would define a term repo as a repo contract with a Final Settlement Date more than one ICC Settlement Day following the Initial Settlement Date. Rule 30B–05 would introduce variable maturity repos, including term repos with put/call features, extendable repos, and evergreen repos, each of which permits adjustment or extension of the Final Settlement Date under specified conditions. Rule 30B–06 would define open repos as repo contracts that do not initially specify a Final Settlement Date but for which ICC or the Treasury Participant may designate the Final Settlement Date by notice. Each of these types of repo contracts may involve Specific Collateral or General Collateral, as defined below.

Rule 30B–07 would define Specific Collateral Repos as repo contracts involving Purchased Securities that are designated to be a particular issue of Treasury security with a specific CUSIP, such that only securities of that CUSIP may be delivered. These contracts would be subject to DVP physical settlement.[23] Rule 30B–08 would define General Collateral Repos as repo contracts where the Purchased Securities may consist of any eligible Treasury security within a defined pool of securities associated with a generic CUSIP or other identifier. General Collateral Repos could be settled through DVP physical settlement, standard triparty settlement on either a gross or net basis, or, in the case of Eligible Money Fund Transactions involving Covered Money Funds, through Fund Model triparty settlement.

ICC additionally proposes Rule 30B–09, which would permit a Repo Seller to substitute eligible Treasury securities for the outstanding Purchased Securities under the repo contract. For DVP-settled repo contracts, substitutions would be permitted for the Repo Seller during a specified period,[24] subject to ICC's consent. For repo contracts subject to standard triparty settlement or Fund Model triparty settlement, substitutions would be permitted as, and to the extent, permitted under the terms of the Triparty Facilities and provided that applicable collateral value requirements are satisfied. Rule 30B–09 would also permit ICC to accelerate the termination of a repo contract if the Purchased Securities are redeemed and not substituted with other eligible securities.

ICC proposes new Rule 30B–10 describing repo contracts subject to standard triparty settlement or Fund Model triparty settlement (''Triparty Settlement Contracts''). This Rule would define key terms, including Eligible Triparty Securities; [25] Triparty Margin Percentage, which is the percentage by which the securities' market value is discounted to determine the Triparty Securities Value; Triparty Securities Value, which is defined as the aggregate value of Eligible Triparty Securities allocated to a Triparty Settlement Contract; and the Triparty Repo Cash Amount and Required Securities Value.[26] Rule 30B–10 would also specify that the amount and identity of the Purchased Securities allocated to a Triparty Settlement Contract may change during its term through the Triparty Facilities. Further, on each ICC Settlement Day, ICC would compare the Triparty Securities Value of the Eligible Triparty Securities in respect of a Triparty Settlement Contract with the Required Securities Value, and Eligible Triparty Securities will be transferred through the Triparty Facilities to eliminate any difference between such amounts. This Rule would provide that coupon payments, income, redemptions, and other distributions paid on Eligible Triparty Securities would be credited through the Triparty Facilities, and would authorize ICC to establish and publish categories of Treasury securities that constitute Eligible Triparty Securities, the applicable Triparty Margin Percentage, as well as concentration limits. In addition, ICC would not transfer, use, rehypothecate, or otherwise dispose of Eligible Triparty Securities credited to an ICC Triparty Settlement Account, except in limited circumstances.

Additional Clarification or Clean-Up Changes

ICC proposes additional clarification or clean-up changes throughout the Rules. Such changes are intended for clarity and consistency and include the following:

- Clarifying that ''Defaulting Treasury Participant'' is synonymous with ''Defaulting Participant'' in Rules 101 and 20–605;
- Updating defined terms throughout the Rules for consistency, including changing ''Mark-to-Market Price'' to ''Mark-to-Market Amount'' and changing ''Customer IM Account'' to ''Client IM Account'';
- Clarifying that a reference to a ''Participant'' refers to ''Treasury Participant'' throughout the Rules;
- Updating ''Risk Committee Reconstruction Date'' to refer to ''Risk Committee Reconstitution Date'' to align with the term in Rule 503;
- Updating cross-references, including in Rules 101 and 316, to reference applicable provisions;
- Replacing ''Parts'' with ''Chapters'', and adding references to new Chapters, Rules, or defined terms (*e.g.,* adding and

[22] Each repo contract would consist of (i) an initial obligation (the ''Initial Leg'') of one party (the ''Repo Buyer'') to purchase from another party (the ''Repo Seller'') a specified principal amount or value of Treasury securities (the ''Purchased Securities'') for an agreed cash purchase price on an initial settlement date (the ''Initial Settlement Date''); and (ii) an obligation (the ''Final Leg'') on a later settlement date (the ''Final Settlement Date'') of the Repo Seller to repurchase the same principal amount or value of Treasury securities for a defined cash repurchase price (taking into account the initial purchase price and an agreed pricing rate).

[23] For the avoidance of doubt, because Eligible Money Fund Transactions of a Covered Money Fund are subject to Fund Model triparty settlement (see proposed Rule 30B–08(c)), they cannot be Specific Collateral Repos.

[24] Such period refers to the period commencing with the ICC Settlement Day following the completion of the on-leg settlement or novation to ICC, whichever is later, and ending with the ICC Settlement Day prior to the final settlement date.

[25] *See supra* note 20.

[26] *See supra* note 21.

updating references to DVP and triparty terminology) throughout the Rules; and

• Minor grammatical changes, including correcting capitalizations and minor typographical errors.

Treasury Risk Documentation

ICC's risk management practices for the Treasury Clearing Service are documented in various policies and procedures, including the IM Approach Model Description, the GF and Stress Test Approach Model Description, and Risk Parameter Policy. The IM Approach Model Description sets forth the quantitative risk models and associated methods and techniques used to estimate IM requirements for cleared portfolios of Treasury-related instruments. The GF and Stress Test Approach Model Description describes the general stress testing framework for GF computations developed by ICC for the Treasury Clearing Service and used for financial resources modeling and GF design. The Risk Parameter Policy describes the process of setting and reviewing the risk management model core parameters and their underlying assumptions for the Treasury Clearing Service, as described in the IM Approach Model Description and the GF and Stress Test Approach Model Description.[27] ICC proposes changes to the Treasury Risk Documentation to reflect ICC's risk management approach for repo contracts as well as to make clarifications throughout the documentation.

IM Approach Model Description

As set out in the IM Approach Model Description, ICC's risk management modeling approach features computations of statistical IM risk measures and add-on requirements. The IM Approach Model Description remains substantively the same under the proposed changes. ICC's risk management model for the Treasury Clearing Service continues to include a statistically calibrated U.S. interest rate (''IR'') dynamics component and liquidation risk add-ons. The IR dynamics component continues to be the main component of the total portfolio IM requirements, which provides collateralization of potential losses in response to mark-to-market changes. The liquidation risk add-on components continue to capture the losses associated with the liquidation process of cleared portfolios, informed from adverse effects of market frictions encountered during major market events.

The proposed changes further reflect ICC's risk management approach for repo transactions and make certain general clarifications (*i.e.,* not repo-specific) throughout the document. ICC proposes to amend Section I, which describes the IM methodology, to add references to repo contracts and related terminology. The proposed changes add triparty and bilateral repo financing rates to the list of IR term structures considered in ICC's methodology. ICC proposes language describing repo contracts and how such contracts are represented in ICC's risk management approach, including in terms of exposure and key terms and features relevant to the IM methodology. In addition, ICC proposes general clarifications, noting that the risk measure used for establishing certain IM requirements is augmented with correlation breakdown and anti-procyclicality components and that the liquidation risk add-ons feature liquidity charge and concentration charge components.

ICC proposes additional changes in Section I.1, which introduces the distributions of IR changes used as part of ICC's IM methodology. In Section I.1, ICC proposes general clarifications to revise certain equations and their descriptions. ICC proposes to amend Equation 11 to incorporate a term that was previously defined in Equation 10 and conform the equation to the existing description. ICC proposes explanatory language regarding the analyzed time series for Equation 12, and to replace one symbol with another symbol in Equation 13. ICC further proposes to add new Equation 14 and to revise the accompanying discussion on the construction of the referenced sample. In Section I.1.ii, ICC proposes to provide additional support for the utilized Treasury repo time series based on observed Secured Overnight Financing Rate (''SOFR'') and historical proxies as well as revisions to the description of a scale to avoid procyclicality (''APC scale''), including the removal of language on sample size. In Section I.1.iii, ICC proposes explanatory language regarding Equations 22 and 23 to clarify the rationale for certain parameter settings.

ICC proposes additional edits in Section I.2, which describes ICC's approach to the construction, estimation, and simulation of the dependence structure among the distributions introduced in Section I.1. In Sections I.2.ii and I.2.iii, ICC proposes explanatory language regarding Figure 3 to clarify that such figure illustrates the simulated distributions and regarding Figure 4 to specify the relevant implementation for Equation 33. ICC also proposes clarifications to the description of the block simulation approach to reflect the production implementation. In Section I.2.iv, ICC proposes revisions to the description of the interest rate level floor in the methodology, including updates specifying that, for each tenor, a minimum rate level ''can be'' rather than ''is'' considered.

ICC proposes additional revisions in Section I.3, which relates to risk estimations. ICC proposes to add new equations along with explanatory text to describe the methodology for calculating the profit and loss response with respect to repo positions. For example, new Equation 40 would provide the profit and loss response to a repo rate scenario for an in flight repo position and would indicate that the computational approach introduces some conservative bias along with anti-procyclical features. New Equation 41 would provide the profit and loss response to a repo rate scenario for a forward starting repo position. ICC proposes additional explanatory language describing the relevant notations, inputs, and other characteristics of such approach. ICC proposes additional revisions to explain its treatment of constant maturity repo tenors shorter than two weeks and to incorporate repo-rate exposure sub-portfolios in Equation 44. In Section I.3.ii, ICC proposes general clarifications to specify that certain reviews relating to concentration charges will occur at least monthly.

ICC also proposes various non-substantive revisions or clarifications throughout the IM Approach Model Description, including grammatical updates, notation changes in equations for clarity, minor language edits and clarifications, and typographical corrections.

GF and Stress Test Approach

The purpose of the GF and Stress Test Approach Model Description is to describe the general stress testing framework for GF computations used for financial resources modeling and GF design for the Treasury Clearing Service. The GF and Stress Test Approach Model Description remains substantively the same under the proposed changes. ICC continues to establish a separate GF for the Treasury Clearing Service designed to provide mutualization of losses associated with extreme but plausible market scenarios where the considered stress losses exceed the collateralized

[27] *See* Securities Exchange Act Release No. 105974 (July 23, 2026), 91 FR 47264 (July 28, 2026) (File No. SR–ICC–2026–005) (containing additional information on ICC's IM approach, GF and stress test approach, and risk parameter setting and review approach).

losses corresponding to the IR dynamics component of the computed IM requirements. ICC continues to utilize statistical stress testing and scenario-based stress loss analysis techniques to estimate potential stress loss over IM for every portfolio.

The proposed changes further reflect ICC's risk management approach for repo transactions and make certain general clarifications (*i.e.,* not repo-specific) throughout the document. ICC proposes to amend Section I, which describes ICC's overall GF and stress test methodology, to add references to repo contracts and related terminology. ICC proposes to clarify that the considered Treasury market term structures include both Treasury cash instruments and repo instruments, including triparty and bilateral repo term structures. Additional language describes the computation of the IR dynamics component in the presence of repo instruments and explains the treatment of repo instruments for risk management purposes based on the underlying security and interest rate payments. Additional revisions amend Equation 1 to specify that the IR dynamics component is defined as a negative quantity. ICC also proposes a new notation for repo-only positions for use in relevant equations, including in Equation 2 where ICC would incorporate such notation. In Section I.1, ICC proposes a terminology update to replace ''Participant'' with ''Proprietary'' in reference to Treasury Participant House portfolios for clarity, and an updated reference to relevant historical stress periods.

ICC proposes additional edits to Sections I.2 through I.4. In Section I.2, ICC proposes to remove explanatory language associated with Equation 4 to streamline the description, while leaving the equation unchanged. ICC proposes clarifications to the description of the tail loss calculation in Equation 5, as well as updates to Equation 6 and related notations throughout the document to maintain consistency. In Section I.3, ICC proposes explanatory language associated with Equations 10 and 11 to clarify that the calculation in Equation 11 reflects the exclusion of certain accounts, as identified by Equations 8 and 9. In Equation 13, ICC proposes to replace one notation with a notation used earlier in the document (see Equation 5) for consistency.

In Section I.4, with respect to Equation 16, ICC proposes to update this same notation for consistency and to clarify the calculation of stress loss over IM. ICC proposes to specify that Equation 17 represents the total stress loss over IM for a Treasury Participant and to identify the notation used to represent this amount. ICC proposes conforming changes to incorporate that notation in the introductory text of Equation 18. In addition, ICC proposes to amend Equation 19 and related text to revise the notation used for Treasury Participant-specific GF contributions, which are expressed as positive quantities, and to conform the notations used in this section (including in Equation 18 and the text following Equation 19). ICC further proposes clarifying that the worst cumulative stress losses over IM are defined as non-positive quantities in the text that follows Equation 19.

ICC also proposes various non-substantive revisions throughout the GF and Stress Test Approach Model Description, including grammatical updates, notation revisions in equations for clarity, equation simplifications, minor language edits and clarifications, and typographical corrections.

Risk Parameter Policy

The Risk Parameter Policy describes the process of setting and reviewing the risk management model core parameters and their underlying assumptions for the Treasury Clearing Service. The Risk Parameter Policy remains substantively the same under the proposed changes. The Risk Parameter Policy continues to describe the tools and methods used to estimate core parameters, determine appropriate parameter settings, and review the IM and GF model assumptions.

The proposed changes further reflect ICC's risk management approach for repo transactions and make certain general clarifications (*i.e.,* not repo-specific). In Section 1.2, which describes liquidity charge parameters, ICC proposes to correct a duplicative notation by revising the affected reference. In Section 1.3, which describes concentration charge parameters, ICC would add that, because repo transactions feature underlying Treasury security instruments as collateral, the same liquidity charge and concentration charge risk management approach applies to outright and repo-related security positions. In Section 1.4, which describes IR dynamics parameters, ICC proposes language describing the analyzed time series for Treasury repo clearing services. In Section 1.4.2 and throughout the document, ICC would incorporate references to ICC's repo clearing services. In Section 1.4.3, which describes the IM anti-procyclicality parameters, ICC proposes to clarify the treatment of constant maturity Treasury repo tenors shorter than two weeks.

ICC proposes additional changes to the appendices to the document. ICC proposes to incorporate references to repo contracts and related terminology. Revisions in Appendix 2 would also amend the stress scenario sets to add repo-specific risk factors to the current stress scenario sets and to add an additional stress scenario set. ICC's stress scenario sets would continue to be constructed by considering market realizations during stress periods and events, as described in Section 2.6. ICC proposes to amend Appendix 3, which presents exponentially weighted moving average (''EWMA'') factors, to incorporate EWMA factors for triparty and bilateral Treasury repo constant maturity tenors. ICC also proposes to amend Appendix 4, which presents minimum rate levels for Treasury constant maturity tenors, to incorporate minimum rate levels for triparty and bilateral Treasury repo constant maturity tenors.

ICC also proposes various non-substantive revisions throughout the Risk Parameter Policy, including grammatical updates, minor language edits and clarifications, and typographical corrections.

(b) Statutory Basis

ICC believes that the proposed rule change is consistent with the requirements of Section 17A of the Act[28] and the regulations thereunder applicable to it, including the applicable standards under Rule 17ad–22.[29] In particular, Section 17A(b)(3)(F) of the Act[30] requires, among other things, that the rules of a clearing agency be designed to promote the prompt and accurate clearance and settlement of securities transactions, to assure the safeguarding of securities and funds in the custody or control of the clearing agency or for which it is responsible, and to protect investors and the public interest.

The proposed rule change would facilitate participation in ICC's Treasury Clearing Service by establishing clear and transparent terms for the clearing of contracts, including repo contracts. The proposed changes facilitate the clearing of such contracts by amending the Rules to (i) update and clarify the rules for Variation Payments, (ii) introduce a new margin model for eligible money funds to facilitate participation by such funds in the Treasury Clearing Service, (iii) expand the rules governing Treasury

[28] 15 U.S.C. 78q–1.

[29] 17 CFR 240.17ad–22.

[30] 15 U.S.C. 78q–1(b)(3)(F).

physical settlement to include triparty as well as DVP settlement, (iv) expand the contract terms applicable to repo contracts, and (v) make additional clarification or clean-up changes. The proposed changes to the Treasury Risk Documentation provide further detail on ICC's risk management approach for repo contracts and make clarifications throughout the documentation, thereby extending ICC's risk management documentation to address the risks presented by repo contracts and ensuring that such documentation remains clear and transparent. The proposed rule change would also facilitate access for registered funds to participate in the Treasury Clearing Service by accommodating applicable regulatory requirements for registered funds through the introduction of the Money Fund Margin Model. Taken together, the proposed changes ensure that the Treasury Rules and Treasury Risk Documentation remain effective, up-to-date and transparent, thereby supporting ICC's ability to continue to maintain clear and comprehensive rules and procedures that provide sufficient information to market participants and promoting the prompt and accurate clearance and settlement of securities transactions and protecting investors and the public interest, within the meaning of Section 17A(b)(3)(F) of the Act.[31]

Rule 17ad–22(e)(1)[32] requires each covered clearing agency to establish, implement, maintain, and enforce written policies and procedures reasonably designed to provide for a well-founded, clear, transparent, and enforceable legal basis for each aspect of its activities in all relevant jurisdictions. The proposed amendments to Chapter 30, which governs cleared Treasury products, establish clear and comprehensive terms applicable to the various contracts that ICC may clear. Similarly, the proposed amendments to Rule 404 provide for a well-defined and comprehensive rule explaining the calculation and treatment of Variation Payments. The proposed amendments to Chapters 22 through 24 establish a clear and comprehensive settlement framework covering DVP physical settlement, standard triparty settlement, and Fund Model triparty settlement. Such changes ensure that the Treasury Rules provide a well-founded, clear, transparent, and enforceable legal basis for ICC's clearing activities, including ICC's repo clearing activities. As such, the proposed rule change is consistent with Rule 17ad–22(e)(1).[33]

Rule 17ad–22(e)(4)[34] requires each covered clearing agency to establish, implement, maintain, and enforce written policies and procedures reasonably designed to effectively identify, measure, monitor, and manage its credit exposures to participants and those arising from its payment, clearing, and settlement processes by maintaining sufficient financial resources to cover its credit exposure to each participant fully with a high degree of confidence. ICC believes the proposed changes to the Treasury Risk Documentation appropriately extend ICC's existing risk management framework to the Treasury repo market without substantively altering its underlying risk management approach. The proposed changes ensure that ICC continues to effectively identify, measure, monitor, and manage its credit exposures to Treasury Participants across the expanded product set that will include repo contracts. As such, ICC believes the proposed rule change meets the requirements of Rule 17ad–22(e)(4).[35]

Rule 17ad–22(e)(6)[36] requires each covered clearing agency to establish, implement, maintain, and enforce written policies and procedures reasonably designed to cover its credit exposure to its participants by establishing a risk-based margin system that, at a minimum, considers, and produces margin levels commensurate with, the risks and particular attributes of each relevant product, portfolio, and market. ICC proposes to extend its IM methodology to consider repo instruments, as described in the amended Treasury Risk Documentation, including new equations along with explanatory text to describe the methodology for calculating the profit and loss response with respect to repo positions. In addition, the Money Fund Margin Model introduced in proposed Rule 411 establishes a new margin model for eligible money funds, which does not rely on IM or Variation Payments, but instead requires that the fund grant a first priority lien and security interest to ICC, as further described above. ICC believes that this approach appropriately reflects the regulatory requirements applicable to registered funds, while continuing to ensure that ICC appropriately covers its credit exposure to its participants. Accordingly, ICC believes that it continues to establish a risk-based margin system that, at a minimum, considers, and produces margin levels commensurate with, the risks and particular attributes of each relevant product, portfolio, and market. As such, ICC believes the proposed rule change is consistent with the requirements of Rule 17ad–22(e)(6).[37]

Rule 17ad–22(e)(10)[38] requires each covered clearing agency to establish, implement, maintain, and enforce written policies and procedures reasonably designed to establish and maintain transparent written standards that state its obligations with respect to the delivery of physical instruments, and establish and maintain operational practices that identify, monitor and manage the risks associated with physical deliveries. Proposed New chapters 23 and 24 of the Rules set out procedures for settlement of physical delivery obligations under repo contracts through triparty settlement at a triparty bank, and establish the rights and obligations of participants and ICC in respect of such settlements. The amendments also deal with the procedures for addressing a delivery or payment failure in triparty settlement. As such, ICC believes the proposed rule change is consistent with the requirements of Rule 17ad–22(e)(10).[39]

Rule 17ad–22(e)(13)[40] requires each covered clearing agency to establish, implement, maintain, and enforce written policies and procedures reasonably designed to ensure that it has the authority and operational capacity to take timely action to contain losses and liquidity demands and continue to meet its obligations. Proposed Rule 411(l) sets out default management provisions and corresponding default management actions to be taken by relevant parties, including in the case of a client default with respect to a Covered Money Fund, a default of the Covered Money Fund's Treasury Participant, and a default of the Original Counterparty or its Treasury Participant. Additional provisions in chapters 23 and 24 of the Rules address failures to make required deliveries or payments on settlement. Under the proposed rule change, ICC will continue to have the authority and operational capacity to take timely action to contain losses and liquidity demands arising in connection with repo contracts, consistent with Rule 17ad–22(e)(13).[41]

[31] *Id.*

[32] 17 CFR 240.17ad–22(e)(1).

[33] *Id.*

[34] 17 CFR 240.17ad–22(e)(4).

[35] *Id.*

[36] 17 CFR 240.17ad–22(e)(6).

[37] *Id.*

[38] 17 CFR 240.17ad–22(e)(10).

[39] *Id.*

[40] 17 CFR 240.17ad–22(e)(13).

[41] *Id.*

Rule 17ad–22(e)(18)(iv)(C)[42] requires, in part, that when the covered clearing agency provides central counterparty services for transactions in Treasury securities, it establish objective, risk-based, and publicly disclosed criteria for participation, which ensure that it has appropriate means to facilitate access to clearance and settlement services of all eligible secondary market transactions in Treasury securities, including those of indirect participants. ICC believes that the proposed changes facilitate access to its Treasury Clearing Service by accommodating applicable regulatory requirements for registered funds. ICC designed the Money Fund Margin Model to be consistent with applicable regulatory requirements for registered funds under the Investment Company Act of 1940,[43] including the full collateralization requirements and existing market practices for repos by registered funds pursuant to Rule 5b–3.[44] As such, ICC believes the proposed rule change is consistent with the requirements of Rule 17ad–22(e)(18)(iv)(C).[45]

Rule 17ad–22(e)(19)[46] under the Act requires that each covered clearing agency establish, implement, maintain and enforce written policies and procedures reasonably designed to identify, monitor, and manage the material risks to the covered clearing agency arising from arrangements in which firms that are indirect participants in the covered clearing agency rely on the services provided by direct participants to access the covered clearing agency's payment, clearing, or settlement facilities. The proposed Money Fund Margin Model in Rule 411 would address the indirect participation of eligible money funds in the Treasury Clearing Service, providing ICC with a clear framework to identify, monitor, and manage any associated risks. In particular, Rule 411(c) through (l) would set out additional legal, risk, operational, and default management provisions applicable to the Money Fund Margin Model, which provide, among other things, a first priority lien and security interest granted by each Covered Money Fund to ICC as well as default management actions to be taken by relevant parties. As such, ICC believes the proposed rule change is consistent with the requirements of Rule 17ad–22(e)(19).[47]

[42] 17 CFR 240.17ad–22(e)(18)(iv)(C).

[43] 15 U.S.C. 80a–1.

[44] 17 CFR 270.5b–3.

[45] 17 CFR 240.17ad–22(e)(18)(iv)(C).

[46] 17 CFR 240.17ad–22(e)(19).

[47] *Id.*

(B) Clearing Agency's Statement on Burden on Competition

ICC does not believe the proposed rule change would have any impact, or impose any burden, on competition not necessary or appropriate in furtherance of the purposes of the Act. The proposed changes to the Treasury Rules and Treasury Risk Documentation will apply uniformly across all market participants. Certain proposed changes, including amendments to establish the Money Fund Margin Model, are intended to facilitate access to clearing by money funds and thus expand access to clearing for a broader range of market participants. ICC does not believe the proposed amendments would adversely affect the costs of clearing or the ability of market participants to access clearing. Therefore, ICC does not believe the proposed rule change would impose any burden on competition that is inappropriate in furtherance of the purposes of the Act.

(C) Clearing Agency's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Written comments relating to the proposed rule change have not been received. ICC will notify the Commission of any written comments received by ICC.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 45 days of the date of publication of this notice in the **Federal Register** or within such longer period up to 90 days (i) as the Commission may designate if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) by order approve or disapprove such proposed rule change, or

(B) institute proceedings to determine whether the proposed rule change should be disapproved.

(IV) Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–ICC–2026–011 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–ICC–2026–011. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*http://www.sec.gov/rules/sro.shtml*). Copies of such filings will be available for inspection and copying at the principal office of ICE Clear Credit and on ICE Clear Credit's website at *https://www.ice.com/clear-credit/regulation.* Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to File Number SR–ICC–2026–011 and should be submitted on or before December 10, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[48]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23552 Filed 11–18–26; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106904; File No. SR–CboeBZX–2026–093]

Self-Regulatory Organizations; Cboe BZX Exchange, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend the Invesco Galaxy Bitcoin ETF and the Invesco Galaxy Ethereum ETF

November 16, 2026.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on November 9, 2026, Cboe BZX Exchange, Inc. (the ''Exchange'' or ''BZX'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule

[48] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

change as described in Items I and II below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Cboe BZX Exchange, Inc. (''BZX'' or the ''Exchange'') is filing with the Securities and Exchange Commission (''Commission'' or ''SEC'') a proposed rule change to amend the Invesco Galaxy Bitcoin ETF (the ''Bitcoin Trust'') and the Invesco Galaxy Ethereum ETF (the ''ETH Trust'' and, together with the Bitcoin Trust, the ''Trusts''), shares (''Shares'') of which have been approved by the Commission to list and trade on the Exchange pursuant to BZX Rule 14.11(e)(4) under approval orders, to permit the Trusts to list and trade under the generic listing standards of that rule.

The text of the proposed rule change is also available on the Commission's website (*https://www.sec.gov/rules/sro.shtml*), the Exchange's website (*https://www.cboe.com/us/equities/regulation/rule_filings/bzx/*), and at the principal office of the Exchange.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Commission has previously approved the listing and trading of shares for the Bitcoin Trust [3] and the ETH Trust [4] under Rule 14.11(e)(4), and each Trust currently lists and trades on the Exchange. The Exchange now proposes to transition the Trusts to operate under the recently Commission-approved generic listing standards for Commodity-Based Trust Shares pursuant to Rule 14.11(e)(4) (''Amended Rule 14.11(e)(4)'').[5] Each Trust will meet the requirements of Amended Rule 14.11(e)(4) and will be required to comply with the continued listing requirements set forth in such Rule.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with the Act and the rules and regulations thereunder applicable to the Exchange and, in particular, the requirements of Section 6(b) of the Act.[6] Specifically, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5) [7] requirements that the rules of an exchange 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 securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. Additionally, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5) [8] requirement that the rules of an exchange not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers.

The Exchange believes the proposed rule change is designed to remove impediments to and perfect the mechanism of a free and open market and, in general, to protect investors and the public interest because it would provide for the transition of the Trusts from being listed pursuant to the Approval Orders to Amended Rule 14.11(e)(4) instead. The proposed change would allow the Shares to continue listing and trading on the Exchange and permit the Trusts to operate in reliance on the generic listing standards in Amended Rule 14.11(e)(4) instead of the terms of the Approval Orders, thereby facilitating the continued listing and trading of exchange-traded products that will enhance competition among market participants, to the benefit of investors and the marketplace. Each Trust will meet the requirements of Amended Rule 14.11(e)(4) and will be required to comply with the continued listing standards set forth in Amended Rule 14.11(e)(4).

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purpose of the Act. As discussed above, the proposed change is intended to facilitate the continued listing and trading of the Fund on the Exchange, thereby promoting competition among exchange-traded products to the benefit of investors and the marketplace.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange neither solicited nor received comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A) of the Act [9] and Rule 19b–4(f)(6) [10] thereunder. 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; or (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 Act [11] and Rule 19b–4(f)(6) [12] thereunder.

[3] *See* Securities Exchange Act Release No. 99306 (January 10, 2024) 89 FR 3008 (January 17, 2024) (SR–CboeBZX–2023–038) (Order Granting Accelerated Approval of Proposed Rule Changes, as Modified by Amendments Thereto, To List and Trade Bitcoin-Based Commodity-Based Trust Shares and Trust Units) (the ''Bitcoin ETP Approval Order'').

[4] *See* Securities Exchange Act Release No. 100224 (May 23, 2024) 89 FR 46937 (May 30, 2024) (SR–CboeBZX–2023–087) (Order Granting Accelerated Approval of Proposed Rule Changes, as Modified by Amendments Thereto, to List and Trade Shares of Ether-Based Exchange-Traded Products) (the ''ETH ETP Approval Order'' and, together with the Bitcoin ETP Approval Order, the ''Approval Orders'').

[5] *See* Securities Exchange Act Release Nos. 103995 (September 17, 2025) 90 FR 45414 (September 22, 2025) (SR–CboeBZX–2025–104) (Order Granting Accelerated Approval of Proposed Rule Changes, as Modified by Amendments Thereto, To Adopt Generic Listing Standards for Commodity-Based Trust Shares); 1096011 (July 29, 2026) 91 FR 48957 (August 3, 2026) (SR–CboeBZX–2026–061) (Notice of Filing, and Order Granting Accelerated Approval of, a Proposed Rule Change To Amend Rule 14.11(e)(4) (Commodity-Based Trust Shares)).

[6] 15 U.S.C. 78f(b).

[7] 15 U.S.C. 78f(b)(5).

[8] *Id.*

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(6).

[11] 15 U.S.C. 78s(b)(3)(A).

[12] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6)(iii) requires the Exchange to give the Commission written notice of its intent to file the

Continued

A proposed rule change filed under Rule 19b–4(f)(6) [13] normally does not become operative prior to 30 days after the date of the filing. However, pursuant to Rule 19b–4(f)(6)(iii),[14] the Commission may designate a shorter time if such action is consistent with protection of investors and the public interest. The Exchange has asked the Commission to waive the 30-day operative delay so that the proposed rule change may become operative immediately upon filing. The Commission believes that waiving the 30-day operative delay is consistent with the protection of investors and the public interest because it will allow the Exchange to implement the proposed rule change without delay, thereby providing for the continued listing and trading of the Trusts' Shares, and does not introduce any novel regulatory issues. Accordingly, the Commission designates the proposed rule change to be operative upon filing.[15]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission will institute proceedings to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include file number SR–CboeBZX–2026–093 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–CboeBZX–2026–093. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the filing will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–CboeBZX–2026–093 and should be submitted on or before December 10, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[16]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23548 Filed 11–18–26; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106910; File No. SR–TXSE–2026–048]

Self-Regulatory Organizations; Texas Stock Exchange LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend TXSE Rule 14.001 Regarding Information Circular Requirements

November 16, 2026.

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 November 3, 2026, Texas Stock Exchange LLC (''Exchange'' or ''TXSE'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend TXSE Rule 14.001 to: (1) add express cross-references to TXSE Rules 3.007 and 3.021; (2) delete Rule 14.001(b)(1), thereby removing the requirement that the Exchange distribute a product-specific information circular prior to the commencement of trading in each UTP Exchange Traded Product that generally includes the same information as contained in the information circular provided by the listing exchange; (3) amend Rule 14.001(b)(2)(B) to require that any written description be provided in a form approved by the listing exchange or prepared by the open-ended management company issuing such securities; (4) renumber Rules 14.001(b)(2) through (6) as Rules 14.001(b)(1) through (5), respectively, and (5) removing the specific reference to subparagraph (2) from current Rule 14.001(b)(2). The Exchange has designated the proposed rule change as non-controversial pursuant to Section 19(b)(3)(A)(iii) [3] of the Act and has provided the Commission with the notice required by Rule 19b–4(f)(6)(iii).[4] The proposal is based on and substantially similar to recent proposals filed by Cboe BZX Exchange, Inc. (''Cboe BZX''), MIAX PEARL, LLC (''MIAX Pearl''), Investors Exchange LLC (''IEX''), and MEMX LLC (''MEMX'').[5] The text of the proposed rule change is provided in Exhibit 5. The text of the proposed rule change is available on the Commission's website (*https://www.sec/gov/rules/sro.shtml*) at the Exchange's website (*https://www.txse.com/reuglations/rules-filings*), and at the principal office of the Exchange.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change

proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[13] 17 CFR 240.19b–4(f)(6).

[14] 17 CFR 240.19b–4(f)(6)(iii).

[15] For purposes only of waiving the 30-day operative delay, the Commission also has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[16] 17 CFR 200.30–3(a)(12) and (59).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A)(iii).

[4] 17 CFR 240.19b–4(f)(6)(iii).

[5] *See* Securities Exchange Act Release No. 105715 (June 17, 2026), 91 FR 37477 (June 23, 2026) (SR–CboeBZX–2026–054); Securities Exchange Act Release No. 105835 (July 1, 2026), 91 FR 41671 (July 7, 2026) (SR–PEARL–2026–28); Securities Exchange Act Release No. 105940 (July 17, 2026), 91 FR 46193 (July 22, 2026) (SR–IEX–2026–20); Securities Exchange Act Release No. 106068 (August 10, 2026), 91 FR 52384 (August 13, 2026) (SR–MEMX–2026–22).

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 self-regulatory organization has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to eliminate the requirement in Rule 14.001(b)(1) that the Exchange distribute an information circular to Members prior to the commencement of trading in each UTP Exchange Traded Product. The information circular generally includes the same information as contained in the information circular provided by the listing exchange. The Exchange also proposes to add express cross-references to Rules 3.007 and 3.021 in Rule 14.001(a), amend the written description provision in Rule 14.001(b)(2)(B), and make conforming renumbering changes.

Rule 14.001(b) governs the trading of UTP Exchange Traded Products on the Exchange. UTP Exchange Traded Products are derivative securities products listed on another national securities exchange that trade on the Exchange pursuant to unlisted trading privileges (''UTP''). Under current Rule 14.001(b)(1), the Exchange must distribute an information circular prior to the commencement of trading in each UTP Exchange Traded Product that generally mirrors the information circular provided by the listing exchange, including: (a) the special risks of trading the UTP Exchange Traded Product; (b) the Exchange Rules that will apply to the product, including Rule 3.007; (c) information about the dissemination of the value of the underlying assets or indices; and (d) the applicable trading hours for the UTP Exchange Traded Product and the risks of trading during the period from 8:00 a.m. to 9:30 a.m. and from 4:00 p.m. to 5:00 p.m. due to the lack of calculation or dissemination of the underlying index value, the IIV or a similar value. The Exchange proposes to delete Rule 14.001(b)(1) in its entirety.

The product-specific information circular requirement is unnecessary because the primary listing exchange's information circular already provides Members [6] with the same disclosures the Exchange would otherwise be required to reproduce. Members have access to the primary listing exchange's information circular prior to the commencement of UTP trading and may rely upon it for the same purposes.[7] Requiring the Exchange to prepare and distribute a separate circular containing duplicative information serves no independent investor-protection function.

The Exchange also proposes to amend Rule 14.001(a) to add express cross-references to Rule 3.007 (Recommendations to Customers) and Rule 3.021 (Customer Disclosures). These rules already apply to Members by operation of the Exchange's rulebook. The cross-references are intended to preserve the visibility of the applicable customer-protection framework in the context of UTP Exchange Traded Products after deletion of Rule 14.001(b)(1). Rule 3.007 independently requires a Member recommending a UTP Exchange Traded Product to have reasonable grounds for believing the recommendation is suitable for the customer based on the facts disclosed by the customer after reasonable inquiry into the customer's other securities holdings, financial situation, and needs. Similarly, Rule 3.021 independently requires Members to disclose the material risks of extended-hours trading before accepting a customer order for execution in the Pre-Market or Post-Market Session. These standing obligations are not contingent on the Exchange's issuance of a product-specific circular.

Because Rule 14.001(b)(1) has historically served as the mechanism through which the Exchange informs Members of the application of the written-description provisions in Rule 14.001(b)(2)(B), the Exchange proposes a conforming amendment to that paragraph. The Exchange will continue to inform Members of the application of the written-description provisions by information circular, but proposes to require that any written description referenced therein be provided in a form approved by the listing exchange, rather than the Exchange, or prepared by the open-ended management company issuing the securities. The Exchange will notify Members by information circular that such written description will only be required when mandated by the listing exchange. This amendment is consistent with the broader purpose of the proposed rule change: where the listing exchange's information circular already provides Members with the information necessary to assess a UTP Exchange Traded Product, a duplicative written description obligation serves no independent investor protection function. Members may rely on the listing exchange's information circular in the same manner and to the same effect.

The Exchange also proposes to renumber existing Rules 14.001(b)(2) through (6) as Rules 14.001(b)(1) through (5), respectively.

Finally, the Exchange proposes to delete the reference to subparagraph (2) in current Rule 14.001(b)(2) (as proposed to be re-numbered to Rule 14.001(b)(1) herein) such that instead of reading ''this subparagraph (2) apply only to'' it would read ''this subparagraph apply only to.''

The proposal is based on and substantially similar to the Cboe BZX proposal and the subsequent MIAX Pearl, IEX, and MEMX proposals.[8]

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Act,[9] in general, and specifically with the objectives of Section 6(b)(5),[10] in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. The Exchange also believes the proposal is consistent with the requirements of Section 6(b)(5) that the rules of an exchange not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers.[11]

The proposed deletion of Rule 14.001(b)(1) is consistent with the Act because the primary listing exchange's information circular already provides Members with the same disclosures that the Exchange's information circular would contain. The investor protection functions historically served by the product-specific circular requirement are independently addressed by the primary listing exchange's information circular and by the Member-level obligations imposed by Rules 3.007 and 3.021, which the Exchange proposes to cross-reference expressly in Rule

[6] *See* TXSE Rule 1.005(q) (defining ''Member'')

[7] Such information circulars are generally available on the primary listing exchange's website.

[8] *See supra* note 5.

[9] 15 U.S.C. 78f(b).

[10] 15 U.S.C. 78f(b)(5).

[11] *Id.*

14.001(a). Members will therefore continue to have access to the relevant product information and remain subject to the same suitability, disclosures, supervisory, and trading obligations after the proposed deletion.

The proposed amendment to Rule 14.001(b)(2)(B) is also consistent with the Act because it requires any written description referenced therein to be provided in a form approved by the listing exchange or prepared by the open-ended management company issuing the securities. The amendment aligns the Exchange's requirement with the disclosure framework of the primary listing market and eliminates duplicative Exchange review without reducing the information available to Members or customers. The proposed renumbering of Rules 14.001(b)(2) through (6) as Rules 14.001(b)(1) through (5), respectively, and the deletion of the specific reference to paragraph (2) in current Rule 14.001(b)(2) are ministerial.

As discussed above, the proposal is substantially similar to rule changes previously filed by other national securities exchanges and does not raise novel regulatory issues.[12] For these reasons, the Exchange believes the proposed rule change is consistent with the Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The proposal eliminates a duplicative procedural obligation applicable to the Exchange in its capacity as a UTP trading venue. It does not alter the terms or conditions under which UTP Exchange Traded Products may be traded on the Exchange, impose any new requirement on Members, or affect the ability of any market participant to access the Exchange's market. Members will continue to have access to the primary listing exchange's information circular prior to the commencement of UTP trading and may rely upon it for the same purposes as the Exchange's current circular.

The proposed amendment to Rule 14.001(b)(2)(B) aligns the written-description obligation with the primary listing market's disclosure framework and does not impose a burden beyond the requirements applicable to the product on its listing market. Accordingly, the Exchange does not believe the proposed rule change imposes any burden on intramarket or intermarket competition that is not necessary or appropriate in furtherance of the purposes of the 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 Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A) of the Act[13] and Rule 19b–4(f)(6)[14] thereunder. 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; or (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 Act[15] and Rule 19b–4(f)(6)[16] thereunder.

A proposed rule change filed under Rule 19b–4(f)(6)[17] normally does not become operative prior to 30 days after the date of the filing. However, pursuant to Rule 19b4(f)(6)(iii),[18] the Commission may designate a shorter time if such action is consistent with the protection of investors and the public interest. The Exchange has asked the Commission to waive the 30-day operative delay so that the proposed rule change may become operative immediately upon filing. The Exchange states that the proposed rule change eliminates duplicative procedural obligations applicable to the Exchange in its capacity as a UTP trading venue because the primary listing exchange's information circular already provides Members with the same disclosures the Exchange would otherwise be required to produce.[19] The Exchange also notes that the proposed rule change does not alter the terms or conditions under which UTP Exchange Traded Products may be traded on the Exchange. For these reasons, the Commission finds that waiver of the 30-day operative delay is consistent with the protection of investors and the public interest. Therefore, the Commission hereby waives the 30-day operative delay and designates the proposed rule change to be operative upon filing.[20]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

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 (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–TXSE–2026–048 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–TXSE–2026–048. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the filing will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–TXSE–2026–048 and

[12] *See supra* note 5.

[13] 15 U.S.C. 78s(b)(3)(A).

[14] 17 CFR 240.19b–4(f)(6).

[15] 15 U.S.C. 78s(b)(3)(A).

[16] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6)(iii) requires the Exchange to give the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[17] 17 CFR 240.19b–4(f)(6).

[18] 17 CFR 240.19b–4(f)(6)(iii).

[19] The Exchange represents that such information circulars are generally available on the primary listing exchange's website. *See supra* note 7.

[20] For purposes only of waiving the 30-day operative delay, the Commission has also considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

should be submitted on or before December 10, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[21]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23553 Filed 11–18–26; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106909; File No. SR–DTC–2026–007]

Self-Regulatory Organizations; The Depository Trust Company; Notice of Designation of Longer Period for Commission Action on Proposed Rule Change To Amend the DTC Operational Arrangements (Necessary for Securities To Become and Remain Eligible for DTC Services)

November 16, 2026.

On May 11, 2026, the Depository Trust Company (''DTC'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change SR–DTC–2026–007 (''Proposed Rule Change'') pursuant to Section 19(b) of the Securities Exchange Act of 1934 (''Exchange Act'')[1] and Rule 19b–4[2] thereunder to amend the DTC Operational Arrangements (Necessary for Securities to Become and Remain Eligible for DTC Services) (the ''OA'')[3] to consolidate and update the documentation for Agents processing Participant instructions for a corporate action offer, election, solicitation or tabulation (each, an ''Offer'') through the DTC Automated Tender Offer Program (ATOP) or DTC Automated Subscription Offer Program (ASOP). The Proposed Rule Change was immediately effective upon filing with the Commission pursuant to Section 19(b)(3)(A) of the Exchange Act.[4] The Proposed Rule Change was published for public comment in the **Federal Register** on May 22, 2026.[5] The Commission has received comments regarding the substance of the changes proposed in the Proposed Rule Change.[6]

On July 9, 2026, pursuant to Section 19(b)(3)(C) of the Exchange Act,[7] the Commission temporarily suspended and instituted proceedings under Section 19(b)(2)(B) of the Exchange Act[8] to determine whether to approve or disapprove the Proposed Rule Change.[9]

Section 19(b)(2) of the Exchange Act[10] provides that, after initiating proceedings, the Commission shall issue an order approving or disapproving the proposed rule change not later than 180 days after the date of publication of notice of filing of the proposed rule change. The Commission may extend the period for issuing an order approving or disapproving the proposed rule change, however, by not more than 60 days if the Commission determines that a longer period is appropriate and publishes its reasons for such determination.[11] As noted above, the Proposed Rule Change was published for public comment in the **Federal Register** on May 22, 2026.[12] November 18, 2026 is 180 days from that date, and January 15, 2027 is 240 days from that date.

The Commission finds it appropriate to designate a longer period within which to issue an order approving or disapproving the Proposed Rule Change so that the Commission has sufficient time to consider the Proposed Rule Change and its comments. Accordingly, pursuant to Section 19(b)(2) of the Act,[13] the Commission designates January 15, 2027, as the date by which the Commission should either approve or disapprove the Proposed Rule Change (File No. SR–DTC–2026–007).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[14]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23554 Filed 11–18–26; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106905; File No. SR–TXSE–2026–049]

Self-Regulatory Organizations; Texas Stock Exchange LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change Amending its Fee Schedule, Amending Certain Definitions, and Adding Notes to the Lead Market Maker Program

November 16, 2026.

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 November 10, 2026, Texas Stock Exchange LLC (''TXSE'' or ''Exchange'') 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 Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to: (i) increase the rebate provided for orders that add displayed liquidity in securities priced at or above $1.00; (ii) increase the fee for orders that add or remove non-displayed liquidity in securities priced at or above $1.00; (iii) reduce the fee for orders that add or remove non-displayed liquidity in securities priced below $1.00; (iv) introduce an enhanced rebate designed to incentivize displayed liquidity in TXSE-listed corporate securities; and (v) amend certain definitions and add notes to the Lead Market Maker Program The text of the proposed rule change is available on the Commission's website (*https://www.sec/gov/rules/sro.shtml*) at the Exchange's website (*https://www.txse.com/reuglations/rules-filings*), and at the principal office of the Exchange.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below.

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[21] 17 CFR 200.30–3(a)(12), (59).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *Available at www.dtcc.com/~/media/Files/Downloads/legal/issue-eligibility/eligibility/operational-arrangements.pdf.* Each term not otherwise defined herein has its respective meaning as set forth in the OA, the Rules, By-Laws and Organization Certificate of DTC (the ''DTC Rules'') and the Reorganizations Service Guide (the ''Reorganizations Guide''), *available at www.dtcc.com/legal/rules-and-procedures.*

[4] 15 U.S.C. 78s(b)(3)(A).

[5] Securities Exchange Act Release No. 105522 (May 19, 2026), 91 FR 30346 (May 22, 2026) (File No. SR–DTC–2026–007) (''Notice of Filing'').

[6] Comments on the Proposed Rule Change are available at *https://www.sec.gov/rules-regulations/public-comments/sr-dtc-2026-007.*

[7] 15 U.S.C. 78s(b)(3)(C).

[8] 15 U.S.C. 78s(b)(2)(B).

[9] *See* Securities Exchange Act Release No. 105875 (Jul. 9, 2026), 91 FCR 43119 (Jul. 14, 2026)(File No. SR–DTC–2026–007) (''Order Instituting Proceedings'')

[10] 15 U.S.C. 78s(b)(2).

[11] 15 U.S.C 78s(b)(2)(B)(ii)(II).

[12] *See* note 5 *supra.*

[13] 15 U.S.C. 78s(b)(2).

[14] 17 CFR 200.30–3(a)(57).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

The self-regulatory organization has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Section A (Transaction Fees) and Section F (Lead Market Maker Program) of the TXSE Fee Schedule to: (i) increase the rebate provided for orders that add displayed liquidity in securities priced at or above $1.00; (ii) increase the fee for orders that add or remove non-displayed liquidity in securities priced at or above $1.00; (iii) reduce the fee for orders that add or remove non-displayed liquidity in securities priced below $1.00; (iv) introduce an enhanced rebate designed to incentivize displayed liquidity in TXSE-listed corporate securities; and (v) amend certain definitions and add notes to the Lead Market Maker Program. The Exchange proposes to implement these changes effective on November 2, 2026.[3]

The Exchange's Fee Schedule sets forth the standard rebates and fees applied per share for orders that add and remove liquidity, respectively. Currently, TXSE provides a rebate of $0.0031 per share for orders priced at or above $1.00 that add displayed liquidity to the Exchange and charges a fee of $0.0030 per share for orders that remove displayed liquidity from the Exchange.[4] For securities priced below $1.00, the Exchange provides a rebate of 0.15% of total dollar value (''TDV'') for orders that add displayed liquidity to the Exchange and charges a fee of 0.15% of TDV for orders that remove displayed liquidity from the Exchange.[5] The Exchange currently charges a fee of $0.0002 per share for orders that add non-displayed liquidity to the Exchange or remove non-displayed liquidity from the Exchange in securities priced at or above $1.00. The Exchange currently charges a fee of 0.05% of TDV for orders that add non-displayed liquidity to the Exchange or remove non-displayed liquidity from the Exchange in securities priced below $1.00.

Base Rates

The Exchange now proposes to amend its base rates applicable to orders that add displayed liquidity in securities priced at or above $1.00. The proposed rebate for orders that add displayed liquidity to the Exchange is $0.0032 per share, an increase of $0.0001 from the current rate of $0.0031 per share. In addition, the Exchange proposes to amend its base rates applicable to orders that add or remove non-displayed liquidity in both securities priced at or above $1.00 and securities priced below $1.00. For orders that add or remove non-displayed liquidity in securities priced at or above $1.00, the Exchange proposes to charge a fee of $0.0006, an increase of $0.0004 from its current rate of $0.0002 per share. For orders that add or remove non-displayed liquidity in securities priced below $1.00, the Exchange proposes to make these executions free.

The purpose of revising the rates associated with adding and removing displayed and non-displayed liquidity is for business and competitive reasons, as the proposed change is intended to incentivize Members[6] to submit displayed liquidity to the Exchange by providing a higher rebate for displayed orders that add liquidity to the Exchange and charging a higher fee for non-displayed orders that add liquidity to the Exchange or remove liquidity from the Exchange in securities priced at or above $1.00. The Exchange notes that its proposed base rebate for orders that add liquidity to the Exchange in securities priced at or above $1.00 would remain significantly higher than the base rebates provided by competitors for orders that add displayed liquidity in securities priced at or above $1.00.[7] The Exchange notes that its proposed fee for orders that add non-displayed liquidity in securities priced at or above $1.00 is similar to at least one competitor.[8] The Exchange's proposed fee for orders that remove non-displayed liquidity in securities priced at or above $1.00 would remain lower than the fees assessed by competitors for orders that remove non-displayed liquidity in securities priced at or above $1.00.[9] The Exchange's proposal to make executions free in all non-displayed orders that add liquidity to the Exchange in securities priced below $1.00 aligns with the pricing that competitors offer for similar executions.[10] In addition, the Exchange's proposal to make executions free in all orders that remove non-displayed liquidity in securities priced below $1.00 differs from competitors in that many competitors assess a fee for non-displayed orders that remove liquidity.[11] In totality, the Exchange believes its proposed fee structure is appropriate in furthering its goal of encouraging Members to submit displayed liquidity to the Exchange as it provides a competitive rebate to Members who add displayed liquidity to the Exchange and charges a fee to those Members who either remove displayed liquidity in all securities or who add or remove non-displayed liquidity in securities priced at or above $1.00.

Displayed Liquidity Enhanced Rebate

The Exchange next proposes to introduce an enhanced rebate designed to incentivize quoting in TXSE-listed corporate securities. The Exchange proposes to provide an enhanced rebate of $0.0038 per share in securities priced at or above $1.00 to Members that add displayed liquidity in a TXSE-listed corporate security. The enhanced rebate would not apply to securities priced below $1.00.

The proposed enhanced rebate is designed to encourage Members to submit displayed liquidity to the Exchange in TXSE-listed corporate securities, which contributes to a deeper, more liquid market and provides additional execution opportunities for active market participants. By offering enhanced rebate opportunities to incentivize increased liquidity provision, the

[3] The Exchange initially submitted the proposed rule change on November 2, 2026 (SR–TXSE–2026–044). On November 10, 2026, the Exchange withdrew that filing and submitted this proposal.

[4] *See* Texas Stock Exchange Fee Schedule, Section A—Transaction Fees.

[5] *Id.*

[6] *See* TXSE Rule 1.005(q). The term ''Member'' shall mean any registered broker or dealer that has been admitted to membership in the Exchange. A Member will have the status of a ''member'' of the Exchange as that term is defined in section 3(a)(3) of the Act. Membership may be granted to a sole proprietor, partnership, corporation, limited liability company or other organization which is a registered broker or dealer pursuant to Section 15 of the Act and which has been approved by the Exchange.

[7] *See, e.g.,* Cboe BZX Exchange Fee Schedule, Standard Rates (BZX provides a standard rebate of $0.0016 per share for orders that add displayed liquidity to BZX in securities priced at or above $1.00); MEMX Equities Fee Schedule, Transaction Fees (MEMX provides a standard rebate of $0.0015 per share for orders that add liquidity to MEMX).

[8] *See, e.g.,* IEX Equities Fee Schedule, Transaction Fees, Base Rates (IEX changes a fee of $0.0010 per share for non-displayed orders that add liquidity in securities priced at or above $1.00

[9] *See, e.g.,* IEX Equities Fee Schedule, Transaction Fees, Base Rates (IEX changes a fee of $0.0010 per share for non-displayed orders that remove liquidity in securities priced at or above $1.00)

[10] *See, e.g.,* IEX Equities Fee Schedule, Transaction Fees, Base Rates (IEX charges a fee of 0.10% of TDV per share to add non-displayed liquidity in securities priced below $1.00).

[11] *See, e.g.,* IEX Equities Fee Schedule, Transaction Fees, Base Rates (IEX assesses a fee of 0.10% of TDV in securities priced below $1.00 for orders that remove non-displayed liquidity); MIAX Pearl Equities Exchange Fee Schedule, Transaction Rebates/Fees, Standard Rates (MIAX Pearl assesses a rate of $0.0030 per share in securities priced at or above $1.00 and a rate of $0.20% of Dollar Value in securities priced below $1.00 for orders that remove non-displayed liquidity).

Exchange seeks to encourage greater trading activity and additional execution opportunities for Members, thereby promoting more robust price discovery and improving overall market quality for all market participants.

Lead Market Maker Program

The Exchange next proposes edits to certain definitions found within Section F (Lead Market Maker Program) of the Fee Schedule. The Exchange introduced its Lead Market Maker (''LMM'') Program in September 2026.[12] The Exchange's LMM Program offers daily stipends paid by the Exchange to LMMs that achieve certain Minimum Performance Standards [13] in TXSE-listed symbols. The Exchange now proposes to amend the definition of ''Size Near the Inside'' and ''Time at NBBO'' to more accurately reflect the Exchange's calculation of those criteria. ''Size Near the Inside'' is currently defined as ''. . .the average notional depth within 25 basis points of the NBBO.'' [14] The Exchange proposes to revise the definition of ''Size Near the Inside'' to state ''. . .the minimum notional value of both bids and offers within 0.25% of the NBBO for at least 95% of the trading day.'' The Exchange notes that this change will continue to measure notional depth relative to the NBBO, but would require the LMM to have a notional depth within 0.25% of each of the NBB and NBO for 95% of the trading day rather than looking at an average of total depth within 25 basis points of the NBBO. The Exchange notes that each of the Signature, Premier, and Core Tiers on the current Fee Schedule indicates the minimum notional value that must be provided on each side of the NBB and NBO.[15] The addition of the 95% threshold is intended to align the calculation of ''Size Near the Inside'' with the calculation of ''Layered Depth'' [16] and is generally in-line with similar criteria of competitor exchange LMM programs.[17]

''Time at NBBO'' is currently defined as ''. . .the percentage of time during Regular Trading Hours [18] in which the LMM maintains both a bid and offer at the NBBO with at least $10,000 notional at each of the NBB and NBO.'' [19] The Exchange proposes to revise the definition of ''Time at NBBO'' to state ''. . .the average of (a) the percentage of time the LMM has at least $10,000 notional at the NBB and (b) the percentage of time the LMM has at least $10,000 notional at the NBO.'' This change is designed to account for situations where an LMM may have a valid business reason for quoting the NBB or NBO with the required notional value at different times throughout a trading day. For instance, an LMM's inventory position and exposure to additional purchases or sales may warrant greater participation at the inside market on one side of the NBB or NBO than the other.[20] Under the current definition of ''Time at the NBBO'', an LMM participating at the NBB or NBO without the required notional value throughout Regular Trading Hours would not satisfy the ''Time at NBBO'' criteria if it did not have the required depth at the NBB and NBO for the requisite amount of time during Regular Trading Hours. Under the proposed definition, however, the Exchange would use the average of the percentage of time that the LMM quoted at each of the NBB and NBO, which would reward LMMs that have valid business cases for having different notional at the NBB and NBO at different times during Regular Trading Hours.

In addition, the Exchange proposes to introduce a ''Notes'' section to Section F of the Fee Schedule. Under the proposed ''Notes'' section, the Exchange proposes to add two notes that provide additional clarity to how it performs certain calculations related to the Minimum Performance Standards. First, the Exchange proposes to add the following note: ''Periods during which the SIP NBBO is missing, invalid, locked, or crossed are treated as ineligible and excluded from denominators for NBBO-referenced metrics.'' Second, the Exchange proposes to add a note stating: ''Certain percentage-based thresholds set forth in the Program shall be adjusted for leveraged ETPs to reflect the product's stated leverage factor. The adjusted threshold shall equal the stated threshold multiplied by the absolute value of the leverage factor (*e.g.,* 2 for a 2x product, 3 for a 3x product, irrespective of direction). The percentage adjustment applies to the following standards: the basis point threshold of Maximum LMM Spread; [21] the basis point threshold of Size Near the Inside; the percentage threshold of Layered Depth; the basis point threshold of Opening/Closing Auction Depth; [22] the basis point threshold of Opening/Closing Auction Reference Price.[23] Notional dollar thresholds are not

[12] *See* Securities Exchange Act Release No. 106505 (September 28, 2026), 91 FR 62572 (October 1, 2026), SR–TXSE–2026–030 (''LMM Fee Filing'').

[13] *See* TXSE Rule 11.024. The term ''Minimum Performance Standards'' means a set of standards applicable to an LMM that may be determined from time to time by the Exchange. Such standards will vary between LMM Securities depending on the applicable listing tier, liquidity, and volatility of the LMM Security in which the LMM is registered. The Minimum Performance Standards include the following measurements: Maximum LMM Spread, Size Near the Inside, Layered Depth, Time at NBBO, Opening Auction Depth, Closing Auction Depth, Opening Auction Reference Price, and Closing Auction Reference Price. *See also* TXSE Fee Schedule, Section F—Lead Market Maker Program, Definitions.

[14] *See* Texas Stock Exchange Fee Schedule, Section F—LMM Program, Definitions.

[15] *See* Texas Stock Exchange Fee Schedule, Section F—LMM Program, LMM Minimum Performance Standards. For example, the Signature Tier requires an LMM to provide ''$80,000 on each side of the NBB and NBO'' to satisfy the ''Size Near the Inside'' criteria for High Volume Products.

[16] *See* Texas Stock Exchange Fee Schedule, Section F—LMM Program, Definitions. ''Layered Depth'' means the minimum notional value of both bids and offers within a certain percentage of the NBBO for at least 95% of the trading day.

[17] *See, e.g.,* Cboe BZX Exchange Equity Fee Schedule, Footnote 14, subsection (B)(3), which requires a minimum notional value within a certain percentage of the NBBO at least 90% of the trading day.

[18] *See* Texas Stock Exchange Fee Schedule, Section F—LMM Program, Definitions. *See also* TXSE Rule 1.005(z). The term ''Regular Trading Hours'' shall mean the time between 9:30 a.m. and 4:00 p.m. Eastern Time.

[19] The threshold amount of time that an LMM must maintain $10,000 notional at each the NBB and NBO varies based on the asset class, tier, and CADV of the ETP being quoted. For example, the Signature Tier requires an LMM to have $10,000 notional at each of the NBB and NBO for 15% of the time during Regular Trading Hours in High Volume Products, but requires an LMM to have $10,000 notional at each of the NBB and NBO for 45% of the time during Regular Trading Hours if the ETP has less than a 250,000 30-DayCADV. *See* Texas Stock Exchange Fee Schedule, Section F—LMM Program, LMM Minimum Performance Standards.

[20] For example, an LMM that has accumulated a long position through the creation of a basket of exchange-traded product shares may seek to reduce that position by maintaining a competitive offer. Requiring the LMM to simultaneously maintain a quotation at the NBB to receive credit for its quotation at the NBO could encourage additional purchases that increase the inventory exposure the LMM is seeking to reduce.

[21] *See* Texas Stock Exchange Fee Schedule, Section F—LMM Program, Definitions. ''Maximum LMM Spread'' means the time weighted average of the LMM's displayed two-sided spread, calculated as (LMM Best Offer minus LMM Best Bid) divided by the SIP NBBO midpoint, expressed in basis points, for a trading day.

[22] *See* Texas Stock Exchange Fee Schedule, Section F—LMM Program, Definitions. ''Closing Auction Depth'' means the aggregate size, expressed in notional value, of all LMM Eligible Auction Orders that are executable in the closing auction and priced within fifty basis points (0.50%) of the NBBO midpoint, as measured immediately prior to the execution of the closing auction. ''Opening Auction Depth'' means the aggregate size, expressed in notional value, of all LMM Eligible Auction Orders that are executable in the opening auction and priced within 100 basis points (1.00%) of the NBBO midpoint, as measured immediately prior to the execution of the opening auction.

[23] *See* Texas Stock Exchange Fee Schedule, Section F—LMM Program, Definitions. ''Closing Auction Reference Price'' means the difference between the midpoint of the NBBO immediately prior to the closing auction and the closing auction price. ''Opening Auction Reference Price'' means the difference between the midpoint of the NBBO immediately prior to the opening auction and the opening auction price.

subject to the leverage adjustment and apply as stated in the applicable tier.'' Each of the proposed revisions to the definitions of ''Size Near the Inside'' and ''Time at NBBO'' and proposed additions to the proposed ''Notes'' section is intended to provide additional clarity to LMMs and other market participants regarding how the Minimum Performance Standards are calculated.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with the requirements of the Exchange Act. The Exchange believes that the proposed fee changes are consistent with the objectives of Section 6(b)(5) of the Act [24] in that they are designed 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 and perfect the mechanism of a free and open market and national market system, and, in general, to protect investors and the public interest, and, particularly, are not designed to permit unfair discrimination between customers, issuers, brokers, or dealers. The Exchange also believes that the proposed rule change is consistent with the provisions of Section 6(b)(4) of the Act,[25] in that it is designed to provide for the equitable allocation of reasonable dues, fees, and other charges among its Members and other persons using its facilities.

The Exchange operates in a highly competitive market in which market participants can readily direct order flow to competing venues if they deem fee levels at a particular venue to be excessive or incentives to be insufficient. The Exchange believes that its proposed changes reflect a simple and competitive pricing change designed to incentivize market participants to direct their order flow to the Exchange, which the Exchange believes would promote price discovery and price formation and deepen liquidity that is subject to the Exchange's transparency, regulation, and oversight as an exchange, thereby enhancing market quality to the benefit of all Members and investors. The Commission and the courts have repeatedly expressed their preference for competition over regulatory intervention in determining prices, products, and services in the securities markets. In Regulation NMS, while adopting a series of steps to improve the current market model, the Commission highlighted the importance of market forces in determining prices and self-regulatory organization revenues, and also recognized that current regulation of the market system ''has been remarkably successful in promoting market competition in its broader forms that are most important to investors and listed companies.'' [26]

The proposed changes are intended to attract additional executable interest to the TXSE Book [27] and encourage Members to compete through displayed quotations. Displayed liquidity informs market participants of available trading interest and contributes to the public price discovery process. Increasing the incentive to display orders, together with providing competitively priced access to those orders, is intended to encourage participation on both sides of a transaction. To the extent these incentives attract additional liquidity, Members seeking executions may benefit from greater available size and additional opportunities to transact, including Members that do not receive an enhanced rebate.

The Exchange competes with other exchanges and off-exchange trading venues for order flow. Members may consider competing venues when evaluating the proposed rates, together with execution quality and other routing considerations. The Exchange believes that the proposed pricing reflects its business judgment concerning the incentives needed to attract order flow and develop its displayed market. The specific relationship between the proposed charges, rebates, and the trading activity they are intended to encourage provides the basis for the Exchange's conclusions concerning reasonableness and equitable treatment, as discussed below.

The Exchange believes that increasing the base rebate for adding displayed liquidity in securities priced at or above $1.00 from $0.0031 to $0.0032 per share is reasonable because the additional $0.0001 per share rewards Members for making their trading interest publicly available and exposing that interest to execution. For non-displayed executions in securities priced at or above $1.00, the Exchange proposes to increase the fee for both adding and removing liquidity from $0.0002 to $0.0006 per share. The Exchange believes that this increase is reasonable in light of its objective of encouraging displayed interest. Non-displayed liquidity provides execution opportunities, but does not communicate publicly available trading interest in the same manner as displayed liquidity. The proposed structure therefore assigns a greater financial incentive to orders that contribute directly to displayed price discovery. A Member may continue to use non-displayed orders when confidentiality or other execution considerations warrant paying the applicable fee.

For securities priced below $1.00, eliminating the existing fee of 0.05% of TDV for adding or removing non-displayed liquidity would reduce transaction charges for both participants in the execution. The Exchange believes that eliminating these charges is reasonable because it removes a direct cost of interacting with non-displayed interest in these securities and may encourage additional executions. The distinction between pricing for securities below $1.00 and pricing for securities at or above $1.00 also recognizes that a fixed per-share charge represents a larger proportion of transaction value as a security's price declines. The proposal addresses that concern by charging neither side of a non-displayed execution in securities below $1.00.

The Exchange believes that the proposed base rates are equitably allocated and do not permit unfair discrimination because each rate applies to all Members executing the same category of transaction. The distinctions depend on the security's execution price, whether liquidity is displayed, and whether an order supplies or accesses that liquidity. These characteristics bear a direct relationship to the transaction being priced and the proposal's objectives. The rates do not depend on a Member's identity or business model. In particular, the different treatment of displayed and non-displayed liquidity recognizes the additional public price discovery contribution of displayed interest, while the elimination of sub-dollar non-displayed charges benefits all Members executing those transactions on the same terms.

The Exchange further believes that the proposed enhanced rebate for adding displayed liquidity in TXSE-listed corporate securities is reasonable because it directs enhanced incentives to displayed interest in TXSE-listed corporate securities. The proposed $0.0038 per-share enhanced rebate rewards the addition of displayed

[24] 15 U.S.C. 78f(b)(5).

[25] 15 U.S.C. 78f(b)(4).

[26] *See* Securities Exchange Act Release No. 51808 (June 9, 2005), 70 FR 37496, 37499 (June 29, 2005) (''Regulation NMS Adopting Release'').

[27] *See* TXSE Rule 1.005(ii). The term ''TXSE Book'' shall mean the System's electronic file of orders.

liquidity, which contributes to a deeper, more liquid market in TXSE-listed corporate securities and provides additional execution opportunities for active market participants. By offering enhanced rebate opportunities to incentivize increased liquidity provision, the Exchange seeks to encourage greater trading activity and additional execution opportunities for Members, thereby promoting more robust price discovery and improving overall market quality for all market participants.. The Exchange notes that while the proposed enhanced rebate is only available for Members that quote in TXSE-listed corporate symbols and is not more broadly available to Members that quote in any name, the Exchange does not believe this is unfairly discriminatory as all Members are eligible to provide quotations in TXSE-listed corporate symbols and the Exchange does not limit this enhanced rebates to Members to register to quote in TXSE-listed corporate symbols. Additionally, Members whose orders do not qualify for the enhanced rebate remain eligible for the applicable base pricing and may benefit from the additional displayed interest the enhanced rebate is intended to attract.

The Exchange believes that encouraging executable displayed interest at competitive prices promotes just and equitable principles of trade and helps perfect the mechanism of a free and open market and a national market system by improving the information and trading opportunities available to market participants. Publicly displayed quotations can inform routing and execution decisions by brokers and other intermediaries. In this manner, the proposal supports coordination among persons processing securities information and facilitating securities transactions.

Additionally, the Exchange's proposed amendments to the definitions of ''Size Near the Inside'' and ''Time at NBBO'' promotes just and equitable principles of trade, helps perfect the mechanism of a free and open market and a national market system, and contributes to the protection of investors and the public by clarifying the definition so that market participants have a more accurate description of the requirements needed to satisfy the Minimum Performance Standards. The proposed amendments to Section F of the Fee Schedule explain the revised calculations the Exchange would use to determine whether an LMM satisfies the Minimum Performance Standards. The proposed changes to the ''Size Near the Inside'' definition continue to measure notional size within 0.25% of the NBBO, but replace the average-depth calculation with a minimum-depth requirement that must be met for at least 95% of the trading day, which is similar to the criteria found on competitor exchanges. Similarly, the proposed change to the ''Time at NBBO'' definition is designed to account for situations where an LMM may have a business justification for not having the requisite notional depth on both the NBB and NBO at the same time during Regular Trading Hours by looking at an average of the percentage of time at each of the NBB and NBO throughout Regular Trading Hours rather than a set percentage at each of the NBB and NBO. The proposed changes are also not unfairly discriminatory as they apply to all LMMs equally, in that all LMMs are subject to the same criteria and calculations when seeking to achieve the daily stipends provided under the LMM Program.

Further, the proposed addition of the ''Notes'' section to Section F of the Fee Schedule promotes just and equitable principles of trade, helps perfect the mechanism of a free and open market and a national market system, and contributes to the protection of investors and the public because the Exchange believes the proposed notes will provide greater clarity and transparency regarding the calculation and application of certain Minimum Performance Standards under the LMM Program, thereby promoting the consistent and equitable application of such standards to participating LMMs. In particular, including a note about SIP NBBO availability and its application to the calculation of NBBO-referenced metrics promotes a more accurate and consistent assessment of LMM performance, while ensuring that LMMs are not unfairly disadvantaged by market conditions or data irregularities that may be outside their control.

In addition, the Exchange believes its proposal to adjust certain percentage-based performance thresholds for leveraged ETPs based on the absolute value of the product's stated leverage factor is consistent with Section 6(b)(5) of the Act because leveraged ETPs are designed to provide returns corresponding to a multiple of the performance of an underlying index or reference asset, which may result in greater price volatility and more pronounced price movements relative to comparable unleveraged products. As such, the Exchange believes that applying identical percentage-based thresholds to leveraged and unleveraged ETPs, without accounting for differences in their respective investment objectives and price characteristics, could impose disproportionately restrictive quoting and liquidity obligations on LMMs assigned to leveraged ETPs. The proposed adjustment is designed to account for these differences by scaling the applicable percentage-based thresholds in proportion to the product's stated leverage factor, thereby establishing performance standards that more appropriately reflect the characteristics of the underlying product. The Exchange also believes that limiting the adjustment to specified percentage-based and basis point thresholds, while maintaining the existing notional dollar thresholds, appropriately balances recognition of the distinct characteristics of leveraged ETPs with the Program's objective of encouraging meaningful liquidity provision. In particular, maintaining the applicable notional dollar thresholds will preserve the existing minimum dollar-denominated liquidity requirements, while the adjustments to the specified percentage-based thresholds will provide LMMs with greater flexibility to accommodate the price characteristics of leveraged products.

B. Self-Regulatory Organization's Statement on Burden on Competition

Section 6(b)(8) of the Act [28] requires that the Exchange's rules not impose any burden on competition that is not necessary or appropriate in furtherance of the purpose of the Exchange Act. The Exchange 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. Rather, as discussed above, the Exchange believes that the proposed fee change would encourage the submission of additional displayed order flow to a public exchange, thereby promoting market depth, execution incentives, and enhanced execution opportunities, as well as price discovery and transparency for all Members. As a result, the Exchange believes that the proposed change furthers the Commission's goal in adopting Regulation NMS of fostering competition among orders, which promotes ''more efficient pricing of individual stocks for all types of orders, large and small.'' [29]

The Exchange does not believe that the proposed rule change will impose any burden on intramarket competition that is not necessary or appropriate in

[28] 15 U.S.C. 78f(b)(8).

[29] *See* Regulation NMS Adopting Release at 37499.

furtherance of the purposes of the Act because the proposed fees and rebates would apply equally to all Members. The proposed fee changes are intended to encourage market participants to add displayed liquidity to the Exchange by increasing the base rebate for adding displayed liquidity in securities priced at or above $1.00, increasing the fees for adding and removing non-displayed liquidity in securities priced at or above $1.00, eliminating the fees for adding and removing non-displayed liquidity in securities priced below $1.00, and introducing an enhanced rebate for adding displayed liquidity in TXSE-listed corporate securities priced at or above $1.00, which the Exchange believes will help to encourage Members to send orders to the Exchange to the benefit of all Exchange participants. As the proposed rates are equally applicable to all market participants, the Exchange does not believe there is any burden on intramarket competition. In addition, the Exchange does not believe the proposed amendments to the definitions found within LMM Program and proposed introduction of a ''Notes'' section under Subsection F of the Fee Schedule will burden competition as these changes are being proposed to provide additional clarity to LMMs and market participants about the calculations used to determine whether an LMM satisfies the Minimum Performance Standards and are not being introduced for competitive reasons.

The Exchange does not believe that the proposed rule change will impose any burden on intermarket competition that is not necessary or appropriate in furtherance of the purposes of the Act. To the contrary, the Exchange believes that the proposed fee change will increase competition and is intended to draw volume to the Exchange. The Exchange believes that the ever-shifting market share among the exchanges from month to month demonstrates that market participants can shift order flow or reduce use of certain categories of products in response to new or different pricing structures being introduced into the market. Accordingly, competitive forces constrain the Exchange's transaction fees, and market participants can readily trade on competing venues if they deem pricing levels at those other venues to be more favorable. Although this fee change is intended to attract liquidity to the Exchange, most other exchanges in operation today already offer multiple incentives to their participants, including tiered pricing that provides discounted executions, and other exchanges will be able to modify such incentives in order to compete with the Exchange. Accordingly, with respect to a participant deciding to submit an order to remove liquidity, there are multiple exchanges that will continue to be competitively priced for such orders when compared to the Exchange's pricing. Further, while pricing incentives can cause shifts of liquidity between trading centers, market participants make determinations on where to provide liquidity or route orders to take liquidity based on factors other than pricing, including execution quality, technology, functionality, and other considerations. Consequently, the Exchange believes that the degree to which its fees could impose any burden on competition is extremely limited and does not believe that such fees would burden competition of Members or competing venues in a manner that is not necessary or appropriate in furtherance of the purposes of the 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 foregoing rule change has become effective pursuant to Section 19(b)(3)(A) of the Act [30] and Rule 19b–4(f)(2) thereunder,[31] because it establishes or changes a due, or fee. At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–TXSE–2026–049 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–TXSE–2026–049. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the filing will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–TXSE–2026–049 and should be submitted on or before December 10, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[32]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23551 Filed 11–18–26; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106912; File No. SR–OCC–2026–012]

Self-Regulatory Organizations; The Options Clearing Corporation; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by The Options Clearing Corporation Concerning the Implementation of a Fee Holiday for the Period Beginning December 1, 2026, and Ending December 31, 2026

November 16, 2026.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Exchange Act'' or ''Act''),[1] and Rule

[30] 15 U.S.C. 78s(b)(3)(A).

[31] 17 CFR 240.19b–4(f)(2).

[32] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

19b–4 thereunder,[2] notice is hereby given that on November 4, 2026, The Options Clearing Corporation (''OCC'') 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 primarily by OCC. OCC filed the proposed rule change pursuant to Section 19(b)(3)(A)[3] of the Act and paragraph (f) or Rule 19b–4[4] thereunder, such that the proposed rule change was immediately effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Clearing Agency's Statement of the Terms of Substance of the Proposed Rule Change

This proposed rule change would implement a fee holiday for the period beginning December 1, 2026, and ending December 31, 2026. Pursuant to OCC's Capital Management Policy, which the Commission has approved as an OCC rule, when OCC's liquid net assets funded by equity (''LNAFBE'') exceed 110% of OCC's Target Capital Requirement and other approved capital needs, OCC may use tools it deems appropriate to lower costs for clearing members including by implementing a fee holiday. OCC has filed proposed changes to its schedule of fees as Exhibit 5 to File Number SR–OCC–2026–012. Material proposed to be added to OCC's schedule of fees as currently in effect is underlined and material proposed to be deleted is marked in strikethrough text. All capitalized terms not defined herein have the same meaning as set forth in the OCC By-Laws and Rules.

II. Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, OCC 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. OCC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of these statements.

(A) Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

Founded in 1973, OCC operates as a central counterparty (''CCP'') under the jurisdiction of both the SEC and the Commodity Futures Trading Commission (''CFTC''). As a registered clearing agency under the SEC's jurisdiction, OCC is the sole clearing agency for equity options listed on national securities exchanges. As a registered Subpart C DCO under the CFTC's jurisdiction, OCC clears and settles transactions in futures and options on futures. OCC also provides central counterparty clearing and settlement services for securities lending transactions. In its role as a CCP, OCC guarantees the performance of its Clearing Members for all transactions cleared by OCC by becoming the buyer to every seller and the seller to every buyer. Given OCC's critical role, OCC has been designated by the Financial Stability Oversight Council as a systemically important financial market utility (''SIFMU'') under Title VIII of the Dodd-Frank Wall Street Reform and Consumer Protection Act, entitled the Payment, Clearing and Settlement Supervision Act of 2010 (''Clearing Supervision Act'').[5]

Beginning in January 2025, OCC increased its clearing fee to $0.025 per contract in part to cover increased capital expenditures and decreasing interest income. Over the past several years, OCC has incurred significant expenses due to investments in a modernized technology infrastructure tied to the development and future launch of OCC's new clearing system, Ovation. This new system will improve efficiency both for the industry and OCC. This has come with increased costs, however, with expense growth in cloud technology, hardware, software, data centers, and disaster recovery; headcount increases and wage inflation; and increased costs related to regulatory obligations. However, given the high clearing volumes over the first half of 2025, OCC implemented a fee holiday for December 2025 effectively returning excess capital to market participants. Clearing volume during the first half of 2026 has been similarly strong and OCC's LNAFBE exceeds 110% of its Target Capital Requirement and appears likely to remain above that mark for the remainder of 2026 and 2027. OCC is therefore using the tools outlined in its Capital Management Policy and returning capital to market participants by implementing a fee holiday for December 2026.

1. Purpose

Background

As the sole clearing agency for standardized equity options listed on national securities exchanges registered with the Commission, and with respect to OCC's clearance and settlement of futures and stock loan transactions, OCC maintains policies and procedures to manage the risks borne by OCC as a central counterparty. One such risk that OCC manages is general business risk, that is, the risk of potential impairment to OCC's financial position resulting from a decline in revenues or an increase in expenses. To manage this risk and help to ensure that OCC can continue operations and services as a going concern if general business losses materialize, OCC has adopted its Capital Management Policy,[6] which provides the framework by which OCC manages its capital. Amending OCC's schedule of fees is one action used by OCC to manage its capital.

Pursuant to OCC's rule-filed Capital Management Policy, and as required by Exchange Act rules applicable to OCC,[7] OCC must maintain LNAFBE[8] sufficient to cover at least six months of operating expenses, among other measures

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] 17 CFR 240.19b–4(f).

[5] 12 U.S.C. 5463.

[6] *See* Notice of Filing and Immediate Effectiveness of Proposed Rule Change Concerning Updates to OCC's Capital Management Policy, Exchange Act Release No. 101151 (Sep. 24, 2024), 89 FR 79668 (Sep. 30, 2024) (File No. SR–OCC–2024–012); Order Approving Proposed Rule Change to Establish OCC's Persistent Minimum Skin-In-The-Game, Exchange Act Release No. 92038 (May 27, 2021), 86 FR 29861 (June 3, 2021) (File No. SR–OCC–2021–003); Order Approving Proposed Rule Change, as Modified by Partial Amendment No. 1, Concerning a Proposed Capital Management Policy That Would Support the Option Clearing Corporation's Function as a Systemically Important Financial Market Utility, Exchange Act Release No. 88029 (Jan. 24, 2020), 85 FR 5500 (Jan. 30, 2020) (File No. SR–OCC–2019–007); see also Notice of Filing of Partial Amendment No. 1 and Notice of No Objection to Advance Notice, as Modified by Partial Amendment No. 1, Concerning a Proposed Capital Management Policy That Would Support the Options Clearing Corporation's Function as a Systemically Important Financial Market Utility, Exchange Act Release No. 87257 (Oct. 8, 2019), 84 FR 55194 (Oct. 15, 2019) (File No. SR–OCC–2019–805).

[7] *See* 17 CFR 240.17ad–22(e)(15)(ii).

[8] While the relevant rules under the Exchange Act do not define the term, the Commission-approved Capital Management Policy defines LNAFBE as the level of cash and cash equivalents, no greater than shareholders' equity, less any approved adjustments. These approved adjustments exclude cash that would not be available to cover general business expenses, including (1) cash collected by OCC in an agency-related capacity, including the SEC Section 31 fees that OCC collects monthly and transmits to the Commission semi-annually on behalf of the options exchanges, and (2) OCC's Minimum Corporate Contribution, which is the minimum level of OCC funds (often referred to as ''skin-in-the-game'') maintained exclusively to cover credit losses or liquidity shortfalls arising from a Clearing Member default.

(''Target Capital Requirement''). Because OCC is required to maintain such funds, the LNAFBE used to meet the Target Capital Requirement cannot be used to cover operational expenses and any increase in expenses must be covered by current revenue or cash held in excess of the Target Capital Requirement. The Capital Management Plan further sets 110% of the Target Capital Requirement as an early warning threshold. If LNAFBE falls below the early warning threshold, OCC management and Board must discuss whether a fee increase is necessary.

In the filing to implement the 2025 fee increase (''2025 Fee Filing''),[9] OCC projected that its LNAFBE would fall below OCC's Target Capital Requirement by the end of Q1 2025 and took action prior to hitting the early warning threshold. At the time, OCC stated it did not believe it would be prudent, given its designation as a SIFMU, to allow its LNAFBE to decline past the early warning threshold prior to taking action to ensure that OCC maintains sufficient LNAFBE to satisfy its regulatory requirements and so that it may continue to operate as a going concern if it were to experience general business losses.[10] However, in the 2025 Fee Filing, OCC emphasized its commitment to aligning its revenues with its costs and capital needs and stated that, consistent with its past practice, if revenues exceed costs and OCC's LNAFBE is above the early warning threshold, OCC would consider utilizing tools to lower the cost of clearing for market participants, as provided under its Capital Management Policy.[11] Later in 2025, OCC followed through and implemented a fee holiday for December 2025 to help lower clearing costs for market participants.[12] Today, OCC is continuing this practice and instituting a fee holiday for December 2026.

Proposed Fee Holiday

OCC proposes to implement a fee holiday for the month of December 2026. OCC has in place policies and procedures, including the Capital Management Policy, to control costs and regularly review fees and operating expenses, including during its annual budgeting process. Consistent with the Capital Management Policy, OCC set its clearing fees based on factors including OCC's annual budgeted or forecasted operating expenses and projected revenue. However, clearing volume, and therefore revenue, have outpaced projections and OCC currently has LNAFBE in excess of its early warning threshold. In addition to clearing fees, OCC receives revenue from the interest paid on the cash margin collateral it holds with the Federal Reserve System and elsewhere. In October 2026, OCC began paying Clearing Members interest on their margin cash at a rate based on the interest rate OCC receives from the Federal Reserve, less a cash management fee. For budgeting purposes, OCC assumed it would begin paying interest on margin cash in July 2026. Therefore, OCC had three fewer months of interest expenses than anticipated, further contributing to the amount of LNAFBE OCC has in excess of the early warning threshold. The fee holiday will allow OCC to return excess capital to market participants and clearing members while still maintaining sufficient capital to maintain compliance with the Capital Management Policy and regulatory requirements.

In evaluating its current LNAFBE and projections for 2027, OCC determined that a fee holiday is warranted for December 2026. Based on recent volumes, OCC estimates that the fee holiday for the month of December will lead to approximately $77 million in lost revenue. Despite this, OCC believes it will remain above the 2026 early warning threshold ($355.3 million) as well as its projected early warning threshold for 2027 ($390.8 million). To make this determination, OCC evaluated revenue and LNAFBE under a wide range of volume scenarios including current average daily volume (''ADV''), 60 million ADV, and –4% ADV growth. In all scenarios except the negative growth scenario, OCC remained above its early warning threshold through the end of 2027 even with the fee holiday. OCC, however, does not believe the negative growth scenario is realistic, and it would result in ADV decreasing by 50% to 35.5 million contracts a day by the end of 2027. The scenario was selected to illustrate the level of volume decrease that would cause OCC to drop below its early warning threshold. Nonetheless, under this extreme scenario, OCC remained above its early warning threshold through October 2027, meaning OCC would have time to react if the negative ADV growth scenario becomes more realistic.[13]

To enact the proposed changes, OCC would update its schedule of fees as set out below.

Current fee schedule (Clearing fees)	Proposed fee schedule (fee Holiday December 2026)
All Transactions $0.025/contract	All transactions $0.00/contract.
Minimum Monthly Clearing Fee $200	$0.00.

OCC proposes to make the removal of the $.025 fee per contract effective December 1, 2026. The removal of the minimum monthly fee of $200 will be made once OCC receives all necessary regulatory approvals. Effective the first trading day of 2027, clearing fees will revert to the fee schedule in effect before December 1, 2026 and OCC will remove the fee holiday from its schedule of fees.

2. Statutory Basis

OCC believes the proposed rule change is consistent with the Act [14] and the rules and regulations thereunder.

Compliance With Section 17A(b)(3)(D) of the Act

In particular, OCC believes that the proposed fee change is consistent with Section 17A(b)(3)(D) of the Act,[15] which requires that the rules of a clearing agency provide for the equitable allocation of reasonable dues, fees, and other charges among its participants. OCC believes that the proposed fee holiday is reasonable because it is designed to decrease the cost of clearing while maintaining sufficient LNAFBE to cover OCC's operating expenses and address potential business or

[9] Exchange Act Release No.102437 (Feb. 18, 2025) (File No. SR–OCC–2025–002), 19b–4 Information, at 8, available at *https://www.sec.gov/files/rules/sro/occ/2025/34-102437-19b-4.pdf.*

[10] *See* 19b–4 Information, at 8 (File No. SR–OCC–2025–002), *available at https://www.sec.gov/files/rules/sro/occ/2025/34-102437-19b-4.pdf.*

[11] *Id.* at 20–21.

[12] *See* Exchange Act Release No. 34–104274 (Nov. 28, 2025), 90 FR 55768 (Dec. 3, 2025), (File No. SR–OCC–2025–019).

[13] OCC has filed a chart showing projected cash outflows and LNAFBE compared to OCC's Target Capital Requirement as Exhibit 3 to File No. SR–OCC–2026–012.

[14] 15 U.S.C. 78a, *et seq.*

[15] 15 U.S.C. 78q–1(b)(3)(D).

operational losses so that OCC can continue to meet its obligations as a SIFMU. The reasonableness of the proposal is supported by oversight, transparency, and OCC's past practice, wherever circumstances allow, to utilize tools to lower the cost of clearing for participants.

First, OCC's funding and operations are subject to oversight by OCC's Board and the Commission. OCC's annual budget, compensation for senior management, and capital initiatives are reviewed and approved by its Board-level CPC. OCC's Board is made up of a broad cross-section of options market participants, including public representatives, Clearing Member representatives from Clearing Members of various sizes, and options exchange representatives. At least a majority of the CPC is composed of independent directors, consistent with Commission Rule 17ad–25(e)[16] and the judgment of the Board.

OCC is also supervised by the Commission throughout the year. Pursuant to Section 807(a) of the Clearing Supervision Act, the Commission's Division of Examinations conducts annual examinations of OCC to determine, among other things, (1) the nature of the operations of, and the risks borne, by OCC; (2) the financial and operational risks presented by OCC to financial institutions, critical markets, or the broader financial system; and (3) the resources and capabilities of OCC to monitor and control such risks.[17] In addition, changes to OCC's rules, procedures and operations that could materially affect the nature or level of risk presented by OCC are also subject to review by the Commission, in consultation with the Federal Reserve, under Section 806(e) of the Clearing Supervision Act.[18] Furthermore, the SEC publishes such proposed changes for public comment.

Second, OCC's commitment to reasonable funding is further supported by the transparency it provides on an ongoing basis regarding its financial performance. Each year, OCC publishes its Annual Report, inclusive of its audited financial statements prepared in accordance with generally accepted accounting principles. OCC maintains a dedicated website that consolidates its annual reports in a readily accessible place.[19] On a quarterly basis, OCC also provides unaudited information concerning its total revenues, average daily contract volume and LNAFBE on its ''Schedule of Fees'' website to aid Clearing Members in assessing the risk associated with a potential Operational Loss Fee in accordance with OCC's capital replenishment plan under its Capital Management Policy.[20]

Third, OCC is committed to aligning its revenues with its costs and capital needs. Consistent with OCC's past practice, if revenues exceed costs and OCC's LNAFBE is above the early warning threshold, OCC would consider utilizing tools to lower the cost of clearing for market participants, as provided under its Capital Management Policy. Such tools may include fee decreases like those OCC implemented in 2020 and 2021,[21] fee holidays like the one OCC implemented from November through December of 2021 and December 2025[22] and proposed to be implemented in December 2026, or fee refunds like the $156 million refund in 2020 and the $76.3 million refund in 2021.

Finally, OCC believes that the fee holiday would be equitably allocated because it applies equally to all transaction types and clearing members.

Compliance With Rule 17ad–22(e)(15)

In addition, OCC believes that the proposed rule change is consistent with Rule 17ad–22(e)(15), which requires that OCC establish, implement, maintain and enforce written policies and procedures reasonably designed to identify, monitor, and manage OCC's general business risk and hold sufficient LNAFBE to cover potential general business losses so that OCC can continue operations and services as a going concern if those losses materialize.[23] The Rule also requires OCC to hold LNAFBE equal to at least six months of OCC's current operating expenses, among other measures.[24] As described above, OCC will be able to continue to meet its ongoing obligations and hold the required amount of LNAFBE following the fee holiday. OCC estimates that the fee holiday will result in approximately $77 million in missed revenue. Nonetheless, based on a wide range of trading volume projections, OCC expects to remain above its Target Capital Requirement and early warning threshold throughout 2026 following the fee holiday.[25]

(B) Clearing Agency's Statement on Burden on Competition

Section 17A(b)(3)(I) of the Act[26] requires that the rules of a clearing agency not to impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. OCC does not believe that the proposed rule change would have any impact or impose a burden on competition. OCC believes that the proposed rule change would not disadvantage or favor any particular user of OCC's services in relationship to another user because the proposed fee holiday would apply equally to all Clearing Members. Accordingly, OCC does not believe that the proposed rule change would have any impact or impose a burden on competition.

(C) Clearing Agency's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Written comments were not and are not intended to be solicited with respect to the proposed change and none have been received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A) of the Act[27] and paragraph (f) of Rule 19b–4[28] thereunder. At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

The proposal shall not take effect until all regulatory actions required with respect to the proposal are completed.[29]

[16] 17 CFR 17ad–25(e).

[17] 12 U.S.C. 5466.

[18] 12 U.S.C. 5465(e).

[19] OCC's audited financials are *available at https://www.theocc.com/company-information/documents-and-archives/annual-reports.*

[20] Schedule of Fees, OCC Capital Management Report, *available at https://www.theocc.com/company-information/schedule-of-fees.*

[21] *See* Exchange Act Release Nos. 89534 (Aug. 12, 2020), 85 FR 50858 (Aug. 18, 2020) (File No. SR–OCC–2020–009); 91920 (May 18, 2021), 86 FR 27916 (May 24, 2021) (File No. SR–OCC–2021–006).

[22] *See* Exchange Act Release Nos. 93195 (Sept. 29, 2021), 86 FR 55039 (Oct. 5, 2021) (File No. SR–OCC–2021–009); 93612 (Nov. 18, 2021), 86 FR 67108 (Nov. 24, 2021) (File No. SR–OCC–2021–012); 104274 (Nov. 28, 2025), 90 FR 55768 (Dec. 3, 2025), (File No. SR–OCC–2025–019).

[23] 17 CFR 240.17ad–22(e)(15).

[24] 17 CFR 240.17ad–22(e)(15)(ii).

[25] OCC has filed Exhibit 3 to File No. SR–OCC–2026–012 showing projected cash outflows and LNAFBE compared to OCC's Target Capital Requirement.

[26] 15 U.S.C. 78q–1(b)(3)(I).

[27] 15 U.S.C. 78s(b)(3)(A).

[28] 17 CFR 240.19b–4(f).

[29] Notwithstanding its immediate effectiveness, implementation of this rule change will be delayed until this change is deemed certified under CFTC Regulation 40.6.

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 (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–OCC–2026–012 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–OCC–2026–012. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of such filing will be available for inspection and copying at the principal office of OCC and on OCC's website at *https://www.theocc.com/Company-Information/Documents-and-Archives/By-Laws-and-Rules.* Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to File Number SR–OCC–2026–012 and should be submitted on or before December 10, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[30]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23547 Filed 11–18–26; 8:45 am]

BILLING CODE 8011–01–P

[30] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106893; File No. SR–NYSEAMER–2026–17]

Self-Regulatory Organizations; NYSE American LLC; Order Approving a Proposed Rule Change To Amend Sections 1003 and 1009 of the NYSE American Company Guide

November 13, 2026.

I. Introduction

On March 6, 2026, NYSE American LLC (''NYSE American'' or the ''Exchange'') filed with the Securities and Exchange Commission (''Commission'' or ''SEC''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] a proposed rule change to amend Sections 1003 and 1009 of the NYSE American Company Guide (''Company Guide'') to establish that an issuer must maintain a certain market capitalization in order to remain listed on the Exchange. The proposed rule change was published for comment in the **Federal Register** on March 20, 2026.[3] On April 29, 2026, pursuant to Section 19(b)(2) of the Act,[4] the Commission designated a longer period within which to take action on the proposed rule change.[5] On June 2, 2026, the Commission instituted proceedings pursuant to Section 19(b)(2)(B) of the Act [6] to determine whether to approve or disapprove the proposed rule change.[7] On September 14, 2026, the Commission issued a notice of designation of a longer period of time for Commission action on proceedings to determine whether to approve or disapprove the proposed rule change.[8] The Commission received several comment letters, which are addressed below.[9] This order approves the proposed rule change.

II. Description of the Proposed Rule Change

Section 1003 of the Company Guide sets forth minimum quantitative and qualitative continued listing standards for securities listed on the Exchange.[10] Currently, Section 1003(b)(i) of the Company Guide enumerates circumstances where the Exchange will consider suspension and delisting of a class of common stock because of a sufficiently limited distribution of shares.[11] Section 1003(b)(i) of the Company Guide does not contain a minimum market capitalization requirement.[12]

The Exchange states that it has noticed a recent increase in companies that have a very small market capitalization.[13] According to the Exchange, an issuer with a small market capitalization is potentially susceptible to manipulation and more likely to experience trading volatility in its shares because, at smaller sizes, less capital is required to undertake manipulative trading activity.[14] Therefore, the Exchange proposes to amend Section 1003 of the Company Guide to require an issuer to maintain a certain market capitalization in order to remain listed on the Exchange.[15]

Specifically, the Exchange proposes to adopt new Section 1003(b)(i)(D) of the Company Guide to specify that if an issuer's class of common stock is determined to have average market capitalization over a consecutive 30 trading-day period of less than $5 million, the Exchange will immediately suspend trading and commence delisting proceedings with respect to such security in accordance with the procedures in Section 1010 of the Company Guide.[16] This order refers to

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 105036 (Mar. 17, 2026), 91 FR 13645 (''Notice'').

[4] 15 U.S.C. 78s(b)(2).

[5] *See* Securities Exchange Act Release No. 105334, 91 FR 24023 (May 4, 2026). The Commission designated June 18, 2026, as the date by which the Commission shall approve, disapprove, or institute proceedings to determine whether to disapprove the proposed rule change. *See id.*

[6] 15 U.S.C. 78s(b)(2)(B).

[7] *See* Securities Exchange Act Release No. 105597, 91 FR 34263 (June 5, 2026).

[8] *See* Securities Exchange Act Release No. 106348, 91 FR 58947 (Sept. 17, 2026). The Commission designated November 15, 2026, as the date by which the Commission must issue an order approving or disapproving the proposed rule change. *See id.*

[9] Comments received on the proposed rule change are available at: *https://www.sec.gov/rules-regulations/public-comments/sr-nyseamer-2026-17.*

[10] *See* Notice, *supra* note 3, at 13645. Specifically, the Exchange stated that Section 1003 of the Company Guide requires issuers of common stock to maintain certain quantitative minimum standards related to stockholders' equity, publicly held shares, public shareholders, and aggregate market value of publicly held shares. In addition, Section 1003 of the Company Guide sets forth qualitative continued listing standards related to, among other things, operations contrary to public interest and reduction of operations. *See id.*

[11] *See id. See also* Section 1003(b) of the Company Guide.

[12] *See* Notice, *supra* note 3, at 13645.

[13] *See id.*

[14] *See id.*

[15] *See id.*

[16] *See id.* For purposes of Section 1003 of the Company Guide, market capitalization includes the total common stock outstanding (excluding treasury shares) as well as any common stock that would be

average market capitalization for an issuer's class of common stock over a consecutive 30 trading-day period of $5 million as the ''Minimum Market Capitalization Criteria.'' The Exchange also proposes that an issuer that falls below the Minimum Market Capitalization Criteria would not be eligible to follow the procedures to regain compliance outlined in Section 1009 of the Company Guide.[17] The Exchange further proposes to amend Section 1009 of the Company Guide to add to the list of continued listing standards for which noncompliance does not entitle the issuer to a compliance period a reference to proposed Section 1003(b)(i)(D) of the Company Guide.[18] The Exchange states that all issuers would retain the right to appeal an Exchange delisting decision.[19]

The Exchange states that, in its experience, an issuer with a sustained market capitalization below $5 million is likely to be financially distressed and is increasingly susceptible to manipulation due to its small size.[20] The Exchange also states that having a market capitalization below $5 million is frequently a leading indicator that an issuer has other financial concerns that often require a substantial amount of regulatory oversight, and accordingly, the Exchange does not believe that an issuer fitting this profile is appropriate for continued listing on the Exchange.[21] Further, the Exchange states that, in its experience, a company trading at a sustained market capitalization below $5 million is unlikely to regain financial stability and it is therefore appropriate to subject the company to immediate suspension and delisting.[22]

The Exchange states that the proposal would become effective immediately upon Commission approval.[23]

III. Discussion and Commission Findings

The Commission has given careful consideration to the Exchange's proposal and all comments submitted to determine whether the proposal is consistent with the Act and the rules and regulations issued thereunder. Under Section 19b(2)(C) of the Act, the Commission must approve the proposed rule change of a self-regulatory organization (''SRO'') if the Commission finds that the proposed rule change is consistent with the Act and the applicable rules and regulations thereunder; if it does not make such a finding, the Commission must disapprove the proposed rule change.[24]

For the reasons discussed herein, the proposed rule change is consistent with the Act and the rules and regulations thereunder applicable to national securities exchange. In particular, the Commission finds that the record before the Commission demonstrates that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange.[25] More specifically, the Commission finds that the proposed rule change is consistent with Section 6(b)(5) of the Act,[26] which requires, among other things, that the rules of an exchange be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest, and not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers. The Commission also finds that the proposed rule change is consistent with Section 6(b)(7) of the Act,[27] which requires, among other things, that the rules of an exchange provide fair procedure for the prohibition or limitation by the exchange of any person with respect to access to services offered by the exchange. In addition, the Commission finds that the proposed rule change is consistent with Section 6(b)(8) of the Act,[28] which requires that the rules of an exchange do not impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act.

The Commission has consistently recognized that the development and enforcement of meaningful listing standards [29] by an exchange is of critical importance to financial markets and the investing public.[30] Among other things, the Commission has stated that listing standards provide the means for an exchange to screen issuers that seek to become listed, and to provide listed status only to bona fide companies that have or will have sufficient public float, investor base, and trading interest to provide the depth and liquidity to promote fair and orderly markets.[31] Those listing standards are informed by an exchange's regulatory and commercial considerations and the Act provides exchanges with discretion, subject to the requirements of the Act, to set those standards as they see fit with the understanding that not all companies will meet those standards initially or over time. Meaningful listing standards also are important given investor expectations regarding the nature of securities that have achieved an exchange listing, and the role of an exchange in overseeing its market and assuring compliance with its listing standards.[32] The imprimatur of listing on a particular exchange correlates to investors' expectations that the listed issuer meets the standards set by the exchange and that the exchange has used its judgment regarding the level at which to set those standards.[33]

issued upon conversion of another outstanding equity security, if such other security is a ''substantial equivalent'' of common stock. *See* footnote to Section 1003 of the Company Guide.

[17] *See* Notice, *supra* note 3, at 13645.

[18] *See id.* at 13646. *See also* proposed Section 1009(a)(ii) of the Company Guide.

[19] *See* Notice, *supra* note 3, at 13646. *See also* Part 12 of the Company Guide (setting forth the procedures for appealing an Exchange delisting decision).

[20] *See* Notice, *supra* note 3, at 13645.

[21] *See id.* at 13645–6.

[22] *See id.* at 13646.

[23] *See id.*

[24] 15 U.S.C. 78s(b)(2)(C).

[25] In approving this proposed rule change, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[26] 15 U.S.C. 78f(b)(5).

[27] 15 U.S.C. 78f(b)(7).

[28] 15 U.S.C. 78f(b)(8).

[29] This reference to ''listing standards'' refers to both initial and continued listing standards.

[30] *See, e.g.,* Securities Exchange Act Release No. 57785 (May 6, 2008), 73 FR 27597 (May 13, 2008) (SR–NYSE–2008–17).

[31] *See, e.g.,* Securities Exchange Act Release Nos. 105494 (May 14, 2026), 91 FR 29183 (May 19, 2026) (SR–NASDAQ–2025–069); 105603 (Jun. 3, 2026), 91 FR 34675 (Jun. 8, 2026) (SR–NASDAQ–2026–009); 106134 (Aug. 14, 2026), 91 FR 53436 (Aug. 18, 2026) (SR–NYSEAMER–2025–72) (''Minimum Bid Price Proposal''); 10633 (Aug. 14, 2026), 91 FR 53458 (Aug. 18, 2026) (NYSE–2025–43). In these releases, the Commission also stated that adequate listing standards, by promoting fair and orderly markets, are consistent with Section 6(b)(5) of the Act, in that they are, among other things, designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, and protect investors and the public interest.

[32] *See, e.g.,* Securities Exchange Act Release Nos. 88716 (Apr. 21, 2020), 85 FR 23393 (Apr. 27, 2020) (SR–NASDAQ–2020–001); 88389 (Mar. 16, 2020), 85 FR 16163 (Mar. 20, 2020) (SR–NASDAQ–2019–089). *See also* Securities Exchange Act Release No. 81856 (Oct. 11, 2017), 82 FR 48296, 48298 (Oct. 17, 2017) (SR–NYSE–2017–31) (stating that ''[a]dequate standards are especially important given the expectations of investors regarding exchange trading and the imprimatur of listing on a particular market'' and that ''[o]nce a security has been approved for initial listing, maintenance criteria allow an exchange to monitor the status and trading characteristics of that issue . . . so that fair and orderly markets can be maintained'').

[33] *See* Securities Exchange Act Release No. 38961 (Aug. 22, 1997), 62 FR 45895, 45899 (Aug. 29, 1997) (SR–NASD–97–16) (finding Nasdaq's proposal to raise its listing standards consistent with the Act because the proposal ''reflects the NASD's judgment that it wants only higher quality companies to avail themselves of the Nasdaq marketplace, and the imprimatur that such inclusion confers'' and the increased standards ''are directly related to the NASD's intended goals of enhancing its listing standards'').

The Exchange's proposal is reasonably designed to enhance the Exchange's continued listing standards. The proposal will accelerate the timeframe within which the Exchange will delist an issuer's class of common stock in instances where the security is below the Minimum Market Capitalization Criteria and result in immediate suspension from trading on the Exchange.[34] Such issuers will not be eligible to receive a cure or compliance period before receiving an Exchange delisting decision. The Exchange states that a company with a sustained market capitalization below $5 million is likely to be financially distressed and is more susceptible to market manipulation.[35]

As discussed further below, a few commenters stated that the proposal is inadequate because it failed to conduct certain analyses that the Commission would generally conduct for its own rulemaking, such as a cost-benefit analysis and an analysis of the combined effect of the proposal together with pending proposals from other exchanges.[36] When submitting a proposed rule change, an SRO is subject to the requirements of Section 19 of the Act,[37] Rule 19b–4 thereunder,[38] and Form 19b–4,[39] which are not the same requirements that apply when the Commission proposes new or amended Federal securities rules and regulations. There presently are 29 registered national securities exchanges[40] that operate trading venues. As private commercial enterprises, the Act provides exchanges with a considerable degree of discretion to operate. This proposal is about listing standards, which the Federal securities laws do not prescribe. Rather, the securities laws leave the establishment of listing standards to the individual exchanges, which have broad discretion to establish such standards as they, in their expertise and judgment, see fit, subject to the requirements of Section 6 of the Act.[41] Those requirements do not include that an exchange conduct a cost-benefit analysis or analyze the effects of its proposals when considered in combination with the proposals or rules of its competitors. Nor does the Act require the Commission to perform such analyses when considering an exchange proposal.

Two commenters expressed support for the Exchange's proposal.[42] One commenter stated that the proposal is a direct response to widespread concerns over the growth of manipulative trading schemes in highly speculative, low priced securities listed on exchanges, which harms investors and undermines confidence in the fairness and efficiency of U.S. equity markets.[43] This commenter stated that the proposal ''supports market integrity and protects investors, strengthens U.S. financial markets, and is clearly consistent with the Exchange Act.'' [44] This commenter further stated that the trend of ''highly speculative, low priced securities listing on exchanges in recent years,'' and the accompanying growth in manipulative trading schemes, are ''directly linked to current listing standards being insufficient and susceptible to circumvention.'' [45] This commenter stated that actions taken thus far by regulators in response ''have yet to stem the tide,'' therefore the commenter has urged the listing exchanges to enhance their continued listing requirements.[46]

Another commenter stated that the Exchange's proposal is a ''meaningful enhancement to its continued listing standards'' and is aligned with its duties as an SRO to design and enforce ''meaningful listing standards that ensure listed companies have sufficient public float, investor base, and trading interest to support fair and orderly markets.'' [47] This commenter stated the number of low-priced securities on U.S. exchanges has grown materially in recent years and that these securities exhibit ''structural fragilities'' such as ''thin trading, wider spreads, limited and unstable investor interest, and heightened vulnerability to promotion driven price spikes.'' [48] This commenter further stated that these ''characteristics make such securities disproportionately associated with manipulative schemes, including pump and dumps, ramp and dumps, serial reverse splits, wash trading, and other volume manufacturing tactics that distort price discovery and expose retail investors to significant harm.'' [49] This commenter stated that approving the proposal would address the specific risks that the Exchange has documented.[50]

Other commenters raised concerns regarding the proposed rule change.[51] Specifically, one commenter stated that the proposal does not provide empirical evidence in support of the proposed $5 million market capitalization threshold, such as evidence demonstrating that issuers below the proposed threshold present a systemic problem warranting categorical intervention.[52] This commenter stated that ''[i]f fraud or

[34] *See* Section 1009(b) of the Company Guide (providing that a listed company receiving a deficiency notification for continued listing standards is granted a compliance period of up to 18 months from the receipt of the deficiency letter, subject to certain conditions).

[35] *See supra* note 20 and accompanying text.

[36] *See infra* Section III.C (Comments Regarding the Need for the Proposed Rule Change).

[37] 15 U.S.C. 78s.

[38] 17 CFR 240.19b–4.

[39] 17 CFR 249.819.

[40] *See* list of current national securities exchanges at: *https://www.sec.gov/rules-regulations/self-regulatory-organization-rulemaking/national-securities-exchanges.*

[41] 15 U.S.C. 78s. *See supra* notes 32–33.

[42] *See* Letters from Stephen John Berger, Managing Director, Global Head of Regulatory Policy, Citadel Securities, dated Aug. 24, 2026 (''Citadel Letter''); Katie Kolchin, CFA, Managing Director, Head of Equity & Options Market Structure, and Gerald O'Hara, Vice President & Assistant General Counsel, SIFMA, dated Sept. 3, 2026 (''SIFMA Letter'').

[43] *See* Citadel Letter at 1.

[44] *Id.* In support of its position that the proposal is consistent with the Act, the commenter cites to prior Commission orders approving enhanced listing standards. *See id.* at 3.

[45] *Id.* at 1 (highlighting ''repeated reverse stock splits to prop up share prices, superficial corporate reorganization, and protracted appeals and cure periods'' as means to circumvent listing standards).

[46] *See id.* at 2 (noting the creation of a Commission task force and Commission suspension of trading in numerous listed companies, as well as review by the Financial Industry Regulatory Authority (''FINRA'') of the firms involved in these companies' public offerings, as actions taken by regulators).

[47] SIFMA Letter at 1–2.

[48] *See id.* at 2.

[49] *Id.*

[50] *See id.*

[51] *See* Letters from Marc Indeglia, The Small Public Company Coalition, dated June 26, 2026 (''SPCC Letter I''); Lucosky Brookman LLP, dated June 27, 2026 (''Lucosky Letter''); Marc Indeglia, The Small Public Company Coalition, dated June 26, 2026 (''SPCC Letter II''); Marc Indeglia, The Small Public Company Coalition, dated July 10, 2026 (''SPCC Letter III''). One commenter attached a comment letter that it had submitted to the Commission regarding a separate proposed rule change filed by the Exchange to immediately suspend trading in and delist a security if its closing price is below $0.25 on any trading day (''Minimum Bid Price Criteria''). *See* Letter from Small Public Company Coalition, dated Mar. 12, 2026 (attached as Exhibit 2 to SPCC Letter I) (''SPCC March Letter''). *See also* Minimum Bid Price Proposal. This commenter also attached a comment letter that it had submitted to the Commission regarding a separate proposed rule change filed by another national securities exchange to immediately suspend trading in and delist a company's security if the company's market value of listed securities falls below $5 million for 30 consecutive business days (''Nasdaq MVLS Proposal''), along with letters submitted by other commenters on that proposal. *See* Letter from Small Public Company Coalition, dated Feb. 19, 2026 (attached as Exhibit 3 to SPCC Letter I); and Letters from Autonomix Medical, Inc., dated Feb. 19, 2026 (''Autonomix Letter''); HeartSciences, Inc., dated. Feb. 19, 2026 (''HeartSciences Letter''); Imunon, Inc., dated Feb. 18, 2026 (''Imunon Letter''); MacKenzie Realty Capital, Inc., dated Feb. 19, 2026 (''MacKenzie Realty Letter''); Edible Garden AG Incorporated, dated Feb. 19, 2026 (''Edible Garden Letter''); IP Strategy Holdings, Inc., dated Feb. 18, 2026 (''IP Strategy Letter''); Donohoe Advisory Associates LLC, dated Feb. 19, 2026 (''Donohoe Letter'') (attached as Exhibit 4 to SPCC Letter I). *See also* Securities Exchange Act Release No. 105971 (July 22, 2026), 91 FR 46995 (July 27, 2026) (SR–NASDAQ–2026–004) (proposal pending before the Commission pursuant to petitions for review).

[52] *See* SPCC Letter I at 3–4. *See also* IP Strategy Letter at 10–11.

manipulation risk is disproportionately concentrated among identifiable issuer profiles, a targeted, risk-based response focused on those characteristics would be more precise and far less damaging than a blanket market-capitalization trigger applied to all issuers regardless of domicile, governance structure, or compliance history.'' [53]

The Commission's data analysis, discussed in more detailed below, supports approval of the Exchange's proposal. Specifically, the Commission's analysis supports the Exchange's statement that there is an increasing trend of companies that have a very small market capitalization and that companies with a sustained market capitalization below $5 million are unlikely to regain financial stability.[54] As discussed further below, in the Commission's view, securities with smaller market capitalization may be more susceptible to manipulation.[55] The continued listing of securities with a market capitalization below $5 million raises concerns that these securities may have heightened susceptibility to manipulation while trading on the Exchange for an extended period. Accordingly, the Exchange's proposal to immediately suspend and delist companies that fail to comply with the Minimum Market Capitalization Criteria is reasonably designed and consistent with the requirements of Section 6(b)(5) of the Act that the rules of the Exchange be designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, protect investors and the public interest, and not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers.[56]

As part of the Commission's consideration of the proposed Minimum Market Capitalization Criteria, the Commission analyzed stock price and delistings data for companies listed on The Nasdaq Stock Market LLC (''Nasdaq'') and on NYSE American from 2006 to 2025.[57] The results of the Commission's analysis show that the number of issuers whose average market capitalization over a consecutive 30 trading-day period would have fallen below $5 million (''Market Capitalization Analysis Threshold''),[58] increased sharply from 5 issuers in 2021 to 176 issuers in 2023.[59] Although the numbers decreased to 159 issuers in 2024, and 110 issuers in 2025, the 2024 and 2025 numbers are still higher than during the rest of the sample period, apart from 2008.

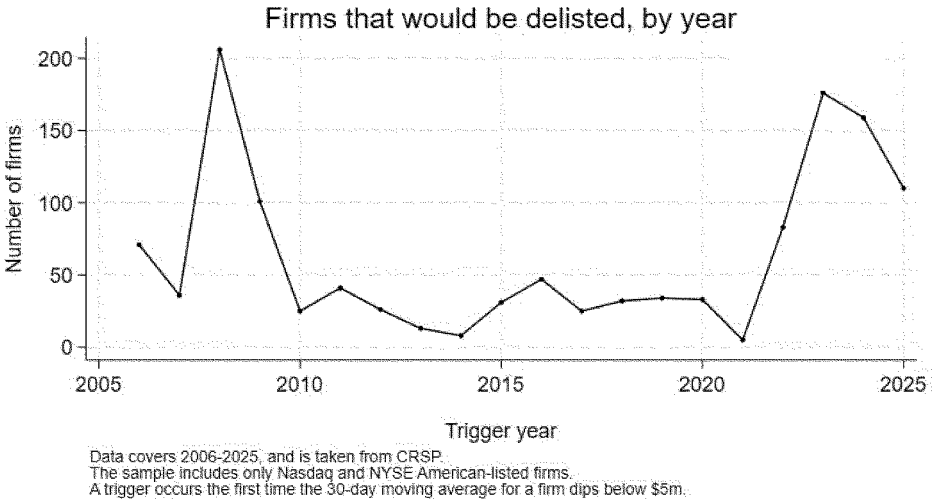


Figure 1. Number of Nasdaq and NYSE American issuers that would have been delisted pursuant to the Market Capitalization Analysis Threshold, by year.

[53] SPCC Letter I at 13–14.

[54] *See supra* notes 13 and 22.

[55] *See supra* notes 78–81 and accompanying text.

[56] 15 U.S.C. 78f(b)(5).

[57] The stock price data, which is at the security level, was sourced from Center for Research in Security Prices (''CRSP'') and accessed through Wharton Research Data Services. This data covers the time period from 2006 to 2025. The data provider calculated the daily market capitalization of each security by multiplying the closing price by the number of shares outstanding. If a closing trade was not available, the closing price was calculated as the midpoint of the best bid and ask quotes at the end of the regular trading session. The Commission analyzed the stock price data at the company level, excluded non-corporate issuers, and only kept issues of common equity (including American Depositary Receipts). The total equity market capitalization of each company was obtained by aggregating the market capitalization of each of the company's issues. The delistings data was sourced from CRSP. The delisting analysis included only cases where the listing exchange dropped the issue (*i.e.,* it excluded cases where an issue was delisted due to a merger, exchange or liquidation). If a company was delisted from an exchange, re-listed, and then was delisted again, only the first delisting event for the company was included in the analysis.

[58] The proposed Minimum Market Capitalization Criteria has a definition closely related to the Market Capitalization Analysis Threshold used in this analysis. The terms differ in that the Market Capitalization Analysis Threshold is based on the number of shares outstanding, as described in note 63, whereas the Minimum Market Capitalization Criteria is based on the total common stock outstanding (excluding treasury shares), as well as any common stock that would be issued upon conversion of another outstanding equity security, if such other security is a ''substantial equivalent'' of common stock. *See supra* note 16 and accompanying text. While counting the number of shares of common stock that would be issued upon conversion, consistent with the definition of the Minimum Market Capitalization Criteria, may influence the quantitative findings in the analysis, the Commission did not attempt to include such details due to the lack of readily available data on such share counts.

[59] Figure 1 and Figure 2 compare the number of issuers that would have been delisted pursuant to the Market Capitalization Analysis Threshold (number of firms) against the year in which the delisting would have taken place (trigger year). Figure 1 includes data on Nasdaq or NYSE American issuers; and Figure 2 only includes data on NYSE American issuers. If an issuer fell below the Market Capitalization Analysis Threshold multiple times during the sample period, both analyses kept only the first of such dates.

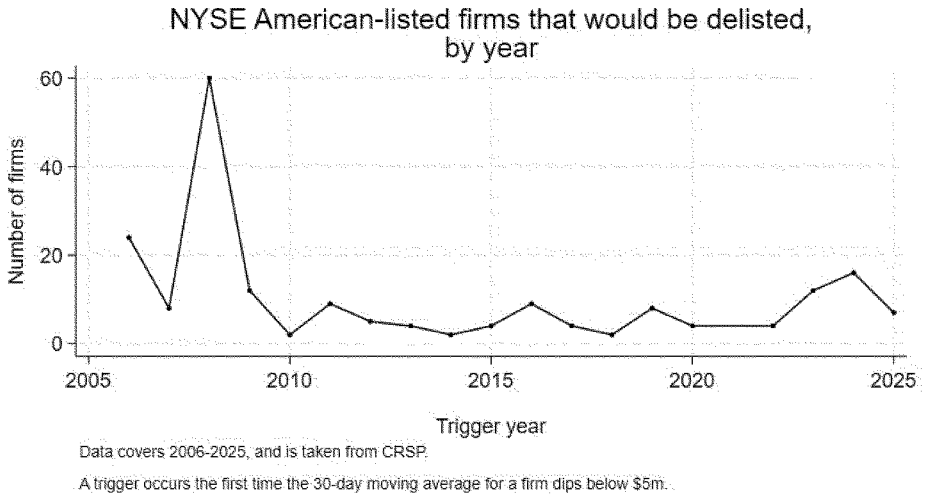


Figure 2. Number of NYSE American issuers that would have been delisted pursuant to the Market Capitalization Analysis Threshold, by year..

In addition, the Commission analyzed the relationship between securities whose average market capitalization over periods ranging between 30 and 90 trading days fell below thresholds between $1 million and $50 million, and their average market capitalization after 180 calendar days of first crossing the market capitalization threshold.[60] According to the analysis, regardless of the market capitalization threshold or time parameter selected, the median market capitalization after 180 days is below the specific market capitalization threshold. This result generally holds true for the Market Capitalization Analysis Threshold (*i.e.,* a consecutive 30 trading-day average market capitalization below $5 million) over the sample period.[61] 59% of the issuers that fell below the Market Capitalization Analysis Threshold had an average market capitalization of under $5 million after 180 days, with a median valuation of $4.1 million. The results show that, in general, issuers that fell below the Market Capitalization Analysis Threshold tend to stay below such threshold for an extended period of time. Accordingly, the Exchange's use of the Market Capitalization Analysis Threshold provides a reasonably designed standard for the Exchange to use when making assessments of compliance with its continued listing standards.

TABLE 1—MARKET CAPITALIZATION OF ISSUERS 180 CALENDAR DAYS AFTER CROSSING THE VARIOUS MARKET CAPITALIZATION THRESHOLDS AND DURATION

Market cap threshold ($, 000's)	Days of moving average	Companies that would have been delisted	Market capitalization of companies 180 calendar days after crossing the threshold ($, 000's)				
			Sample statistics:				
			Average	P25	P50	P75	P90
$50,000	30	4,567	$41,304	$16,541	$31,026	$47,743	$74,347
20,000	30	3,170	20,591	7,661	13,315	21,027	36,877
10,000	30	2,220	14,342	4,195	7,257	11,957	20,813
7,000	30	1,718	10,228	3,178	5,243	9,018	16,898
5,000	30	1,261	9,262	2,397	4,142	7,082	13,415
3,000	30	727	8,231	1,651	2,745	5,050	9,754
1,000	30	122	7,492	537	908	2,762	7,993
50,000	60	4,398	38,816	15,656	29,211	45,515	70,176
20,000	60	2,979	19,379	6,996	12,660	20,162	34,175
10,000	60	2,003	11,222	3,867	6,579	11,176	19,684
7,000	60	1,480	10,366	2,891	4,964	8,182	14,988
5,000	60	1,059	8,264	2,199	3,831	6,423	11,468
3,000	60	570	8,539	1,480	2,527	4,708	9,759

[60] Table 1 analyzes two variables: market capitalization thresholds ranging from $1 million to $50 million, and the number of consecutive trading days over which the average market capitalization is calculated. Table 1 shows the corresponding number of issuers that would have fallen below the specific market capitalization threshold and specific duration, and their average and percentile distribution of average market capitalization after 180 calendar days. For example, the sample for the first row includes the 4,567 issuers that would have been delisted under a rule with a 30 consecutive trading-day average market capitalization of $50 million. The 180-day window reflects a cure period that may be available for many failures to satisfy continued listing requirements, including under Section 1007 (late SEC filings) of the Company Guide. If the market capitalization for a company is not available at the end of the 180-day window—either because the company was delisted or because the data did not include 2026—then the last market capitalization in the window is used.

[61] Figure 3 shows the percentile distribution of average market capitalization 180 days after issuers first cross the Market Capitalization Analysis Threshold by the 25th percentile (P25), the median (P50), and the 75th percentile (75) against the year such issuers first cross the Market Capitalization Analysis Threshold.

TABLE 1—MARKET CAPITALIZATION OF ISSUERS 180 CALENDAR DAYS AFTER CROSSING THE VARIOUS MARKET CAPITALIZATION THRESHOLDS AND DURATION—Continued

Market cap threshold ($, 000's)	Days of moving average	Companies that would have been delisted	Market capitalization of companies 180 calendar days after crossing the threshold ($, 000's)				
			Sample statistics:				
			Average	P25	P50	P75	P90
1,000	60	78	8,729	537	868	2,410	4,735
50,000	90	4,251	37,582	14,801	28,102	44,967	68,157
20,000	90	2,805	20,694	6,465	11,994	19,233	32,756
10,000	90	1,800	11,060	3,651	6,420	10,799	19,431
7,000	90	1,310	9,041	2,762	4,709	7,770	14,920
5,000	90	933	9,019	2,154	3,654	6,527	11,831
3,000	90	464	8,535	1,448	2,486	4,495	10,066
1,000	90	53	7,240	479	867	1,876	7,859

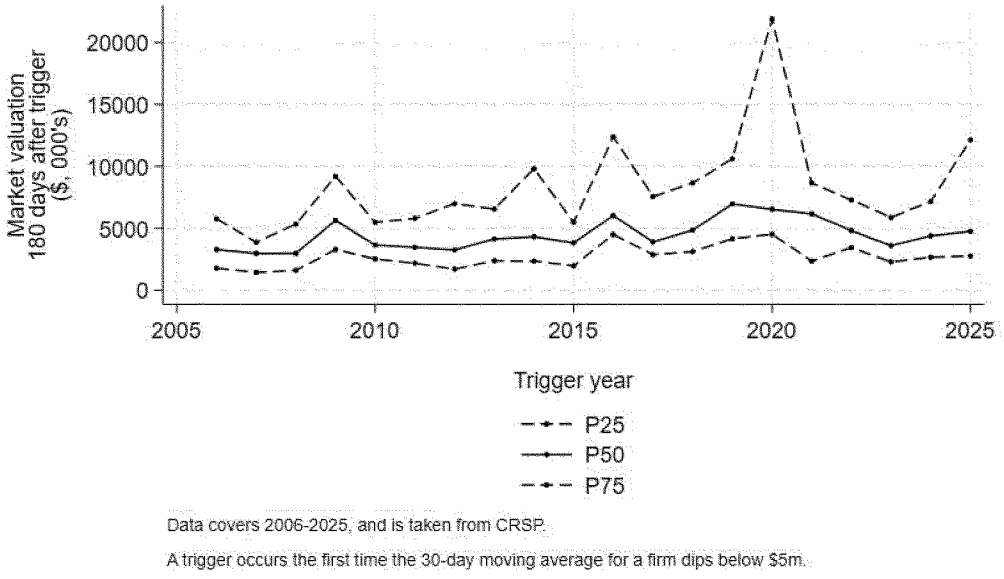


Figure 3. Percentile distribution of market capitalization 180 days after issuers first crossed the Market Capitalization Analysis Threshold.

The Commission's analysis also shows that issuers that fell below the Market Capitalization Analysis Threshold had a high likelihood of being delisted for reasons that indicate a failure to comply with other quantitative continued listing requirements.[62] Historically, when an issuer fell below the Market Capitalization Analysis Threshold and was later delisted, such delisting, at the median, occurred 230 days later, and at the 75th percentile, 621 days later.[63]

[62] The analysis, as shown in Figure 4, compared the fraction of issuers on NYSE American who were subsequently delisted after dropping below the Market Capitalization Analysis Threshold against the year such companies fell below the Market Capitalization Analysis Threshold. The analysis only took into account delistings by the Exchange, and excluded delistings by mergers and acquisitions, liquidations, and exchanges. *See* CRSP US DATABASES DATA DESCRIPTIONS GUIDE FOR CRSPACCESS (FIZ) (2026) at 247–250, *available at https://indexes.morningstar.com/docs/guide/crsp-us-stock-databases-data-descriptions-guide-for-crspaccess-fiz?isRdp=true* for the available delisting codes. In the sample described in note 63, *supra,* the following five codes represent over 75% of delistings that occurred after dropping below the Market Capitalization Analysis Threshold: ''does not meet exchange's financial guidelines for continued listing,'' ''insufficient capital, surplus, and/or equity,'' ''price fell below acceptable level,'' ''bankruptcy, declared insolvent,'' and ''delinquent in filing, non-payment of fees.'' Approximately 18% of the delistings occurred at the request of the issuer—*e.g.,* the issue moved to the over-the-counter (''OTC'') market voluntarily—and the delisting code does not indicate whether or not the issuer was in compliance with listing requirements at the time of delisting; however, most of these voluntary delistings occurred when the stock price was below $1, indicating difficulty complying with minimum price standards.

[63] The relationship between an issuer crossing the Market Capitalization Analysis Threshold and subsequently being delisted weakened over time. One reason for the weakened relationship may be the amount of time that the delisting and hearings process takes (*i.e.,* some companies that fell out of compliance with continued listing requirements in the later portion of the time period analyzed may ultimately be delisted based on these deficiencies, but remain listed at this time). *See, e.g.,* Section 1009 of the Company Guide (providing companies with an opportunity to submit a plan to come back into compliance with continued listing standards).

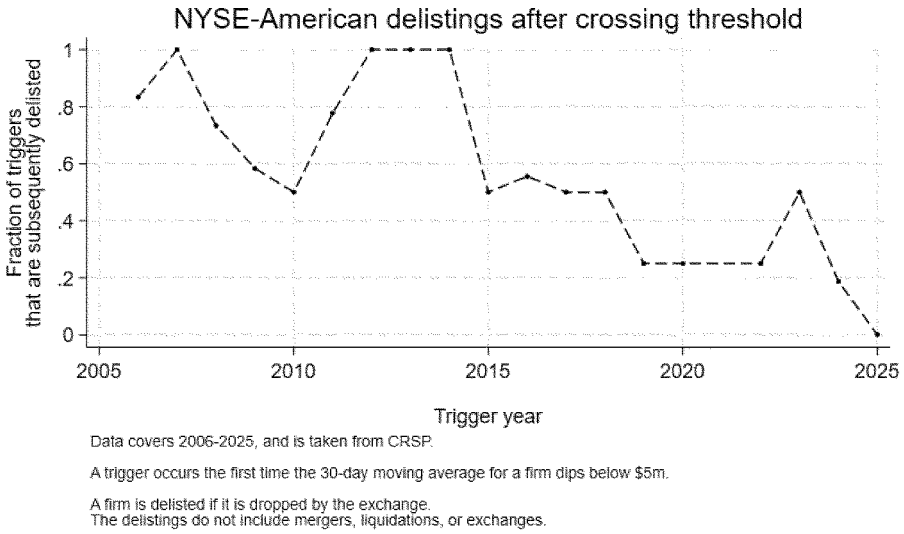


Figure 4. Fraction of NYSE American issuers that were subsequently delisted after first crossing the Market Capitalization Analysis Threshold.

Finally, the Commission's analysis indicates a fundamental tradeoff inherent in selecting a threshold for delisting: a more stringent threshold (*i.e.,* higher average market capitalization or shorter duration over which that average is calculated) would capture issuers that will eventually be delisted for other reasons, but also implicate issuers that otherwise would have remained above the threshold and stayed listed.[64]

TABLE 2—DELISTING OUTCOMES OF ISSUERS CROSSING THE VARIOUS MARKET CAPITALIZATION THRESHOLDS AND TIME DURATIONS, BETWEEN 2006 AND 2025

Market cap threshold ($,000's)	Days of moving average	Companies that would have been delisted	Expedited delistings	False positives	False negatives	False positives as a fraction of companies that would have been delisted (%)
50,000	30	4,567	1,724	2,845	266	62
20,000	30	3,170	1,470	1,700	520	54
10,000	30	2,220	1,119	1,103	871	50
7,000	30	1,718	881	840	1,109	49
5,000	30	1,261	661	601	1,329	48
3,000	30	727	375	352	1,615	48
1,000	30	122	75	47	1,915	39
50,000	60	4,398	1,676	2,726	314	62
20,000	60	2,979	1,396	1,585	594	53
10,000	60	2,003	992	1,011	998	50
7,000	60	1,480	752	729	1,238	49
5,000	60	1,059	538	521	1,452	49
3,000	60	570	287	284	1,703	50
1,000	60	78	50	28	1,940	36
50,000	90	4,251	1,633	2,624	357	62
20,000	90	2,805	1,315	1,495	675	53
10,000	90	1,800	887	917	1,103	51
7,000	90	1,310	657	656	1,333	50
5,000	90	933	452	482	1,538	52
3,000	90	464	223	241	1,767	52
1,000	90	53	34	19	1,956	36

[64] The Commission conducted analysis on false positives (issuers falling below the Market Capitalization Analysis Threshold, but were never delisted), and false negatives (issuers never falling below the Market Capitalization Analysis Threshold, but were delisted), as shown in Table 2. Similar to Table 1, Table 2 analyzes two variables: average market capitalization thresholds ranging from $1 million to $50 million, and the number of consecutive trading days over which the average market capitalization is calculated. Table 2 shows the corresponding number of issuers that would have been delisted based on the specific average market capitalization threshold and specific duration, issuers that would have failed to meet the relevant average market capitalization threshold and duration and were subsequently delisted (*i.e.,* expedited delistings), false positives, and false negatives. Table 2 shows a mechanical inverse relationship between false positives and false negatives. As the thresholds become more stringent (*i.e.,* higher average market capitalization or shorter duration), the number of false positives generally increases.

The Minimum Market Capitalization Criteria threshold of $5 million is substantially lower than the market capitalization initial listing standard threshold on NYSE American.[65] For example, the total value of market capitalization required in applicable standards for *initial listing* is at least $50 million.[66] Similarly, the Minimum Market Capitalization Criteria threshold is substantially lower than the average global market capitalization threshold for the existing *continued listing* standard thresholds on NYSE American.[67] The average global market capitalization standard for continued listing requires at least $50 million for a consecutive 30 trading-day period.[68] Accordingly, a company persistently and consistently trading at levels below an average $5 million market capitalization for approximately six calendar weeks (*i.e.,* 30 trading days) would be trading significantly below such initial and continued listing requirements for NYSE American-listed companies, raising questions about the company's suitability for continued listing on NYSE American. Further, it is likely that a company that substantially declines from the market capitalization at which it initially listed on NYSE American to the average $5 million market capitalization level will most likely find itself in that position without surprise and, accordingly, will have had the opportunity to raise capital, explore business opportunities, or explore other options to increase assets, reduce liabilities, and increase revenues before crossing the average $5 million market capitalization threshold and remaining below that level for a consecutive 30 trading days.[69]

The Exchange has identified risks pertaining to securities with a market capitalization below $5 million, including a heightened susceptibility to manipulation. The results of the Commission's analysis support approval of the Exchange's proposal to impose the Minimum Market Capitalization Criteria. The increased number of securities with an average market capitalization over a consecutive 30 trading-day period below $5 million in recent years, along with the significant likelihood that such securities will eventually be delisted, warrants the Exchange's consideration of the continued listing of securities with a low level of market capitalization.[70] Moreover, when securities fall below an average market capitalization of $5 million for a consecutive 30 trading-day period, there is a significant likelihood that they will continue to have an average market capitalization below $5 million for another 180 calendar days, which is a significant period of time.[71] While the delisting process sometimes affords companies experiencing truly temporary financial or business issues a cure period for them to regain compliance with continued listing standards, they necessarily prolong the delisting process which also prolongs the exposure of investors to potential harm for a company that ultimately is likely to be delisted. The Exchange's proposed $5 million market capitalization threshold and 30-day time parameter reflects a reasonably balanced approach for a continued listing requirement that provides companies with time to recover from short-term unexpected declines without prolonging the delisting process.

In the Commission's view, securities with a small market capitalization may be more prone to manipulation.[72] When a security has a smaller market capitalization, the cost required to accumulate a position that is large enough to influence the price of the security is reduced. Accordingly, a would-be manipulator may find it less costly to manipulate the price of the security. Thus, the continued listing of companies with small market capitalization raises concerns that these securities may have heightened susceptibility to manipulation. These concerns are exacerbated if companies with low market capitalization lack sufficient natural trading interest that could otherwise mitigate the susceptibility to manipulation by promoting fair and orderly markets in the security. The Commission, certain exchanges, and FINRA have allocated resources to identify and address manipulation in securities of companies with small market capitalization.[73] Despite these efforts, the Exchange's concerns about the potential for manipulation persist.[74] Manipulative schemes that target the securities of companies with small market capitalization, like ''ramp and dump'' and ''pump and dump,'' are often identified and responded to after the fact. The Exchange's proposal represents a reasonable approach to address concerns that companies with a persistent (*i.e.,* at least 30 consecutive trading days) market capitalization below $5 million may be susceptible to types of manipulation that result in harm to investors. The immediate suspension and delisting of these securities with a small market capitalization, as measured by considering average market capitalization over a consecutive 30 trading-day period, is designed to prevent fraudulent and manipulative acts and practices, and more broadly, the rule is reasonably designed to promote just and equitable principles of trade and to protect investors and the public interest.[75]

The proposal is reasonably designed to enhance the Exchange's listing standards by immediately suspending trading and commencing delisting proceedings for securities that fall below the Minimum Market Capitalization Criteria, which facilitates the continued listing of securities of issuers that are financially sound. As noted above, the imprimatur of listing on a particular exchange correlates to investors' expectations that the listed issuer meets certain standards set by the exchange and that a listing exchange will use its judgment regarding the level at which to set those standards. Those standards are informed by an exchange's regulatory and commercial considerations and exchanges have discretion, subject to the requirements of the Act, to set those standards as they see fit.

Moreover, the addition of the Minimum Market Capitalization Criteria is not unfairly discriminatory because

[65] *See, e.g.,* NYSE American Company Guide, *available at https://nyseamericanguide.srorules.com/company-guide.*

[66] *See* Section 101(c)(2) and (d)(1) of the Company Guide.

[67] *See, e.g., supra* note 71.

[68] *See* Section 1003(a) of the Company Guide.

[69] *See also infra* note 136, and accompanying text.

[70] *See* Figure 1, Figure 2, and Figure 4. *See supra* notes 20–21 and accompanying text.

[71] *See* Table 1. In addition, the Commission's analysis demonstrates that there is an inherent tradeoff to be made when selecting a numerical threshold for a continued listing requirement between eliminating those companies that are the intended target and providing increased flexibility for listed issuers. *See* Table 2 and Figure 3.

[72] This view supports the Exchange's statements that an issuer with a small market capitalization is potentially or increasingly susceptible to manipulation. *See supra* notes 14 and 20 and accompanying text. *See also supra* notes 48–56 and accompanying text.

[73] For example, the Commission has issued temporary 12(k) suspensions of trading in securities in response to potential manipulation in the last year. *See, e.g.,* Securities Exchange Act Release Nos. 104112 (Sept. 26, 2025) (Smart Digital Group Limited), 104113 (Sept. 26, 2025) (QMMM Holding Limited), 104163 (Oct. 3, 2025) (Etoiles Capital Group Co., Ltd.), 104164 (Oct. 3, 2025) (Platinum Analytics Cayman Limited), 104165 (Oct. 3, 2025) (Pitanium Limited), 104166 (Oct. 8, 2025) (Empro Group Inc.), 104167 (Oct. 8, 2025) (NusaTrip Incorporated), 104168 (Oct. 16, 2025) (Premium Catering (Holdings) Limited), 104169 (Oct. 22, 2025) (Robot Consulting Co., Ltd.), 104176 (Nov. 11, 2025) (Charming Medical Limited), 104317 (Dec. 4, 2025) (Magnitude International Ltd), 104613 (Jan. 14, 2026) (JM Group Limited), 104763 (Feb. 1, 2026) (TechCreate Group Ltd.), 105675 (June 11, 2026) (Happy City Holdings Limited), 106668 (Oct. 14, 2026) (TJGC Group Limited).

[74] *See supra* note 13 and accompanying text.

[75] *See* 15 U.S.C. 78f(b)(5).

the proposed standard is reasonably tailored to the Exchange's goal of addressing the risks that it has identified with respect to securities with a small market capitalization. The $5 million market capitalization threshold will provide for a level of market capitalization below which there may be a heightened susceptibility to manipulation and difficulties maintaining fair and orderly markets in these securities. And the requirement that a security have an average market capitalization over a consecutive 30 trading-day period of less than $5 million before being subject to immediate suspension and delisting will target instances where securities have demonstrated a significant longevity of these risks. Therefore, the Commission finds that the Exchange's proposal to immediately suspend and delist companies that fail to comply with the Minimum Market Capitalization Criteria is reasonably designed and consistent with the requirements of Section 6(b)(5) of the Act that the rules of the Exchange be designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, protect investors and the public interest, and not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers.[76]

A. Comments Regarding the Minimum Market Capitalization Criteria

One commenter stated that issuers with a sustained market capitalization below $5 million ''is often a leading indicator of broader financial and compliance concerns that demand disproportionate regulatory oversight and pose significant risks to investors, who generally view companies that meet the requirements to be listed on an exchange as more financially sound and less risky than OTC securities.'' [77] This commenter stated that a bright line continued listing threshold of $5 million in market capitalization ''provides an objective, quantitative marker that is reasonably related to initial listing standards and appropriately identifies companies whose ongoing exchange listing, after failing to meet this threshold for 30 consecutive trading days, is no longer consistent with maintaining fair, orderly, and efficient markets.'' [78] This commenter further stated that the Exchange's proposal to utilize an average market capitalization threshold as measured over a consecutive 30 trading-day period would ''reduce[] the risk of gaming the threshold through short term price spikes and better reflect[] the sustained market value of the issuer.'' [79]

Several commenters stated that the proposed Minimum Market Capitalization Criteria could result in the delisting of companies based on broader market- or sector-wide conditions that may cause temporary fluctuations that are not related to their underlying business or financial condition.[80] Commenters also raised concerns that the proposal would disproportionately burden microcap and emerging growth issuers.[81] One commenter stated that the proposed rule disproportionately impacts microcap and emerging growth issuers because these types of issuers ''frequently experience temporary fluctuations in market capitalization resulting from broader market conditions, financing cycles, sector-specific developments, and investor sentiment rather than long-term business performance.'' [82]

Another commenter stated that the Exchange does not demonstrate that the $5 million market capitalization threshold ''is a reliable predictor of sustained financial distress, manipulation risk, or future non-compliance with existing listing standards.'' [83] This commenter attached a report by Professor Craig M. Lewis that presents an empirical study raising concerns that the proposal may prematurely delist companies that would otherwise regain compliance.[84] The Lewis Report analyzed approximately 190 companies that fell below the $5 million average market capitalization threshold between 2006 and 2025, and concluded that ''a temporary decline below the $5 million average market capitalization threshold does not reliably predict business failure or inevitable delisting.'' [85] The Lewis Report stated that of the 190 companies that would have been delisted based on the proposal, 64% recovered at least once above the $5 million threshold during the time period studied, 28% of the 190 companies have not been not delisted, and 37 companies are still trading with market capitalizations above $5 million, representing an average market capitalization of $61.6 million.[86]

One commenter stated that these arguments opposing the adoption of a $5 million continued listing threshold ''rest on a misunderstanding of the purpose of continued listing standards and do not undermine the investor protection rationale supporting NYSE American's proposal.'' [87] This commenter stated that listing standards are designed to protect investors and maintain fair, orderly, and efficient markets, ''not to maximize issuer survival or ensure uninterrupted access to exchange listing.'' [88] This commenter also stated that whether a subset of issuers recover does not negate that periods below $5 million in market capitalization are linked to ''thin liquidity, elevated spreads, heightened volatility, and disproportionate susceptibility to manipulative trading activity,'' which are conditions that exchanges must address through risk-based listing standards.[89] This commenter also raised concerns regarding a reliance on backward-looking data, arguing that ''[c]ontinued listing standards must operate ex ante, based on observable risk indicators'' rather than ''ex post based on whether a company eventually stabilizes.'' [90] Finally, this commenter asserted that the Act's framework relies on exchanges ''to set and refine listing standards based on front line surveillance of trading activity, issuer behavior, and market quality.'' [91]

In response to commenters, the Exchange states that the Minimum Market Capitalization Criteria is a ''measured approach to address concerns about volatility and potential manipulation in low priced stocks.'' [92] According to the Exchange, ''microcap stocks are more susceptible to manipulation because it necessarily requires a smaller capital investment to

[76] 15 U.S.C. 78f(b)(5).

[77] SIFMA Letter at 3.

[78] *Id.*

[79] *Id.*

[80] *See* Lucosky Letter at 3–5; SPCC Letter I at 8, 19. *See also* Imunon Letter; MacKenzie Realty Letter at 2; IP Strategy Letter at 2, 7; Donohoe Letter at 4.

[81] *See* Lucosky Letter at 4; SPCC Letter I at 8.

[82] Lucosky Letter at 4. *See also* IP Strategy Letter at 9.

[83] SPCC Letter I at 5. *See also* IP Strategy Letter at 8–9.

[84] *See* SPCC Letter I at 6 (stating that an empirical analysis indicates that ''the proposed rule would have unnecessarily removed dozens of companies that ultimately stabilized, saw their market capitalization increase, and continued operating successfully''). *See also* NYSE American's Proposed Minimum Market Capitalization Continued Listing Requirement, Craig M. Lewis, Ph.D., dated Apr. 10, 2026 (attached as Exhibit 1 to SPCC Letter I) (''Lewis Report'').

[85] *See* Lewis Report, paragraph 5. *See also* SPCC Letter I at 5–6; SPCC Letter II at 2.

[86] *See* Lewis Report, paragraph 6. *See also* SPCC Letter I at 5–6; SPCC Letter II at 2.

[87] SIFMA Letter at 4.

[88] *Id.* at 5.

[89] *See id.*

[90] *Id.*

[91] *Id.*

[92] Letter from Patrick J. Troy, Senior Director and Associate General Counsel, New York Stock Exchange, dated Sept. 9, 2026 (''Exchange Letter''), at 1.

transact in a substantial percentage of a microcap issuer's securities, thereby opening the door to a wider range of potential bad actors.'' [93] The Exchange states that, based on the Lewis Report, while only 28% of the companies that fell below the Minimum Market Capitalization Criteria remain listed today on the Exchange, 72% of such companies are no longer listed on the Exchange, and this data is consistent with the Exchange's historical observation that companies falling below the $5 million average market capitalization standard frequently face additional financial challenges that require a substantial amount of regulatory oversight and make them unsuitable for public market trading.[94] The Exchange further states that its proposal is not premised on the notion that a company with an average market capitalization below $5 million is without value and instead is seeking to address problematic trading in extremely small companies, which are frequently below other Exchange listing standards.[95]

While the overall conclusion of the Lewis Report is that the Exchange's proposal to immediately suspend trading and commence delisting proceedings for securities that fail to comply with the Minimum Market Capitalization Criteria may result in delisting of companies that later recover and that some of those companies may otherwise have remained listed on the Exchange, the possibility of a meaningful recovery is not indicative that the Exchange would be acting unreasonably in determining to delist such a security, and ultimately is not determinative that the proposed rule change is inconsistent with the Act. Both the Commission's analysis and the Lewis Report agree that a significant number of companies that fell below an average market capitalization over a consecutive 30 trading-day period of $5 million did not recover.[96] Moreover, as discussed above, the Commission's analysis shows that 59% of the companies that fell below the Market Capitalization Analysis Threshold had an average market capitalization over a consecutive 30 trading-day period under $5 million after 180 days.[97] Even if some of the companies that remained below $5 million average market capitalization after 180 days eventually recovered, this analysis indicates that such companies persisted with an average market capitalization below $5 million for an extended period of time. The Commission interprets these results as indicating that, similarly, companies that fall below the Minimum Market Capitilization Criteria would likely remain below that threshold for an extended period of time.[98] Given the risks that securities with a small market capitalization have heightened susceptibility to manipulative trading activity, which could be exacerbated by a lack of trading interest sufficient to promote fair and orderly markets, the Commission finds that it is not unfairly discriminatory and is consistent with Section 6(b)(5) of the Act's requirements that the rules of the Exchange prevent fraud and manipulative acts and practices, promote just and equitable principles of trade, and protect investors and the public interest for the Exchange to immediately suspend trading and commence delisting proceedings for securities that fall below the Minimum Market Capitalization Criteria.[99]

One commenter expressed concern that factors influencing trading price, and in turn market capitalization, ''may fluctuate significantly over relatively short periods without any corresponding change in the issuer's underlying business, financial condition, governance, or compliance with other continued listing standards.'' [100] Further, this commenter stated ''a bright-line $5 million market capitalization requirement creates a framework in which immediate suspension and delisting may be triggered by temporary market dislocations rather than meaningful deterioration in an issuer's suitability for continued exchange listing,'' [101] and that the proposed 30 trading-day measurement period is not meaningful in distinguishing between such temporary market dislocations from sustained issuer deficiencies.[102] Another commenter stated that ''the proposal creates a cliff effect: issuers trading anywhere near the threshold will face persistent delisting risk based on ordinary market volatility.'' [103] In addition, commenters stated that a company's market capitalization can be impacted by directional pressure exerted by opportunistic traders and short sellers.[104]

Several commenters expressed concern that the ''rigid, time-bound'' $5 million average market capitalization threshold could create incentives for manipulative trading activity and market abuse, contrary to the Act's goals of preventing fraud and manipulation.[105] In particular, commenters stated the mechanical trigger could incentivize coordinated short selling pressure that could force a company below the $5 million market capitalization threshold for long enough to trigger delisting.[106] One commenter stated that the trigger itself would cause downward price pressure because investors will discount issuers trading near the threshold, lenders would assign additional risk premiums or tighter covenants, and counterparties may hesitate to transact.[107]

One commenter stated that the concerns that automatic delisting could create a ''cliff effect'' or incentivize strategic short selling ''do not reflect actual market dynamics.'' [108] This commenter stated that exchanges already use ''bright line, quantitative triggers—such as bid price, public float, and market value of publicly held shares requirements—without evidence of systemic cliff effects or widespread manipulation designed to force delisting.'' [109] This commenter further stated that ''sustaining depressed prices for 30 consecutive trading days requires significant capital and is constrained by market maker liquidity provision, natural buying interest, and existing anti

[93] *Id.* at 2.

[94] *See id.*

[95] *See id.* at 2–3.

[96] *See* Table 1 and surrounding discussion, and *supra* note 92.

[97] *See* Table 1 and surrounding discussion.

[98] While the Commission agrees with the commenter that raised concerns about a reliance on backward-looking data rather than observable risk factors (*see supra* note 96 and accompanying text), the Commission's data analysis helps to validate the Exchange's statements and informs the Commission's view of how securities with small market capitalization may behave in the future, thereby supporting the Commission's statutory findings.

[99] 15 U.S.C. 78f(b)(5).

[100] Lucosky Letter at 3 (stating that the trading price of securities ''is influenced by numerous external factors, including macroeconomic conditions, sector-specific trends, liquidity constraints, interest rate movements, institutional portfolio reallocations, and investors sentiment''). *See also* Mackenzie Realty Letter at 1; Donohoe Letter at 2 and 4; IP Strategy Letter at 2.

[101] Lucosky Letter at 3. *See also* Nasdaq's Proposed Amended Listing Requirements, Craig M. Lewis, Ph.D., dated Feb. 19, 2026 (attached as Exhibit A to SPCC Letter I) (''Lewis February Report''), at paragraph 21; SPCC March Letter at 18–19.

[102] Lucosky Letter at 5.

[103] SPCC Letter I at 7.

[104] *See* Lucosky Letter at 3–4; SPCC Letter I at 11; SPCC Letter II at 3.

[105] *See* SPCC Letter II at 3; SPCC Letter I at 11; Lucosky Letter at 3–4.

[106] *See* SPCC Letter I at 11; SPCC Letter II at 3; Lucosky Letter at 3–4. *See also* Imunon Letter; MacKenzie Realty Letter at 2; IP Strategy Letter at 3–4; Donohoe Letter at 2. Commenters also stated that the threat of delisting may contribute to and encourage further downward price pressure and incentivize opportunistic trading behavior. *See* Donohoe Letter at 2; IP Strategy Letter at 3 and 5; HeartSciences Letter at 2.

[107] *See* SPCC Letter I at 8–9. *See also* IP Strategy Letter at 3.

[108] *See* SIFMA Letter at 5.

[109] *Id.*

manipulation rules.'' [110] Another commenter stated that commenters that oppose the proposal are ''unable to explain'' why the Exchange should be prohibited from setting a $5 million market capitalization listing requirement when that level is far below the $15 million minimum market capitalization imposed by its affiliate, the New York Stock Exchange, and based on its direct experience regarding trading activity on the Exchange.[111]

In response to commenters, the Exchange states that minimum market capitalization continued listing standards have existed for many years—for example, the New York Stock Exchange requires that listed companies maintain a minimum average market capitalization of at least $15 million over a consecutive 30 trading-day period—and the Exchange is not aware that they have had an outsized detrimental effect on listed companies.[112]

Market capitalization, as a combination of the quantity of total common stock outstanding (excluding treasury shares) as well as any common stock that would be issued upon conversion of another outstanding equity security, if such other security is a ''substantial equivalent'' of common stock,[113] and their market value, is a reasonable measure to be used in a quantitative listing standard to determine whether a company should continue to be listed on the Exchange because it provides an indication of the issuer's size and how the market values the issuer's securities. The Exchange and other national securities exchanges rely on market capitalization or other measures of market value in existing initial and continued listing standards.[114] While commenters expressed concern that the Minimum Market Capitalization Criteria would create an incentive for opportunistic trading behavior, or for bad actors to manipulate the price of a company's securities to trigger automatic suspension and delisting (including that the consecutive 30 trading-day period may contribute to this risk), commenters have not provided any data showing that similarly structured, existing listing requirements based on market capitalization or other quantitative metrics have created such incentives. Moreover, the requirement to immediately suspend trading and commence delisting proceedings for securities that fall below $5 million average market capitalization over a consecutive 30 trading-day period would help mitigate the risk of actual opportunistic or manipulative activities in securities that may have a heightened susceptibility to manipulative trading activity. Therefore, the Commission finds that the Exchange's proposal to immediately suspend trading and commence delisting proceedings for securities that fail to comply with the Minimum Market Capitalization Criteria is reasonably designed and consistent with the requirements of Section 6(b)(5) of the Act that the rules of the Exchange be designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, and protect investors and the public interest.[115]

B. Comments Regarding the Lack of a Cure Period or Exchange Discretion

One commenter raised concerns about the proposal's absence of a cure period that would allow companies that fall below the Minimum Market Capitalization Criteria to regain compliance before being delisted.[116] In particular, this commenter stated that the Exchange had not explained why the proposal lacks a cure period while the Exchange affords cure periods and discretionary review for other continued listing deficiencies, such as where a company's aggregate market value of publicly-held shares is less than $1 million for more than 90 consecutive days.[117] Another commenter stated that the Exchange has historically maintained discretion in administering its continued listing standards in a manner that allows individual circumstances to be considered and that preserving Exchange discretion would better serve investors.[118] Another commenter raised concerns about the lack of discretion on the part of the Exchange in administering the Minimum Market Capitalization Criteria based on facts and circumstances.[119] For example, according to the commenter, an issuer experiencing long-term operation deterioration may be distinguishable from an issuer that is experiencing temporary market dislocation or a pending financing transaction.[120] This commenter stated that the proposal would largely eliminate the Exchange's ability to exercise judgement developed from decades of experience evaluating whether individual issuers remain suitable for continued listing.[121]

One commenter, however, stated that ''protracted appeals and cure periods'' are among the factors that can make listing standards ''susceptible to circumvention.'' [122] Another commenter stated that the proposal's immediate suspension and delisting requirement ''appropriately recognizes that, at such low market capitalization levels over an extended period, the challenges facing these companies are generally not temporary and are unlikely to be resolved within a conventional compliance period.'' [123] This commenter also stated that continued listing of such issuers can impair the Exchange's ability to maintain fair and orderly markets by making it more difficult for market makers to provide stable liquidity and for investors to rely on the exchange listing as a signal of issuer quality.[124]

In response to commenter concerns about eliminating Exchange discretion, the Exchange states that ''transparent bright-line rules . . . enable investors to

[110] *Id.*

[111] *See* Citadel Letter at 3.

[112] *See* Exchange Letter at 3 (citing Section 802.01B of the NYSE Listed Company Manual).

[113] *See supra* note 16.

[114] Existing Exchange rules include market capitalization as a component of an initial or continued listing requirement. *See* Sections 101(c)(2), 101(d)(1), and 1003(a)(1) of the Company Guide. In addition, the New York Stock Exchange (''NYSE'') will promptly initiate suspension and delisting procedures if a listed company has an average global market capitalization over a consecutive 30 trading-day period of less than $15 million. *See* Section 802.01B of the NYSE Listed Company Manual. *See also, e.g.,* Section 102.01C of the NYSE Listed Company Manual (utilizing global market capitalization in initial listing requirements); Nasdaq Rules 5505(b)(2)(A), 5505(b)(4)(A), and 5550(b)(2) (utilizing market value of listed securities in initial and continued listing requirements); TXSE Rules 16.310(c)(2) and 16.320(b)(2) (utilizing global market capitalization in initial and continued listing requirements). The Commission is not aware of any widespread concerns that the existing continued listing requirements that utilize market capitalization or similar metrics have caused an increase in opportunistic or manipulative trading.

[115] *See* 15 U.S.C. 78f(b)(5).

[116] *See* SPCC Letter I at 15. *See also* Autonomix Letter at 2.

[117] *See id.* (citing Section 1003(b)(i)(C) of the Company Guide and stating that the Exchange could provide a meaningful cure period, as it does for other continued listing standards); SPCC Letter II at 5–6. This commenter also stated that ''[b]y mandating automatic and immediate delisting for companies whose 30-day average market capitalization falls below $5 million, without any cure period, pre-deprivation process, or discretion, the rule reduces any subsequent appeal to a ministerial exercise regarding whether the company's 30-day average market capitalization did or did not fall below the threshold,'' and that there is not a ''meaningful opportunity to be heard'' on whether circumstances demonstrate that ''immediate delisting is unwarranted.'' SPCC Letter II at 5. The proposed rule change does not restrict the issues that the Exchange may consider in connection with any appeal of a delisting determination, as discussed further below.

[118] *See* Lucosky Letter at 3.

[119] *See id.* at 3, 5.

[120] *See id.* at 3.

[121] *See id.* at 5.

[122] *See* Citadel Letter at 1.

[123] SIFMA Letter at 3.

[124] *See id.* at 3.

clearly evaluate and understand an issuer's listing status.'' [125] The Exchange also states that continued listing requirements on the Exchange related to minimum price, stockholders' equity, and filing of periodic reports all mandate ''non-discretionary regulatory action'' for issuer noncompliance.[126] The Exchange further states that ''[o]bjective application of listing rules promotes predictability and transparency which benefits issuers and investors alike.'' [127]

In addition, the Exchange states that it disagrees that the proposal does not account for temporary market downturns.[128] The Exchange states that the Minimum Market Capitalization Criteria is calculated over a consecutive 30 trading-day period (*i.e.,* at least six weeks of trading activity), thus covering only companies with a prolonged period of noncompliance with the proposed rule.[129] The Exchange also states that it proactively engages with companies whose average market capitalization falls below $15 million over 30 trading days, and therefore companies would receive meaningful advance notice of their potential noncompliance with the proposed rule.[130]

While the Commission acknowledges that Exchange rules provide for a cure period for noncompliance with certain continuing listing standards, other Exchange rules provide that the Exchange will immediately suspend trading and commence delisting proceedings, without a cure period, for violation of other continued listing standards.[131] The Exchange's practice of engaging with companies when their average market capitalization falls below $15 million over 30 trading days, along with the Minimum Market Capitalization Criteria's use of an average market capitalization over a consecutive 30 trading-day period, will provide listed companies with a period of time within which to raise their average market capitalization before they fall below the Minimum Market Capitalization Criteria. The requirement's focus on a consecutive 30 trading-day period also means that a security would have a small market capitalization for a prolonged period of time before being subject to immediate suspension of trading and commencement of delisting proceedings.

The Exchange has proposed to immediately suspend and delist companies that fall below the Minimum Market Capitalization Criteria, without any opportunity to cure, based on concerns that such companies have a heightened susceptibility to manipulation.[132] The decline of a company's average market capitalization below the Minimum Market Capitalization Criteria may be indicative of serious difficulties within such company that are likely to continue to put downward pressure on the stock price. As discussed above, according to the Commission's analysis, 59% of the issuers that fell below $5 million market capitalization continued to have a market capitalization under $5 million after 180 days, with the median market capitalization under $4.1 million. The Commission's analysis indicates that the likelihood of companies regaining $5 million market capitalization within 180 days after failing to comply with such market capitalization threshold is limited.[133] Accordingly, the Commission expects that a significant number of companies that fall below the Minimum Market Capitalization Criteria either will not recover or will persist with an average market capitalization for a prolonged period of time. Companies that remain below the Minimum Market Capitalization Criteria may have heightened susceptibility to manipulative trading activity, as discussed above, and requiring their delisting is consistent with the goal of protecting investors and the public interest. Thus, the Exchange's proposal is reasonably designed to protect investors by preventing the prolonged trading of companies with a small market capitalization that may be more susceptible to fraud and manipulation and seeks to help ensure that only financially sound issuers remain listed on the Exchange. Therefore, the Commission finds that the Exchange's proposal to immediately suspend trading and commence delisting proceedings for securities that fail to comply with the Minimum Market Capitalization Criteria is reasonably designed and consistent with the requirements of Section 6(b)(5) of the Act that the rules of the Exchange be designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, and protect investors and the public interest.[134]

The proposal is also consistent with Section 6(b)(7) of the Act in that, while the Exchange will immediately suspend trading and commence delisting proceedings without a cure period when an issuer's securities fall below the Minimum Market Capitalization Criteria, Exchange rules will continue to provide a fair procedure for the prohibition or limitation by the Exchange of any person with respect to access to services offered.[135] As discussed above, existing Exchange rules provide for immediate suspension of trading and commencement of delisting proceedings, without a cure period, when a security is out of compliance with continued listing requirements.[136] Pursuant to the Exchange's proposal, a listed company whose security is subject to immediate suspension of trading and the commencement of delisting proceedings after falling below the Minimum Market Capitalization Criteria will be able to appeal the delisting decision pursuant to Part 12 of the Company Guide.[137] Depending on the level of proceeding under Part 12 of the Company Guide, a Listing Qualifications Panel, the Committee for Review, or the Exchange Board of Directors will continue to have the authority to consider any failure to meet any quantitative standard for continued listing, and the company will continue to be given a notice of such consideration and an opportunity to respond.[138] A Listing Qualifications Panel, the Committee for Review, or the Exchange Board of Directors, as part of its respective review, may consider, among other things, the issuer's stock price or any information that the issuer

[125] Exchange Letter at 3.

[126] *Id.* at 4.

[127] *Id.*

[128] *Id.*

[129] *See id.*

[130] *See id.*

[131] *See* Sections 1003(f), (h), and (i) of the Company Guide. In addition, NYSE will promptly initiate suspension and delisting procedures, without a cure period, for a company that has an average global market capitalization over a consecutive 30 trading-day period of less than $15 million. *See* Section 802.01B of the NYSE Listed Company Manual.

[132] *See* Notice, *supra* note 3, at 13645–6. *See also supra* notes 20–22 and accompanying text.

[133] *See supra* notes 66–67 and accompanying text.

[134] *See* 15 U.S.C. 78f(b)(5).

[135] 15 U.S.C. 78f(b)(7).

[136] *See supra* note 137 and accompanying text.

[137] *See supra* note 19 and accompanying text. *See also* Part 12 of the Company Guide (providing that a company may request review of a Staff Determination by a Listing Qualification Panel and review of a Panel Decision by the Committee for Review, whose written decisions may subsequently be called for review by the Exchange Board of Directors upon the request of one or more Directors). Under existing Exchange rules, a request for a hearing will ordinarily stay a delisting action pursuant to a Staff Determination to prohibit the continued listing of an issuer's securities in accordance with Section 1204(d) of the Company Guide, but the Exchange staff may immediately suspend trading in any security or securities pending review should it determine that such immediate suspension is necessary or appropriate in the public interest, for the protection of investors, or to promote just and equitable principles of trade. *See* Section 1203(c) of the Company Guide. The Exchange has not proposed any changes to these provisions.

[138] *See* Sections 1201(d) of the Company Guide.

releases to the public, including any additional quantitative deficiencies or qualitative considerations reflected in the released information.[139] Therefore, the Commission finds that the proposal is consistent with Section 6(b)(7) of the Act in that it provides a fair procedure for the prohibition or limitation by the Exchange of any person with respect to access to services offered.

C. Comments Regarding the Need for the Proposed Rule Change

One commenter stated that the Exchange has not demonstrated the incremental benefit of its proposal against the backdrop of its recently strengthened initial listing standards.[140] In particular, this commenter stated that the Exchange should explain how the Minimum Market Capitalization Criteria is justified on its own terms, particularly given that the Exchange originally presented the Minimum Market Capitalization Criteria and the Minimum Bid Price Criteria [141] as addressing the same underlying concern.[142] This commenter stated that the Exchange must explain the incremental work of the Minimum Market Capitalization Criteria or, if the Exchange's proposal is intended to work together with the Minimum Bid Price Criteria, the Exchange must analyze their combined effects.[143] In addition, this commenter stated that the Exchange has not explained why its existing, conduct-focused tools are inadequate to address concerns about manipulation.[144]

While existing Exchange continued listing requirements may address some similar concerns, as discussed above, the risks of heightened susceptibility to manipulative trading activity and difficulty maintaining fair and orderly markets in the securities of companies that are not able to sustain an average market capitalization of at least $5 million support the adoption of the proposed Minimum Market Capitalization Criteria.[145] The addition of a non-discretionary, objective metric for continued listing on the Exchange is reasonably designed to enhance its existing conduct-focused regulatory tools to promote administrative predictability and transparency that will benefit issuers and investors alike. Further, the Exchange has separately proposed, and the Commission has approved with separate, independent justification, certain price-based continued listing requirements that reduce the period of time for a company to regain compliance based on investor protection concerns, including the Minimum Bid Price Criteria recently implemented by the Exchange.[146] That the Exchange previously filed a proposal that included both the Minimum Bid Price Criteria and a proposed continued listing requirement that was substantially similar to the Minimum Market Capitalization Criteria, the latter of which was removed before the Commission approved the Minimum Bid Price Proposal, does not alter the Commission's required analysis regarding whether the proposal is consistent with the Act, because the two rules operate independently, and each must be independently approved if the Commission finds that it is consistent with the Act.[147]

The current proposal and prior Commission-approved rules address different continued listing requirements that independently operate to address similar Exchange concerns with lower-priced securities, while taking different approaches to target securities that another continued listing requirement may not capture. For example, the Commission stated, in the context of removing compliance periods for securities that have had excessive reverse stock splits and securities that are trading at very low prices,[148] that there were investor protection concerns with allowing the securities identified in that proposal to have an extended period of time to regain compliance with the relevant requirements.[149] Similar to the Reverse Stock Split Proposal, with respect to its current proposal, the Exchange states that companies identified in this proposal may have financial concerns that render them inappropriate for trading on the Exchange for investor protection reasons.[150] Moreover, while a reverse stock split increases a company's stock price and thus could help a security comply with the Minimum Bid Price Criteria or other continued requirements related to minimum bid price, it does not directly change the company's market capitalization.[151] If a company is trading at a price compliant with the relevant bid price requirements, but has a very small market capitalization, it could continue to be susceptible to manipulative trading. Similarly, if a company has a large market capitalization but its securities fail to meet the relevant bid price requirements, the low trading price of the securities may make these securities more prone to manipulation.[152] Therefore, the Commission finds that the Exchange's proposal is reasonably designed and consistent with the requirements of Section 6(b)(5) of the Act that the rules of the Exchange be designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, and protect investors and the public interest.[153]

[139] *See* Sections 1201(b) and (c), 1202(a), and 1204 of the Company Guide.

[140] *See* SPCC Letter II at 4.

[141] *See supra* note 57.

[142] *See* SPCC Letter I at 4–5. The Exchange originally proposed the Minimum Market Capitalization Criteria and the Minimum Bid Price Criteria together in one filing. *See* Minimum Bid Price Proposal at 53436, n.8. In Amendment No. 3 to the Minimum Bid Price Proposal, the Exchange removed the Minimum Market Capitalization Criteria from that proposal and separately filed the current proposal. *See id.* This commenter stated that the Exchange has not explained why the proposals were disaggregated or whether each rule standing on its own is justified under the Exchange Act. *See* SPCC Letter I at 2. While this commenter also raised whether the present filing should be implemented before the Commission issues a decision on the Minimum Bid Price Proposal (*see id.*), the Commission has since approved the Minimum Bid Price Proposal. *See supra* note 57.

[143] *See* SPCC Letter I at 4–5; SPCC Letter II at 5. *See also* SPCC Letter I at 12 (stating that the Exchange does not examine whether the Minimum Bid Price Proposal would separately and fully address its concerns). This commenter also stated that the proposal should be considered in recognition that Nasdaq had proposed a similar continued listing requirement, and the system-wide effect should be analyzed. *See id.* at 16–17 (citing Nasdaq MVLS Proposal).

[144] *See id.* at 14; SPCC Letter II at 4.

[145] *See supra* notes 78 to 81, and accompanying discussions.

[146] *See, e.g.,* Securities Exchange Act Release No. 102220 (Jan. 16, 2025), 90 FR 8073 (Jan. 23, 2025) (SR–NYSEAMER–2024–61) (''Reverse Stock Split Proposal'') (approving modification of delisting process for securities that have had excessive reverse stock splits); Minimum Bid Price Proposal (approving Minimum Bid Price Criteria and stating that ''the Exchange's proposal is reasonably designed to protect investors by preventing the prolonged trading of very low-priced securities and seeks to provide meaningful assurance that only financially sound and quality issuers remain listed on the Exchange'').

[147] *See* 15 U.S.C. 78s(b)(2)(C). *See also supra* notes 38–42 (discussing the standards for SRO filings).

[148] *See* Reverse Stock Split Proposal at 8075. *See also* Sections 1003(f)(vi) and (vii) of the Company Guide, which, as modified by the Reverse Stock Split Proposal, provides for the immediate suspension and delisting of any listed company that (i) has effectuated one or more reverse stock splits over the prior two-year period with a cumulative ratio of 200 shares or more to one or (ii) has effectuated a reverse stock split and the effectuation of such reverse stock split results in the company's security falling below any of the continued listing requirements of Section 1003 of the Company Guide.

[149] *See* Reverse Stock Split Proposal at 8075.

[150] *See id. See also supra* note 21 and accompanying text.

[151] *See supra* note 16.

[152] *See* Minimum Bid Price Proposal at 53443.

[153] *See* 15 U.S.C. 78f(b)(5).

D. Comments Regarding Effects on Companies and the Market

One commenter stated that delisting from the Exchange does not eliminate an issuer's ability to access public capital markets as they can continue to trade in the OTC markets, which operate under a ''regime that emphasizes disclosure, risk flagging, and heightened scrutiny of low priced and thinly traded securities.'' [154] This commenter further stated that, ''[f]rom an investor protection standpoint, this is an appropriate outcome: exchange listing is reserved for companies that meet robust quantitative and qualitative standards, while OTC markets provide an alternative venue for public trading in higher risk or less established issuers, subject to tailored safeguards.'' [155]

Other commenters stated that the proposal would negatively impact capital formation for small public companies and increase risk to investors.[156] One commenter discussed the benefits of exchange listing for both smaller companies and investors in the context of cost of capital.[157] Specifically, this commenter stated that exchange listing provides smaller companies access to a larger set of investors and greater liquidity through access to secondary markets and allows investors to benefit from a set of Commission rules designed to enhance and organize the flow of information to investors.[158] The commenter concluded that this lowers the cost of capital because investors ''are willing to pay a premium for the ability to trade easily'' and ''are more willing to make long-dated investments when they know their positions can be readily transferred to other investors.'' [159] This commenter also stated that investors are less inclined to invest in, and lenders are less willing to extend financing, to companies trading close to the bright-line threshold, which intensifies the downward price pressure.[160] Another commenter stated that the proposal would not only impact companies with a market capitalization under $5 million, but also companies between $5 million and $50 million, as those companies could face a risk of being delisted as a result of temporary market fluctuations.[161]

Several commenters discussed the negative consequences of trading in the OTC market upon immediate delisting and suspension.[162] These commenters stated that when a security is delisted and moves from a national securities exchange to the OTC market, trading occurs with reduced liquidity, diminished analyst coverage, wider bid-ask spreads, lower institutional participation, fewer financing opportunities, and reduced oversight.[163] One commenter also stated that retail shareholders may face difficulty purchasing and selling securities efficiently.[164] This commenter stated that trading in the OTC market would materially impact issuers' ability to access capital, make strategic acquisitions, attract institutional investment, and ultimately regain compliance with exchange listing standards.[165] Another commenter discussed the benefits of the regulatory framework for exchange-listed securities, which are NMS securities.[166]

The Commission acknowledges that there are many benefits to companies and their shareholders related to being listed on a national securities exchange, including increased access to capital formation and promotion of market efficiency. Commenters have raised concerns that delisting companies that fall below the Minimum Market Capitalization Criteria may lead to several negative outcomes, including, but not limited to, making raising capital more difficult for small companies.[167] However, the benefits of listing and possible consequences of delisting for issuers and their shareholders do not override the need for an exchange to maintain and enforce continued listing standards such as the proposed rule, which is consistent with Section 6(b)(5) of the Act.[168] As discussed above, the immediate suspension and delisting of companies that do not comply with the Minimum Market Capitalization Criteria will address identified risks of heightened susceptibility to manipulative trading activity, and it is not unfairly discriminatory to impose a standard that is reasonably tailored to address those risks. Moreover, companies that fail to comply with the Minimum Market Capitalization Criteria and are subsequently delisted will be able to trade in the OTC market, which provides a viable alternative for the trading of companies that do not meet the requirements for Exchange listing. While companies that are no longer eligible to list on the Exchange may apply to list on another national securities exchange, other national securities exchange may choose to impose similar continued listing requirements, as is the case with the Nasdaq MVLS Proposal. However, the OTC market remains a viable trading venue for securities that are not eligible for listing on any national securities exchange. As such, competition among issuers and national securities exchanges would not be unnecessarily or inappropriately burdened as a result of this proposed rule change. These companies may also apply for Exchange listing in the future. Therefore, the Commission finds that the Exchange's proposal to immediately suspend and delist companies that fail to comply with the Minimum Market Capitalization Criteria is reasonably designed to prevent fraudulent and

[154] *See* SIFMA Letter at 3–4. The commenter stated that the ''Commission's 2020 amendments to Rule 15c2–11 [of the Act] were explicitly designed to modernize the OTC market, promote investor protection, and curb fraud and manipulation by strengthening disclosure requirements and narrowing reliance on exceptions.'' *Id.* at 4.

[155] *Id.* at 4.

[156] *See* Lucosky Letter at 4; SPCC Letter I at 7. *See also* Heart Sciences Letter at 1–2; Imunon Letter; MacKenzie Realty Letter at 2; Edible Garden Letter at 2; Donohoe Letter at 3–4. One of these commenters stated that, if this proposal and the Nasdaq MVLS Proposal are adopted, substantially similar automatic delisting triggers would operate simultaneously to affect a large portion of the national market system, especially in periods of market stress. *See* SPCC Letter I at 17.

[157] *See* Lewis February Report at paragraphs 6–15.

[158] *See id.* at paragraph 6.

[159] *Id.* at paragraphs 8–9. This commenter also stated that ''[f]irms with more liquid equity rely more heavily on equity financing and incur lower issuance costs, which in turn facilitates greater investments in physical assets and R&D.'' *Id.* at paragraph 10.

[160] *See* SPCC Letter II at 3. One commenter stated that incentivized ''sustained downward price pressure'' in proximity to the proposed threshold and amplification of ''valuation compression in otherwise solvent issuers'' implicates Section 3(f) of the Act and questioned whether the proposal will promote efficiency, competition, and capital formation. *See* IP Strategy Letter at 4.

[161] *See* Lucosky Letter at 1. *See also* SPCC Letter I at 8 (''[t]he rule does not merely affect firms that fall below $5 million in market capitalization; it affects every company that could plausibly approach it''). *See also supra* note 70 and accompanying text (discussing the analysis regarding the fundamental tradeoff inherent in selecting a threshold for delisting).

[162] *See* Lucosky Letter at 4; Lewis Report at paragraph 3. *See also* Donohoe Letter at 4; Mackenzie Realty Letter at 2; HeartSciences Letter at 2; IP Strategy Letter at 3, 6.

[163] *See* Lucosky Letter at 4; SPCC Letter I at 11. *See also* HeartSciences Letter at 2; MacKenzie Realty Letter at 2; IP Strategy Letter at 3, 6.

[164] *See* Lucosky Letter at 4.

[165] *See id.* One commenter stated that increasing the involuntary migration of solvent issuers to less transparent venues may alter competitive positioning among trading venues without a demonstrable investor protection justification, and the Commission must determine whether such burden on competition is necessary under Section 6(b)(8) of the Act. *See* IP Strategy Letter at 4, 9–10.

[166] *See* Lewis February Report at paragraphs 16–18. This commenter provided examples of Commission rules and industry plans designed to improve the information environment and trade execution quality that apply to NMS securities, or exchange-listed securities, but not to OTC securities. *See id.*

[167] *See supra* notes 162–166 and accompanying text.

[168] 15 U.S.C. 78f(b)(5).

manipulative acts and practices, promote just and equitable principles of trade, and protect investors and the public interest, consistent with Section 6(b)(5) of the Act.[169] The Commission also finds that the Exchange's proposal is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers, consistent with Section 6(b)(5) of the Act;[170] and will not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act, consistent with Section 6(b)(8) of the Act.[171]

E. Comments Suggesting Alternatives

Commenters suggested alternatives to the proposal.[172] One commenter suggested providing a reasonable cure period and adopting a ''graduated compliance framework'' similar to other continued listing standards.[173] This commenter also recommended authorizing the Hearing Panel to consider issuer-specific circumstances.[174] Another commenter suggested that the Exchange develop a targeted, risk-based response based on characteristics such as public float, insider ownership, and limitation to U.S. regulatory access; provide a meaningful cure period; or consider delisting based on the existence of an additional compliance deficiency.[175] This commenter also stated that the Exchange could employ graduated supervisory responses, such as enhanced monitoring, watch-list status, or disclosure obligations to distinguish temporary volatility from structural deficiencies.[176]

Further, this commenter suggested providing a twelve-month implementation delay for the proposed rule change to allow issuers, investors, and lenders time to adjust their capital structures, contractual arrangements, and risk assessments in an orderly manner.[177]

The Act governs the Commission's review of SRO-proposed rules. Section 19(b)(2)(C)(i) provides that the Commission ''shall approve'' a proposal if it finds that the rule is consistent with the requirements of the Act and the rules and regulations applicable to the SRO—including requirements in Section 6(b).[178] The statute does not give the Commission the ability to make any changes to the rule proposal as submitted, or to disapprove the rule proposal on the ground that the Commission would prefer some alternative rule on the same topic and the Exchange has not amended its proposal in response to commenters' suggestions. The Commission must evaluate the proposal before it and approve if it finds the proposal is consistent with the Act and the rules thereunder. Even if commenters' suggestions could provide alternative, potentially preferable means to address concerns that securities with small market capitalization are susceptible to manipulative trading activity and may present difficulties with the maintenance of fair and orderly markets in these securities, these suggestions are not part of the Exchange's proposal. For the reasons discussed herein, the Commission finds that the Exchange's proposal to immediately suspend trading and commence delisting proceedings for companies that fall below the Minimum Market Capitalization Criteria is reasonably designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and to protect investors and public interest, and is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers, consistent with Section 6(b)(5) of the Act.[179] The Commission also finds that the proposed rule change is consistent with Section 6(b)(7) of the Act,[180] which requires, among other things, that the rules of an exchange provide fair procedure for the prohibition or limitation by the exchange of any person with respect to access to services offered by the exchange. In addition, the Commission finds that the proposed rule change is consistent with Section 6(b)(8) of the Act,[181] which requires that the rules of an exchange do not impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act.

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[182] that the proposed rule change (SR–NYSEAMER–2026–17) be, and hereby is, approved.

By the Commission.

J. Matthew DeLesDernier,

Deputy Secretary.

[FR Doc. 2026–23528 Filed 11–18–26; 8:45 am]

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[169] *Id.*

[170] *Id.*

[171] 15 U.S.C. 78f(b)(8).

[172] *See* Lucosky Letter at 5; SPCC Letter I at 13–14; SPCC Letter II at 6.

[173] *See* Lucosky Letter at 5.

[174] *See id.*

[175] *See* SPCC Letter I at 16.

[176] *See id.*

[177] *See* SPCC Letter II at 6.

[178] *See* 15 U.S.C. 78s(b)(2)(C)(i).

[179] 15 U.S.C. 78f(b)(5).

[180] 15 U.S.C. 78f(b)(7).

[181] 15 U.S.C. 78f(b)(8).

[182] 15 U.S.C. 78s(b)(2).

SECURITIES AND EXCHANGE COMMISSION

[OMB Control No. 3235–0102]

Agency Information Collection Activities; Submission for OMB Review; Comment Request; Extension: Tender Offer-Regulation 14D and Regulation 14E, Schedule 14D–9

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of FOIA Services, 100 F Street NE, Washington, DC 20549–2736

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (''Commission'') has submitted to the Office of Management and Budget this request for extension of the previously approved collection of information discussed below. The Commission also is requesting approval from OMB to designate this existing collection of information (OMB Control No. 3235–0102) as a ''common form'' for purposes of PRA submissions [1] because the Board of Governors of the Federal Reserve System uses this information collection (under OMB Control No. 7100–0091).

Regulation 14D (17 CFR 240.14d–1 through 240.14d–11) and Regulation 14E (17 CFR 240.14e–1 through 240.14e–8) and related Schedule 14D–9 (17 CFR 240.14d–101) require information intended to help security

[1] *See* ROCIS PRA Module User Guide v.8.2, at 110–111 (Mar. 2024), available at *https://www.rocis.gov/rocis/viewResources.do* (''A 'common form' is an information collection that can be used by two or more agencies, or government-wide, for the same purpose. The Common Forms Module [in ROCIS] allows a 'host' agency to obtain [OMB] approval of an information collection for use by one or more 'using' agencies. After OMB grants approval, any prospective using agency that seeks to collect identical information for the same purpose can obtain approval to use the 'common form' by providing its agency-specific information to OMB (*e.g.,* burden estimates and number of respondents). . . . The host agency will indicate in the **Federal Register** notices that it is requesting approval of a common form and, if known, identify other agencies that may use the information collection. Both the **Federal Register** notices and the ICR should account only for the burden imposed by the host agency's use of the common form. Once the host agency has received approval from OMB, any agency will be able to request OMB approval for its use of the common form in ROCIS by providing its agency specific information to OMB (*e.g.,* burden estimates and number of respondents). Additional public notice by those agencies will not be required.'').

holders determine how to respond to tender offers. The information required by Schedule 14D–9 is mandatory, and Schedule 14D–9 filings are publicly available on the Commission's Electronic Data Gathering, Analysis, and Retrieval (''EDGAR'') system. We estimate that Schedule 14D–9 is filed once per year by approximately 54 respondents, for a total of approximately 54 responses annually. We estimate that respondents incur 65.14 burden hours per Form 10–K response, for a total annual reporting burden of 3,518 hours (65.14 burden hours per response × 54 responses). We estimate that respondents incur $117,252 cost burden per Schedule 14D–9 response, for a total annual cost burden of $6,331,608 ($117,252 cost burden per response × 54 responses).

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 public may view and comment on this information collection request at: *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202609-3235-005* or send an email comment to *MBX.OMB.OIRA.SEC_desk_officer@omb.eop.gov* within 30 days of the day after publication of this notice by December 21, 2026.

Dated: November 16, 2026.

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23546 Filed 11–18–26; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106911; File No. SR–NASDAQ–2026–098]

Self-Regulatory Organizations; The Nasdaq Stock Market LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend General 4, Rule 1240 To Adopt a New Senior Leader Regulatory Element Interim Program

November 16, 2026.

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 November 9, 2026, The Nasdaq Stock Market LLC (''Nasdaq'' or ''Exchange'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I, and II, below, which Items have been prepared by the Exchange. Nasdaq has designated the proposed rule change as constituting a ''non-controversial'' rule change under paragraph (f)(6) of Rule 19b–4 under the Act,[3] which renders the proposal effective under receipt of this filing by the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend General 4, Rule 1240 (Continuing Education) to adopt new Supplementary Material .03 (Senior Leader Regulatory Element Interim Program) and to harmonize General 4, Rule 1240(a)(6) (Delivery of the Regulatory Element) with recent changes to FINRA Rule 1240.

The text of the proposed rule change is available on the Exchange's website at *https://listingcenter.nasdaq.com/rulebook/nasdaq/rulefilings,* and at the principal office of the Exchange.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change is to amend General 4, Rule 1240 (Continuing Education) to adopt new Supplementary Material .03 (Senior Leader Regulatory Element Interim Program) and to make a conforming amendment to General 4, Rule 1240(a)(6) (Delivery of the Regulatory Element) to conform the Exchange's continuing education requirements to recent changes made by the Financial Industry Regulatory Authority, Inc. (''FINRA'') to FINRA Rule 1240.[4]

Pursuant to General 4, Rule 1240, registered persons of Exchange members are required to complete continuing education (''CE'') that consists of two mandatory programs, a Regulatory Element and a Firm Element. Regulatory Element CE, which is administered by FINRA, focuses on regulatory requirements and industry standards. Firm Element CE is provided by each member to its registered persons and focuses on the member's securities products, services, and strategies, its policies, and industry trends. The Exchange's Rule 1240 is identical to FINRA Rule 1240, and the Exchange periodically amends its rule to remain harmonized with FINRA's rule.

FINRA has represented that it received a variety of suggestions from member firms and industry groups regarding changes to the Regulatory Element CE requirement for senior leaders (*e.g.,* chief executive officer, chief financial officer), including in response to FINRA Regulatory Notice 25–07.[5] The Exchange agrees with FINRA that Regulatory Element CE provides individuals with valuable training on recent developments in regulatory requirements and industry standards and, as such, is appropriate for all registered persons, including senior leaders. Senior leaders, however, may realize greater benefit from Regulatory Element CE training that draws from the annual Regulatory Element content but is tailored to their unique roles at a member. Senior leaders may engage with applicable rules differently than frontline representatives and principals because they have broader visibility and responsibilities across their member firm, and, often, its broader organizational structure. Regulatory Element CE content for such leaders therefore may be more effective if it covers the information addressed in the various Regulatory Element CE learning plans but presents the information from a broader, firm-wide perspective, such as firm risks, control systems, approaches to pressure-test firm capabilities and vulnerabilities, and similar enterprise-level considerations.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 17 CFR 240.19b–4(f)(6).

[4] *See* Securities Exchange Act Release No. 106797 (November 2, 2026), 91 FR 69897 (November 5, 2026) (SR–FINRA–2026–023) (Notice of Filing and Immediate Effectiveness of a Proposed Rule Change to Adopt FINRA Rule 1240.03 (Senior Leader Regulatory Element Interim Program) to Establish an Interim Program of Regulatory Element Continuing Education) (''FINRA Filing'').

[5] *See id.* at 69867, n. 4 (citing letter from Bernard V. Canepa, Managing Director and Associate General Counsel & Alyssa Pompei, Vice President and Assistant General Counsel, Securities Industry and Financial Markets Association, to Jennifer Piorko Mitchell, Office of the Corporate Secretary, FINRA, dated July 14, 2025).

Accordingly, the Exchange proposes to adopt Supplementary Material .03 to General 4, Rule 1240 to establish a Senior Leader Regulatory Element Interim Program (''Interim Program'') identical to that adopted and administered by FINRA. A member may elect to have a covered person who is a senior leader satisfy the requirement to complete the Regulatory Element by participating in the Interim Program. For purposes of the Interim Program, the term ''senior leader'' means any covered person listed on a member's Schedule A of Form BD; any other covered person serving on a member's executive, management or operations committees; or any covered person with similar status or functions who is employed at an affiliate of a member.[6] Participating senior leaders would continue to be required to take Regulatory Element CE on an annual basis, but the content of the training and the method of delivery would be different.

The Interim Program would be administered in a manner prescribed by FINRA and as set forth in the FINRA Filing, for a period starting on November 2, 2026, and ending on December 31, 2028. The Regulatory Element material for participating covered persons would be developed by FINRA and based on the roles and responsibilities of senior leaders. As described in the FINRA Filing, FINRA would consider the annual learning plan topics assigned to each registration category, but, rather than limiting the content to the specific registration categories the senior leaders hold, the materials would cover content across all registration categories and present significant rule changes, key regulatory developments, and other Regulatory Element topics from the unique organizational vantage point of senior leaders. The materials would remain consistent with the core objectives of Regulatory Element CE.

Under the Interim Program, the chief compliance officer (''CCO'') or other senior compliance officer at a participating member would provide the training to participating senior leaders (including any participating senior leaders of affiliated entities), and would have the discretion to supplement the training materials to provide the most relevant and effective training for the member's senior leaders.[7] The CCO of a member designated under General 9, Section 21(c)[8] would provide FINRA with the list of participating senior leaders and represent to FINRA that the senior leaders completed the Regulatory Element material in a manner prescribed by FINRA. Further, a senior leader who participates in the Interim Program would certify that he or she has completed the Regulatory Element material, and the member would retain such certification.[9] Senior leaders who participate and successfully complete the training would satisfy their annual Regulatory Element requirement under Rule 1240; those who do not participate would be required to complete the Regulatory Element CE courses assigned by FINRA, as they do today.

In connection with the Interim Program, the Exchange also proposes to amend General 4, Rule 1240(a)(6) (Delivery of the Regulatory Element), which currently provides that the Regulatory Element shall be administered through Web-based delivery or such other technological manner and format as specified by the Exchange. The Exchange proposes to delete the word ''technological'' so that the rule would provide that the Regulatory Element shall be administered through Web-based delivery or such other manner and format as specified by the Exchange. This conforming amendment, which mirrors FINRA's amendment to FINRA Rule 1240(a)(6), would permit the CCO or other senior compliance officer at a member participating in the Interim Program to deliver the Regulatory Element training to participating senior leaders.

The Interim Program would be voluntary, and no member would be required to participate. While the Interim Program is in place, FINRA would evaluate demand for the program and whether it is meeting the goals of Regulatory Element CE for senior leaders.[10] If the Interim Program is not extended or Rule 1240.03, as may be amended, is not approved as permanent by the Commission, Supplementary Material .03 would automatically sunset on December 31, 2028, and covered persons who are senior leaders would not be able to participate in the Interim Program after such date.

Nasdaq has filed the proposed rule change for immediate effectiveness and has requested that the Commission waive the requirement that the proposed rule change not become operative for 30 days after the date of filing so Nasdaq can implement the proposed rule change immediately.[11]

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act,[12] in general, and furthers the objectives of Section 6(b)(5) of the Act,[13] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. The Exchange also believes the proposal is consistent with Section 6(c)(3) of the Act,[14] which authorizes the Exchange to prescribe standards of training, experience and competence for persons associated with Exchange members.

The proposed rule change continues the Exchange's commitment to Regulatory Element CE while providing appropriate flexibility for members and senior leaders, and maintains the requirement that all registered persons complete appropriate Regulatory Element content on an annual basis. Because participation would be voluntary, a member could require its senior leaders to continue to take the Regulatory Element CE assigned for their specific registration categories if the member concludes such training would be more appropriate. Senior leaders would not be exempt from the annual Regulatory Element requirement; only the framing and method of delivery of the training would differ. The ability of a member's CCO or other senior compliance officer to supplement the

[6] A member would determine which of its senior leaders, if any, should participate in the Interim Program based on the member's annual evaluation of the training needs for such individuals.

[7] Currently, Regulatory Element CE is provided to all individuals via the online CE platform available through FINRA's Financial Professional Gateway. FINRA made a conforming amendment to FINRA Rule 1240(a)(6) to remove the requirement that Regulatory Element CE be administered in a technological manner. *See* FINRA Filing at 69898, n. 7.

[8] Nasdaq General 9, Section 21(c) requires Nasdaq members and persons associated with a member to comply with FINRA Rule 3130 (Annual Certification of Compliance and Supervisory Processes) as if such rule were part of Nasdaq's rules. FINRA Rule 3130(a) requires each member to designate and specifically identify on Schedule A of Form BD one or more principals to serve as chief compliance officer to FINRA.

[9] In the FINRA Filing, FINRA stated that members would need to retain such certification for at least three years, and that FINRA would include in a Regulatory Notice additional information on how CCOs would demonstrate compliance. *See* FINRA Filing at 69898.

[10] FINRA anticipates collecting feedback and data from a variety of stakeholders, including CCOs and senior leaders at participating firms, as well as the CE Council. *See* FINRA Filing at 69898, n. 9.

[11] FINRA notes that the proposed rule change would not impact members that are funding portals but would impact all other members including members that have elected to be treated as capital acquisition brokers (''CABs''), given that the CAB rule set incorporates the impacted FINRA rules by reference. *See* FINRA Filing at 69898, n. 10.

[12] 15 U.S.C. 78f(b).

[13] 15 U.S.C. 78f(b)(5).

[14] 15 U.S.C. 78f(c)(3).

training materials would further help to ensure that the training is particularly effective for the member's senior leaders.

Moreover, the proposed rule change will harmonize the Exchange's continuing education rule with FINRA Rule 1240, thereby promoting consistency in CE requirements across self-regulatory organizations and avoiding the confusion and burden that could arise if dual members were subject to divergent standards. The Exchange believes this harmonization promotes just and equitable principles of trade and protects investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. The proposed rule change is not intended to address competitive issues, but rather to conform the Exchange's continuing education requirements to those of FINRA. The Interim Program is voluntary and would be available equally to all members, which may elect participation based on their own evaluation of the training needs of their senior leaders and may switch senior leaders between the Interim Program and the assigned Regulatory Element CE. Because the Interim Program is voluntary, members are not expected to use it unless they believe it benefits their firms, and any potential unintended impacts would be limited due to the term of the Interim Program.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

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)(iii) of the Act [15] and subparagraph (f)(6) of Rule 19b–4 thereunder.[16]

A proposed rule change filed under Rule 19b–4(f)(6) normally does not become operative for 30 days after the date of filing. However, pursuant to Rule 19b–4(f)(6)(iii),[17] the Commission may designate a shorter time if such action is consistent with the protection of investors and the public interest. As noted in its Form 19b–4 and above in Item II, Nasdaq has requested that the Commission waive the 30-day delay requirement so that the proposed rule change may become operative immediately upon filing.

More specifically, Nasdaq stated in its request that immediate operability is consistent with the protection of investors and the public interest because the Interim Program is a FINRA program that is already in operation. As Nasdaq noted, FINRA's identical Interim Program began on November 2, 2026, and Nasdaq's proposal creates no new program, content or oversight process. Rather, Nasdaq stated that its proposal allows Exchange members to take part, on the same terms as FINRA members, in a program that is already running and that delaying the operative date of the proposal for 30 days would not change how the Interim Program is administered and would serve no investor protection purpose. Nasdaq also claimed that the absence of a waiver here would keep Exchange members, many of which are also FINRA members, out of a program already open to FINRA members and, as a result, would create a period in which Exchange and FINRA continuing education requirements diverge, which could cause confusion and burden for dual members. According to Nasdaq, the waiver would give Exchange members a meaningful opportunity to elect participation, identify eligible senior leaders, and complete necessary planning before the December 31, 2026, Regulatory Element CE deadline, and to begin evaluating participation for the 2027 CE cycle. For these reasons, the Commission believes that waiving the 30-day operative delay for this proposed rule change is consistent with the protection of investors and the public interest. Accordingly, the Commission hereby waives the 30-day operative delay and designates the proposed rule change operative upon filing.[18]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–NASDAQ–2026–098 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–NASDAQ–2026–098. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the filing will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to File Number SR–NASDAQ–2026–098 and should be submitted on or before December 10, 2026.

[15] 15 U.S.C. 78s(b)(3)(A)(iii).

[16] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[17] 17 CFR 240.19b–4(f)(6)(iii).

[18] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule change's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[19]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23550 Filed 11–18–26; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–106913; File No. SR–C2–2026–031]

Self-Regulatory Organizations; Cboe C2 Exchange, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend Rules 5.7 and 5.31(b)(1) and (c) for the Queuing Period, Order and Quote Entry, and Opening Auction Times Regarding the Global Trading Hours (''GTH'') Sessions

November 17, 2026.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on November 4, 2026, Cboe C2 Exchange, Inc. (''Exchange'' or ''C2'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Exchange filed the proposal as a ''non-controversial'' proposed rule change pursuant to Section 19(b)(3)(A)(iii) of the Act [3] and Rule 19b–4(f)(6) thereunder.[4] 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

Cboe C2 Exchange, Inc. (''C2'' or the ''Exchange'') is filing with the Securities and Exchange Commission (''Commission'' or ''SEC'') a proposed rule change to amend Rules 5.7 and 5.31(b)(1) and (c) to provide that the start of the pre-opening order Queuing Period [5] and the time at which the Exchange begins accepting orders and quotes begins at such time as the Exchange determines, but no earlier than 6:00 a.m.[6] The Exchange will announce all times it determines pursuant to this filing via Exchange Notice. The text of the proposed rule change is provided in Exhibit 5.

The text of the proposed rule change is also available on the Commission's website (*https://www.sec.gov/rules/sro.shtml*), the Exchange's website (*https://www.cboe.com/us/options/regulation/rule_filings/ctwo/*), and at the principal office of the Exchange.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Rules 5.7 and 5.31(b)(1) and (c) to permit the Queuing Period and order and quote entry on C2 to begin earlier than they do today. The proposed rule change is substantively identical to the changes Cboe Exchange, Inc. (''Cboe Options'') recently made to the Queuing Period, order and quote entry, and opening auction update dissemination times in Cboe Options Rules 5.7(a), 5.31(b)(1), and 5.31(c) for option classes other than index options eligible for Global Trading Hours (''GTH'').[7]

Background

C2 offers Global Trading Hours (''GTH'') for certain index options (currently, DJX options) from 8:30 a.m. to 9:15 a.m. Under current Rule 5.31(b)(1), the Queuing Period begins at 7:30 a.m. for all classes, including both RTH Only classes and classes eligible for GTH. The Queuing Period is the time period prior to the initiation of an opening rotation during which the System accepts orders and quotes in the Queuing Book for participation in the opening rotation for the applicable trading session. Under current Rule 5.31(b)(1), the Queuing Period begins at 7:30 a.m. Eastern Time for all classes. Consistent with that time, current Rule 5.7 provides that Users can enter orders into the System from 7:30 a.m. until market close, and cancel previously entered orders. Under current Rule 5.31(c), the Exchange disseminates opening auction updates for a series beginning at a time (determined by the Exchange) no earlier than one hour prior to the expected initiation of the opening rotation for a trading session and until the conclusion of the opening rotation for a series.

Pre-Opening Queuing Period Start Time

The Exchange proposes to amend Rule 5.31(b)(1) to provide that the Queuing Period for Opening Auctions begins at such time as the Exchange determines, but no earlier than 6:00 a.m., for all classes. Moving the start of the Queuing Period to no earlier than 6:00 a.m. allows the Exchange to lengthen the pre-opening Queuing Period, affording market participants additional time to enter, modify, and cancel orders and quotes for participation in the opening rotation and promoting a smoother, more orderly opening. This change is administrative and ministerial in nature. It adjusts only the time window during which orders and quotes are accepted for the Queuing Book and does not alter trading mechanics, order priority, execution logic, or price formation. Participants are not required to submit orders earlier; the extended window simply provides additional flexibility for those who choose to use it. This change affects only when orders and quotes are accepted for the Queuing Book, not when trading begins; the opening rotation times remain unchanged. The Exchange's approach provides for a start time determined by Exchange notice rather than a fixed time, affording the Exchange operational flexibility.

For consistency, the Exchange also proposes to amend the opening auction update dissemination time in Rule 5.31(c) to begin at such time as the Exchange determines, but no earlier than 6:00 a.m., so that the Exchange may begin disseminating opening auction updates at the start of the Queuing Period (and thus incorporate orders and quotes submitted during the entire Queuing Period in those updates).

The Exchange also proposes to amend Rule 5.7 to update the order and quote

[19] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A)(iii).

[4] 17 CFR 240.19b–4(f)(6).

[5] The term ''Queuing Period'' means the time period prior to the initiation of an opening rotation during which the System accepts orders and quotes in the Queuing Book for participation in the opening rotation for the applicable trading session. *See* Exchange Rule 5.31(a).

[6] All times referenced herein are Eastern Time, unless otherwise specifically noted.

[7] *See* Securities Exchange Act No. 106620 (October 7, 2026) 91 FR 64960 (October 13, 2026) (SR–CBOE–2026–078) (Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend Certain Rules Regarding the Global Trading Hours (''GTH'') and Curb Trading Hours Sessions) (''Cboe Options Filing'').

entry time to conform to the proposed Queuing Period change in Rule 5.31(b)(1). As amended, Rule 5.7 will provide that Users can enter orders into the System from such time as the Exchange determines, but no earlier than 6:00 a.m., until market close, and cancel previously entered orders. These changes ensure that Users can begin entering orders and quotes at the same time the System begins accepting orders and quotes into the Queuing Book. Because Rule 5.33(c)(1) provides that the System accepts complex orders for inclusion in the COB Opening Process at the times and in the manner set forth in Rule 5.31, the proposed change to the Queuing Period start time will also apply to the entry of complex orders for the COB Opening Process.

These changes are administrative in nature. The Queuing Period concept already exists, and the opening auction update dissemination process is unchanged in substance. The change raises no novel policy questions. It merely expands an existing administrative preparation window without affecting how orders are prioritized, matched, or executed. The Exchange notes that while NYSE American LLC's (''NYSE American'') extended trading hours framework provides for a fixed 6:00 a.m. order acceptance time rather than a time determined by Exchange notice,[8] the Exchange believes its discretionary approach is appropriate. The rule merely sets a floor (''no earlier than 6:00 a.m.''); it does not mandate the Exchange to begin queuing at that time. All Exchange determinations regarding the time at which the Queuing Period will begin will be announced via Exchange Notice, so market participants will have advance notice and transparency regarding the applicable start time. In addition, the Exchange believes providing the Exchange with discretion affords operational flexibility to adjust the start time in response to feedback from market participants and evolving market conditions, which benefits investors by allowing the Exchange to optimize the preparation window based on actual market participant needs.

The proposed rule change does not amend the operation of the Queuing Period following a trading halt pursuant to Rule 5.31(g), and does not change any other aspect of the opening auction process.

The Cboe Options Filing also adopted new ''GTH Only'' and ''GTH and RTH Only'' order instructions, provided for a Curb session on trading days with shortened Regular Trading Hours, applied the Designated Primary Market-Maker opening quote obligation to the GTH session, and provided for a Queuing Period beginning no earlier than 6:00 p.m. (previous day) for index options eligible for GTH.[9] C2 does not offer Curb Trading Hours or overnight GTH (C2's GTH session runs from 8:30 a.m. to 9:15 a.m.), and therefore the Exchange is not proposing the Cboe Options GTH-specific changes at this time.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with the Act and the rules and regulations thereunder applicable to the Exchange and, in particular, the requirements of Section 6(b) of the Act.[10] Specifically, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5) [11] requirements that the rules of an exchange 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 securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. Additionally, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5) [12] requirement that the rules of an exchange not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers.

Moving the start of the Queuing Period for the Opening Auction to no earlier than 6:00 a.m. (and conforming the related opening auction update time in Rule 5.31(c) and order entry time in Rule 5.7) protects investors and the public interest and promotes just and equitable principles of trade, as it will permit the Exchange to afford market participants additional time to enter, modify, and cancel orders and quotes ahead of the opening rotation. The change is administrative and ministerial. It adjusts only a technical parameter (the time window during which orders queue) without altering trading mechanics, order priority, execution logic, or the price discovery process. This change affects only when orders and quotes are accepted for the Queuing Book, not when trading begins; the opening rotation times remain unchanged. Participants are not required to submit orders during the extended window; the change simply provides additional flexibility for those who choose to use it, with no corresponding investor risk. The change has no impact on how the Queuing Period will work, applies uniformly to all Users, and is not unfairly discriminatory. The Exchange's approach provides for a start time determined by Exchange notice rather than a fixed time, affording the Exchange operational flexibility to adjust the preparation window based on participant feedback and market conditions.

The Exchange further believes the proposed rule change removes impediments to and perfects the mechanism of a free and open market and a national market system because it is substantively identical to the Queuing Period, order and quote entry, and opening auction update changes Cboe Options adopted for option classes other than index options eligible for GTH,[13] and is based on NYSE American's 6:00 a.m. order acceptance time.[14] Harmonizing these times across the Exchange and its affiliated options exchanges provides consistency for market participants that access multiple Cboe options exchanges.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

The Exchange does not believe that the proposed rule change will impose any burden on intramarket competition because it will apply equally to all similarly situated market participants. The changes to the Queuing Period start time, order and quote entry time, and opening auction update dissemination time apply uniformly to all Users entering orders and quotes for the opening rotation, and entering, modifying, or cancelling orders during an extended Queuing Period is within the discretion of Users. No participant is required to act earlier, and the extended window creates no advantage for any subset of participants.

The Exchange does not believe that the proposed rule change will impose any burden on intermarket competition. The proposed rule change is substantively identical to changes Cboe Options adopted in the Cboe Options

[8] *See* NYSE American Rule 901.1NY(d)(3).

[9] *See* Cboe Options Filing.

[10] 15 U.S.C. 78f(b).

[11] 15 U.S.C. 78f(b)(5).

[12] *Id.*

[13] *See* Cboe Options Filing.

[14] *See* NYSE American Rule 901.1NY(d)(3).

Filing and is based on NYSE American's 6:00 a.m. order acceptance time. While NYSE American provides for a fixed 6:00 a.m. order acceptance time, the Exchange's approach provides for a start time determined by Exchange notice, which does not impose any burden on competition because it merely provides the Exchange with operational flexibility to adjust order acceptance times and affects only when orders and quotes are accepted, not when trading begins. Market participants on other exchanges are welcome to become Trading Permit Holders and trade at the Exchange if they determine that this proposed rule change has made the Exchange more attractive or favorable.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants, or Others

The Exchange neither solicited nor received comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not:

A. significantly affect the protection of investors or the public interest;

B. impose any significant burden on competition; and

C. become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A) of the Act [15] and Rule 19b–4(f)(6) [16] thereunder. At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission will institute proceedings to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–C2–2026–031 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–C2–2026–031. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the filing will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–C2–2026–031 and should be submitted on or before December 10, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[17]

Vanessa A. Countryman,

Secretary.

[FR Doc. 2026–23590 Filed 11–18–26; 8:45 am]

BILLING CODE 8011–01–P

[15] 15 U.S.C. 78s(b)(3)(A).

[16] 17 CFR 240.19b–4(f)(6).

[17] 17 CFR 200.30–3(a)(12).

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22066 and #22067; TENNESSEE Disaster Number TN–20043]

Administrative Declaration of a Disaster for the State of Tennessee

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Administrative declaration of a disaster for the state of Tennessee dated November 16, 2026.

Incident: Flooding.

DATES: Issued on November 16, 2026.

Incident Period: November 5, 2026.

Physical Loan Application Deadline Date: January 15, 2027.

Economic Injury (EIDL) Loan Application Deadline Date: August 16, 2027.

ADDRESSES: *Visit the MySBA Loan Portal at https://lending.sba.gov* to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Sharon Henderson, Office of Disaster Recovery, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's disaster declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Polk.

Contiguous Counties:

Tennessee: Bradley, McMinn, Monroe.

Georgia: Fannin, Murray.

North Carolina: Cherokee.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	6.250
Homeowners without Credit Available Elsewhere	3.125
Businesses with Credit Available Elsewhere	8.000
Businesses without Credit Available Elsewhere	4.000
Private Non-Profit Organizations with Credit Available Elsewhere	3.750
Private Non-Profit Organizations without Credit Available Elsewhere	3.750
For Economic Injury:	
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.750

The number assigned to this disaster for physical damage is 220666 and for economic injury is 220670.

The states which received an SBA Administrative declaration are Tennessee, Georgia, North Carolina.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23578 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22068; CALIFORNIA Disaster Number CA–20054 Declaration of Economic Injury]

Administrative Declaration of an Economic Injury Disaster for the State of California

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Economic Injury Disaster Loan (EIDL) declaration for the state of California dated November 16, 2026.

Incident: Old Town Newhall Fire.

DATES: Issued on November 16, 2026.

Incident Period: August 24, 2026.

Economic Injury (EIDL) Loan Application Deadline Date: August 16, 2027.

ADDRESSES: *Visit the MySBA Loan Portal at https://lending.sba.gov* to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Shaquille Lewis, Office of Disaster Recovery, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's EIDL declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary County: Los Angeles.

Contiguous Counties:

California: Kern, Orange, San Bernardino, Ventura.

The Interest Rates are:

	Percent
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.625

The number assigned to this disaster for economic injury is 220680.

The state which received an EIDL declaration is California.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23600 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

SBIC License Issuance

AGENCY: U.S. Small Business Administration.

ACTION: Notice of Small Business Investment Company (SBIC) Licenses.

SUMMARY: Pursuant to the authority granted to the United States Small Business Administration under section 301(c) of the Small Business Investment Act of 1958, as amended, to grant Small Business Investment Company licenses under the Small Business Investment Company Program, this notice satisfies the requirement effective August 17, 2023 under 13 CFR 107.501(a) to publish in the **Federal Register** the names of SBICs with date of licensure and Total Intended Leverage Commitments. The following SBICs received SBIC licenses as of the date indicated below:

SBIC fund name	Date of licensure	Leverage tiers [1]
Graycliff Mezzanine V (SBIC) L.P	10/29/2026	2.00x.
MGCP HLTH, L.P	10/27/2026	1.25x.
HighVista Small Buyout Opportunities I, L.P	10/19/2026	1.25x.
Mare Liberum Critical Technologies Fund I, L.P	10/15/2026	1.25x.
FINTOP IV SBIC, L.P	10/15/2026	Non-Leveraged.
Rochefort Ventures II, L.P	10/16/2026	2.00x.
GHPC SBIC Fund I, L.P	9/28/2026	1.00x.
Independent Bankers Capital Fund V, L.P	9/24/2026	2.00x.
Bay Point Credit Opportunities SBIC Fund I, L.P	9/2/2026	0.50x.

[1] Maximum amount of Leverage expressed as a multiple of Leverageable Capital pursuant to 13 CFR 107.1150.

Paul Van Eyl,

Director of Policy, Office of Investment and Innovation, U.S. Small Business Administration.

[FR Doc. 2026–23596 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22057; CALIFORNIA Disaster Number CA–20053 Declaration of Economic Injury]

Administrative Declaration of an Economic Injury Disaster for the State of California

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Economic Injury Disaster Loan (EIDL) declaration for the state of California dated November 12, 2026.

Incident: Hurricane Marie.

DATES: Issued on November 12, 2026.

Incident Period: September 1, 2026 through September 11, 2026.

Economic Injury (EIDL) Loan Application Deadline Date: August 12, 2027.

ADDRESSES: *Visit the MySBA Loan Portal at https://lending.sba.gov* to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Shaquille Lewis, Office of Disaster Recovery, U.S. Small Business

Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's EIDL declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary County: Orange.

Contiguous Counties:

California: Los Angeles, Riverside, San Bernardino, San Diego.

The Interest Rates are:

	Percent
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.625

The number assigned to this disaster for economic injury is 220570.

The state which received an EIDL declaration is California.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23574 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22051 and #22052; MINNESOTA Disaster Number MN–20028]

Administrative Declaration of a Disaster for the State of Minnesota

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Administrative declaration of a disaster for the state of Minnesota dated November 9, 2026.

Incident: Severe Storms and Flooding.

DATES: Issued on November 9, 2026.

Incident Period: July 2, 2026 through July 8, 2026.

Physical Loan Application Deadline Date: January 8, 2027.

Economic Injury (EIDL) Loan Application Deadline Date: August 9, 2027.

ADDRESSES: Visit the MySBA Loan Portal at *https://lending.sba.gov* to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Shaquille Lewis, Office of Disaster Recovery, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's disaster declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Fillmore, Mower.

Contiguous Counties:

Minnesota: Dodge, Freeborn, Houston, Olmsted, Steele, Winona.

Iowa: Howard, Mitchell, Winneshiek, Worth.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	5.750
Homeowners without Credit Available Elsewhere	2.875
Businesses with Credit Available Elsewhere	8.000
Businesses without Credit Available Elsewhere	4.000
Private Non-Profit Organizations with Credit Available Elsewhere	3.625
Private Non-Profit Organizations without Credit Available Elsewhere	3.625
For Economic Injury:	
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.625

The number assigned to this disaster for physical damage is 220516 and for economic injury is 220520.

The states which received an SBA Administrative declaration are Minnesota and Iowa.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23573 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22064 and #22065; GEORGIA Disaster Number GA–20031]

Administrative Declaration of a Disaster for the State of Georgia

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Administrative declaration of a disaster for the state of Georgia dated November 16, 2026.

Incident: Severe Flooding.

DATES: Issued on November 16, 2026.

Incident Period: November 4, 2026.

Physical Loan Application Deadline Date: January 15, 2027.

Economic Injury (EIDL) Loan Application Deadline Date: August 16, 2027.

ADDRESSES: *Visit the MySBA Loan Portal at https://lending.sba.gov* to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Shaquille Lewis, Office of Disaster Recovery, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's disaster declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary County: Fannin.

Contiguous Counties:

Georgia: Dawson, Gilmer, Lumpkin, Murray, Union.

North Carolina: Cherokee.
Tennessee: Polk.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	6.250
Homeowners without Credit Available Elsewhere	3.125
Businesses with Credit Available Elsewhere	8.000
Businesses without Credit Available Elsewhere	4.000
Private Non-Profit Organizations with Credit Available Elsewhere	3.750
Private Non-Profit Organizations without Credit Available Elsewhere	3.750
For Economic Injury:	
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.750

The number assigned to this disaster for physical damage is 220646 and for economic injury is 220650.

The states which received an SBA Administrative declaration are Georgia, North Carolina, and Tennessee.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23582 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22070 and #22071; CALIFORNIA Disaster Number CA–20052]

Administrative Declaration of a Disaster for the State of California

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Administrative declaration of a disaster for the state of CALIFORNIA dated November 16, 2026.

Incident: Los Angeles City Kingsley Apartment Fire.

DATES: Issued on November 16, 2026.

Incident Period: October 15, 2026.

Physical Loan Application Deadline Date: January 15, 2027.

Economic Injury (EIDL) Loan Application Deadline Date: August 16, 2027.

ADDRESSES:

Visit the MySBA Loan Portal at https://lending.sba.gov to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Sharon Henderson, Office of Disaster Recovery, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's disaster declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Los Angeles.

Contiguous Counties:

California: Kern, Orange, San Bernardino, Ventura.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	6.000
Homeowners without Credit Available Elsewhere	3.000
Businesses with Credit Available Elsewhere	8.000
Businesses without Credit Available Elsewhere	4.000
Private Non-Profit Organizations with Credit Available Elsewhere	3.625
Private Non-Profit Organizations without Credit Available Elsewhere	3.625
For Economic Injury:	
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.625

The number assigned to this disaster for physical damage is 220705 and for economic injury is 220710.

The state which received an SBA Administrative declaration is California.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23599 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22060 and #22061; OHIO Disaster Number OH–20018]

Administrative Declaration of a Disaster for the State of Ohio

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Administrative declaration of a disaster for the state of Ohio dated November 13, 2026.

Incident: Severe Storms and Flooding.

DATES: Issued on November 13, 2026.

Incident Period: September 9, 2026 through September 13, 2026.

Physical Loan Application Deadline Date: January 12, 2027.

Economic Injury (EIDL) Loan Application Deadline Date: August 13, 2027.

ADDRESSES: *Visit the MySBA Loan Portal at https://lending.sba.gov* to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Shaquille Lewis, Office of Disaster Recovery, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's disaster declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Gallia, Morgan.

Contiguous Counties:

Ohio: Athens, Jackson, Lawrence, Meigs, Muskingum, Noble, Perry, Vinton, Washington.

West Virginia: Cabell, Mason.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	6.000
Homeowners without Credit Available Elsewhere	3.000
Businesses with Credit Available Elsewhere	8.000
Businesses without Credit Available Elsewhere	4.000
Private Non-Profit Organizations with Credit Available Elsewhere	3.625
Private Non-Profit Organizations without Credit Available Elsewhere	3.625
For Economic Injury:	
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.625

The number assigned to this disaster for physical damage is 220606 and for economic injury is 220610.

The states which received an SBA Administrative declaration are Ohio and West Virginia.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23577 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22058 and #22059; TEXAS Disaster Number TX–20096]

Administrative Declaration of a Disaster for the State of Texas

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Administrative declaration of a disaster for the state of Texas dated November 13, 2026.

Incident: Severe Storms, Flooding, Hail, and Straight-line Winds.

DATES: Issued on November 13, 2026.

Incident Period: October 23, 2026 through October 26, 2026.

Physical Loan Application Deadline Date: January 12, 2027.

Economic Injury (EIDL) Loan Application Deadline Date: August 13, 2027.

ADDRESSES: *Visit the MySBA Loan Portal at https://lending.sba.gov* to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Milton Murphy, Office of Disaster Recovery, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's disaster declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary County: El Paso.

Contiguous Counties:

Texas: Hudspeth.

New Mexico: Doña Ana, Otero.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	6.250
Homeowners without Credit Available Elsewhere	3.125
Businesses with Credit Available Elsewhere	8.000
Businesses without Credit Available Elsewhere	4.000
Private Non-Profit Organizations with Credit Available Elsewhere	3.750
Private Non-Profit Organizations without Credit Available Elsewhere	3.750
For Economic Injury:	
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.750

The number assigned to this disaster for physical damage is 220586 and for economic injury is 220590.

The states which received an SBA Administrative declaration are New Mexico, Texas.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23592 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #22062 and #22063; OHIO Disaster Number OH–20019]

Administrative Declaration of a Disaster for the State of Ohio

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Administrative declaration of a disaster for the state of Ohio dated November 13, 2026.

Incident: Severe Storms and Flooding.

DATES: Issued on November 13, 2026.

Incident Period: September 20, 2026 through September 21, 2026.

Physical Loan Application Deadline Date: January 12, 2027.

Economic Injury (EIDL) Loan Application Deadline Date: August 13, 2027.

ADDRESSES: *Visit the MySBA Loan Portal at https://lending.sba.gov* to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Milton Murphy, Office of Disaster Recovery, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's disaster declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal *https://lending.sba.gov* or in person at other locally announced locations. For further assistance please contact the SBA disaster assistance customer service center by email at *disastercustomerservice@sba.gov* or by phone at 1–800–659–2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Greene, Meigs, Vinton.

Contiguous Counties:

Ohio: Athens, Clark, Clinton, Fayette, Gallia, Hocking, Jackson, Madison, Montgomery, Ross, Warren.

West Virginia: Jackson, Mason, Wood.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	6.000
Homeowners without Credit Available Elsewhere	3.000
Businesses with Credit Available Elsewhere	8.000

	Percent
Businesses without Credit Available Elsewhere	4.000
Private Non-Profit Organizations with Credit Available Elsewhere	3.625
Private Non-Profit Organizations without Credit Available Elsewhere	3.625
For Economic Injury:	
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.625

The number assigned to this disaster for physical damage is 220626 and for economic injury is 220630.

The states which received an SBA Administrative declaration are Ohio, West Virginia.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery.

[FR Doc. 2026–23575 Filed 11–18–26; 8:45 am]

BILLING CODE 8026–09–P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2026–0100]

Privacy Act of 1974; Matching Program

AGENCY: Social Security Administration (SSA).

ACTION: Notice of a new matching program.

SUMMARY: In accordance with the provisions of the Privacy Act of 1974, this notice announces a new matching program with the Department of Labor (DOL). Under this matching program, DOL, as the source agency, will disclose Federal Employees' Compensation Act (FECA) payment data to SSA, the recipient agency. SSA will use the FECA payment data or the purpose of facilitating the administration of title II Disability Insurance (DI) benefits to eligible beneficiaries and their auxiliaries. DOL will provide the data to SSA every 28 days, consistent with its FECA benefit payment cycle. Each data transmission is expected to include payment information for approximately 40,000 FECA beneficiaries.

DATES: The deadline to submit comments on the proposed matching program is no later than December 21, 2026.

The matching program will be applicable on December 28, 2026, or once a minimum of 30 days after publication of this notice has elapsed, whichever is later. The matching program will be in effect for a period of 18 months.

ADDRESSES: You may submit comments by any one of three methods—internet, fax, or mail. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please state that your comments refer to Docket No. SSA–2026–0100 so that we may associate your comments with the correct regulation *Caution:* You should be careful to include in your comments only information that you wish to make publicly available. We strongly urge you not to include in your comments any personal information, such as Social Security numbers or medical information.

1. *Internet:* We strongly recommend that you submit your comments via the internet. Please visit the Federal eRulemaking portal at *https://www.regulations.gov.* Use the *Search* function to find docket number SSA–2026–0100 and then submit your comments. The system will issue you a tracking number to confirm your submission. You will not be able to view your comment immediately because we must post each submission manually. It may take up to a week for your comments to be viewable.

2. *Fax:* Fax comments to 833–410–1631.

3. *Mail:* Matthew Ramsey, Head of Privacy and Disclosure Policy, Law & Policy, Social Security Administration, G–401 WHR, 6401 Security Boulevard, Baltimore, MD 21235–6401, or emailing *Matthew.Ramsey@ssa.gov.* Comments are also available for public viewing on the Federal eRulemaking portal at *https://www.regulations.gov* or in person, during regular business hours by arranging an appointment with the contact person identified below.

FOR FURTHER INFORMATION CONTACT: Interested parties may submit general questions about the matching program to Andrea Huseth, Division Director, Electronic Interchange, Liaison & Breach Division, Privacy and Disclosure Policy, Law & Policy, Social Security Administration, G–401 WHR, 6401 Security Boulevard, Baltimore, MD 21235–6401, at telephone: (410) 608–9675, or send an email to *Andrea.Huseth@ssa.gov.*

SUPPLEMENTARY INFORMATION: This establishment of a matching program between SSA and DOL supports SSA's efficient administration of its title II DI program.

Matthew D. Ramsey,

Head of Privacy and Disclosure Policy, Law & Policy.

Participating Agencies

SSA and DOL.

Authority for Conducting the Matching Program

Legal authority for the FECA payment data disclosures under this matching program is section 224(a) and (h)(1) of the Social Security Act (Act), 42 U.S.C. 424(a) and (h)(1), as well as 5 U.S.C. 8116(d)(1). Notably, section 224(h)(1) of the Act requires Federal agencies to provide SSA with information in their possession that SSA may require for making timely determinations as to the amounts of reduction required under section 224(a) of the Act.

Purpose(s)

This matching program establishes the terms, safeguards, and procedures under which DOL as the source agency, will disclose FECA payment data to SSA, the recipient agency. SSA will use the DOL's FECA payment data for the purpose of facilitating the administration of DI benefits to both beneficiaries and their auxiliaries. SSA will utilize this data to improve SSA's ability to accurately offset Title II DI benefits in accordance with applicable laws and regulations.

Categories of Individuals

The individuals whose information is involved in this matching program are DI beneficiaries and their auxiliaries who are concurrently receiving FECA benefit payments.

Categories of Records

The API (Application Programming Interface) communication of DI beneficiaries DOL provides to SSA every 28 days consistent with its pay cycle for FECA benefit payments will contain the FECA payment amount of approximately 40,000 FECA beneficiaries. DOL FECA payment records will be matched against SSA's Master Beneficiary Record and Master Files of Social Security Numbers (SSN) Holders and SSN Applications. SSA will match DOL FECA payment records with SSA records to identify DI beneficiaries and eligible auxiliaries who may be concurrently receiving FECA payments. The records will include the individual's SSN; primary or auxiliary beneficiary claimant name; address information (address lines, city, state, ZIP code, and country); date of

birth; roll type; time lost; weekly pay rate; compensation rate; cancellation payment flag; payee relationship code; payment details, including gross payment amount, Consumer Price Index adjustment, health benefit insurance, basic life insurance, optional life insurance, post-retirement basic life insurance, miscellaneous deductions, attendant allowance, and net payment amount; entitlement period beginning and ending dates; benefit type code; date paid; FECA case number; Federal agency employer; date of injury or illness; case status; and adjudication status. SSA will use this information to determine whether a reduction of DI benefits is applicable to the DI beneficiary or any eligible auxiliary.

System(s) of Records

DOL will provide SSA with FECA benefit data from DOL's system of records: DOL/GOVT–1, Office of Workers' Compensation Programs, Federal Employees' Compensation Act File, 81 **Federal Register** (FR) 47,418 (July 21, 2016).

SSA will match the DOL data with two SSA's systems of records:

1. Master Beneficiary Record, 60–0090, last fully published at 71 FR 1826 (January 11, 2006) and updated at 72 FR 69723 (December 10, 2007), 78 FR 40542 (July 5, 2013), 83 FR 31250–31251 (July 3, 2018), 83 FR 54969 (November 1, 2018), 89 FR 825 (January 5, 2024), 89 FR 14554 (February 27, 2024), and 90 FR 53413 (November 25, 2025); and

2. Master Files of SSN Holders and SSN Applications (Enumeration System) (60–0058), last fully published at 90 FR 10025 (February 20, 2025).

[FR Doc. 2026–23591 Filed 11–18–26; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF STATE

[Public Notice: 13174]

Advisory Committee on Historical Diplomatic Documentation—Notice of Closed and Open Meeting in December 2026

The Advisory Committee on Historical Diplomatic Documentation will meet on December 15, 2026, in open and closed sessions, to discuss matters concerning declassification and transfer of Department of State records to the National Archives and Records Administration and the status of the *Foreign Relations of the United States (FRUS)* series.

Open Session. The open session for the meeting will take place online only from 10:00 a.m. until 11:00 a.m. RSVP and requests for reasonable accommodation for the meeting should be sent not later than December 8, 2026.

Closed Session. The following session will be closed in accordance with 5 U.S.C. 1009(d):

- December 15—morning.

The agenda for the closed in-person meeting calls for discussions of agency declassification decisions concerning the *FRUS* series and other declassification issues. These are matters properly classified and not subject to public disclosure under 5 U.S.C. 552b(c)(1) and the public interest requires that such activities be withheld from disclosure.

RSVP Instructions. Members of the public planning to attend the virtual open meeting should RSVP to Alina Khachatourian at *KhachatourianA@state.gov* by December 8, 2026. The platform type and instructions on how to join the virtual meeting will be provided upon receipt of RSVP. Note that requests for reasonable accommodation received after December 8 will be considered but might not be possible to fulfill.

Questions concerning the meeting should be directed to John Powers, Acting Executive Secretary, Advisory Committee on Historical Diplomatic Documentation, Department of State, Office of the Historian, Washington, DC, 20372, telephone (771) 327–0058, email *history@state.gov*.

(Authority: 5 U.S.C. 1009 and 22 U.S.C. 2651a)

John C. Powers,

Acting Director, Office of the Historian, U.S. Department of State.

[FR Doc. 2026–23512 Filed 11–18–26; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice: 13149]

30-Day Notice of Proposed Information Collection: 1405–0241 Improving Customer Experience (OMB Circular A–11, Section 280 Implementation)

ACTION: Notice of request for public comment and submission to OMB of proposed collection of information.

SUMMARY: The Department of State has submitted the information collection described below to the Office of Management and Budget (OMB) for approval. In accordance with the Paperwork Reduction Act of 1995 we are requesting comments on this collection from all interested individuals and organizations. The purpose of this Notice is to allow 30 days for public comment.

DATES: Submit comments up to December 21, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

SUPPLEMENTARY INFORMATION:

A. Purpose

Under the PRA, (44 U.S.C. 3501–3520) Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, the Department of State is publishing notice of the proposed collection of information set forth in this document.

Whether seeking a loan, Social Security benefits, veteran's benefits, or other services provided by the Federal Government, individuals and businesses expect Government customer services to be efficient and intuitive, just like services from leading private-sector organizations. Yet the 2016 American Consumer Satisfaction Index and the 2017 Forrester Federal Customer Experience Index show that, on average, Government services lag nine percentage points behind the private sector.

A modern, streamlined and responsive customer experience means: raising government-wide customer experience to the average of the private sector service industry; developing indicators for high-impact Federal programs to monitor progress towards excellent customer experience and mature digital services; and providing the structure (including increasing transparency) and resources to ensure customer experience is a focal point for agency leadership. To support this, OMB Circular A–11 Section 280

established government-wide standards for mature customer experience organizations in government and measurement. To enable Federal programs to deliver the experience taxpayers deserve, they must undertake three general categories of activities: conduct ongoing customer research, gather and share customer feedback, and test services and digital products.

These data collection efforts may be either qualitative or quantitative in nature or may consist of mixed methods. Additionally, data may be collected via a variety of means, including but not limited to electronic or social media, direct or indirect observation (*i.e.,* in person, video and audio collections), interviews, questionnaires, surveys, and focus groups. The Department of State will limit its inquiries to data collections that solicit strictly voluntary opinions or responses. Steps will be taken to ensure anonymity of respondents in each activity covered by this request.

The results of the data collected will be used to improve the delivery of Federal services and programs. It will include the creation of personas, customer journey maps, and reports and summaries of customer feedback data and user insights. It will also provide government-wide data on customer experience that can be displayed on *performance.gov* to help build transparency and accountability of Federal programs to the customers they serve.

Method of Collection

The Department of State will collect this information by electronic means when possible, as well as by mail, fax, telephone, technical discussions, and in-person interviews. The Department of State may also utilize observational techniques to collect this information.

Data:

Form Number(s): DS–4318.

Type of Review: Extension.

B. Annual Reporting Burden

Affected Public: Collections will be targeted to the solicitation of opinions from respondents who have experience with the program or may have experience with the program in the near future. For the purposes of this request, ''customers'' are individuals, businesses, and organizations that interact with a Federal Government agency or program, either directly or via a Federal contractor. This could include individuals or households; businesses or other for-profit organizations; not-for-profit institutions; State, local or tribal governments; Federal government; and Universities.

- *Estimated Number of Respondents:* 1,101,550.
- *Estimated Time per Response:* Varied, dependent upon the data collection method used. The possible response time to complete a questionnaire or survey may be 3 minutes or up to 1.5 hours to participate in an interview.
- *Estimated Total Annual Burden Hours:* 100,800.
- *Estimated Total Annual Cost to Public:* $0.

C. Public Comments

The Department of State published a 60-day notice for this collection on August 20, 2026. 91 FR 53925. There was one public comment, which stated that data collection is limited to ''non-sensitive opinions'' and feedback regarding government service, and asked if this collection satisfies those legal requirements. The Department believes that it does, and by this notice invites further comment on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden (including hours and cost) 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. Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they also will become a matter of public record.

Alden F. Fahy,

Acting Director, Office of Privacy and Organizational Policy, Department of State.

[FR Doc. 2026–23586 Filed 11–18–26; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice 13148]

30-Day Notice of Proposed Information Collection: Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery

ACTION: Notice of request for public comment and submission to OMB of proposed collection of information.

SUMMARY: The Department of State has submitted the information collection described below to the Office of Management and Budget (OMB) for approval. In accordance with the Paperwork Reduction Act of 1995 we are requesting comments on this collection from all interested individuals and organizations. The purpose of this Notice is to allow 30 days for public comment.

DATES: Submit comments up to December 21, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain*. Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Direct requests for additional information regarding the collection listed in this notice, including requests for copies of the proposed collection instrument and supporting documents, to Brandi Beam, who may be reached on 202–996–1881 or at *PRA@state.gov*.

SUPPLEMENTARY INFORMATION:

- *Title of Information Collection:* Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery.
- *OMB Control Number:* 1405–0193.
- *Type of Request:* Extension of a Currently Approved Collection.
- *Originating Office:* Office of Privacy and Organizational Policy, A/SKS/PPKM/POP.
- *Form Number:* Various public surveys.
- *Respondents:* Individuals responding to Department of State customer service evaluation requests.
- *Estimated Number of Respondents:* 2,000,000.
- *Estimated Number of Responses:* 2,000,000.
- *Average Time per Response:* 3.5 minutes.
- *Total Estimated Burden Time:* 116,667 annual hours.
- *Frequency:* Once per request.
- *Obligation to Respond:* Voluntary.

We are soliciting public comments to permit the Department to:

- Evaluate whether the proposed information collection is necessary for the proper functions of the Department.
- Evaluate the accuracy of our estimate of the time and cost burden for this proposed collection, including the validity of the methodology and assumptions used.
- Enhance the quality, utility, and clarity of the information to be collected.

• Minimize the reporting burden on those who are to respond, including the use of automated collection techniques or other forms of information technology.

Please note that comments submitted in response to this Notice are public record. Before including any detailed personal information, you should be aware that your comments as submitted, including your personal information, will be available for public review.

Abstract of Proposed Collection

The information collection activity will measure qualitative customer feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving service delivery. This qualitative feedback will provide insights into customer perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. These collections will allow for ongoing, collaborative and actionable communication between the Department and its customers. It will also allow feedback to contribute directly to the improvement of program management.

Feedback collected under this generic clearance will provide useful information, but it will not yield data that can be used for quantitative information collections that are designed to yield reliably actionable results, such as monitoring trends over time or documenting program performance. Such data uses require more rigorous designs that address: the target population to which generalizations will be made, the sampling frame, the sample design (including stratification and clustering), the precision requirements or power calculations that justify the proposed sample size, the expected response rate, methods for assessing potential non-response bias, the protocols for data collection, and any testing procedures that were or will be undertaken prior fielding the study. Depending on the degree of influence the results are likely to have, such collections may still be eligible for submission for other generic mechanisms that are designed to yield quantitative results.

Methodology

Respondents will fill out a brief customer survey after completing their interaction with a Department Program Office or Embassy. Surveys are designed to gather feedback on the customer's experiences.

Public Comment

The Department of State received one public comment in response to the proposed extension of this information collection. The commenter expressed interest in more information regarding the specific survey instruments and sub-collections included under the ''Various Public Surveys'' generic clearance; specifically, information about their scope, target audiences, administration methods, estimated respondent burden, and the availability of a public inventory. The Department appreciates the comment and directs the commenter to the data on *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202402-1405-001*. Checking the ''All'' box at the top of that page will display a list of all of the surveys included under this information collection, along with their associated instruments and data.

Alden F. Fahy,

Acting Director, Office of Privacy and Organizational Policy, Department of State.

[FR Doc. 2026–23556 Filed 11–18–26; 8:45 am]

BILLING CODE 4710–24–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent of Waiver With Respect to Land; Marquette Sawyer Regional Airport, Gwinn, Michigan

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice.

SUMMARY: The FAA is considering a proposal to change approximately 15.78 acres of airport land from aeronautical use to non-aeronautical use and to authorize the sale of airport property located at Marquette Sawyer Regional Airport, Gwinn, Michigan. The aforementioned land is not needed for aeronautical use. The subject property is located east of the commercial terminal and parking lot generally bounded by Avenue G. and 11th Street to the north, Kelly Johnson Memorial Drive to the east, 10th Street to the south and Gerry Corkin Drive to the west. The property proposed to be released for sale contains a portion of a non-aeronautical manufacturing facility with the remainder vacant land. The proposed non-aeronautical use of the property is an expansion of the existing non-aeronautical manufacturing facility.

DATES: Comments must be received on or before December 21, 2026.

ADDRESSES: All requisite and supporting documentation will be made available for review by appointment at the FAA Detroit Airports District Office, Anthony Sebastian, Program Manager, 11677 South Wayne Road, Suite 107, Romulus MI 48174 Telephone: (734) 229–2900/ Fax: (734) 229–2950 and Duane R. DuRay, 125 G Avenue, Gwinn, MI 49841, (906) 225–8150.

Written comments on the Sponsor's request may be submitted using any of the following methods:

• *Federal eRulemaking Portal:* Go to *http://www.regulations.gov,* and follow the instructions for sending your comments electronically.

• *Mail:* Anthony Sebastian, Program Manager, Federal Aviation Administration, Detroit Airports District Office, 11677 South Wayne Road, Suite 107, Romulus MI 48174.

• *Hand Delivery:* Deliver to mail address above between 7:30 a.m. and 4:30 p.m. Monday through Friday, excluding Federal holidays.

• *Fax:* (734) 229–2950.

FOR FURTHER INFORMATION CONTACT: Anthony Sebastian, Program Manager, Federal Aviation Administration, Detroit Airports District Office, 11677 South Wayne Road, Suite 107, Romulus MI 48174. Telephone Number: (734) 229–2900/FAX Number: (734) 229–2950.

SUPPLEMENTARY INFORMATION: In accordance with section 47107(h) of Title 49, United States Code, this notice is required to be published in the **Federal Register** 30 days before modifying the land-use assurance that requires the property to be used for an aeronautical purpose.

The subject property is not needed for aeronautical purposes and is made up of an existing manufacturing facility and vacant land. The parcel consists of portions of three (3) larger airport owned parcels of which only one (1) was acquired with federal assistance. The federally acquired portion of the parcel was conveyed in a Quitclaim Deed, accepted by the Airport Sponsor on December 16, 1999, under and pursuant to the powers and authority contained in the Defense Base Closure and Realignment Act of 1990. The airport sponsor plans to sell the subject property at fair market value for the expansion of the existing manufacturing facility.

The disposition of proceeds from the sale of this airport property will be in accordance sections 47125 and 47151 of Title 49, United States Code and 14 CFR part 155, Release of Airport Property From Surplus Property Disposal Restrictions.

This notice announces that the FAA is considering the release of the subject

airport property at the Marquette Sawyer Regional Airport, Gwinn, Michigan from federal land covenants, subject to a reservation for continuing right of flight as well as restrictions on the released property as required in FAA Order 5190.6C section 22.13. Approval does not constitute a commitment by the FAA to financially assist in the disposal of the subject airport property nor a determination of eligibility for grant-in-aid funding from the FAA.

Legal Description

A PARCEL OF LAND SITUATED IN PART OF THE NORTHWEST QUARTER OF THE SOUTHWEST QUARTER (NW ¼, SW ¼) AND IN PART OF THE SOUTHWEST QUARTER OF THE SOUTHWEST QUARTER (SW¼, SW¼) AND IN PART OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER (SE¼, SW/4), ALL WITHIN SECTION 25. TOWNSHIP 46 NORTH, RANGE 25 WEST, SANDS TOWNSHIP. MARQUETTE COUNTY, MICHIGAN, DESCRIBED AS FOLLOWS:

COMMENCING AT THE SOUTHWEST CORNER OF SECTION 25; THEN S89′40′09″ E ALONG THE SOUTH SECTION UNE. 70,277 FEET; THEN DUE NORTH 338.29 FEET TO THE INTERSECTION OF THE NORTHERLY RIGHT-OF-WAY OF TENTH STREET AND THE EASTERLY RIGHT-OF-WAY OF GERRY CORKIN DRIVE; THEN N0915′12″ E ALONG SAID EASTERLY RIGHT-OF-WAY OF GERRY CORKIN DRIVE, 483.33 FEET; THEN 457.69 FEET ALONG A 280.00 FOOT RADIUS CURVE TO THE LEFT WITH A DELTA ′ANGLE OF 93′39′22″ AND A CHORD BEARING N37′34′29″ W 408.41 FEET TO THE POINT OF BEGINNING; THEN N84′24′10″ W 86.15 FEET; THEN 51.92 FEET ALONG A 182.00 FOOT RADIUS CURVE TO THE RIGHT WITH A DELTA ANGLE OF 1620′38″ AND A CHORD BEARING N7613′51″ W 51.74 FEET; THEN N68V3′32″ W 118.51 FEET; THEN 259.76 FEET ALONG A 225.00 FOOT RADIUS CURVE TO THE RIGHT WITH A DELTA ANGLE OF 66′08′51″ AND A CHORD BEARING N3459′06″ W 245.57 FEET; THEN N0050′45″ E 146.15 FEET; THEN 69.57 FEET ALONG A 467.00 FOOT RADIUS CURVE TO THE RIGHT WITH A DELTA ANGLE OF 08′32′06″ AND A CHORD BEARING N0506′48″ E 69.50 FEET; THEN N09′22′51″ E 73.89 FEET; THEN 130.71 FEET ALONG A 83.00 FOOT RADIUS CURVE TO THE LEFT WITH A DELTA ANGLE OF 9013′40″ AND A CHORD BEARING N35′43′59″W 117.61 FEET; THEN NO7′54′21″ E 12.81 FEET; THEN S82′05′39″ E 92.11 FEET TO THE WESTERLY RIGHT-OF-WAY OF AVENUE G; THEN S82V5′39″ E 66.02 FEET TO THE EASTERLY RIGHT-OF-WAY OF AVENUE G; THEN S0912′35″ W (PREVIOUSLY RECORDED AS S0914′27″ W), ALONG SAID EASTERLY RIGHT-OF-WAY OF AVENUE G, 75.01 FEET; THEN S82V5′24″ E 331.99 FEET (PREVIOUSLY RECORDED AS S82V5′33″ E 332.05 FEET); THEN 57.33 FEET ALONG A NON-TANGENT 470.40 FOOT RADIUS CURVE TO THE RIGHT WITH A DELTA ANGLE OF 06′58′57″ AND A CHORD BEARING S84′27′39″ E 57.29 FEET (PREVIOUSLY RECORDED AS 57.39 FEET ALONG A 450.00 FOOT RADIUS CURVE TO THE RIGHT WITH A DELTA ANGLE OF 0718′24″ AND A CHORD BEARING S84′22′33″ E 57.35 FEET); THEN S80′40′37″ E 95.62 FEET (PREVIOUSLY RECORDED AS S80′43′21″ E 95.55 FEET); THEN S82V6′23″ E 190.11 FEET (PREVIOUSLY RECORDED AS S82′05′33″ E 190.13 FEET); THEN S82′05′20″ E (PREVIOUSLY RECORDED AS 582′05′33 * 5) 431.18 FEET; THEN S0051′47″ W, ALONG THE WEST 1/16TH UNE, 138.15 FEET TO THE SOUTHERLY RIGHT-OF-WAY OF ELEVENTH STREET; THEN THE FOLLOWING TWO COURSES ALONG SAID SOUTHERLY RIGHT-OF-WAY; 20.03 FEET ALONG A 348.31 FOOT RADIUS CURVE TO THE RIGHT WITH A DELTA ANGLE OF 0317′39″ AND A CHORD BEARING S5O′44′15″ E 20.02 FEET; THEN S49V5′25″ E (PREVIOUSLY RECORDED AS S49′05′25″ E) 493.64 FEET TO THE NORTHWESTERLY RIGHT-OF-WAY OF KELLY JOHNSON MEMORIAL DRIVE; THEN ALONG SAID NORTHWESTERLY RIGHT-OF-WAY S40′50′48″ W (PREVIOUSLY RECORDED AS 540′51′02″ W) 70.13 FEET; THEN N84′24′1O″ W 1153.09 FEET TO THE POINT OF BEGINNING, CONTAINING 15.78 ACRES, MORE OR LESS.

SUBJECT TO ALL EXCEPTIONS, RESTRICTIONS, RESERVATIONS AND CONDITIONS CONTAINED IN PRIOR CONVEYANCES OF RECORD.

Issued in Romulus, Michigan on November 5, 2026.

Katherine Susanna Delaney,

Manager, Detroit Airports District Office, FAA, Great Lakes Region.

[FR Doc. 2026–23526 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No. FAA FAA–2026–7669]

Agency Information Collection Activities: Requests for Comments; Clearance of Renewed Approval of Information Collection: Monitoring, Reporting, and Verification (MRV) Program for Annex 16, Volume IV of the Convention on Civil Aviation

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FAA invites public comments about our intention to request the Office of Management and Budget (OMB) approval for a renewed information collection. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on July 20, 2026. FAA received five comments to this notice. The collection involves a request that airplane operators subject to the applicability of Annex 16, Volume IV of the Convention on Civil Aviation (hereinafter the ''Chicago Convention'') submit electronically an Emissions Monitoring Plan (EMP), an annual Emissions Report (ER), and an optional annual ER Eligible Fuels Annex (EFA) to the FAA. The information to be collected is necessary because FAA will use the information to fulfill the United States' responsibilities under the Chicago Convention.

DATES: Written comments should be submitted by December 21, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Kevin Partowazam by email at: *Kevin.Partowazam@faa.gov;* phone: 202–267–3563.

SUPPLEMENTARY INFORMATION:

Public Comments Invited: You are asked to comment on any aspect of this information collection, including (a) Whether the proposed collection of information is necessary for FAA's performance; (b) the accuracy of the estimated burden; (c) ways for FAA to enhance the quality, utility and clarity

of the information collection; and (d) ways that the burden could be minimized without reducing the quality of the collected information.

OMB Control Number: 2120–0790.

Title: CORSIA Monitoring, Reporting, and Verification (MRV) Program.

Form Numbers: 1. Emissions Monitoring Plan (EMP) Template; 2. Emissions Report (ER) Template; 3. ER Eligible Fuels Annex (EFA).

Type of Review: Clearance of a renewal of an information collection.

Background: The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on July 20, 2026 (91 FR 45317). FAA received five comments in response to this notice.

The FAA MRV Program is a voluntary program for certain U.S. air carriers and commercial operators (collectively referred hereinafter as ''operators'') to submit certain airplane emissions data to the FAA to enable the United States to establish uniformity with ICAO Standards And Recommended Practices (SARPs) for Annex 16, Volume IV of the Chicago Convention, which were adopted in June 2018, as Annex 16, Volume IV to the Chicago Convention. Facilitating voluntary reporting by U.S. operators will ensure fair and reciprocal commercial competition by avoiding a patchwork of country- or regionally-based regulatory measures that are inconsistently applied, bureaucratically costly, and economically damaging.

According to Annex 16, Volume IV, all ICAO Member States whose airplane operators undertake international flights were required to develop an MRV system for emissions from those international flights starting January 1, 2019. The FAA MRV Program is intended to be the United States' MRV system for monitoring, reporting, and verification of U.S. airplane operator emissions from international flights.

Operators that are subject to the applicability of Annex 16, Volume IV will submit their EMPs, ERs, and optional ER EFAs electronically.[1] Each document uses Microsoft Excel-based templates and can be transmitted via email. EMPs that are submitted by operators will be used as a collaborative tool between the operator and FAA to document a given operator's chosen fuel use monitoring procedures. FAA will retain a copy of the EMP and will share with ICAO a list of operators that submit EMPs. FAA will not submit any specific EMPs from U.S. operators to ICAO. Operators may gather data through a ''fuel use monitoring method'' or a simplified monitoring method depending on the scale of their operations. Annual ERs that are submitted to FAA by operators and verifiers will be used to document each operators' international emissions. FAA will use the ERs, and optional ER EFAs, to calculate aggregated emissions data for all U.S. operators. FAA will submit the aggregated emissions data to ICAO to demonstrate U.S. implementation of Annex 16, Volume IV.

Respondents: Respondents will be airplane operators subject to the applicability of Annex 16, Volume IV of the Chicago Convention. FAA expects between 40 and 50 operators to submit an EMP and ER. Some additional operators could submit an EMP and ER over time based on their international aviation activities.

Frequency: An EMP is a one-time submission. An ER and optional ER EFA is an annual submission.

Estimated Average Burden per Response:

—For an EMP (one-time submission), FAA expects that filling and submitting an EMP could on average take approximately 28.6 hours.

—For an ER (annual submission), FAA expects that the reporting burden could be approximately 68 hours per operator using a Fuel Use Monitoring Method, inclusive of approximately 8 hours per operator that chooses to voluntarily submit an optional ER EFA. FAA expects the reporting burden could be approximately 21.5 hours per operator for operators using a simplified Monitoring Method, inclusive of approximately 4 hours per operator that chooses to voluntarily submit an optional ER EFA.

Estimated Total Annual Burden: Based on the above, FAA expects that the annual submission of an EMP and ER, including optional ER EFA, could take approximately 37.5 to 115.5 hours for each of the 40–50 operators.

Issued in Washington, DC, on November 17, 2026.

Julie Ann Marks,

Executive Director, Office of Environment and Energy.

[FR Doc. 2026–23612 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–13–P

[1] The following activities are excluded from Annex 16, Volume IV:

—Domestic flights;

—Humanitarian, medical, and firefighting operations, including flight(s) preceding or following a humanitarian, medical, or firefighting flight provided such flight(s) were conducted with the same airplane, were required to accomplish the related humanitarian, medical, or firefighting activities or to reposition thereafter the airplane for its next activity;

—Operations using an airplane with a maximum certificated take-off mass equal to or less than 5,700 kg;

—Operations on behalf of the military.

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

[Docket No. FHWA–2026–1321]

Agency Information Collection Activities: Request for Comments for a New Information Collection

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice and request for comments.

SUMMARY: The FHWA has forwarded the information collection request described in this notice to the Office of Management and Budget (OMB) to approve a new information collection. We are required to publish this notice in the **Federal Register** by the Paperwork Reduction Act of 1995.

DATES: Please submit comments by December 21, 2026.

ADDRESSES: You may submit comments identified by DOT Docket ID Number 1321 by any of the following methods:

Website: For access to the docket to read background documents or comments received go to the Federal eRulemaking Portal: Go to *http://www.regulations.gov.*

Follow the online instructions for submitting comments.

Fax: 1–202–493–2251.

Mail: Docket Management Facility, U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590–0001.

Hand Delivery or Courier: U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590, between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Melissa Maiefski, *melissa.maiefski@dot.gov,* (402) 326–7960, Office of Competitive Grants and Workforce Programs, Federal Highway Administration, Department of Transportation, 1200 New Jersey Avenue SE, Washington, DC 20590. Office hours are from 8 a.m. to 5 p.m., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION: We published a **Federal Register** Notice

with a 60-day public comment period on this information collection on May 21, 2026, at [91 FR 30024]. No comments were received.

Title: Stopping Threats on Pedestrians (STOP) Grant Program, also known as the Bollards Competitive Grant Program.

Background: The Federal Highway Administration (FHWA) administers the Stopping Threats on Pedestrians (STOP) program. It was established by Congress in Section 11502 of the Infrastructure Investment and Jobs Act (IIJA), Public Law 117–58.

The purpose of the Bollards Competitive Grant program is to provide competitive grants to local government entities and State Departments of Transportation to install bollards and other physical barriers designed to prevent death and injury from motor vehicle-pedestrian accidents. The program's goals include hardening ''soft targets'' in high-pedestrian areas, enhancing public safety in crowded spaces such as plazas and transit hubs, and reducing the frequency of vehicle-ramming incidents.

The program provides competitive grants for which the Federal share of the cost of an installation project may be up to 100 percent. The FHWA has authorized $5 million for fiscal year 2026 grants to support these critical safety and security infrastructure efforts.

Respondents: The Notice of Funding Opportunity (NOFO) announcing up to $5 million of Fiscal Year (FY) 2026 funding for STOP competitive grants will be available for State Departments of Transportation and local government entities on *grants.gov*. FHWA is expecting roughly 50 applicants to apply for STOP grant funding, 15 grant agreements, and 30 respondents during the project management phase.

Frequency: NOFOs and grant solicitations may be published annually by FHWA but, are subject to the availability of funds in appropriations or any legislation signed into law authorizing funds.

Estimated Average Burden per Response: 4 hours per respondent per applicant during the application and project management phase and 2 hours per respondent during the grant agreement phase.

Estimated Total Annual Burden Hours: It is expected that there will be an estimated total of 350 annual burden hours.

Public Comments Invited: You are asked to comment on any aspect of this information collection, including: (1) Whether the proposed collection is necessary for the FHWA's performance; (2) the accuracy of the estimated burdens; (3) ways for the FHWA to enhance the quality, usefulness, and clarity of the collected information; and (4) ways that the burden could be minimized, including the use of electronic technology, without reducing the quality of the collected information. The agency will summarize and/or include your comments in the request for OMB's clearance of this information collection.

Authority: The Paperwork Reduction Act of 1995; 44 U.S.C. chapter 35, as amended; and 49 CFR 1.48.

Issued on: November 17, 2026.

Jazmyne Lewis,

Information Collection Officer.

[FR Doc. 2026–23613 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Great Lakes St. Lawrence Seaway Development Corporation

Advisory Board; Meeting Notice

AGENCY: Great Lakes St. Lawrence Seaway Development Corporation, DOT.

ACTION: Notice of public meeting.

SUMMARY: This notice announces the virtual public meeting of the Great Lakes St. Lawrence Seaway Development Corporation (GLS) Advisory Board.

DATES: The virtual public meeting will be held on:

- Thursday, December 10, 2026, from 10 a.m.–12 p.m. EST.
  - Requests to participate in the meeting must be received by November 26, 2026.
  - Requests for accommodations for a disability must be received by November 26, 2026.
  - If you wish to speak during the meeting, you must submit a written copy of your remarks to GLS by November 19, 2026.
  - Requests to submit written materials to be reviewed during the meeting must be received by GLS no later than November 19, 2025.

ADDRESSES: The meeting will be held virtually. Details on how to participate will be forwarded to those who RSVP.

FOR FURTHER INFORMATION CONTACT: Sylvonica Madlock, Executive Officer, Great Lakes St. Lawrence Seaway Development Corporation, 1200 New Jersey Avenue SE, Suite W98–300, Washington, DC 20590; (202) 870–6335.

SUPPLEMENTARY INFORMATION: Pursuant to Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463; 5 U.S.C. App. 2), notice is hereby given of meetings of the GLS Advisory Board. The agenda for each meeting is the same and will be as follows:

1. Opening Remarks
2. Consideration of Minutes of Past Meeting
3. Quarterly Report
4. Old and New Business
5. Closing Discussion
6. Adjournment

Public Participation

Attendance at the meeting is open to the interested public. With the approval of the Administrator, members of the public may present oral statements during the meeting. Persons wishing further information should contact the person listed under the heading, **FOR FURTHER INFORMATION CONTACT**. There will be three (3) minutes allotted for oral comments from members of the public joining the meeting. To accommodate as many speakers as possible, the time for each commenter may be limited. Individuals wishing to reserve speaking time during the meeting must submit a request at the time of registration, as well as the name, address, and organizational affiliation of the proposed speaker. If the number of registrants requesting to make statements is greater than can be reasonably accommodated during the meeting, GLS will conduct a lottery to determine the speakers. Speakers are requested to submit a written copy of their prepared remarks for inclusion in the meeting records and for circulation to GLS Advisory Board members. All prepared remarks submitted will be accepted and considered as part of the meeting's record. Any member of the public may submit a written statement after the meeting deadline, and it will be presented to the committee.

The U.S. Department of Transportation is committed to providing equal access to this meeting for all participants. If you need alternative formats or services because of a disability, such as sign language, interpretation, or other ancillary aids, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section. Any member of the public may present a written statement to the Advisory Board at any time.

Donna O'Berry,

Chief Counsel.

[FR Doc. 2026–23564 Filed 11–18–26; 8:45 am]

BILLING CODE 4910–61–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Agency Information Collection Activities; Comment Request on Application for Security Summit Membership

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of Information Collection; request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the IRS is inviting comments on the information collection request outlined in this notice.

DATES: Written comments should be received on or before January 19, 2027 to be assured of consideration.

ADDRESSES: Direct all written comments to Andres Garcia, Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224, or by email to *pra.comments@irs.gov.* Include ''OMB Control No. 1545–2295'' in the subject line of the message.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of this collection should be directed to Jason Schoonmaker, (801) 620–6008.

SUPPLEMENTARY INFORMATION: The IRS, in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the IRS assess the impact and minimize the burden of its information collection requirements. Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record, and viewable on relevant websites. For this reason, please do not include in your comments information of a confidential nature, such as sensitive personal information. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Title: Application for Security Summit Membership.

OMB Control Number: 1545–2295.

Form Number: 15320.

Abstract: The IRS has joined with representatives of the software industry, tax preparation firms, payroll and tax financial product processors and state tax administrators to combat identity theft refund fraud to protect the nation's taxpayers. The Security Summit consists of IRS, state tax agencies and the tax community, including tax preparation firms, software developers, payroll and tax financial product processors, tax professional organizations and financial institutions.

Applicants use Form 15320 to apply for membership.

Current Actions: There is no change to the previously approved information collection.

Type of Review: Extension of a currently approved collection.

Affected Public: State, Local, or Tribal Government, business or other for-profit organizations.

Estimated Number of Responses: 62.

Estimated Time per Response: 5 minutes.

Estimated Total Annual Burden Hours: 5.

Dated: November 17, 2026.

Jason M. Schoonmaker,

Tax Analyst.

[FR Doc. 2026–23610 Filed 11–18–26; 8:45 am]

BILLING CODE 4831–GV–P

DEPARTMENT OF THE TREASURY

[TREAS–TRIP–2026–0694]

Information Collections for Claims Processing and Other Purposes Under the Terrorism Risk Insurance Program (Extension of Currently Approved Data Collections Under OMB No. 1505–0200)

AGENCY: Departmental Offices, U.S. Department of the Treasury

ACTION: Notice and request for comments.

SUMMARY: The Secretary of the Treasury (Secretary) administers the Terrorism Risk Insurance Program (TRIP or Program), including the issuance of regulations and procedures regarding the Program. The Federal Insurance Office (FIO) assists the Secretary in the administration of the Program. The Department of the Treasury (Treasury), as part of its continuing effort to reduce paperwork burdens, invites the public and other federal agencies to comment on approved information collections that are due for extension by the Office of Management and Budget (OMB) (under OMB 1505–0200), relating to claims processing and other administrative matters under the Program.

DATES: Written comments must be received not later than January 19, 2027.

ADDRESSES: Interested persons may submit comments electronically through the Federal eRulemaking Portal at *http://www.regulations.gov,* (docket number TREAS–TRIP–2026–0694) in accordance with the instructions on that site. Electronic submissions are encouraged; comments may also be mailed to the Terrorism Risk Insurance Program, Room 1410, U.S. Department of the Treasury, 1500 Pennsylvania Avenue NW, Washington, DC 20220.

All comments, including attachments and other supporting materials, are part of the public record and subject to public disclosure. You should submit only information that you wish to make available publicly. In general, Treasury will post all comments to *www.regulations.gov* without change, including any business or personal information provided such as names, addresses, email addresses, or telephone numbers.

FOR FURTHER INFORMATION CONTACT: Richard Ifft, Lead Management and Senior Insurance Policy Analyst, Terrorism Risk Insurance Program, Federal Insurance Office, Room 1410, U.S. Department of the Treasury, 1500 Pennsylvania Avenue NW, Washington, DC 20220, at (202) 622–2922 (this is not a toll-free number), Sherry Rowlett, Program Analyst, Federal Insurance Office, Room 1410, U.S. Department of the Treasury, 1500 Pennsylvania Avenue NW, Washington, DC 20220, at (202) 622–1890 (this is not a toll-free number). Persons who have difficulty hearing or speaking may access this number via TTY by calling the toll-free Federal Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION:

I. Background

The Terrorism Risk Insurance Act of 2002, as amended (TRIA or the Act),[1] established the TRIP.[2] The Act establishes a temporary federal program of shared public and private compensation for insured commercial property and casualty losses resulting from an ''act of terrorism,'' as defined by

[1] 15 U.S.C. 6701 note. Because the provisions of TRIA (as amended) appear in a note, instead of particular sections, of the United States Code, the provisions of TRIA are identified by the sections of the law.

[2] *See* 31 CFR part 50.

TRIA. In order for the Program to make payments following a certified ''act of terrorism,'' the losses from an event must exceed certain thresholds and be in excess of participating insurer deductibles. Only ''acts of terrorism'' that have been certified as such by the Secretary (in consultation with the Attorney General and the Secretary of Homeland Security) are subject to the compensation provisions of the Program. In the event Treasury does make payments under the Program, it may be required, through surcharges imposed upon all commercial policyholders, to recoup some or all of amounts expended.

Since the inception of the Program in 2002, Treasury has sought and obtained from the OMB approvals for information collections that will be necessary if Treasury needs to process claims for the federal share of compensation, and potentially recoup amounts expended as required under TRIA.[3] Most of these information collections are managed through forms that have been developed by Treasury to permit participating insurers to demonstrate that they are entitled to payments for the federal share of compensation. In some cases (as explained further in this Notice), the information collection is not subject to a specific form but is based upon circumstances that may develop in the future, in the event the Program is triggered, or might be triggered, by the Secretary's certification of an act of terrorism.

The Terrorism Risk Insurance Program Reauthorization Act of 2019 extended the Program until December 31, 2027.[4] Therefore, to administer the Program, Treasury needs to continue the existing information collections to permit the receipt and resolution of claims, and potential recoupment of amounts expended by Treasury. Treasury seeks to extend these previously approved collections without substantive change. Treasury has updated the burden estimates associated with the renewal of the existing forms or collection obligations to account for the current number of insurers participating in the Program, based upon the best information now available to Treasury. As there are no proposed changes to the current forms or collection obligations, there are no changes to the previously estimated time burdens associated with the completion of those forms and collection obligations. None of the identified information collections will be triggered unless there is a certified act of terrorism (including the claims information that an insurer seeking payment of the federal share of compensation would need to provide), or in some cases where Treasury is considering certification of an act of terrorism. Treasury has designed the forms to identify elements that insurers typically collect already in their ordinary course of business when handling insurance claims, which will minimize any burden associated with their completion.

Further information concerning each of these requirements is provided below.

II. Information Collections: Existing Information Collections Under OMB Number 1505–0200

Title: Terrorism Risk Insurance Program; Commercial Property and Casualty Insurers Submission for Federal Share of Compensation.

Abstract: This information collection addresses information that participating insurers must submit in support of their claims for payment of the federal share of compensation. The forms identifying the information to be collected are as follows:

Treasury Form TRIP 01 (Notice of Deductible Erosion)
Treasury Form TRIP 02 (Certification of Loss (initial and supplementary))
Treasury Form TRIP 02A Schedule A (Declaration of Direct Earned Premium and Calculation of Insurer Deductible)
Treasury Form TRIP 02B Schedule B (Certification of Compliance with Section 103(b) of TRIA)
Treasury Form TRIP 02C Schedule C (Bordereau)

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Affected Public: Business/Financial Institutions.

Estimated Number of Respondents: 100.[5]

Estimated Average Time per Respondent:

Treasury Form TRIP 01: 1.0 hours × 1 response = 1 hours.
Treasury Form TRIP 02 (initial and supplementary): 1.5 hours × 6 responses = 9 hours.
Treasury Form TRIP 02A Schedule A: 6.5 hours × 1 response = 6.5 hours.
Treasury Form TRIP 02B Schedule B: 0.25 hours × 6 responses = 1.5 hours.
Treasury Form TRIP 02C Schedule C: 4 hours × 6 responses = 24 hours.

Estimated Total Annual Burden Hours: 4,200 hours.[6]

Title: Terrorism Risk Insurance Program; Litigation Management—Information Collection Regarding Proposed Settlements.

Abstract: This information collection addresses settlement approval requirements under the Program that were initially adopted by Treasury by regulation and subsequently incorporated by Congress within TRIA. For third-party claims that are in excess of certain thresholds, Treasury must provide advance approval of the settlement before it is finalized by the participating insurer. The information collection provides Treasury with the necessary information to evaluate claims subject to advance approval. The form identifying the information to be collected is as follows:

Treasury Form TRIP 03 (Notice of Proposed Settlement of Third-Party Claim—Request for Approval)

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Affected Public: Business/Financial Institutions.

Estimated Number of Respondents: 100.

Estimated Average Time per Respondent: 4.0 hours.

Estimated Total Annual Burden Hours: 5,144 hours.[7]

[3] Annual collections of information and data, outside of the claims process, that are required under TRIA are addressed in a separate notice and comment process, under OMB Control No. 1505–0257.

[4] Public Law 116–94, 133 Stat 2534. Treasury is seeking authority to continue to use the existing forms for an additional three-year period following their current expiration date of January 30, 2027. In the absence of an extension of the Program beyond December 31, 2027, the forms, if reauthorized for a three-year period following January 30, 2027, could still be utilized for the full three years, provided that the Secretary certifies an act of terrorism prior to December 31, 2027.

[5] The number of insurers required to file claims will depend upon the size and nature of the event in question. Treasury has historically estimated that 100 insurers will have insured losses as a result of a certified act of terrorism that could lead to potential claims for payment of the Federal share of compensation under the Program.

[6] The burden estimate includes assumptions regarding the number of times each form will need to be completed by an insurer making claims for the federal share of compensation, as identified above, resulting in total hours for each of the 100 insurers of 42 hours.

[7] Based upon the assumption that: (1) each of the 100 insurers will have 100 claims (10,000 in total), (2) 1 in 7 claims will involve amounts above the approval threshold (1,429 claims in total), and (3) 90 percent of those claims will be settled, and thus trigger settlement approval reporting (1,286 claims in total). This estimate of the number of claims that will require settlement approval reporting (1,286), multiplied by the 4 hours estimated to complete the form, results in the total figure of 5,144 hours. The reporting burden on insurers has not changed.

Title: Recordkeeping Requirements for Insurers Compensated Under Terrorism Risk Insurance Program.

Abstract: This requirement is for the maintenance (recordkeeping) of an insurer's records that are relevant to claims for reimbursement by participating insurers and amounts paid by Treasury as the Federal share of compensation for insured losses. The recordkeeping is needed for Treasury to conduct investigations and audits, as permitted under TRIA § 104(a)(1). 31 CFR 50.81(a) requires insurers to retain all records necessary to fully disclose material matters pertaining to insured losses. This record retention requirement is not subject to any common form or generalized reporting.

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Estimated Number of Respondents: 100.

Estimated Average Time per Respondent: 8.33 hours.[8]

Estimated Total Annual Burden Hours: 833 hours.

Title: Surcharge Records Maintenance.

Abstract: This requirement is for the maintenance (recordkeeping) of an insurer's records that are relevant to any surcharges collected and remitted by insurers to Treasury. The recordkeeping is needed for Treasury to conduct investigations and audits as permitted under TRIA § 104(a)(1). 31 CFR 50.81(b) requires insurers to retain all records necessary to fully disclose material matters pertaining to the collection of surcharges. This record retention requirement is not subject to any common form or generalized reporting.

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Estimated Number of Respondents: 2,250.[9]

Estimated Average Time per Respondent: 4 hours.

Estimated Total Annual Burden Hours: 9,000 hours.

Title: Recoupment Provisions of the Terrorism Risk Insurance Act (TRIA).

Abstract: Section 103(e) of TRIA extends authority to Treasury to conduct mandatory and discretionary recoupment (depending upon the circumstances presented) of federal payments made under the Program through policyholder surcharges. In order to determine the amount of recoupment that may be necessary, as well as implement any recoupment process that is required, Treasury may issue a data call for aggregate loss information. Accordingly, all insurers subject to TRIA will be required to create and maintain records concerning their direct written premium, surcharges, surcharge amounts collected, and surcharge amounts remitted to Treasury. The forms identifying the information to be collected are as follows:

Treasury Form TRIP 04A (Direct Written Premium and Monthly Surcharge Calculation)

Treasury Form TRIP 04B (Direct Written Premium and End of Year Calculation)

Treasury Form TRIP 05 (Data Call)

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Affected Public: Business/Financial Institutions.

Estimated Number of Respondents: 2,250 (TRIP 04A and TRIP 04B recoupment processing) and 200 (TRIP 05 data call).

Estimated Average Time per Respondent:

Treasury Forms TRIP 04A and TRIP 04B: 5 hours per month (60 hours per year).

Treasury Form TRIP 05: 5 hours.

Estimated Total Annual Burden Hours: 135,000 hours (TRIP 04A and TRIP 04B), and 1,000 hours (TRIP 05).

Title: Terrorism Risk Insurance Program; Cap on Annual Liability.

Abstract: The Program is subject to a total annual cap of aggregate industry losses of $100 billion, and Treasury directed under TRIA to advise Congress within 15 days of an ''act of terrorism'' whether estimated total losses are expected to exceed the cap. In order to comply with the liability cap provisions of TRIA, Treasury may be required to conduct a data call for insured loss and deductible information to assess aggregate industry losses and determine if the $100 billion cap may be exceeded, as well as to determine and adjust the ''pro rata loss percentage'' to be applied against claim payments. The form identifying the information to be collected is as follows:

Treasury Form TRIP 05 (Terrorism Risk Insurance Program; Data Call).

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Affected Public: Business/Financial Institutions.

Estimated Number of Respondents: 200

Estimated Average Time per Respondent: 5 hours.

Estimated Total Annual Burden Hours: 1,000 hours.

Title: Terrorism Risk Insurance Program; Certification Data Call.

Abstract: In order for the Secretary to determine whether an event is subject to certification as an ''act of terrorism'' under TRIA and 31 CFR 50.62, Treasury may need to collect loss data and estimates from affected insurers in order to confirm that losses are above statutory thresholds. The information collection includes both actual loss data, as well as estimates that may be generated in the immediate aftermath of an event that do not constitute loss data but could inform the certification determination. The form identifying the information to be collected is:

Treasury Form TRIP 06 (Certification Data Call).[10]

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Affected Public: Business/Financial Institutions.

Estimated Number of Respondents: 20.

Estimated Average Time per Respondent: 15 hours.

Estimated Total Annual Burden Hours: 300 hours.

Title: Terrorism Risk Insurance Program; Monthly Claims Report.

Abstract: Treasury payments of the federal share of compensation require that average industry losses reach a certain threshold even if the losses of a particular insurer are in excess of its deductible. Pursuant to 31 CFR 50.53, the monthly claims report provides for truncated monthly reporting of losses so that Treasury may evaluate loss experience as it develops and make timely payments to insurers entitled to the Federal share of compensation. The report will enable payments to smaller

[8] This calculation includes assumptions regarding the number of claims that will be received for which some marginal additional costs (estimated to be 5 minutes per claim) will be incurred by the affected insurer.

[9] Treasury currently uses a figure of 2,250 insurers to approximate the number of individual insurance companies (as distinguished from groups) participating in the Program, for purposes of information collections that could apply to all participating insurers on an individual basis. *See* Information Collections for Claims Processing and Other Purposes Under the Terrorism Risk Insurance Program (Extension of Currently Approved Data Collections Under OMB No. 1505–0200), 88 FR 56123 (August 17, 2023).

[10] Although potentially available for the collection of information, the Certification Data Call will not need to be utilized if Treasury is able to confirm that statutory thresholds will, or will not, be met through other means. See 31 CFR 50.62(b).

insurers that cannot demonstrate, based upon their own losses, that the Program Trigger amount has been reached. The form identifying the information to be collected is as follows:

Treasury Form TRIP 07 (Monthly Claims Report).

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Affected Public: Business/Financial Institutions.

Estimated Number of Respondents: 100.

Estimated Average Time per Respondent: 2 hours.

Estimated Total Annual Burden Hours: 9,600 hours.[11]

Title: Terrorism Risk Insurance Program; Commutations under Final Netting Rule.

Abstract: Under 31 CFR 50.76(b), the Secretary may set a final netting date, at which time all claims relating to an insured loss or act of terrorism become final. As part of a final netting determination, Treasury may require (or consider the request of a particular insurer for) a commutation of an insurer's future claims for the federal share of compensation. This process could require the insurer to produce information justifying a final payment estimate, including supporting actuarial factors and methodology. This information collection is not subject to any common form or generalized reporting requirement, as it will necessarily be tailored to the circumstances presented by a particular insurer, which will need to be determined at the time any particular commutation process takes place.

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Affected Public: Business/Financial Institutions.

Estimated Number of Respondents: 15

Estimated Average Time per Respondent: 40 hours.

Estimated Total Annual Burden Hours: 600 hours.

Title: Terrorism Risk Insurance Program; Rebuttal of Controlling Influence Submissions.

Abstract: Treasury has promulgated procedures at 31 CFR 50.7 for an insurer to follow in seeking to rebut a regulatory presumption of ''controlling influence'' over another insurer (which, because of the way in which the Program operates, would affect the amount of direct earned premium attributable to the insurer's deductible calculation). These procedures require insurers to provide Treasury necessary information to determine whether a ''controlling influence'' exists, and if it does, whether it has been rebutted. This information collection is not subject to any common form or generalized reporting requirement, as it will necessarily be tailored to the circumstances presented by the ''controlling influence'' issue presented by a particular insurer. No assurance of confidentiality is provided, although applicable exemptions under the Freedom of Information Act could apply, *e.g.,* to any confidential business or trade secret material submitted.

Type of Review: Extension of a currently approved data collection.

Current Expiration Date: January 30, 2027.

Affected Public: Business/Financial Institutions.

Estimated Number of Respondents: 10.

Estimated Average Time per Respondent: 40 hours.

Estimated Total Annual Burden Hours: 400 hours.

All of the existing forms and associated instructional materials (none of which will substantively change on account of this renewal) are available for review on Treasury's website at *https://home.treasury.gov/policy-issues/financial-markets-financial-institutions-and-fiscal-service/federal-insurance-office/terrorism-risk-insurance-program/federal-share-claim-process.*

Request for Comments: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information collections; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Kathleen Shannon,

Executive Secretary.

[FR Doc. 2026–23560 Filed 11–18–26; 8:45 am]

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[11] The burden estimate includes the assumption that the monthly report will need to be completed each month over a 48-month period as all claims are resolved. Each monthly report will take 2 hours during this 48-month period, resulting in 96 hours per each insurer, or 9,600 hours for all 100 insurers combined.

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0500]

Agency Information Collection Activity Under OMB Review: Mandatory Verification of Dependents

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995, this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, will submit 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 it includes the actual data collection instrument.

DATES: Comments and recommendations for the proposed information collection should be sent by December 21, 2026.

ADDRESSES: To submit comments and recommendations for the proposed information collection, please type the following link into your browser: *www.reginfo.gov/public/do/PRAMain,* select ''Currently under Review—Open for Public Comments'', then search the list for the information collection by Title or ''OMB Control No. 2900–0500.''

FOR FURTHER INFORMATION CONTACT: VA PRA information: Dorothy Glasgow, 202–461–1084, *VAPRA@va.gov.*

SUPPLEMENTARY INFORMATION:

Title: Mandatory Verification of Dependents (VA Form 21–0538).

OMB Control Number: 2900–0500. *https://www.reginfo.gov/public/do/PRASearch.*

Type of Review: Revision of a currently approved collection.

Abstract: VA Form 21–0538 is used to request verification of the status of dependents for whom additional compensation is being paid to veterans. Without this information, determination

of entitlement would not be continued. This is a revision due to the burden increase since the previous approval resulting from the estimated number of receivables averaged over the past year.

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 at insert citation date: 91 FR 52402, August 13, 2026.

Affected Public: Individuals or Households.

Estimated Annual Burden: 23,033 hours.

Estimated Average Burden per Respondent: 10 minutes.

Frequency of Response: One time.

Estimated Number of Respondents: 138,197 per year.

Authority: 44 U.S.C. 3501 *et seq.*

Shunda Willis,

Acting, VA PRA Clearance Officer, Office of Information and Technology/Office of Data Governance and Analytics, Department of Veterans Affairs.

[FR Doc. 2026–23606 Filed 11–18–26; 8:45 am]

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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 417, 422, et al.

Office of the Secretary

45 CFR Part 155

Medicare, Medicaid, and Marketplace Programs; Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH); Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 417, 422, 423, 424, 431, 438, 447, 455, 457, 498

Office of the Secretary

45 CFR Part 155

[CMS–6098–P]

RIN 0938–AV97

Medicare, Medicaid, and Marketplace Programs; Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise provisions regarding provider enrollment, medical review, investigations, and other program integrity oversight provisions to greatly strengthen our ability to crush fraud, enhance program integrity efforts across Medicare, Medicaid, Children's Health Insurance Program, and the Marketplace and maximize regulatory authorities to address inappropriate payments.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by January 19, 2027.

ADDRESSES: In commenting, please refer to file code CMS–6098–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://www.regulations.gov/docket/CMS-2026-0826.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6098–P, P.O. Box 8013, Baltimore, MD 21244–8013.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6098–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT: Eli Boone, (227) 232–6768, or Katie O'Malley, (410) 786–8987.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/.*

I. Executive Summary

A. Purpose

On June 6, 2025, President Trump issued a Presidential Memorandum on Eliminating Waste, Fraud, and Abuse in Medicaid, expressing this Administration's commitment to preserve and protect the integrity of government programs. Similarly, President Trump, U.S. Department of Health and Human Services (HHS) Secretary Kennedy (the HHS Secretary), and Centers for Medicare & Medicaid Services (CMS) Administrator Oz (the CMS Administrator) have strongly demonstrated this Administration's dedication to crushing fraud in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace. In alignment with this strategic objective, as well as in line with our statutory authorities to undertake rulemaking, CMS is issuing this proposed rule to solicit stakeholder feedback on proposed regulatory changes that would strengthen CMS' ability to address vulnerabilities that make Federal health programs attractive targets to fraudsters, with the ultimate goal of ensuring greater affordability and sustainability of these programs for generations to come.

B. Summary of the Major Provisions

1. Strengthening State Medicaid and CHIP Oversight

CMS intends to enhance Federal oversight of State Medicaid programs through proposed measures that would, if finalized as proposed, expand its authority to enforce program integrity and strengthen State accountability. These initiatives include: (1) facilitating States' ability to rapidly suspend Medicaid payments based on credible allegations of fraud and strengthening State fraud reporting requirements; (2) establishing consistent provider identification requirements to increase State and Federal oversight capabilities; (3) increasing oversight of Medicaid and CHIP beneficiary eligibility determination errors; and (4) establishing strengthened State program integrity corrective action plan requirements to ensure compliance with Federal requirements. Additional provisions include:

- Requiring prompt reporting and return of Medicaid overpayments
- Enhancing managed care integrity reporting
- Broadening grounds for Medicaid provider denials and terminations
- Increasing data reporting on provider ownership
- Requiring electronic visit verification (EVV) data review for specific activities

Collectively, these enhancements aim to strengthen CMS' and States' ability to detect and address fraud, waste, and abuse in Medicaid and CHIP, while fostering improved collaboration between State and Federal efforts in program integrity.

In addition, we are including a request for information within this proposed rule. Specifically, CMS is requesting additional information and public comment regarding deductions from Medicaid payments for benefits such as union dues.

2. Reinvigorating the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Program and Introducing New Ways To Hold Plan Sponsors Accountable

CMS proposes MA RADV program reforms to ensure oversight of a program responsible for $21 billion per year in overpayments due to the improper inflation of beneficiary risk scores, and proposes provisions to make referrals of substantiated or suspicious fraud, waste, and abuse mandatory for MA organizations and Part D plan sponsors,

as well as to expand the required reporting of credible allegation of fraud payment suspensions by pharmacies to all provider and supplier types.

3. Establishing Enhanced Medicare Provider Enrollment and Oversight Requirements

CMS proposes to tighten provider enrollment safeguards across Medicare, Medicaid, and CHIP by strengthening identity verification, accelerating reporting of changes in enrollment information, expanding grounds for enrollment denial and revocation, and adding a requirement that all providers and suppliers billing MA be enrolled in Original Medicare.

4. Stopping the Bleeding in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Benefit

CMS proposes strengthening protections against fraudulent and high-pressure marketing by DMEPOS suppliers, including expanding the prohibition on unsolicited contact and ensuring transparency regarding domestic and foreign marketers. CMS also proposes reinforcing DMEPOS surety bond requirements to reduce Medicare Trust Fund losses when overpayments occur.

5. Crushing Marketplace Fraud

CMS proposes to greatly strengthen its authority to suspend or terminate agents, brokers, and web-brokers engaging in abusive conduct and to exclude or terminate agents, brokers, and web-brokers who pose an unacceptable risk of fraud, waste, and abuse, including those convicted of certain felonies or misdemeanors. Additionally, CMS proposes to increase transparency in enforcement actions following findings of agent, broker, and web-broker noncompliance with regulatory standards and enhance the security of Exchange systems and consumer information.

C. Summary of Costs and Benefits

Currently, the CMS Office of the Actuary (OACT) has not completed a quantitative score of the Federal budgetary or trust fund impacts of this proposed rule. OACT will score the rule and provide detailed financial impact projections in the final rule once policy parameters are finalized and public comments have been evaluated. We specifically request data and feedback from commenters regarding potential administrative, operational, and utilization impacts to assist OACT in developing its final estimates.

We estimate that, taken together, the quantified provisions of this proposed rule would result in approximately $379 million in costs from 2027 to 2036. This estimate does not include the over $90 billion in transfers expected between the Federal government and State governments or private entities that may result from this proposed rule. CMS is seeking public comment on the accuracy of all cost and burden estimates included in this proposed rule.

II. Background

A. Authority

CMS' authority to issue program integrity rules flows primarily from the Social Security Act (the Act), as amended. The general authorities described here are in addition to the specific statutory authorities discussed with respect to each proposal. Sections 1102(a) and 1871(a)(1) of the Act provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program.

Section 1102(a) of the Act likewise provides general authority for the Secretary to prescribe regulations for the efficient administration of the Medicaid program and CHIP, while with respect to Medicaid, section 1902(a)(4) of the Act requires State plans to provide such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan.

For MA, the Secretary has authority under section 1856(b)(1) of the Act to adopt standards consistent with, and to carry out, Part C. The Secretary also has authority under section 1857(e)(1) to establish new MA contract terms and conditions where necessary and appropriate and not inconsistent with Part C. For Medicare Part D, section 1860D–12(b)(3)(D) provides that the Secretary's authority under section 1857(e) of the Act also applies to Part D.

For Medicaid, section 1902(a)(4) of the Act requires State plans to provide such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan. For the Exchanges, section 1312(e) of the Affordable Care Act provides the Secretary with the authority to establish procedures under which a State may allow agents or brokers to (1) enroll qualified individuals and qualified employers in QHPs offered through Exchanges, and (2) assist individuals in applying for advance payments of the premium tax credit (APTC) and cost sharing reductions (CSRs) for QHPs sold through an Exchange. Section 1321(a) of the Affordable Care Act directs the Secretary to issue regulations setting standards for meeting the applicable requirements of title I of the Affordable Care Act and the amendments made by that title. These standards concern the establishment and operation of Exchanges, the offering of qualified health plans through Exchanges, and such other requirements as the Secretary determines appropriate. Section 1313(a)(5) of the Affordable Care Act further directs the Secretary, with respect to activities carried out under title I, to provide for the efficient and nondiscriminatory administration of Exchange activities. It also directs the Secretary to implement any measure or procedure that the Secretary determines is appropriate to reduce fraud and abuse in the Administration of title I and has authority to implement under title I or another Act.

B. This Administration's Fight To Crush Health Care Fraud

Health care fraud, waste, and abuse is a pervasive issue that this Administration is tackling in an unprecedented fashion. For example, on March 16, 2026, President Trump issued Executive Order 14395, establishing the White House Task Force to Eliminate Fraud. Similarly, the HHS Secretary and the CMS Administrator have strongly demonstrated this Administration's dedication to crushing fraud in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Program (BHP), and the Marketplace. In June 2026, the Secretary and the Administrator joined the then-Acting Attorney General to announce the Justice Department's 2026 National Health Care Fraud Takedown, which resulted in charges against 455 defendants, including 90 doctors and other licensed medical professionals, for their alleged participation in health care fraud and opioid abuse schemes involving over $6.5 billion in false claims and significant patient harm.[1] This is an example of the significant steps this Administration has taken to crush fraud since President Trump began his second term in January 2025.

During his first term, on October 3, 2019, President Trump issued Executive Order (E.O.) 13890 on Protecting and Improving Medicare for Our Nation's Seniors. This order directed CMS to annually promulgate regulatory or subregulatory changes to Medicare to enhance program integrity and promote

[1] More information is available at *https://www.justice.gov/criminal/criminal-fraud/2026-national-health-care-fraud-takedown.*

payment accuracy and efficiency. CMS subsequently finalized a program integrity rule in 2023 (88 FR 80141) that required the disclosure of certain ownership, managerial, and other information regarding Medicare skilled nursing facilities (SNFs) and Medicaid nursing facilities (NFs). While CMS has issued many program integrity provisions in various rules or direction through subregulatory guidance, subsequent annual stand-alone program integrity rulemaking has not taken place.

Crushing fraud has been a central tenet of President Trump's second term, and undertaking rulemaking to address fraud vulnerabilities is a critical component of that fight. On February 27, 2026, CMS issued a Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH RFI) (91 FR 9803) to solicit interested parties' feedback on potential regulatory changes that might be included in this proposed rule, as well as other programmatic changes that could be implemented to make CMS more effective in crushing fraud.

Working tirelessly to crush waste, abuse, and fraudulent activities in our health care system remains a key CMS strategic priority. This includes leveraging new techniques, authorities, and policies that will enable CMS to continue shifting away from pay and chase methods to ''stop and caught'' approaches that allow us to swiftly remove bad actors from our programs which prevents dollars from going out the door towards fraud. We are issuing this Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) proposed rule to solicit interested parties' feedback on proposed regulatory changes to make CMS more effective in crushing fraud to protect taxpayer dollars and the Americans we serve.

C. Severability

CMS proposes that if any provision of the CRUSH proposed rule, if or when finalized, were held to be invalid or unenforceable—facially or as applied to any person, plaintiff, or circumstance—or stayed pending further judicial or agency action, such provision shall be severable from other provisions finalized, and from rules and regulations otherwise in effect, and not affect the remainder of provisions finalized. It was and continues to be our intent that, unless such provision shall be held to be utterly invalid or unenforceable, it be construed to give the provision maximum effect permitted by law including in the application of the provision to other persons not similarly situated or to other, dissimilar circumstances from those where the provision may be held to be invalid or unenforceable. The CRUSH proposed rule addresses numerous stand-alone proposals that can largely operate independently of one another. We seek public comments on these proposed approaches to severability and whether similar regulatory text should be added to additional proposals within this proposed rule.

D. Effective Dates

We propose that, unless we specify otherwise with respect to a particular a provision, the effective date would be 60 days after the publication of the CRUSH final rule. We request public comment on the feasibility of effective dates for each provision.

III. Medicaid and CHIP Program Integrity Proposals

Medicaid and CHIP are Federal-State partnerships, and these partnerships are central to the programs' success. CMS provides States with guidance; technical assistance, including tools and data; Federal matching funds for expenditures; and other resources to use in meeting statutory and regulatory requirements.

The Federal Government and each State jointly fund each State's Medicaid and CHIP programs. The Federal Government matches State Medicaid program expenditures at a specified percentage, called the Federal Medical Assistance Percentage (FMAP), which has a statutory minimum of 50 percent and maximum of 83 percent, though enhanced FMAP exceeding 83 percent is available for certain covered populations and services (for example, the 90 percent FMAP available for expenditures attributable to the Medicaid expansion population under section 1905(y) of the Act).[2] State CHIP expenditures are matched at an enhanced FMAP equal to the State's regular FMAP increased by 30 percent, but bounded by an upper limit as section 2105(b) of the Act provides that the CHIP enhanced FMAP may not exceed 85 percent.[3] Total Fiscal Year (FY) 2024 Medicaid and CHIP spending exceeded $962 billion, or over 18 percent of total national health expenditures.[4] The FY 2024 Federal share of Medicaid expenditures constituted 64.7 percent of total Medicaid spending[5]—in other words, nearly ⅔ of all Medicaid expenditures were Federal dollars, evidencing the need for heightened Federal scrutiny—while the FY 2024 Federal share of CHIP expenditures was $20 billion. Because Medicaid expenditures are a large and growing portion of Federal and State budgets, controlling inappropriate Medicaid spending has been, and continues to be, an Administration priority.

States fund their share of their Medicaid programs and, within Federal and State guidelines, operate their individual programs through various activities, such as setting payment rates, paying claims, enrolling providers and beneficiaries, contracting with managed care plans,[6] improving service quality via quality improvement activities, claiming the Federal match of expenditures, and, critically, ensuring program integrity. States and CMS share responsibility for ensuring that State and Federal dollars are used to efficiently deliver quality health care services to eligible individuals and are not misused for fraud, waste, or abuse.

Effective program integrity controls are essential to ensure that Medicaid and CHIP funds are expended appropriately, providers meet applicable enrollment and screening requirements, and beneficiaries receive covered benefits and services in accordance with Federal and State requirements. Titles XIX and XXI of the Act contain provisions, several of which we describe here, establishing core State responsibilities related to provider oversight, fraud and abuse prevention, payment integrity, and proper administration of the Medicaid and CHIP programs. For example:

- Section 1902(a)(4) of the Act requires States to maintain such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the State plan.
- Section 1902(a)(30)(A) of the Act requires States to provide methods and procedures necessary to safeguard against unnecessary utilization of care and services and to assure that

[2] The FMAP is calculated annually, and Federal law specifies that the FMAP will be no lower than 50 percent and no higher than 83 percent. See section 1905(b) of the Act.

[3] The CHIP enhanced FMAP is calculated annually, and Federal law specifies that the enhanced FMAP available for CHIP expenditures may not exceed 85 percent. See section 2105(b) of the Act.

[4] *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.*

[5] CMS, Form CMS–64 Data as reported by States to the Medicaid Budget and Expenditure System, as of May 29, 2024, at *https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.*

[6] For these purposes, managed care plans refers to MCOs, PAHPs, and PIHPs as defined at § 438.2.

payments are consistent with efficiency, economy, and quality of care, reinforcing States' responsibility to maintain effective payment integrity and program oversight.

- Section 1902(a)(27) of the Act requires States to enter into agreements with providers under which such providers agree to maintain and, upon request, furnish to the State agency or CMS records sufficient to support appropriate payment for services.
- Section 1902(a)(37) of the Act, in addition to containing certain prompt payment requirements, requires States to maintain procedures for claims payment and prepayment and postpayment claims review, including review of appropriate data regarding recipients, providers, and services, to ensure proper and efficient payment of claims and management of the Medicaid program.
- Section 1902(a)(64) of the Act requires States to provide a mechanism to receive reports concerning alleged fraud, waste, and abuse, and compile data relating to such activities.
- Sections 1902(a)(77) and 2107(e)(1)(G) of the Act require States to comply with certain provider screening, oversight, and reporting requirements established by the Secretary in accordance with Section 1902(kk).
- Section 1936 of the Act establishes the Medicaid Integrity Program, which authorizes the HHS Secretary, acting through CMS, to enter into contracts with eligible third-party entities to carry out certain program integrity related activities. Pursuant to section 1936(b) of the Act, contractors may review the actions of individuals or entities providing Medicaid items or services; conduct audits of claims for payment for items or services furnished or administrative services rendered; identify overpayments to individuals or entities receiving Federal Medicaid funds; and provide education and training to providers, beneficiaries, managed care entities, and other stakeholders.

CMS has implemented many of the Medicaid and CHIP program integrity requirements established under Title XIX and XXI of the Act, including requirements implementing sections 1902(a)(38), 1902(a)(39), 1902(a)(42), 1902(a)(77), 1902(a)(78), 1936, 2107(e)(1)(C), 2107(e)(1)(D), and 2107(e)(1)(G) through regulations in 42 CFR part 455 and 42 CFR part 457, subpart I. These regulations establish Medicaid and CHIP program integrity requirements related to administering effective fraud detection and investigation programs, provider enrollment and screening, reporting, payment suspensions, provider terminations, recovery audit contractors, and related program integrity activities. Together, these statutory and regulatory provisions reflect States' primary program integrity responsibilities to maintain effective systems to identify, prevent, detect, investigate, and address program integrity risks, including improper payments and fraud, waste, and abuse.

Relatedly, section 1904 of the Act authorizes the Secretary, after reasonable notice and opportunity for a hearing, to withhold Federal payment to a State after determining that a State plan no longer complies with the requirements of section 1902 of the Act, or that the State's administration of its State plan fails to comply substantially with those requirements. Accordingly, when CMS establishes regulatory requirements implementing provisions of section 1902 of the Act, States must comply with those requirements as part of their obligations under approved Medicaid State plans and may be subject to withholding of Federal matching funds should they fail to do so. States must also comply with applicable CHIP requirements, including provisions of title XIX incorporated through specific cross-references within Title XXI. Pursuant to section 2106(d)(2) of the Act, States may also be subject to withholding for substantial noncompliance with CHIP requirements.

Although existing statutory and regulatory requirements provide a strong foundation for Medicaid and CHIP program integrity when properly executed, CMS continues to identify vulnerabilities that limit States' and CMS' ability to effectively oversee Medicaid expenditures and address evolving fraud, waste, and abuse risks. Despite State and Federal efforts, Medicaid and CHIP improper payment rates have also remained persistently high. Improper payments are not always directly attributable to fraud, waste, or abuse, but they remain an important indicator of payment integrity challenges. For example, in FY 2025, eligibility errors specifically accounted for approximately 72 percent of all Medicaid and CHIP improper payments, resulting in an estimated $27 billion in projected Federal improper payments.[7] Recognizing that fraud schemes continually evolve in response to perceived opportunity, CMS is committed to maintaining a sustained, long-term program integrity strategy that leverages advanced data analytics, innovative investigative tools and techniques, and close collaboration with State Medicaid Agencies and Federal, State, and local law enforcement partners to identify emerging threats and respond quickly as they arise.

CMS has recently intensified its efforts to crush fraud in Medicaid and CHIP nationwide. In the course of our efforts, we have identified instances of significant State noncompliance with program integrity requirements and have discerned new and emerging vulnerabilities in State program integrity operations and processes that put taxpayer dollars and beneficiaries at risk. These risks and vulnerabilities include inconsistent provider identification practices across Medicaid and CHIP systems and activities, limitations in the scope and detail of information currently reported to CMS regarding fraud and abuse investigations, and underutilization of electronic visit verification (EVV) information collected by States.

A. Overview of Proposed Policies

To strengthen Medicaid and CHIP program integrity and address the risks, vulnerabilities, and oversight challenges discussed above, we are proposing a series of regulatory changes designed to enhance provider oversight, strengthen payment integrity, improve data and reporting, support more effective fraud prevention and detection, and reinforce State accountability for meeting Federal program integrity requirements. Specifically, this rule proposes regulatory revisions at 42 CFR parts 431, 438, 447, 455, and 457 to strengthen Medicaid and CHIP program integrity oversight that would, unless otherwise stated, be effective 60 days after the publication of the final rule. We seek public comments on the following Medicaid and CHIP regulatory provisions, including the proposed effective dates:

- State Payment Suspension Updates and Reporting Requirements
  - ++ Allowing States to Rely on CMS' or Other Federal Agencies' Credible Allegation of Fraud Determinations
  - ++ Aligning Modifications to the Definition of Credible Allegation of Fraud
  - ++ Maintaining a Medicaid and CHIP Payment Suspension During an Investigation
  - ++ Verifying Good Cause Exceptions to Payment Suspension Requirements
  - ++ Updating Payment Suspension Reporting Requirements
  - ++ Applicability to CHIP

[7] 2025 Medicaid and CHIP Supplemental Improper Payment Data. *https://www.cms.gov/files/document/2025-medicaid-chip-supplemental-improper-payment-data.pdf.*

- Enhanced Electronic Visit Verification (EVV) Requirements
++ Use of EVV in Preliminary Investigations
++ EVV Data in Prepayment Claims Review
- Requiring National Provider Identifiers (NPIs) for Eligible Medicaid Provider Types
- Updating State Program Integrity Reporting Requirements
- Deregulation of the Medicaid Eligibility Quality Control (MEQC) Program
- Medicaid and CHIP Beneficiary Eligibility Audit Program
- Medicaid and CHIP Beneficiary Eligibility-Related Disallowances
- Payment Error Rate Measurement (PERM) Corrective Action Plans (CAPs)
++ State Submission of a Combined Medicaid and CHIP PERM CAP
++ Monitoring Implementation Progress and Evaluating the Effectiveness of Each Corrective Action
++ CMS Approval, Revision, Disapproval, and Implementation of State-Specific PERM CAPs
++ Semi-Annual Reporting Requirements for States with an Eligibility Improper Payment Rate Above 3 Percent for Consecutive Cycles
- Program Integrity Corrective Action Plans
- Medicaid Fee-For-Service Overpayment Reporting (60-day rule)
- Medicaid and CHIP Managed Care Oversight Policies
++ Medicaid and CHIP Eligibility Determination Requirements for Beneficiary Residency and Death
++ Overpayments for Ineligible Enrollees
++ Working Families Tax Cut (WFTC) Legislation (Pub. L. 119–21) and Capitation Overpayments
++ Request for information regarding how to protect Medicaid payments from improper deductions

CMS is also proposing a number of provisions related to Medicaid and CHIP provider enrollment, which are addressed in the larger discussion of provider enrollment in section V. of this proposed rule.

B. State Payment Suspension Updates and Reporting Requirements

Sections 1903(i)(2) and 2107(e)(1) of the Act relate to limitations on payment. In 2010, section 6402(h)(2) of the Affordable Care Act (ACA) amended the Act to provide that State payments to a Medicaid provider under investigation for a credible allegation of fraud are not eligible for Federal matching funds unless a good cause exception is met. Specifically, section 1903(i)(2)(C) of the Act provides that Federal payment shall not be made with respect to any amount expended for items or services furnished ''by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, *as determined by the State* [emphasis added] in accordance with regulations promulgated by the Secretary for purposes of section 1395y(o) [1862(o)] of this title and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments[.]''

Our experience working on payment suspension matters has demonstrated to us that States often apply this important administrative tool inconsistently and frequently underutilize it. Although our existing regulations do establish certain ''floor'' requirements, we also recognize that States have varying standards and processes with their respective Medicaid Fraud Control Units (MFCUs) and other law enforcement partners, reflecting individual State policies on how payment suspensions are determined, applied, and maintained, as well as the applicability of these requirements to CHIP. Some of this variation is a feature rather than a flaw: it allows States to develop best practices tailored to their own legal and administrative environments, which can then be shared with and adapted by other States. States' legal frameworks differ and we expect and respect that variation; however, we believe that all States, pursuant to their statutory and regulatory program integrity oversight obligations, should be identifying and investigating credible allegations of fraud, making referrals to law enforcement, and issuing payment suspensions when appropriate to prevent inappropriate payments. CMS expects all States to design and execute payment suspension strategies adapted to that State's fraud risk profile; both the strategies and the risk profile generally will be fluid as fraud is rarely static by location, point in time, or any other factor as fraudsters attempt to leverage and exploit vulnerabilities and points of weakness wherever they discern them. Especially given that the target is ever evolving and the administration of the programs varies based on State laws and policies within Federal contours, our goal is not attaining inter-State uniformity (indeed, among our objectives is fostering and promoting effective creativity), but instead for each State to work within its own legal landscape to maximize the effectiveness of payment suspensions as an administrative tool. States must utilize payment suspensions when appropriate and should draw on the experience of States that have implemented them successfully. States should also ensure they have the funding, staffing, data analytics, and other support needed to identify potential fraud, issue payment suspensions, and make appropriate referrals to law enforcement when potential fraud is uncovered.

At the same time, we are mindful that the consequences of a payment suspension on a provider can be significant and may adversely affect business operations well before any allegation is resolved, and that sometimes what originate as genuine credible allegations ultimately may not be indicative of fraud, waste, or abuse. We recognize that the threshold for establishing a credible allegation of fraud is intentionally lower than the evidentiary standards required for a formal fraud finding, as it is a temporary intervention to stop payments from going out the door to a potentially fraudulent actor. A payment suspension imposed against a legitimate provider, even if only temporarily, can jeopardize that provider's viability and, in turn, disrupt beneficiary access to care, which might be most acutely felt in rural or underserved areas with few alternative providers. The current regulatory framework around good cause exceptions under § 455.23(e) and the additional proposals discussed in this section help ensure that payment suspensions remain a targeted, well-supported program integrity tool.

The following proposals outline how, consistent with statutory and regulatory authority, States may rely on other agencies for credible allegation of fraud determinations and for conducting investigations of such allegations, and the roles that CMS and law enforcement agencies play along with State Medicaid Agencies (SMAs) and CHIP agencies in determining when to issue and maintain payment suspensions.

Specifically, we propose that a State may choose to rely on credible allegation of fraud determination made by CMS or by other Federal agencies. These proposed changes would aim to streamline CMS', SMAs', and CHIP agencies' efforts to ensure Medicaid and CHIP integrity by allowing States to more quickly stop payments where a credible allegation of fraud exists. The regulatory proposals in this rule would be essential to help States quickly and correctly determine whether allegations of fraud are credible so that they could

rapidly stop payments to individuals and entities and in connection with schemes under investigation for credible allegations of fraud, thus protecting the financial integrity of the Medicaid and CHIP programs and Federal taxpayer dollars.

1. Allowing States To Rely on CMS or Other Federal Agencies' Credible Allegation of Fraud Determinations

Under current regulations at § 455.23(a), an SMA must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud against such provider for which an investigation is pending, unless the agency has good cause to not suspend payments or to suspend payment only in part. When an investigation leads to the initiation of a payment suspension in whole or part, § 455.23(d) requires the SMA to also make a fraud referral to either the State's MFCU or, in States with no certified MFCU, to an appropriate law enforcement agency. If the MFCU, or law enforcement agency accepts the fraud referral for investigation, the payment suspension may continue until such time as the investigation and any associated enforcement proceedings are completed. There is a similarly defined path for a MFCU to refer a credible allegation of fraud for payment suspension to the SMA at § 1007.9(e). In CHIP, § 457.915 requires the CHIP agency to refer suspected fraud and abuse cases to the CHIP program integrity unit (if such a unit is established) and to appropriate law enforcement officials.

The current payment suspension regulatory framework has led to differing interpretations of what the statutory language ''as determined by the State'' in section 1903(i)(2)(C) of the Act requires of each State. This has led to variation as to what additional verification steps SMAs or CHIP agencies take when receiving referrals from outside sources, such as CMS or a Federal law enforcement agency, with States handling this process in different ways: some accept a referral as a credible allegation of fraud and immediately impose a payment suspension, while others independently determine the credibility of the allegation(s) before imposing a payment suspension. These divergent approaches create exploitable loopholes that bad actors may use to continue receiving Medicaid and CHIP payments and that make recoupment of improperly paid funds difficult. This is particularly problematic in those States that may not have the internal resources to independently investigate and establish a credible allegation of fraud in every instance. The longer payment suspensions are delayed, the greater the chance of payments continuing to flow to actors potentially defrauding the program.

To address these issues, we propose to add subparagraph § 455.23(a)(1)(i) to specify that a State may rely on a determination by CMS or any other Federal agency that a credible allegation of fraud exists for purposes of imposing a payment suspension and may rely on these agencies' investigations to satisfy the statutory requirement that there is pending an investigation of a credible allegation of fraud against an individual or entity. This would include, for example, investigations conducted by CMS or another Federal agency, such as the U.S. Department of Justice, U.S. Department of Health and Human Services Office of Inspector General (HHS–OIG), or the Department of Veterans Affairs. We believe this proposal would ease the burden on SMAs or CHIP agencies and reduce the time between when a credible allegation of fraud is referred and a payment suspension is implemented, translating into potential monetary savings for those States and for State and Federal taxpayers, as well as additional protections for those who could experience bodily or financial harm due to the possible underlying fraudulent activity. As stated under the proposed definition of credible allegation of fraud at § 455.2, a State may rely on such other agency determinations as a credible allegation of fraud unless the State has specific information indicating that reliance on the CMS or other agency determinations would be unreasonable under the circumstances. Thus, when accepting credible allegations of fraud from CMS or Federal agencies, SMAs and CHIP agencies may choose to adopt those agencies' determinations as their own.

2. Aligning Modifications to the Definition of Credible Allegation of Fraud

''Credible allegation of fraud'' is a statutory term as reflected in section 1903(i)(2)(C) of the Act. On February 2, 2011, CMS published a final rule with comment period (CMS–6028–FC) implementing the new Medicaid payment suspension requirements with an effective date of March 25, 2011. As part of that 2011 final rule, we declined to provide a more precise definition of the term, recognizing that different States may have different considerations in determining what may be a credible allegation of fraud. Instead, we specified at § 455.2 that a credible allegation of fraud may be an allegation verified by the State from any source, and that allegations are considered to be credible when they have an indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. However, as discussed in III(B)(1) of this proposed rule, although the statutory language says that a credible allegation of fraud should be ''determined by the State,'' it is left to each State in accordance with the Secretary's regulations to decide what that determination must entail. Currently, § 455.2 states that a credible allegation of fraud may arise from sources like fraud hotline tips, claims data mining, or patterns identified through audits and investigations, with credibility established through a State's review for indicia of reliability. In cases where CMS or another Federal agency has already made a credible allegation of fraud determination, requiring the State to independently re-verify that determination is duplicative, time consuming, and oftentimes not necessary. Moreover, the current definition does not explicitly address whether a State may rely on a credible allegation of fraud determination or investigation by CMS or another Federal agency. Without an explicit basis for relying on another agency's determination, we understand that some States duplicate investigative work, delay action, or forgo payment suspensions even when a credible referral already exists. Therefore, we are proposing several changes to the definition of ''credible allegation of fraud'' at 455.2 to make the Medicaid payment suspension process more efficient and to provide States with clarity as to when the imposition of a payment suspension is appropriate.

First, we propose to revise the definition to explicitly recognize determinations from CMS or another Federal agency as a potential source of a credible allegation of fraud. We are not including State agencies within this new provision; the existing referral pathway at § 1007.9(e) already addresses this category of State-level finding and is not amended by this rule. We believe this proposal would give States a clearer, faster path to act on well-supported referrals from CMS and other Federal agencies, while leaving the established MFCU referral process undisturbed and without need for a conforming amendment to the MFCU regulations at 42 CFR part 1007.

Second, we are proposing to reorganize the language of the credible allegation of fraud definition at § 455.2 to alleviate duplicative effort that we

believe the phrase ''which has been verified by the State'' has caused. We propose that the definition instead provide that a credible allegation of fraud is an allegation that has indicia of reliability that may come from any source, including but not limited to fraud hotline tips verified by further evidence, claims data mining, patterns identified through provider audits, civil false claims cases, and law enforcement investigations, or a determination by CMS or by another Federal agency that an allegation of fraud against a provider is credible.

Third, we propose at § 455.2 that an allegation has indicia of reliability through one of two pathways, depending on its source. For allegations arising from fraud hotline tips, claims data mining, or patterns identified through audits, civil false claims cases, and law enforcement investigations, an allegation has indicia of reliability when the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis, consistent with the existing standard. For allegations based on a determination by CMS or another Federal agency, we propose that the State may adopt the referring agency's determination as its own without conducting an independent redetermination of credibility, unless the State has specific information indicating that reliance on the referring agency's determination would be unreasonable under the circumstances. We believe this presumption would appropriately reduce duplicative State effort while preserving a State's ability to decline reliance where it has a concrete basis to question the referring agency's determination.

We are not proposing to further define ''indicia of reliability'' in this rule. We have historically left this term undefined to preserve State flexibility to evaluate allegations according to the facts and circumstances presented, consistent with our approach in the 2011 final rule. We recognize, however, that the absence of further definition may create inconsistency across States in how allegations are evaluated, particularly as States begin to rely on determinations made by CMS or other Federal agencies under this proposal, where the referring agency's own application of ''indicia of reliability'' may not be transparent to the State relying on it. We solicit comments on the following questions:

- Should CMS further define ''indicia of reliability'' in regulation, and if so, what specific factors or criteria should that definition include?
- Would a non-exclusive list of factors, for example, the specificity of the allegation, the existence of corroborating documentation, the source's track record of reliability, or the existence of a related law enforcement referral provide useful guidance without unduly constraining State discretion on a case-by-case basis?
- Are there existing State-level frameworks for evaluating indicia of reliability that CMS should consider as models if it were to adopt further criteria in future rulemaking?
- What burden, if any, would a more detailed definition impose on States, and would that burden be offset by increased consistency?
- What additional internal controls, if any, States should be required to maintain to ensure that payment suspensions sustained under this provision are subject to adequate oversight, including the appropriate length of the law enforcement notice-and-objection period?

3. Maintaining a Medicaid and CHIP Payment Suspension During an Investigation

Currently, § 455.23(d)(4) directs that a payment suspension be discontinued if law enforcement declines the fraud referral, unless the SMA has alternative Federal or State authority to impose a suspension or make a referral to another law enforcement agency.

Payment suspensions are temporary measures, subject to defined procedural timeframes, and must be terminated upon specific triggering events specified at § 455.23(c) and (d), and through cross reference at § 457.935(b)(1). However, in practice CMS has observed that payment suspensions may be terminated prematurely, potentially causing at-risk funds to go unrecovered and taxpayer dollars to be lost. For instance, law enforcement agencies may decline State or Federal referrals for various reasons unrelated to the quality of the referral, such as personnel or other resource constraints or competing priorities. As the Medicaid payment suspension regulations currently stand, we did not directly account for the extent of resource constraints that law enforcement agencies may have in accepting a referral for investigation, nor the SMA resources it may take to refer a credible allegation of fraud to multiple agencies for an investigation to commence.

Therefore, we propose revising our regulations to specify that a SMA or CHIP agency may maintain a payment suspension when a credible allegation of fraud is present while the SMA or CHIP agency completes its own investigation, regardless of whether Federal or State law enforcement accepts the referral, if the SMA or CHIP agency documents in writing that the credible allegation of fraud remains under active investigation by the SMA or CHIP agency or by another State or Federal agency. We believe this proposal would appropriately preserve State flexibility to maintain suspensions in cases where the underlying credible allegation of fraud has not been resolved to ultimately determine whether payment should be made, or whether the provider's ability to bill the Medicaid or CHIP programs should be terminated. This would allow the SMA conducting the active investigation to act on its findings, such as by determining that a claim should be denied, that an overpayment exists and can therefore be recouped, or that a provider should be terminated.

However, we are mindful that Congress tied the payment suspension authority under sections 1903(i)(2)(C) and 2107(e)(1)(O) of the Act to the existence of a pending investigation of a credible allegation of fraud, and that the new authority provided by this regulation is not intended to function as an indefinite or open-ended tool. To ensure that a suspension maintained on this basis would remain pursuant to an active ongoing investigation, we are also proposing a requirement that the SMA or CHIP agency redetermine and document in writing, at least quarterly, whether the credible allegation of fraud continues to be under active investigation warranting continuation of the suspension. We propose that, where a Federal or State law enforcement agency accepted the referral and is conducting the investigation, prior to each quarterly redetermination taking effect, the SMA or CHIP agency notify the Federal or State law enforcement agency investigating the alleged fraud of its intent to continue or terminate the suspension, and afford that law enforcement agency the right to request that the payment suspension be kept (or terminated). Should the referring agency timely make such a request, the SMA or CHIP agency would consider the request in its decision to maintain or terminate the payment suspension for that quarter. This approach would give the referring law enforcement agency a direct and time-limited mechanism to provide the least interference with a law enforcement investigation or prosecution. Where no law enforcement agency accepted the referral and the SMA or CHIP agency is conducting its own investigation, its quarterly written redetermination alone would satisfy this

requirement. Furthermore, should an SMA or CHIP agency be unable to make a finding that there remains an active investigation at any such redetermination, we propose that it must immediately terminate the suspension. We believe this would ensure payment suspensions remain time-limited and subject to meaningful review while protecting Medicaid and CHIP dollars.

We note that this redetermination and termination authority would rest with the SMA and CHIP agency, and that their conclusions could sometimes diverge from those of the agency or agencies that referred the credible allegation of fraud in the first place. We have observed that defendants in Federal matters have, in some instances, cited a State's decision to decline to impose or its decision to subsequently terminate a payment suspension following a credible allegation of fraud referral as evidence that their conduct was believed to be permissible, potentially undermining an ongoing Federal investigation or prosecution involving substantially the same conduct. We encourage coordination between the SMA or/and CHIP agency, and the referring agency before a payment suspension maintained on the basis of that agency's referral is terminated. This would not give the referring agency veto power over the redetermination of a payment suspension at an SMA or CHIP agency, but, instead, would ensure the referring agency would have notice and a meaningful opportunity to share relevant information. For example, a law enforcement agency could share that a matter remains under active investigation and that terminating a payment suspension could adversely affect a related enforcement proceeding.

4. Verifying Good Cause Exceptions to Payment Suspension Requirements

Sections 455.23(e) and (f) currently specify bases for good cause exceptions to payment suspensions. In our experience, good cause exceptions are often invoked when a MFCU or other law enforcement agency requests that a payment suspension not be imposed to prevent a provider from being made aware they are under investigation, which could jeopardize a civil or criminal case and possibly even the safety of the law enforcement officials conducting an investigation. Though that is a laudable and important goal, in recent years we have seen instances in which States seem to invoke good cause exceptions to avoid imposing payment suspensions for other reasons that do not meet the criteria outlined at § 455.23(e)(1). For example, CMS believes that some States may use the (e)(1) clause to avoid provider abrasion (that is, friction, frustration, and administrative stress) to retain providers within the State's Medicaid and/or CHIP network. Other States may want to avoid the administrative burden of implementing a payment suspension or the subsequent litigation risk inherent when payment is paused.

Data analysis bolsters our belief that States are over-relying on exercising § 455.23(e) and (f) payment suspension good cause exceptions. In CY 2025, for example, approximately 75 percent of credible allegation of fraud cases reported to CMS pursuant to State Medicaid payment suspension reporting requirements at § 455.23(g)(3) did not proceed to a payment suspension because an SMA invoked a good cause exception. Good cause exceptions have a legitimate place in payment suspension decision-making, but States should not use them as a blanket policy to reduce litigation risk or avoid their administrative responsibilities. Similarly, we encourage States to provide the most accurate good cause exception reasons and not solely rely—potentially inaccurately—on law enforcement exceptions. And while we expect variability among States, State-reported data revealed that several States had over 90 percent of their potential payment suspensions end with the exercise of a good cause exception, with some States exercising hundreds of good cause exceptions while instituting only a handful of payment suspensions. Such outlier scenarios potentially could be explained in very limited situations by events such as large law enforcement take-down operations in a State, but in no event should they, as we have seen, recur year-over-year. Instead, such patterns warrant our exercising additional oversight to ensure good cause exceptions are applied in accordance with regulatory requirements.

To address this concern, we propose to require additional verifications as to whether the exercise of a good cause exception is appropriate. Specifically, we propose to modify § 455.23(e) to require States to evaluate, and document in writing, that the specific criteria for the exception invoked have been met in each instance. Further, we propose to modify § 455.23(e)(1) to require States to verify the reasons for good cause exceptions with law enforcement and send CMS the basis for each invocation of a good cause exception. Good cause exceptions must be invoked on a case-by-case basis, and SMAs and CHIP agencies must affirmatively verify with the relevant law enforcement agency that the exception is warranted for each individual case. A general or standing request from a law enforcement agency would be insufficient to satisfy this requirement.

We would not intend for this provision, if finalized as proposed, to serve as a categorical bar to good cause exceptions in all cases involving an active law enforcement investigation, nor would we expect SMAs or CHIP agencies to receive or ask for confidential, privileged, or legally protected information from law enforcement. But we would expect the case-specific merits for a good cause exception to be reviewed, confirmed or denied, and communicated by the MFCU or other law enforcement agency to the SMA or CHIP agency. At a minimum, the shared Federal and State goals—and, we believe, universally shared goals—should be to ensure that fraudulent providers are not inappropriately paid, while being circumspect and prudent with exercising authorities to best ensure legitimate providers are not inadvertently ensnared.

5. Updating Payment Suspension Reporting Requirements

Under our current regulations at § 455.23(g)(3), States are required to annually report to CMS summary information on the State's payment suspensions, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension. In the 2011 regulation update of the Medicaid payment suspension regulations, we contemplated balancing SMA burden and transparency as they determine whether to implement payment suspensions. At that time, we did not believe it would be necessary to review information on individual payment suspensions by a State with any regularity, and that an annual cadence would allow sufficient oversight over States' payment suspension activities. As discussed previously, however, we have observed over the past several years significant inconsistencies between States, and sometimes within each State over time, in payment suspension utilization. We understand and expect a degree of variability among States as this is a State-implemented program and States vary in program integrity risk profiles, but also expect a consistent level of due diligence in ensuring payments are made appropriately and that inappropriate payments are avoided. Important in that calculus, technological advancements

over the past decade—including greatly improved data analytics yielding the ability to act on data in near-real time—have altered how businesses and governments run and make more regular reporting more feasible without commensurate burden.

We therefore propose to update § 455.23(g) reporting requirements to increase the reporting cadence from annual to quarterly, and to remove the word ''summary'' from the description of information to accommodate the increased detail that States would need to report to CMS. As we encourage States to appropriately utilize payment suspensions to halt potentially fraudulent payments, we strive for closer-to-real-time data and analytics on how those decisions are being made. As part of our oversight duties, if finalized as proposed, we would utilize this data to foster deeper discussions within SMAs and CHIP agencies on potential payment suspensions, and provide technical assistance and guidance, when requested or needed. We believe that more frequent reporting of payment suspension data would help States use this tool more effectively and obtain the necessary guidance from CMS.

We also believe that more frequent reporting would enable CMS to compile and analyze program-wide data on payment suspension activity within and across States more effectively. This information would be used to identify systemic trends and patterns in the use of payment suspensions as a program integrity tool. Similar to how we use the data today, should our proposals be finalized as proposed, we would use this data to assess whether States are maintaining effective processes for evaluating credible allegations of fraud and making timely suspension decisions consistent with the proposed updates in §§ 455.23 and 457.935(b)(8), to inform CMS' State auditing activities, and to support aggregate reporting on Medicaid and CHIP program integrity outcomes. More frequent State reporting would also enable CMS to provide States more timely technical assistance to address any inconsistencies or other concerns.

We do not believe that more frequent reporting of this information would be substantially more burdensome to States than their current data sharing. For example, much of the data that States currently share annually with CMS already is shared quarterly, and perhaps even more frequently, between SMAs and their MFCUs through States' existing case tracking systems. In fact, § 1007.9(h) already requires MFCUs to send certain information regarding payment suspensions to SMAs, which the SMA must request quarterly per § 455.23(d)(3)(ii). Accordingly, we believe that any additional burden on States to supply such information to CMS would be nearly negligible. Similarly, while we expect that the shift to quarterly reporting would modestly increase CMS' administrative burden, we believe this increase would be negligible relative to our existing oversight infrastructure and be offset by the program integrity benefits of more timely reporting.

The proposed enhanced reporting requirements would not be intended to enable CMS to substitute its judgment for that of the State in individual cases, nor would they expand CMS' authority by permitting enforcement action based solely on disagreement with a State's individual suspension determination. Rather, CMS would use the reporting data to identify potential systemic deficiencies in a State's program integrity processes, which then could be examined through additional oversight activities, such as audits, and addressed through technical assistance or existing enforcement mechanisms, including deferral and disallowance of Federal Financial Participation (FFP) under §§ 430.40, 430.42, and 457.628(a), where appropriate.

We also propose a technical edit to update the title of § 455.23(g) to include reporting, to more accurately reflect all the subparagraphs.

6. Applicability to CHIP

Current regulations at § 438.608(a)(8) require that Medicaid managed care contracts include a provision for the suspension of payments to a network provider when the State determines there is a credible allegation of fraud, in accordance with § 455.23. Through the cross-reference at § 457.1285, we note that the requirements in § 455.23 are already applicable to CHIP managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). Accordingly, any finalized provisions to § 455.23 would also apply to CHIP MCOs, PIHPs, and PAHPs.

However, we are concerned that the existing regulatory framework does not fully address payment suspensions in the CHIP fee-for-service (FFS) context. We therefore propose to update § 457.935(b) to include a cross-reference to § 455.23. This change would ensure that standalone CHIP programs would be held to the same standards as Medicaid MCOs, PIHPs, PAHPs, and FFS. We believe that including the cross-reference to § 455.23 would close potential program integrity gaps in the CHIP program and support stronger, more consistent program administration.

We seek comments on whether the proposed update to § 457.935(b) and current cross-references to § 455.23 provide sufficient clarity regarding the applicability of payment suspension requirements to CHIP. We also seek comments on whether additional regulatory text or cross-references would be needed to ensure that State CHIP agencies and their managed care partners have clear and actionable guidance on implementing these requirements.

C. Enhanced Electronic Visit Verification (EVV) Requirements

Personal care services (PCS) and home health care services (HHCS) that are delivered during an in-home visit are particularly vulnerable to fraud, waste, and abuse due to the limited direct oversight of services furnished in beneficiaries' homes. PCS are services that support beneficiaries with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) and generally include, but are not limited to, meal preparation, grooming, dressing, and bathing.[8] [9] PCS can be agency-based or self-directed. Under agency-based models, a personal care agency provides oversight, management, and supervision of a beneficiary's PCS. By contrast, self-directed PCS allows individuals, or their representatives, to exercise decision-making authority in the planning, accessing, managing, and purchasing of their PCS with available necessary supports and subject to applicable State oversight requirements, including, as applicable, the requirements specified at §§ 441.464 and 441.585(a).[10] Regardless of the PCS delivery model, the SMA is responsible for monitoring the quality of services.

PCS fraud and abuse schemes have been well documented in Federal oversight actions and prosecutions. Common PCS fraud and abuse schemes include personal care attendants (PCAs) billing for services not rendered, billing for excessive units, and billing for medically unnecessary services. In FY 2025, MFCUs reported 326 PCA fraud convictions, significantly higher than any other provider type.[11] PCS fraud and abuse leaves beneficiaries at risk for harm and neglect, and in severe cases

[8] § 440.167.

[9] The definition of PCS and the specific services covered vary depending on the applicable Medicaid authority.

[10] §§ 441.450 and 441.505.

[11] OEI–09–26–00140, Medicaid Fraud Control Units Annual Report: Fiscal Year 2025.

has resulted in hospitalizations and deaths.

HHCS include, at a minimum, nursing services; home health aide services; and medical supplies, equipment, and appliances. At a State's option, HHCS can include physical therapy, occupational therapy, and speech pathology and audiology services. HHCS is a mandatory State plan benefit for specified individuals under section 1902(a)(10)(D) of the Act and is described in section 1905(a)(7) of the Act. Under specific circumstances, HHCS may also be provided under a waiver of the plan. HHCS are generally susceptible to many of the same fraud and abuse schemes as PCS, including but not limited to providers billing for services not rendered, excessive units, or medically unnecessary services, and services provided by unqualified providers.[12] Like PCS, HHCS fraud and abuse can result in significant harm to beneficiaries.

In CY 2023, home and community-based services (HCBS) accounted for 63.8 percent of total Medicaid long-term services and supports (LTSS) expenditures.[13] Individuals who receive HCBS have significantly lower average expenditures than individuals who receive institutional care, but PCS and HHCS represent a substantial and growing share of HBCS spending.[14] Of the $145.9 billion in total HCBS expenditures in 2023, PCS spending totaled at least $36.1 billion and HHCS at least $6.9 billion.[15] When utilized and delivered appropriately, these services provide important supports that allow individuals to remain in home and community settings. However, they also present unique program integrity challenges because services are furnished in locations allowing for limited, if any, direct oversight.

EVV is a system used for in-home services, including PCS and HHCS, to electronically verify the service type, service recipient, date, location, provider, and service start and end time. Congress enacted EVV requirements in section 12006(a) of the 21st Century Cures Act, which added section 1903(l) of the Act, requiring States to implement an EVV system for Medicaid PCS and HHCS requiring an in-home visit by a provider. The requirements were established, in part, to reduce fraud, waste, and abuse in PCS and HHCS by increasing States' ability to validate that services are provided and monitor the accuracy of payments to providers.[16] States were generally required to have an EVV system in place for PCS by January 1, 2020, and for HHCS by January 1, 2023. States are subject to incremental FMAP reductions of up to 1 percent for failing to comply with these requirements by the applicable deadlines.[17]

States' EVV systems are required to electronically verify the following data elements for in-home PCS and HHCS visits: (1) the type of service performed; (2) the individual receiving the service; (3) the date of service; (4) the location of service delivery; (5) the individual providing the service; and (6) the time the service begins and ends.[18] Section 1903(l) of the Act does not require States to use a particular type of EVV system, affording States significant discretion in their EVV design and operation. There is also no statutory requirement for States to use global positioning system (GPS) data with respect to their EVV systems, and States are required only to collect the location of service delivery and the time the service begins and ends. States may, however, elect to collect additional information to mitigate fraud, waste, and abuse.[19]

Today, States routinely collect EVV data elements as part of program operations. However, as one commenter stated in response to the 2026 CRUSH RFI, there is currently a gap between the technical infrastructure—the EVV system—and its effective use for program integrity. The statute required that by not later than January 1, 2018, the Secretary collect and disseminate to SMAs best practices regarding the operation of EVV systems and the prevention of fraud with respect to the provision of PCS or HHCS.[20] State best practices for improved PCS and HHCS oversight include integrating EVV systems with other Medicaid systems, such as the State's Medicaid Management Information System (MMIS), Eligibility and Enrollment System (E&E), and Financial Management Systems (FMS), and conducting prepayment reviews of PCS and HHCS claims against EVV data.[21] By integrating EVV systems with claims processing systems, States can automatically compare claims with EVV data and prevent payments for PCS and HHCS claims that do not have matching EVV records. Additionally, some States have expanded EVV requirements to other in-home services beyond just PCS and HHCS.

Although CMS has published guidance on how States can use EVV to enhance quality monitoring and oversight of Medicaid services,[22] [23] neither the statute nor current regulations establish EVV-specific requirements regarding the use of EVV records in claims review or program integrity activities.[24] In this proposed rule, we propose two related but distinct regulatory changes to require SMAs to use collected EVV data for program integrity and payment oversight. First, we propose to amend § 455.14 to require that SMAs incorporate a review of EVV records as part of preliminary investigations into potential Medicaid fraud or abuse involving in-home service providers subject to EVV requirements in a State. Accordingly, this requirement would apply to Medicaid providers furnishing services subject to Federal EVV requirements, as well as those subject to State

[12] *See,* for example, United States Attorney's Office Northern District of Georgia, *Home Health Agency to Pay $4.2 Million to Settle False Claims Act Allegations, https://www.justice.gov/usao-ndga/pr/home-health-agency-pay-42-million-settle-false-claims-act-allegations-0* (November 2021); United States Attorney's Office Southern District of Ohio, *Columbus Home Health Care Provider Sentences for Fraud, https://www.justice.gov/usao-sdoh/pr/columbus-home-health-care-provider-sentenced-fraud* (February 2019); *United States Attorney's Office Southern District of New York, Owner Of Home Health Agency Sentenced To 54 Months In Prison For Over $100 Million Health Care Fraud, https://www.justice.gov/usao-sdny/pr/owner-home-health-agency-sentenced-54-months-prison-over-100-million-health-care-fraud (*February 2023).

[13] *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2023.pdf.*

[14] The average institutional services expenditure per user in 2023 was $54,462, compared to $17,298 for HCBS (*see https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2023.pdf*).

[15] The PCS spending estimate was calculated based on $18.6 billion for section 1915(j) services, $12.6 billion for section 1905(a) State plan PCS, and $4.9 billion for section 1915(k) services and the HHCS spending estimate was based on $6.9 billion for section 1905(a) State plan home health services (*see https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-users-expenditures-category-brief-2023.pdf*).

[16] *See e.g., https://www.congress.gov/committee-report/114th-congress/house-report/667/1.*

[17] Section 1903(l)(1) of the Act.

[18] Section 1903(l)(5)(A) of the Act.

[19] CMS, *Frequently Asked Questions: Section 12006 of the 21st Century Cures Act Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS) and Home Health Care Services (HHCS), https://www.medicaid.gov/federal-policy-guidance/downloads/faq051618.pdf.*

[20] Public Law 114–255, § 12006(b)(1).

[21] CMCS Information Bulletin, *Electronic Visit Verification, https://www.medicaid.gov/federal-policy-guidance/downloads/cib051618.pdf (*May 2018).

[22] CMS, *Leveraging EVV to Enhance Quality Monitoring and Oversight in 1915(c) Waiver Programs (February 2020), https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-training-series.*

[23] *Electronic Visit Verification, https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-guidance-additional-resources/electronic-visit-verification.*

[24] Statutory EVV requirements are not referenced in current Medicaid regulations.

requirements that extend EVV requirements to additional Medicaid services. Second, we propose to amend § 447.45(f)(1) to require that SMAs verify that billed Medicaid services are supported by EVV records, where applicable under Federal or State requirements, during prepayment claims review. Together, these proposals are intended to maximize States' existing EVV systems for improved program integrity oversight and better position States to crush Medicaid fraud and abuse within high-risk services.

1. Use of EVV Data in Preliminary Investigations

In accordance with § 455.14, when a SMA receives a complaint of potential Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether the complaint warrants a full investigation. States currently have broad flexibility in establishing procedures for preliminary investigations, including for those investigations conducted by managed care plans.[25]

When a State receives an allegation or complaint of potential Medicaid fraud, the State should review all allegations, facts, and evidence carefully to determine their validity; act on a case-by-case basis; and consider the totality of the facts and circumstances associated with any allegation.[26] In accordance with § 455.15, should a State believe that an incident of provider fraud or abuse has occurred based on the findings of a preliminary investigation, it is required to refer the case of suspected fraud or abuse to the State's MFCU for investigation, except in limited cases where no referral to the MFCU is required, in which case the State must conduct a full investigation or refer the case to the appropriate law enforcement agency.[27] [28] As discussed previously, States must also suspend payments to a provider after the SMA determines that a credible allegation of fraud exists, unless good cause not to suspend or to suspend only in part exists.[29]

We propose to amend § 455.14 to require that SMAs incorporate a review of EVV records, where EVV use is required with respect to the underlying Medicaid service(s) in question under applicable Federal or State requirements, as part of preliminary investigations into potential Medicaid fraud or abuse. Specifically, we propose at new § 455.14(a)(1) that States be required to review and analyze the associated EVV records to attempt to verify the validity of an allegation of fraud or abuse or any identified questionable practice(s). This requirement would apply to any preliminary investigations of allegations of Medicaid fraud or abuse involving Medicaid services subject to EVV requirements under Federal or State requirements and the related providers suspected of such fraud or abuse.

The primary goal of this proposal would be to ensure that SMAs analyze and compare EVV records and claims to identify any discrepancies that warrant further investigation of providers subject to EVV requirements with fraud or abuse allegations or identified questionable practices. For example, during a preliminary investigation of an applicable provider, the SMA would be expected to review a sample of the provider's EVV records for the period under investigation to attempt to verify that services were delivered as billed, including for the appropriate duration and at the appropriate location, or determine if a full investigation pursuant to § 455.15 was warranted. This proposal seeks to enhance State identification and oversight of fraudulent and abusive activities by in-home service providers, including billing simultaneously for two beneficiaries in different locations, billing for improbably large volumes of services, and billing for services on the same day that would be geographically impossible to perform.[30] [31] [32]

We seek comments on this proposal, including on whether the proposed requirement should extend to investigations conducted by managed care plans under State managed care contracts and what operational steps States would need to take to integrate EVV record review into existing preliminary investigation procedures.

2. EVV Data in Prepayment Claims Review

Section 1902(a)(37)(B) of the Act requires States to have procedures for prepayment and post-payment claims review to ensure the proper and efficient payment of claims and management of the program. Regulations at 42 CFR 447.45 implement this statutory requirement. In accordance with § 447.45(f)(1), SMAs are currently required to conduct prepayment reviews for all claims consisting of: (1) verification of beneficiary and provider eligibility; (2) checks that services delivered are consistent with beneficiary characteristics and circumstances; (3) verification that the claim does not duplicate or conflict with other claims; (4) verification that payment does not exceed State plan payment rates or limits; and (5) checks for third party liability.

We propose to amend § 447.45 by adding § 447.45(f)(1)(vi) to require that SMAs verify, during prepayment review, that billed in-home Medicaid services subject to Federal or State EVV requirements are supported by an EVV record, where applicable. Specifically, we propose that for home-based services subject to the requirements of section 1903(l) of the Act, and additional Medicaid services that the State independently subjects to EVV requirements, States verify during prepayment claims review that the following data elements are supported by an EVV record: (1) the type of service performed; (2) the individual receiving the service; (3) the date of service; (4) the location of service delivery; (5) the individual providing the service; and (6) the time the service begins and ends.

With this proposal to require that States use EVV data to verify applicable service claims during prepayment review prior to payment, we aim to encourage States to begin applying automated prepayment claims edits that take into consideration EVV data to stop inappropriate payments on the front-end, an approach we have long labeled ''cost avoidance'' and that is far more effective than ''pay and chase.'' We believe this proposal, if finalized as proposed, would ensure States address Medicaid fraud in some of the highest risk services areas using technology, data analytics, and automated systems. We also believe this proposal is consistent with States' existing obligations under section 1902(a)(37) of the Act to maintain procedures for prepayment claims review to ensure the proper and efficient payment of claims. We also note that this proposal would

[25] CMS, *Medicaid and CHIP Managed Care Program Integrity Toolkit, https://www.cms.gov/files/document/managed-care-fraud-referral.pdf* (June 2025).

[26] CPI—CMCS Informational Bulletin, *Affordable Care Act Program Integrity Provisions—Guidance to States -Section 6402(h)(2)—Suspension of Medicaid Payments Based Upon Pending Investigations of Credible Allegations of Fraud, https://www.medicaid.gov/federal-policy-guidance/downloads/payment-suspensions-info-bulletin-3-25-2011.pdf (March 2011).*

[27] § 455.15(a).

[28] § 455.21(a).

[29] § 455.23.

[30] *https://www.medicaid.gov/medicaid/downloads/evv-enhance-quality.pdf.*

[31] OIG–OR–2017–01.

[32] *https://www.justice.gov/criminal/media/1405081/dl?inline.*

complement our proposed amendment to § 455.14 described earlier in this proposed rule, as well as our proposal to require consistent use of NPIs for eligible Medicaid providers described in section E of this proposed rule. Together, these proposals, if finalized as proposed, would create a more integrated and effective framework for program integrity oversight of home-based services.

CMS would not condition claiming for FFP for EVV-required services on compliance with this provision. However, evidence of noncompliance (for example, as identified in a CMS audit) could cause CMS to reassess a State's compliance determination related to Section 1903(l) of the Act (as added by Section 12006 of the 21st Century Cures Act), which could result in FMAP reductions until compliance was achieved. Under section 1903(l) of the Act, States were required to attest that EVV use was required for all Medicaid-funded PCS (for calendar quarters beginning in 2020) and HHCS (for calendar quarters beginning in 2023) or otherwise be subject to FMAP reductions up to 1 percent. Although section 1903(l) does not specifically require EVV as a prepayment condition, substantive evidence that a State's claims for EVV-required services were not supported by EVV records could indicate that the State was not sufficiently requiring EVV use for those services. Similarly, CMS could take compliance with this provision into account during the certification process for States requesting enhanced FFP for their EVV systems.[33]

We seek comments on this proposal, including on the operational feasibility of requiring EVV-based prepayment review for all Medicaid service claims subject to Federal or State EVV requirements, whether States would need a transition period before this requirement could take effect, and whether there could be circumstances in which an EVV record might not be available for a legitimate claim, and how States should handle such situations.

Additionally, we acknowledge that, because the prepayment and post-payment review requirements in § 447.45 do not apply to risk-based managed care plans (as there is no cross-reference to § 447.45(f) in § 447.46(c)), the proposals in this section would only apply to Medicaid FFS; however, we are considering extending this proposed requirement to Medicaid managed care as a part of this rulemaking and explicitly seek comments on this approach. Applying this proposed requirement to managed care would necessarily require first extending the established prepayment and post-payment claims review requirements at § 447.45(f) to MCOs, PIHPs, and PAHPs. We believe that many plans already use prepayment and post-payment processes as a part of their program integrity framework, and we request public comment on the feasibility of applying prepayment and post-payment claims review, and in turn the EVV prepayment requirements, to risk-based managed care.

D. Requiring National Provider Identifiers (NPIs) for Eligible Medicaid and CHIP Provider Types

We propose to revise § 455.440 to establish broader requirements for States to collect, maintain, and use NPIs for eligible Medicaid and CHIP providers. We would retain, without substantive change, the existing requirement that claims for ordered or referred items and services contain the NPI of the physician or other professional who ordered or referred those items or services, and designate that requirement as paragraph (a). We propose to add paragraphs (b) through (d) to establish the broader NPI requirements described below. Under § 457.990(b), the requirements of part 455, subpart E, including § 455.440, apply to separate CHIP programs in the same manner as they apply to Medicaid. Accordingly, the proposed requirements would apply to separate CHIP programs through that existing cross-reference.

Effective provider identification is foundational to Medicaid and CHIP provider enrollment, screening, ownership, and disclosure review; claims oversight; managed care oversight; auditing; reporting; and other program integrity activities. The Department adopted the NPI as the standard unique health care provider identifier under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification provisions.[34] The NPI final rule (69 FR 3434) established the NPI as the standard unique identifier for health care providers and recognized that NPIs may be used for numerous provider identification purposes, including provider enrollment systems, fraud and abuse files and other program integrity functions, and debt collection activities. The NPI was developed in part to address longstanding challenges associated with multiple provider identifiers. Prior to implementation of the NPI, providers often maintained different identifiers across health plans, programs, and administrative systems. The NPI established a nationally standardized identifier capable of supporting provider identification across operational and administrative functions.

Although NPIs are widely used throughout the health care system, CMS has observed significant variation in how provider identifiers are collected, maintained, and used within Medicaid programs, and has determined that broader and more consistent use of NPIs would strengthen States' ability to carry out their program integrity responsibilities. Under current Medicaid program requirements, however, States are not required to collect, maintain, or use NPIs consistently across all Medicaid systems and activities. As such, the same provider may be identified differently across a State's provider enrollment system, claims processing system, managed care oversight system, and program integrity system, which can lead to difficulties identifying providers in Federal reporting systems, such as the Data Exchange System (DEX). For example, a PCA who is not required to have an NPI may be assigned different State or system-specific identifiers across these systems; may be identified individually in one system but associated with an employing agency or fiscal intermediary in another; or may have variations in recorded information such as name, address, or provider type. These State inconsistencies create meaningful vulnerabilities in program oversight on both State and Federal levels. For example, providers operating across State lines may maintain multiple identifiers, making it more difficult to detect billing for overlapping shifts or other suspicious billing patterns across programs. Reliable provider identification is particularly important for providers furnishing services in home- and community-based settings, where direct oversight is limited and fraud risk is elevated.[35]

These inconsistencies also reduce the usefulness of data reported to CMS under § 455.17, limit cross-State

[33] *https://cmsgov.github.io/CMCS-DSG-DSS-Certification/Outcomes%20and%20Metrics/Electronic%20Visit%20Verification%20(EVV)/.*

[34] 45 CFR part 162, subpart D; HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers, 69 FR 3434 (January 23, 2004).

[35] CMS has previously clarified that Medicaid PCAs who qualify as health care providers under applicable Federal regulations may obtain NPIs, and that a unique numeric identifier, such as the NPI, is an efficient mechanism for electronically recording which individual furnished services to a specific beneficiary. Medicaid and CHIP FAQs: Allowability of Using National Provider Identifiers (NPIs) for Medicaid Personal Care Attendants (PCAs).

matching efforts, and complicate CMS' ability to conduct national trend analysis and identify emerging fraud schemes. Program integrity professionals often use proactive data models to identify suspicious billing patterns, such as payment outliers, or to identify potential networks of fraudulent providers, but the accuracy of these analytics depends on consistent use of uniform metrics, including NPIs, and the absence of standardized provider identifiers limits CMS' and States' ability to effectively conduct this kind of analysis. Consistent use of NPIs enables States and national data aggregators, such as the Healthcare Fraud Prevention Partnership, to more accurately identify suspect providers across payors, programs, and States. Requiring consistent NPI use may also simplify States' screening of exclusion and termination lists maintained by the HHS–OIG and other oversight entities, improving States' ability to identify and act on adverse provider actions across programs. Additionally, requiring States to collect and use NPIs for all Medicaid and CHIP providers eligible to obtain an NPI would strengthen oversight of many high-risk service areas and better position States to use EVV data effectively for program integrity purposes, as discussed further in section C of this proposed rule. We believe these policies are necessary to strengthen program integrity, improve data quality and information sharing, support more effective data analytics, and promote the proper and efficient administration of State Medicaid programs under section 1902(a)(4) of the Act. Applying the proposed NPI requirements to CHIP through § 457.990(b) would similarly support consistent provider identification and program integrity oversight in separate CHIP programs.

Accordingly, we propose at § 455.440(b) through (d) to require States to collect, maintain, and use NPIs for all Medicaid and CHIP providers that are eligible to obtain an NPI under applicable Federal law and regulations. Specifically, under this proposal, States would be required to collect, maintain, and use NPIs as part of Medicaid and CHIP provider enrollment, revalidation, claims processing, managed care oversight, program integrity, and reporting activities for all providers eligible to obtain an NPI as a covered health care provider under 45 CFR part 162. As it relates to managed care oversight under 42 CFR part 438, we believe that States should ensure MCPs include applicable NPIs in any data, reporting, or other elements needed for effective oversight of MCPs. Such consistency in NPI use across Medicaid fee-for-service, managed care, and CHIP programs would allow States and CMS to conduct comprehensive and consistent data analytics and oversight.

We recognize that not all providers enrolled in Medicaid or CHIP are eligible to obtain NPIs under applicable Federal law. Eligibility for NPI enumeration is governed by the HIPAA Administrative Simplification regulations, including the definition of ''health care provider'' at 45 CFR 160.103, as discussed in the NPI final rule (69 FR 3436 through 3441, and 3466). Our proposal would not modify those existing eligibility requirements. Accordingly, some individuals or entities furnishing Medicaid and CHIP services, including certain PCAs and other non-traditional provider types, may not qualify as covered health care providers under 45 CFR 160.103 and therefore, may not be eligible for NPI enumeration. For those entities and individuals, we continue to strongly encourage as a best practice that States maintain another unique identifier capable of supporting enrollment, screening, claims oversight, reporting, and program integrity activities. Regardless of NPI eligibility, CMS encourages States to maintain a unique identifier for every provider enrolled in their Medicaid program, and we may consider proposing a formal requirement in future rulemaking as we gather more information through this comment process.

We seek comments on these proposals, including on the operational feasibility of requiring consistent NPI use across all Medicaid and CHIP systems, the timeframe States would need to come into compliance, and any challenges States anticipate in implementing these requirements for specific provider types. In the absence of comprehensive national data identifying the number and characteristics of all providers that would be newly affected by these proposed requirements, we use PCAs as a reasonable proxy when estimating the potential administrative and financial burden associated with obtaining an NPI and completing related provider enrollment activities. We also seek comment on whether PCAs are an appropriate proxy for these estimates.

E. Updating State Program Integrity Reporting Requirements

States currently report certain provider fraud and abuse information to CMS pursuant to § 455.17. These reporting requirements were established in a January 27, 1983 final rule (48 FR 3742) (hereinafter referred to as the January 1983 final rule) and designed primarily to capture basic information regarding provider fraud and abuse investigations. The authority to collect this information expired in 1986, and following that expiration, CMS did not collect the information from States under § 455.17. While these reporting requirements may have provided useful information to CMS and its oversight partners, they have not been updated to reflect significant changes in the law and regulatory landscape. They were, for example, developed decades before the 2006 enactment of the Medicaid Integrity Program at section 1936 of the Act, which significantly bolstered our development of nationwide Medicaid program integrity efforts, and before the widespread use of modern data analytics, cross-State information sharing, managed care program integrity activities, and many current fraud detection techniques.

Under the existing requirements at § 455.17(a), States are required to report to CMS the number of fraud and abuse complaints that warrant preliminary investigation. Under § 455.17(b), for each case of suspected provider fraud and abuse that warrants a full investigation, States are required to report the: (1) provider's name and number; (2) source of the complaint; (3) type of provider; (4) nature of the complaint; (5) approximate range of dollars involved; and (6) legal and administrative disposition of the case, including actions taken by law enforcement. Consistent with the January 1983 final rule, these reporting requirements have applied only to suspected provider fraud and abuse cases and have not extended to suspected beneficiary fraud cases.

These requirements have provided a foundation for Medicaid program integrity reporting for over 40 years, but CMS has determined that they no longer provide the level of detail necessary to support effective national oversight or provide CMS with sufficient information to hold States accountable for lacking program integrity operations. Specifically, existing reporting requirements do not consistently provide information necessary to support national trend analysis, identify emerging fraud schemes, evaluate investigative outcomes, or coordinate oversight activities among Federal and State partners. CMS, SMAs, MFCUs, Unified Program Integrity Contractors, managed care plans, and law enforcement entities routinely coordinate activities involving provider investigations and administrative actions, and more detailed and

standardized reporting would meaningfully strengthen those efforts. Modern data analytic systems also allow us to rapidly ingest and synthesize vast amounts of data and information, and in near-real time convert that to actionable intelligence.

We have also identified specific data gaps in existing reporting that limit its usefulness for program integrity purposes. The current language at § 455.17 only requires States to report on the six data elements enumerated earlier in this proposed rule. The prior reporting requirement did not consistently capture provider identifiers in a standardized format, limiting CMS' ability to cross-reference reported cases against other data sources or match investigation records across States and programs. It also does not capture the estimated or final overpayment amounts associated with investigated cases, limiting CMS' ability to evaluate the financial impact of fraud and abuse activity or assess the effectiveness of State investigative efforts. Finally, the prior reporting requirement does not capture administrative actions taken by SMAs (such as provider terminations, payment suspensions, and overpayment recovery actions) separately from law enforcement dispositions, limiting CMS' visibility into the full range of program integrity actions States are taking in response to identified fraud and abuse.

To address these issues, we propose to revise § 455.17 to modernize Medicaid fraud and abuse reporting requirements and improve the usefulness of information reported to CMS. Consistent with the existing scope of § 455.17, these proposed revisions would apply only to suspected provider fraud and abuse cases and would not extend reporting requirements to beneficiary fraud and abuse cases. Specifically, we propose to amend § 455.17(b) to require States to report the following data elements for cases of suspected provider fraud and abuse that warranted a full investigation, the: (1) provider's name; (2) provider's NPI or Medicaid provider identification number if the provider is ineligible to receive an NPI under applicable Federal law; (3) provider's Employer Identification Number or Taxpayer Identification Number (EIN/TIN), if available; (4) State in which the investigation is being conducted; (5) source of the complaint; (6) type of provider; (7) type of service involved; (8) nature of the complaint; (9) payor (for example, Medicaid fee-for-service or managed care); (10) relevant claim dates; (11) approximate time period covered by the investigation; (12) estimated overpayment amount; (13) final over payment amount where a final determination has been made; (14) investigation status; and (15) legal and administrative disposition of the case, including actions taken by law enforcement and administrative actions taken by the State Medicaid agency, such as provider termination, payment suspension (including good cause exceptions identified under § 455.23), and overpayment recovery status.

We also propose to renumber the existing § 455.17(b)(6) and expand is scope to include additional reporting options to expand the reporting options for include the disposition of the case to include administrative actions taken by the SMA, including provider termination, payment suspension (including good cause exceptions identified under § 455.23), and overpayment recovery status, in addition to the existing requirement to report actions taken by law enforcement.

We believe these changes would meaningfully improve CMS' nationwide visibility into program integrity activities, facilitate trend analysis, improve coordination among Federal and State oversight entities, and support evaluation of program integrity outcomes. We also believe these enhanced reporting requirements would strengthen States' ability to meet their responsibilities relating to fraud and abuse reporting, oversight, and data analysis under section 1902(a)(64) of the Act. We also specifically seek comment on the operational feasibility of the proposed data elements, whether additional data elements should be included, and the timeframe States would need to come into compliance with the revised reporting requirements.

F. Deregulation of the Medicaid Eligibility Quality Control (MEQC) Program

On July 5, 2017, we published a final regulation entitled Changes to the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) Programs (82 FR 31158). This final rule updated the PERM and MEQC programs based on the changes to Medicaid and CHIP eligibility requirements under the Affordable Care Act. Those regulations restructured the MEQC program into an ongoing series of pilots that States are required to conduct during the two off years between triennial PERM review years, aiming to reduce repeat errors during the next PERM review.[36] The restructured MEQC program was designed to complement the PERM program by giving States [37] an opportunity to improve the quality, accuracy, and timeliness of their Medicaid and CHIP eligibility determinations before their next PERM measurement, helping ensure they make accurate and timely eligibility determinations so that Medicaid and CHIP services are appropriately provided to eligible individuals. States can use the MEQC pilots to address error-prone areas identified during past PERM reviews and prepare for upcoming triennial PERM reviews, but, importantly, MEQC requires States to conduct reviews of negative Medicaid and CHIP eligibility determinations (individuals denied or terminated from Medicaid and CHIP) whereas PERM reviews only paid claims related to active cases (individuals eligible for and enrolled in Medicaid and CHIP). During the States' MEQC review year, States are required to review at least 400 active cases and a minimum of 200 Medicaid and 200 CHIP negative cases, with flexibility to focus on vulnerable or error-prone areas. This approach allows States to assess the complete enrollment process to determine if any terminations or denials were improper.

CMS oversees the MEQC program and ensures that States implement its requirements specified at § 431.800 through § 431.820. Following the conclusion of the pilot, States must submit to CMS detailed case-level reports on the case review findings and a CAP to address all the identified errors and deficiencies. The MEQC pilots do not generate an eligibility improper payment rate, but instead allow States to implement corrective actions before their next PERM eligibility improper payment rate measurement.[38] In addition, under current regulations, participation in and compliance with the MEQC program is required for a State to qualify for a good faith waiver

[36] Under the PERM requirements at 42 CFR 431 Subpart Q, the PERM program annually measures the national Medicaid and CHIP improper payment rates using a 17-State 3-year rotation process. The national Medicaid improper payment rate includes findings from the most recent three cycle measurements so that all States are captured in one rate. As such, each State is reviewed once every 3 years, and the year in which a State is measured is known as its ''PERM year.'' A State is not required to conduct a MEQC pilot during its PERM year. When a State is not under PERM review (that is, in the 2-year interval between a State's PERM review cycles), the State is required to conduct MEQC activities, including one (1) 12-month MEQC pilot. We refer to this 2-year interval between PERM review periods as PERM ''off-years.''

[37] States defined as the 50 States, District of Columbia, and the Commonwealth of Puerto Rico; *https://www.medicaid.gov/medicaid/eligibility/downloads/meqc-updated-phase1-guidance-05132021.pdf.*

[38] For more information on the traditional MEQC program, *see generally,* 82 FR 31158.

of the disallowance should their eligibility improper payment error rate exceed the 3 percent statutory threshold.[39]

Notwithstanding our well-meaning efforts around MEQC program design and the benefits we aimed for States to achieve, our longtime experience with it has demonstrated that its significant CMS and State administrative burden has substantially outweighed its benefits. MEQC pilots have not effectively reduced PERM eligibility improper payment rates. For example, overall Medicaid and CHIP eligibility improper payment rates increased during review years 2019 through 2021 (8.36 percent to 16.62 percent, and 23.53 percent to 28.71 percent, respectively).[40]

The MEQC program is largely a State-led audit process, with States developing the case sampling and review methodologies, and determining, based on their own interpretations of Federal regulations and State policy, whether findings represent errors or technical deficiencies.

That system has not enabled CMS to render significant oversight, and we have limited ability to require States to target known areas of risk and ensure meaningful corrective action. More specifically, we currently have limited authority to direct MEQC case reviews to proactively target emerging or known high-risk areas in a State; ensure consistent application of Federal standards across State case reviews; or ensure that States properly calculate, quantify, and report confirmed overpayments, including estimated FFP. Furthermore, under § 431.812(b)(3)(ii), we may direct a State to perform focused reviews only if the State's PERM eligibility improper payment rate exceeds the 3 percent national standard for two consecutive PERM cycles.

MEQC regulations require States to provide updates on corrective actions reported for the previous MEQC pilot, but the current MEQC program design makes comprehensive oversight of those CAPs challenging. For example, should a CAP not adequately address a previously identified error, we may not become aware of this until the next MEQC or triennial PERM cycle. Also, the MEQC and PERM programs have often proved to be largely duplicative in both the errors identified and the associated corrective actions. States often rely on the same staff to administer their MEQC program and cooperate with CMS contractors and staff during PERM reviews. The labor-intensive nature of addressing findings may require States to temporarily pause MEQC work to appeal/dispute PERM findings. This overlap increases administrative burden, particularly for States balancing limited resources and staff. In fact, States have reported that limited State funding and competing priorities have, in some cases, resulted in State eligibility system errors remaining unaddressed in subsequent MEQC and PERM reviews. Additionally, the PERM and MEQC measurement cycles do not effectively align to enable States to test PERM CAP mitigation interventions during MEQC reviews before the State's next PERM review.

Although the MEQC payment review process allows us the limited ability to recover FFP associated with certain overpayments arising out of erroneous eligibility determinations, such recoveries have been minimal. Consistent with § 431.812, our May 13, 2021 MEQC guidance specifies that States must report and return the Federal share of any self-identified overpayment(s) that occurred for paid claims with dates of service in the first 3 months after the effective date of eligibility that was triggered by an identified erroneous eligibility determination.[41] This State-driven process has led to limited overpayment recoveries from the MEQC pilots and a lack of effective oversight of the accuracy of States' self-reported overpayment amounts. Also, section 1903(u) of the Act sets a 3 percent allowable threshold for program-wide eligibility improper payment rates in any full fiscal year after 1983, and specifies that the Secretary is generally required to disallow payments to States with respect to the amount of erroneous excess payments above that threshold.[42] However, the Secretary has the authority to waive all or part of the disallowance of FFP should a State be unable to reach the 3 percent allowable threshold despite a good faith effort to reduce its eligibility improper payment rate. As stated above, under current regulations, participation in and compliance with the MEQC program is required for a State to qualify for a good faith waiver of the disallowance should their eligibility improper payment error rate exceed this 3 percent statutory threshold. This is a relatively low bar that allows States to easily avoid disallowances, even if their improper payment rate for eligibility errors is well above 3 percent. In fact, to date, we have granted good faith waivers from disallowances to every State that had an eligibility improper payment rate measured through the PERM program above the 3 percent allowable threshold.

Given the program limitations and persistent beneficiary eligibility errors described previously, we do not believe that proposing changes to the MEQC regulations would effectively strengthen our beneficiary eligibility oversight efforts. Instead, to address inefficiencies and reduce burden—and as a part of an enhanced strategy to promote more robust and effective program integrity oversight of Medicaid and CHIP beneficiary eligibility determinations—we propose to deregulate (that is, eliminate) the MEQC program at §§ 431.800 through 431.820 and, separately, to codify a new audit and disallowance strategy that we describe in sections III.G. and III.H. of this proposed rule. We propose to phase out the MEQC program over the course of 3 years following publication of the final rule. We will ensure there is no overlap between PERM and beneficiary eligibility audits for purposes of disallowances in a given year. We propose that the section 1903(u) disallowance authority would be applicable under the eligibility audit program instead of PERM, starting on July 1, 2027, before the next PERM cycle begins (RY 2029). The MEQC payment review process for over and underpayments will continue to operate under current regulations § 431.812 (e) until the program is phased out for each review cycle. For the MEQC program, current good faith effort regulatory criteria would be applied until the proposed § 455.804 becomes effective. At that point MEQC participation would no longer be a factor in States receiving a good faith effort waiver from disallowance. Starting July 1, 2027, PERM CAPs would remain part of the good faith waiver criteria (under new 455.804) but disallowances would no longer by determined by the PERM program. Processes related to the other components of PERM (managed care and fee-for-service) would remain unchanged. The good faith waiver criteria in proposed § 455.804 would be applicable for disallowances arising under proposed § 455.802 once the MEQC program is phased out, should our proposals be finalized as proposed. Because the MEQC program would no

[39] § 431.1010 outlines the Secretary's authority to issue disallowances for certain eligibility-related overpayments.

[40] *https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm/perm-error-rate-findings-and-reports.*

[41] *https://www.medicaid.gov/medicaid/eligibility/downloads/meqc-updated-phase1-guidance-05132021.pdf.*

[42] Section 1903(u) of the Act does not apply to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

longer exist, MEQC participation could no longer be included as a criterion for determining a good faith waiver.

We propose to deregulate the MEQC program in phases to ensure States would have adequate transition time to unwind from a longstanding program. Should this proposal be finalized, we anticipate that we would release additional information through sub-regulatory guidance that would provide further operational details for each 17-State MEQC cycle. We propose to remove §§ 431.800 through 431.820 from the Code of Federal Regulations at the conclusion of the phase-out period, with an effective end date 3 years after the publication of the final rule is published. We seek comment on this proposal to deregulate the MEQC program.

G. Medicaid and CHIP Beneficiary Eligibility Audit Program

Beneficiary eligibility determination errors account for a significant percentage of Medicaid and CHIP improper payments. In FY 2025, these errors represented approximately 72 percent and 73 percent of Medicaid and CHIP improper payments, respectively, totaling an estimated $27 billion in projected Federal Medicaid improper payments and $1 billion in projected CHIP improper payments.[43] One way that we currently address this challenge is through beneficiary eligibility audits, which are CMS audits of States' Medicaid and CHIP beneficiary eligibility determinations. These audits, which are separate from PERM eligibility reviews and MEQC pilots, provide us with enhanced oversight of States' eligibility determination processes and enable us to offer recommendations to prospectively improve the accuracy of States' eligibility determinations.

We conducted beneficiary eligibility audits across seven States from 2019 to 2022 to verify States' compliance with Federal and State eligibility requirements.[44] The primary objective was identifying whether the selected States correctly determined Medicaid or CHIP eligibility at the point of application or renewal and claimed the appropriate FMAP. We reviewed States' eligibility determinations for sampled beneficiaries to assess compliance with Medicaid eligibility requirements under 42 CFR part 435 and where applicable, CHIP eligibility requirements under 42 CFR part 457.[45] Those Medicaid and CHIP beneficiary eligibility audits revealed significant State errors leading to frequent inaccurate beneficiary eligibility determinations and identified substantial estimated potential overpayments. Because statutory and regulatory provisions limited our ability to recover FFP associated with eligibility-related overpayments,[46] the audit focus was providing States with best practices to improve eligibility determination processes. For example, across the seven States audited, we identified $2.9 million in sampled overpayments associated with ineligible beneficiaries, which could be extrapolated to $231 million in potential overpayments for the universe sampled; as discussed in greater detail in section H of this proposed rule, we lacked the statutory and regulatory authority to recover those funds. These audits found that eligibility errors were largely attributable to caseworker and system errors, including States determining individuals to be ineligible but continuing to pay claims; incorrectly calculating income when determining eligibility; failing to verify income or resources; placing beneficiaries in incorrect eligibility categories; or not conducting required annual renewals.

Because of MEQC's limitations described in section F of this proposed rule and the need to strengthen oversight of Medicaid and CHIP beneficiary eligibility determinations, we propose to codify the Medicaid and CHIP beneficiary eligibility audits. These audits would help us better understand States' eligibility determination processes to better enable us to offer States recommendations and technical assistance to prospectively improve their eligibility determinations and, where appropriate, effect recoveries consistent with the requirements of section 1903(u) of the Act. These audits would be distinct from, and operate independently of, PERM eligibility reviews, with separate processes and purposes.[47] For example, these proposed eligibility audits would differ from PERM eligibility reviews in that they would not include the sampling and review of paid claims, but, instead, the sampling frame would consist of Medicaid and CHIP beneficiaries and applicants. Specifically, the sampling frame of enrolled Medicaid and CHIP beneficiaries would include those on whose behalf the State made Medicaid and CHIP payments for services during the audit period.

As opposed to State-run MEQC pilots that, as we explained, have not significantly reduced eligibility errors, our proposed expanded beneficiary eligibility audits would provide direct Federal oversight of States' Medicaid and CHIP beneficiary eligibility determinations. Because CMS and its contractors would conduct these Medicaid and CHIP beneficiary eligibility audits, we expect States to have reduced administrative burden compared to the MEQC program. The Secretary, acting through CMS, is authorized by the Medicaid Integrity Program (MIP) at section 1936 of the Act to enter into contracts with eligible entities to carry out specific Medicaid oversight activities. Consistent with MIP provisions, States would be required to cooperate with CMS' contractors during the beneficiary eligibility audit process just as they are obligated to engage with CMS contractors during all Medicaid program integrity audits or reviews supporting MIP oversight efforts.

We are proposing to codify a regulatory structure for these Medicaid and CHIP beneficiary eligibility audits ensuring they would be consistent with the requirements of section 1903(u) of the Act and that would, in certain circumstances and as described in more detail in section III.H. of this proposed rule, permit us to pursue potential disallowances of FFP from States for overpayments identified in such audits. Previously, such disallowances were effectuated pursuant to the PERM program. We propose in section H of this proposed rule that we would issue eligibility-related disallowances in accordance with section 1903(u) of the Act for Medicaid and section 2105(e) of the Act for CHIP pursuant to these new

[43] 2025 Medicaid and CHIP Supplemental Improper Payment Data. *https://www.cms.gov/files/document/2025-medicaid-chip-supplemental-improper-payment-data.pdf.*

[44] The eligibility audit reports are available on *CMS.gov* on the *Reports & Guidance* web page at: *https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity/reports-guidance.* Eligibility audits were previously conducted in New York, Kentucky, Louisiana, Pennsylvania, Connecticut, Kansas, and Missouri. The audit target population varied across States, with three audits focusing on the Medicaid adult expansion population and four audits covering beneficiaries enrolled in the general Medicaid population, Medicaid adult expansion population, and CHIP.

[45] Individual cases were selected from a stratified random sample of beneficiaries whose eligibility was determined or redetermined during the audit period.

[46] The PERM program is used to implement section 1903(u) of the Act, and therefore, is currently the only mechanism for CMS to recover identified eligibility-related overpayments in Medicaid.

[47] The PERM program measures the national Medicaid and CHIP improper payment rates through reviews of State's FFS, managed care, and eligibility components to comply with the Payment Integrity Information Act of 2019 (PIIA; Pub. L. 116–117). Additionally, PERM eligibility reviews currently measure eligibility improper payment rates in accordance with section 1903(u) of the Act. Each State is reviewed every 3 years, with 17–18 States reviewed annually.

beneficiary eligibility audits. Additionally, to improve our oversight effectiveness, we propose explicit regulatory authority by which we could require States to submit and implement CAPs to address eligibility errors identified during these audits to help them comply with Federal requirements.

Improper payment rates reported under the Payment Integrity Information Act of 2019 (PIIA) [48] would continue to be determined solely through PERM reviews, which occur on a routine triennial cycle covering 17–18 States each year and enable the calculation of a national improper payment rate. Conversely, the proposed Medicaid and CHIP beneficiary eligibility audits would prioritize high-risk States identified using a risk formula, though also ensuring that each State would undergo an eligibility audit at least once every 5 years.[49] Assuming our proposals are finalized as proposed, we would articulate more information on the risk formula and the specific audit cadence via future sub-regulatory guidance. We believe that the PERM program, with its triennial cycle, is more appropriate for ongoing measurement of the national Medicaid and CHIP improper payment rates than the proposed eligibility audits, which, on average, would have longer intervals between audits.

The proposed eligibility audit process would allow CMS to review States' eligibility determinations with respect to individuals who are actively enrolled in or were denied enrollment or disenrolled from Medicaid or CHIP. Each beneficiary eligibility audit would include four statistically valid samples, two samples of active cases defined as individuals enrolled in Medicaid or CHIP, and two samples of negative cases defined as individuals who had been denied enrollment in or disenrolled from Medicaid or CHIP. Specifically, each audit would include a sample of active Medicaid cases, active CHIP cases, negative Medicaid cases, and negative CHIP cases. Any inaccurate eligibility determinations and deficiencies in documentation identified for sampled individuals would be reported to the State as soon as possible during the audit period to enable State correction and potential clarification. Notably, a beneficiary is entitled to Medicaid benefits unless and until a SMA determines them ineligible and provides advance notice of the termination and fair hearing rights.[50] Thus States would still be required to follow established procedures before disenrolling beneficiaries from Medicaid or CHIP due to audit findings. This proposed approach, coupled with the disallowance authority described in section H of this proposed rule, would provide us with greater oversight of Medicaid and CHIP beneficiary eligibility determinations, including State processes and the steps that States take to address any identified vulnerabilities.

This proposed rule would establish the requirements and procedures for the CMS Medicaid and CHIP beneficiary eligibility audits. Specifically, we propose to amend part 455 by establishing a new subpart H (§ 455.700, *et seq.*), titled Medicaid and CHIP Beneficiary Eligibility Audit Program. For any Medicaid and CHIP beneficiary eligibility audits that may result in a disallowance of FFP, we propose that part 455, subpart H would apply to audits initiated after the completion of the PERM review period that is underway as of the effective date of the final rule (60 days after the publication).

Proposed § 455.700 would be authorized by sections 1903(u), 2105(e), and 1936 of the Act and articulate the basis and scope of these beneficiary eligibility audits aimed at reducing eligibility errors. We propose that during these audits, we would review States' Medicaid and CHIP eligibility processes and policies, and the appropriateness of eligibility determinations for sampled cases. Should our proposals be finalized as proposed, States would be required to participate when selected for an audit. To promote clarity and ensure consistent application of requirements, at § 455.702 we propose to define the following terms for purposes of this subpart: ''corrective action,'' ''eligibility,'' ''eligibility audit,'' ''eligibility determination,'' ''eligibility error,'' ''erroneous excess payments for medical assistance,'' and ''observation.'' ''Eligibility'' would be defined as meeting the State's categorical, financial, and non-financial criteria for receipt of benefits under the Medicaid or CHIP programs. ''Eligibility audit'' would be defined as a CMS and Federal contractor conducted, primarily risk-based, audit of States' Medicaid and CHIP point of application or renewal eligibility determinations, designed to verify compliance with Federal and State eligibility requirements, reduce eligibility errors, and assist States in improving their eligibility determination processes. ''Eligibility determination'' would be defined with the same meaning as at § 435.4 for Medicaid and § 457.301 for CHIP, an approval or denial of eligibility in accordance with § 435.911 or § 457.340, as well as a renewal or termination in accordance with § 435.916 or § 457.344. ''Eligibility error'' would be defined as an error resulting from the State's improper application of Federal or State requirements, causing an improper beneficiary eligibility determination. For purposes of this definition, an eligibility error could include, but would not be limited to, authorizing an ineligible individual as eligible when they received services, providing certain ineligible services to an otherwise eligible individual, improperly denying an individual's Medicaid or CHIP application, improperly terminating a beneficiary from Medicaid or CHIP, or enrolling in managed care an individual ineligible for managed care. ''Erroneous excess payments for medical assistance'' for purposes of these proposed eligibility audits would be defined as the term is defined in section 1903(u)(1)(D)(i) of the Act to mean the total of payments under the State plan (or waiver of such plan) with respect to ineligible individuals and families, and overpayments on behalf of eligible individuals and families by reason of errors in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.[51] To comport with section 1903(u)(1)(D)(i) of the Act, only those erroneous payments meeting this definition would be factored into determining a State's error rates for purposes of potential disallowance arising from these audits, and thus any resulting disallowance amount. ''Observation'' would be defined as an instance where a beneficiary's or applicant's eligibility was correctly determined notwithstanding the State failing to follow Federal and State eligibility requirements. For example, an observation could occur where a State incorrectly calculated a beneficiary's income, but even when correctly calculated the beneficiary's income remained under the applicable income limit for Medicaid or CHIP coverage. ''Corrective action'' would be defined as a specific action that a State would be required to implement to

[48] Public Law 116–117 (2020).

[49] As section 1903(u) does not apply to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa, the territories are excluded from the proposed eligibility audit cadence and risk-based selection methodology.

[50] §§ 435.917, 435.918, 435.930(b) and part 431, subpart E.

[51] Effective beginning in FY 2030, section 71106 of the WFTC legislation revised the definition for ''erroneous excess payments for medical assistance'' in section 1903(u)(D)(i) of the Act. Proximate to the effective date of the revised language we plan to do additional rulemaking to update the definition in § 455.702.

address identified eligibility errors to achieve compliance with Federal requirements and Medicaid and CHIP State plans (or waiver of such plans). Corrective actions would only be required for eligibility errors identified during the beneficiary eligibility audit, not for standalone observations, and would be required regardless of whether the eligibility error had an associated erroneous excess payment amount.

At § 455.704, we propose the general requirements for Medicaid and CHIP beneficiary eligibility audits. Consistent with standard CMS audit practices, we propose that a State would be required to participate in an eligibility audit upon notification that we were going to conduct such an audit, though allowing for limited exceptions for rare cases where a State could demonstrate experiencing extraordinary circumstances beyond the State agency's control making audit participation impracticable during the applicable fiscal year audit period. Every State would undergo a beneficiary eligibility audit at least once every 5 years. As discussed, more information on the specific audit cadence would prospectively be made available through sub-regulatory guidance. Outside of the audit cadence, we would prioritize States with Medicaid and CHIP programs determined to be at high-risk for eligibility errors for more frequent beneficiary eligibility audits, enabling us to focus our resources on States where eligibility errors were more likely to occur and reduce the burden on States consistently compliant with Federal and State requirements. We would identify for audit States at heightened risk for eligibility errors by conducting risk-based analyses informed by findings and data from sources including, but not limited to, prior PERM eligibility reviews, HHS–OIG audits, prior Medicaid and CHIP beneficiary eligibility audits, U.S. Government Accountability Office (GAO) reports, State Auditor reports, State-reported data, data analytics, and results from other ongoing CMS Medicaid and CHIP beneficiary eligibility oversight work. Our risk-based analyses would apply varying weights using a point system based on the risk associated with States making eligibility errors to the metrics drawn from such sources. This risk formula would assign each State a risk score, enabling us to compare States based on the number of risk points received and prioritize for audit those with the highest risk scores beyond the minimum 5-year audit cadence. The risk formula would be reviewed and updated annually by CMS to reflect change in any recent Federal Medicaid and CHIP eligibility laws or regulations. The same risk formula would be continually applied in a given year to identify States to prioritize for audit, while we would exclude those already being audited pursuant to the established cadence. In limited circumstances, we propose that we could select a State for audit regardless of its annual risk score were we to receive credible information regarding eligibility issues occurring in that State requiring immediate oversight action. Sources of such credible information could include HHS–OIG audits and investigations, referrals, and other beneficiary eligibility oversight work conducted by CMS.

CMS would issue an engagement letter to the Medicaid director of a State selected for audit that specifies the audit objectives, scope, applicable disallowance authorities, data and documentation request, and corresponding data and documentation submission due dates. Pursuant to proposed § 455.704(b), States would be required to: (1) provide the requested eligibility and enrollment data (that is, the audit universe data) and documentation that could include, but not be limited to State policy manuals, eligibility operations manuals, eligibility training and guidance materials, and the State's verification plan within 10 business days from the engagement letter issuance date unless granted an extension by CMS; (2) assign at least two subject matter experts (SMEs) to navigate the necessary information contained in the State's eligibility and enrollment system(s) in coordination with the auditors during the case review portion of the audit to allow CMS to verify if eligibility determinations were made in accordance with Federal and State requirements for the sampled cases; [52] (3) provide requested copies of additional eligibility case records and any other necessary documentation within 5 business days of the written request unless granted an extension by CMS; (4) respond to the draft report in writing within 10 business days, unless granted an extension by CMS, indicating whether the State agreed or disagreed with each eligibility error cited; and (5) as applicable, submit CAPs for approval that would address each identified eligibility error by the deadline specified in the final audit report. The State's designated SMEs required under § 455.704(b)(2) would participate in scheduled case review sessions with the auditors to assist with providing the necessary supporting documentation within the State's systems for each sampled case. This approach would mean that State personnel would not have to train the auditors on their systems or provide them with system credentials. Based on experience with prior eligibility audits, this approach would reduce the overall burden on CMS and the State and allow CMS to more expeditiously and accurately complete the individual case review portion of the audit and communicate identified eligibility errors to the State, allowing it to more promptly correct identified issues. Pursuant to proposed § 455.704(b)(4), for any eligibility error with which the State would disagree, the State would have to provide a detailed written explanation of the basis for disagreement and submit supporting documentation to CMS to substantiate its position.

We propose that findings from our Medicaid and CHIP beneficiary eligibility audits would be subject to potential section 1903(u) of the Act eligibility-related disallowances at new § 455.706(d). Notably, as section 1903(u) of the Act is not explicitly listed in section 2107(e) to apply to a State's CHIP in the same manner that it applies to its Medicaid program, any eligibility-related disallowances for erroneous excess payments made on behalf of CHIP beneficiaries would be pursuant to the general payment recovery authority at section 2105(e) of the Act rather than 1903(u) of the Act. However, to ensure standardization across the Medicaid and CHIP programs, using our discretionary enforcement authority, CHIP samples in audits yielding findings subject to potential disallowance would still be treated in accordance with the requirements of section 1903(u) of the Act. That would include having an audit period covering a full fiscal year, a statistically valid random active case sample drawn from all eligibility categories included in the State's CHIP program during the audit period, and the calculation of a program-wide eligibility error rate.

Accordingly, we propose to make the requirements in new part 455, subpart H (§§ 455.700 through 455.712) applicable to CHIP in the same manner as they apply to Medicaid by amending § 457.628. The same audit methodology would therefore be used for the Medicaid and CHIP samples, ensuring consistent treatment between both programs.

[52] As part of the beneficiary eligibility audit process, CMS and its Federal contractors do not request, access, or review Federal Tax Information (FTI). Where a State used FTI during an eligibility determination, we ask the State only to confirm that FTI was used and not show it to us.

Regardless of whether this proposal is finalized as proposed, we could still, as we do now, conduct other Medicaid and CHIP beneficiary audits that would not result in disallowances and that could use different audit and extrapolation methodologies. Specifically, we may, as appropriate, conduct other Medicaid and CHIP beneficiary eligibility audits that use targeted methodologies to focus on a subset of eligibility categories or only disenrolled beneficiaries.

To ensure consistent treatment across States and compliance with section 1903(u) of the Act, at § 455.706 we propose the general audit methodology would apply to all States selected for beneficiary eligibility audits and would yield findings potentially subject to disallowance. For such audits, we propose to use statistically valid methodologies to select stratified random samples from a State's eligibility categories, calculate error rates, and extrapolate eligibility error rates to the entire universes of Medicaid and CHIP beneficiaries, and at § 455.706(a) we propose to codify general sample requirements. Every beneficiary eligibility audit would include four statistically valid random samples. As specified at new § 455.706(a)(1), one sample would include individuals enrolled in Medicaid whose eligibility was determined or redetermined and on whose behalf the State made payments for services provided during the full fiscal year audit period, while the second Medicaid sample would include individuals whose eligibility was denied or terminated during the audit period. The third sample would consist of individuals enrolled in CHIP whose eligibility was determined or redetermined and on whose behalf the State made CHIP payments for services provided during the audit period, while the fourth sample would consist of individuals whose CHIP eligibility was denied or terminated during the audit period. As proposed in § 455.706(a)(2), we would obtain the Medicaid and CHIP beneficiary and applicant data and their associated Medicaid and CHIP payments from the State's Medicaid and CHIP information systems, such as the Medicaid Management Information System (MMIS). The assigned State SMEs would provide this information to CMS auditors. As proposed in § 455.706(a)(3), we would use a statistical software package to generate random numbers to select Medicaid and CHIP samples from each corresponding stratum.[53] Strata would be nested within the program (Medicaid or CHIP) and established by statisticians based on, but not limited to, eligibility category, match rate, eligibility rules, and the dollar amount the State spent on services. As proposed at new § 455.706(a)(4), audit sample sizes would be designed to support statistically valid extrapolations of individuals associated with eligibility errors and their improper payments at a 90 percent confidence level, if applicable. For the active case samples, this would include individuals who did not meet eligibility requirements yet were improperly determined eligible and enrolled in Medicaid or CHIP and their associated payments for services during the audit period. For the negative case samples, this would include individuals who met eligibility requirements yet were improperly denied or disenrolled from Medicaid or CHIP. We propose using the lower limit of a 90 percent confidence level for these eligibility audits because 90 percent is consistent with longstanding HHS–OIG and Medicare extrapolation practices and would provide a conservative estimate accounting for statistical uncertainty.[54] Furthermore, we propose using a 90 percent confidence interval with a 5 percent precision level for the beneficiary eligibility audits, instead of a 95 percent confidence interval with a 3 percent precision level like the PERM program uses, to have smaller, more manageable audit sample sizes. Using a 95 percent confidence interval could require substantially larger sample sizes if we want to achieve greater precision, which would make the audit process more burdensome for States and CMS and mean that audits would take longer to complete.

Proposed § 455.706(b) specifies that we would use statistical software to, as applicable, estimate the total number of individuals with associated eligibility errors extrapolated to the entire Medicaid and CHIP universes based on findings from the active and negative samples, and the total extrapolated amount of erroneous excess payments made on behalf of the individuals who were improperly enrolled in Medicaid or CHIP and received services during the audit period based on findings in the active samples. We anticipate that we would use RAT–STATS for this purpose, but welcome comments regarding other statistical software that could be used. The statistical software would also be used to calculate the lower limit of the 90 percent confidence interval for the estimated numbers of individuals associated with eligibility errors and, where applicable, the total value of erroneous excess payments for medical assistance, as defined in section 1903(u)(1)(D)(i) of the Act and at proposed § 455.702.

At proposed § 455.706(c), we would calculate two error rates, one rate for Medicaid and one for CHIP, using the lower limit of the 90 percent confidence interval for the total dollar amount attributable to erroneous excess payments for medical assistance during the audit period. Each error rate would be calculated by dividing the total erroneous excess payments for medical assistance in the active sample by the total dollar amount associated with all individuals in the sample. This rate would then be statistically extrapolated to represent the overall error rate of erroneous excess payments for medical assistance for the State's entire Medicaid or CHIP population during the audit period. This proposal at new § 455.706(c) would, based on the results of the beneficiary eligibility audits, establish the path for us to determine Medicaid and CHIP eligibility error rates in accordance with the requirements of section 1903(u) of the Act. We would provide additional information on the statistical methodology in future sub-regulatory guidance.

We propose to add § 455.706(d) to specify that Federal payments associated with erroneous excess payments for medical assistance during the full fiscal year audit period could be subject to an extrapolated disallowance. We would issue such a disallowance in accordance with proposed § 455.802 and follow the requirements and procedures outlined in § 430.42. We propose that the eligibility error rates established in proposed § 455.706(c) could be used to determine the disallowance amount if above the section 1903(u) of the Act statutory allowable 3 percent eligibility error rate threshold. The eligibility error rates specified in § 455.706(c) would not include identified observations as those would not be subject to disallowances because beneficiaries' and applicants' ultimate eligibility determinations would have been found to be accurate notwithstanding discerning some underlying calculation error. Our State audit engagement letter would, where applicable, include information about potential disallowances under sections 1903(u) and 2105(e) of the Act and new § 455.706(d).

[53] We currently use HHS–OIG's Office of Audit Services (OAS) statistical software package RAT–STATS for this purpose.

[54] Medicare Program Integrity Manual, Chapter 8—Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation.

We propose to add § 455.708 to clarify that protections of applicant and beneficiary information and due process rights, consistent with the provisions of 42 CFR part 431, subpart F, §§ 435.930(b), 435.917, 435.918, part 431, subpart E, and 457.1110 would apply during Medicaid and CHIP beneficiary eligibility audits. At new § 455.708(a) we propose that States would be required to safeguard applicant and beneficiary information and limit disclosures to information necessary to conduct the Medicaid and CHIP eligibility audits. We propose at § 455.708(b) that a State would be required to continue providing Medicaid benefits to eligible individuals in accordance with § 435.930(b) until it had made a final determination of ineligibility and provided advance notice and fair hearing rights.[55]

We also propose to add § 455.710 to make clear that States, upon our written request, would be required to provide CMS and its Federal contractors copies of eligibility case records for sampled cases and all available State policy and process documents related to eligibility determinations in effect during the beneficiary eligibility audit period. Requested documentation could include, but would not be limited to, State eligibility policy manuals, eligibility operations manuals, training and guidance materials, the State verification plan in effect during the audit period, and eligibility case record information that was not collected during the case review portion of the audit referenced at proposed § 455.704(b)(2).

At § 455.712, we propose that States would, as applicable, be required to submit CAPs in accordance with the proposed § 455.602 to implement corrective actions as specified in the final audit report. For each identified eligibility error, we would specify in the final report whether a corrective action was required, as we might determine in some instances that implementation of corrective action was not necessary. Examples of such latter instances might include where a State had already implemented system changes or other corrective measures after the audit period that would prevent similar eligibility errors from recurring.

Where a CAP would be required, we propose that a State's CAP submission to us would need to clearly address the identified eligibility errors and the underlying causes of those errors. Pursuant to the proposed § 455.602 discussed further in section III.J. of this proposed rule, States' CAP submissions would require CMS approval, and, once a CAP had been approved, a State would be required to make sufficient progress implementing it within the CAP's established milestone timeframes. Requiring States to submit CAPs for our approval and implement approved CAPs within a specified timeframe would help them more expeditiously attain compliance with Federal requirements and reduce the likely recurrence of similar eligibility errors.

This proposed enhanced audit framework would address the key deficiencies in the existing MEQC program that we describe in section F of this proposed rule and that form part of the basis for our proposal to deregulate that program. These proposed provisions would provide us with greater oversight of States' Medicaid and CHIP eligibility determination processes and enable us to focus additional resources on high-risk States. We seek comment on this proposed audit strategy for Medicaid and CHIP beneficiary eligibility determinations, explicitly on the proposed minimum five-year audit cadence, feasibility for SMA personnel to meet the specified audit timelines, and inclusion of CHIP cases.

H. Medicaid and CHIP Beneficiary Eligibility-Related Disallowances

Section 1903(u) of the Act sets a 3 percent allowable threshold for program-wide eligibility improper payment rates in any full fiscal year after 1983, and specifies that the Secretary is generally required to disallow payments to States with respect to the amount of erroneous excess payments above that threshold.[56] However, the Secretary has the authority to waive all or part of the disallowance of FFP should a State be unable to reach the 3 percent allowable threshold despite a good faith effort to reduce its eligibility improper payment rate.[57]

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) added section 1903(u) to the Act.[58] [59] Section 1903(u) was first implemented using the pre-existing Medicaid Quality Control (MQC) system, which was established in 1978 and reviewed the quality of eligibility determinations, third-party liability activities, and claims processing.[60] The MQC system consisted of six month sampling periods conducted by States to detect case errors, with State error rates verified using a Federal subsample.[61] The MQC system's eligibility review component became known as the MEQC program (referred to as the traditional MEQC program).[62] In 1992, the HHS Departmental Appeals Board (DAB) struck down the traditional MEQC disallowance methodology over concerns about the small sample sizes used to calculate error rates. In response, starting in 1994 we gave States the option to conduct MEQC pilots in place of traditional MEQC reviews.[63] [64] [65] States that elected to conduct MEQC pilots had their error rates frozen at the most recent traditional MEQC rate, as the pilots did not calculate error rates. Over time, most States elected to conduct pilots as they provided States with more flexibility in the review design.[66]

With the publication of the July 2017 final rule titled, ''Medicaid Program and CHIP; Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act,'' (82 FR 31158), we changed the mechanism for measuring and addressing Medicaid beneficiary eligibility errors under section 1903(u) of the Act from the MEQC to the PERM program. The codified MEQC program was revised to resemble the existing MEQC pilots, and we explained in the 2017 final rule that this would benefit States by allowing them to focus on refining and improving their eligibility determinations during the 2 off-years between PERM reviews, without using

[55] The State is required to provide advance notice and fair hearing rights in accordance with §§ 435.917–435.918 and Part 431, Subpart E.

[56] Section 1903(u) of the Act does not apply to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

[57] Under current regulations, a good faith effort means the State has taken the action it believed was needed to meet the allowable threshold and still failed to achieve that threshold. See § 431.1010(b)(2).

[58] Public Law 97–248.

[59] 42 U.S.C. 1396b: Payment to States Amendments.

[60] Medicaid Program; Reduction in Error Rate Tolerance; Medicaid Quality Control Program; Final Rule.

[61] Medicaid Program; Reduction in Error Rate Tolerance; Medicaid Quality Control Program; Final Rule.

[62] Medicaid Program; Medicaid Eligibility Quality Control (MEQC) Program Requirements; Final Rule.

[63] FY 1981 Medicaid Quality Control Disallowances, DAB No. 1332 (1992).

[64] Medicaid/CHIP Program; Medicaid Program and Children's Health Insurance Program (CHIP); Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act; Final Rule (82 FR 31158).

[65] GAO–20–157, *Medicaid Eligibility: Accuracy of Determinations and Efforts to Recoup Federal Funds Due to Errors.*

[66] Medicaid/CHIP Program; Medicaid Program and Children's Health Insurance Program (CHIP); Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act; Final Rule (CMS–6068–F).

MEQC pilot findings as a basis for payment reductions or disallowances (82 FR 31158).

Under statute and current regulations, our authority to recover the Federal share of overpayments resulting from eligibility errors is limited to those over the 3 percent error rate threshold as identified through the PERM program.[67] Even in such instances, however, section 1903(u)(1)(B) of the Act and § 431.1010(b) permit CMS to waive a disallowance should a State be unable to reach the threshold despite a good faith effort. Specifically, per § 431.1010(b)(2) a State may qualify for a good faith waiver of disallowance if it (1) participates in the MEQC program in accordance with §§ 431.800 through 431.820; and (2) implements a PERM CAP in accordance with § 431.992. Conversely, a State's failure to comply with either requirement would be considered a failure to demonstrate a good faith effort. Although there have been instances where States' calculated eligibility error rates have exceeded the 3 percent threshold, to date we have granted good faith waivers from disallowances to any such affected States.[68] Should a State not meet the good faith waiver requirements, we would reduce its FFP for medical assistance by the percentage by which the lower limit of its PERM eligibility improper payment rate exceeded the 3 percent threshold.

As discussed in section III.G. of this proposed rule, prior CMS beneficiary eligibility audits in seven States identified $231 million in potential extrapolated overpayments based on $2.9 million in sampled overpayments. When we conducted those audits, section 1903(u) of the Act was implemented solely through the PERM program and we were cognizant we would not have explicit regulatory authority to recover estimated overpayments, so we did not conduct them using methodologies designed to lead to full fiscal year disallowances under section 1903(u). As discussed in section G, we are proposing in §§ 455.700 through 455.712 to implement a Medicaid and CHIP beneficiary eligibility audit program that would operate independently from the PERM program and would be used to calculate error rates based on the total dollar amount attributable to erroneous excess payments for medical assistance and child health assistance, in a manner consistent with section 1903(u) of the Act. Accordingly, we also propose a disallowance framework for recovering overpayments identified through these eligibility audits when either the Medicaid or CHIP eligibility error rates exceeds the statutory threshold of 3 percent.

We propose to implement disallowances that meet the requirements of section 1903(u) of the Act pursuant to the proposed Medicaid and CHIP beneficiary eligibility audits that we would establish in new 42 CFR part 455, subpart H (as described in section G of this proposed rule) instead of under the PERM program established in part 431, subpart Q. We believe this approach would strengthen our ability to identify and recover erroneous excess payments and, by better holding States accountable when they make improper Medicaid and CHIP eligibility determinations, incentivize them in the first instance to make proper eligibility determinations.

We propose to remove the current PERM disallowance provision at § 431.1010 and, instead, establish comprehensive, unified eligibility-related disallowance regulations at 455 subpart I (§ 455.800, *et seq.*) that would only apply to the Medicaid and CHIP beneficiary eligibility audits proposed under 455 subpart H. We propose to use this framework to issue disallowances in compliance with the requirements of section 1903(u) of the Act and § 430.42 based on eligibility error rates calculated during the Medicaid and CHIP beneficiary eligibility audits in accordance with new § 455.706(c). We propose that the requirements in subpart I would apply to Medicaid and CHIP beneficiary eligibility audits initiated after the completion of the PERM review period that is underway as of the effective date of the final rule.

To date, we have not issued any disallowances resulting from eligibility improper payment error rates identified through the PERM program primarily because all States with error rates above the 3 percent threshold have met the good faith waiver requirements at § 431.1010(b)(2), which include, in part, participation in MEQC pilots.[69] Should our proposal be finalized as proposed, the MEQC program would, after phase out, no longer exist (see section F of this proposed rule). Accordingly, we propose to replace the existing good faith waiver framework with new criteria in new § 455.804 that would establish the process and standards by which CMS could reduce, in whole or part, eligibility-related disallowances based on a State's demonstration of a good faith effort to meet the 3 percent allowable threshold while preserving CMS' discretion to deny such a waiver in cases of systemic or persistent program integrity failures.

Under proposed § 455.802(a), we would calculate potential disallowances using the eligibility error rates derived from a Medicaid and CHIP beneficiary eligibility audit subject to disallowance, with the disallowance(s) corresponding to the audit period (that is, the full fiscal year audit period). During a beneficiary eligibility audit conducted in a fashion by which it would be susceptible to our taking a disallowance, we would calculate two error rates, one for Medicaid and one for CHIP, for the total dollar amount attributable to ''erroneous excess payments for medical assistance,'' as proposed at § 455.706(c).[70]

Under proposed § 455.802(b), we would calculate the potential Medicaid and CHIP disallowance amounts by subtracting the 3 percent allowable threshold from the lower limit of the State's error rates established in § 455.706(c), as determined through an eligibility audit subject to disallowance, and multiplying those results, if greater than zero, by the corresponding Federal share of medical assistance or child health assistance expenditures for the audit period. We propose to use the lower limit of the State's calculated error rates because that would be consistent with PERM and HHS–OIG extrapolation practices and provide reliable and conservative estimates of the true error rates accounting for statistical uncertainty. As discussed in the 2017 final rule (82 FR 31158), using the lower limit of the calculated Medicaid or CHIP error rate for disallowances would assist in ensuring there was reliable evidence that an error rate exceeded the 3 percent statutory threshold. These Medicaid and CHIP error rate calculations would result in potential extrapolated disallowance amounts consistent with section 1903(u) of the Act, and absent a good faith waiver, we would initiate disallowances in accordance with the procedures in § 430.42.

Section 1903(u)(1)(B) of the Act authorizes the Secretary to waive all or part of an eligibility-related

[67] § 431.1010.

[68] Payment reductions/disallowances were able to be issued for PERM reviews starting on and after July 1, 2020.

[69] By its terms, the 2017 PERM final rule did not allow for such disallowances until review years ending after July 1, 2020.

[70] The error rate would be calculated by dividing the total erroneous excess payments for medical assistance in the active sample by the total dollar amount associated with all beneficiaries in the sample and then statistically extrapolating this amount to determine the overall error rate of erroneous excess payments for the entire Medicaid or CHIP population.

disallowance where a State fails to achieve the statutory allowable threshold of 3 percent despite making a good faith effort to do so. Consistent with what we have articulated in prior rulemaking,[71] we believe a good faith determination should reflect both a State's efforts to establish and maintain appropriate controls before eligibility errors occur and its responsiveness after such errors are identified. As discussed, to date, we have granted good faith waivers from disallowances to every State that had an eligibility improper payment rate detected through the PERM program above the 3 percent allowable threshold. We propose to establish new good faith effort criteria, in part because one element of the current good faith waiver at § 431.1010, participation in the MEQC pilot program, is proposed to be deregulated and replaced with the Medicaid and CHIP beneficiary eligibility audit program, and because we aim to require States to take more detailed, eligibility-focused actions to be granted a good faith waiver. Accordingly, we propose in § 455.804(b) that CMS would evaluate whether a State made a good faith effort using three complementary indicators. Specifically, we would evaluate whether a State: (1) implemented all elements associated with eligibility errors in its most recent CMS-approved PERM CAP in accordance with § 431.992; (2) where applicable, submitted and made sufficient progress implementing a CMS-approved CAP under proposed § 455.712 in response to previous beneficiary eligibility audit findings; and (3) undertook additional reasonable actions to prevent, identify, or mitigate eligibility determination errors it believed were necessary to fall within the allowable 3 percent statutory threshold. We would use these complementary indicators as a comprehensive and objective framework to determine a State's good faith waiver eligibility.

Under proposed § 455.804(b)(3), CMS would evaluate whether the State undertook additional reasonable actions to prevent, identify, or mitigate eligibility determination errors based on the totality of the circumstances. Relevant considerations could include, but would not be limited to, whether the State maintained reasonable pre-existing eligibility controls; whether the same errors had been identified in previous audits or reviews; the timeliness and substance of the State's response after error identification; any corrective actions already taken; and the State's cooperation and transparency during CMS audits and reviews. We would consider these factors collectively when assessing whether the State exercised reasonable diligence to prevent and address eligibility errors beyond satisfying the CAP requirements described in proposed § 455.804(b)(1) and (2).

We also believe that including a State's implementation of the eligibility-related elements of its most recent PERM CAP in accordance with § 431.992 and, where applicable, any previous CMS-approved beneficiary eligibility audit CAP under proposed § 455.712 as indicators of a good faith effort would be appropriate and necessary because these corrective actions would represent a State's commitment to addressing eligibility errors and deficiencies identified through Federal oversight activities.

Under proposed § 455.804(c)(1), a State would, unless granted an extension by CMS, be required within 30 calendar days of CMS' issuance of a final audit report for a beneficiary eligibility audit and the associated potential disallowance amount to submit evidence demonstrating that its failure to meet the allowable threshold occurred despite a good faith effort to do so. A State could submit documentation such as policy manuals, staff training records, documentation of eligibility and enrollment system enhancements, self-audit reports, and detailed CAPs with proof of implementation and effectiveness. Should circumstances prevent a State from submitting such documentation within the proposed timeframe, it could submit a request for extension to CMS in writing and CMS could consider granting an extension commensurate with the extenuating circumstances. Pursuant to proposed § 455.804(a), CMS could grant a State a full or partial waiver based on the extent to which it demonstrated satisfaction of the proposed good faith criteria.

Under proposed § 455.804(d), CMS could determine that a State was not eligible for a good faith waiver, or was eligible for only a partial waiver, where the information and evidence available to CMS regarding the State's eligibility administration during the audit period demonstrated systemic or persistent program integrity failures inconsistent with a good faith effort to achieve the statutory allowable threshold. We believe that systemic or persistent program integrity failures may demonstrate that a State had not made a good faith effort as they indicate that known eligibility weaknesses were not abated despite prior opportunities to identify, correct, or mitigate those deficiencies. For example, CMS could consider whether similar eligibility deficiencies had been identified through previous audits, reviews, or other Federal oversight activities and if so, whether the State failed to take timely and effective corrective actions.

Proposed § 455.804(e) specifies examples of circumstances that CMS may consider in determining that a State had not demonstrated the good faith effort necessary to qualify for a full or partial waiver under section 1903(u)(1)(B) of the Act. These examples are intended to be illustrative of circumstances that may indicate systemic or persistent program integrity deficiencies but are not meant to constitute an exhaustive list or establish automatic disqualifying criteria. Such circumstances could include, but would not be limited to: repeated Medicaid and CHIP beneficiary eligibility audit or PERM findings involving the same or substantially similar errors; failure to address or implement prior CMS audit recommendations related to eligibility determination errors; known system defects, operational deficiencies, or policy weaknesses affecting eligibility determinations that remained unaddressed by the State during the audit period; or patterns of eligibility-related noncompliance identified through other Federal oversight activities, including audits, investigations, or findings by the HHS–OIG or other Federal agencies. These provisions would ensure that good faith waivers remain available for States demonstrating reasonable and proactive steps towards improving program integrity, while preserving CMS' discretion to deny a waiver or grant only a partial waiver where ongoing or unresolved deficiencies would undermine the integrity of eligibility determinations.

Proposed § 455.804(f) would establish the notification and timing requirements that would apply after CMS had made a good faith waiver determination. Under this provision, CMS would, via a single notice, notify each State with an eligibility error rate above the allowable threshold of its good faith waiver determination, including whether CMS had granted a full waiver, a partial waiver, or no waiver, and, where applicable, the amount of the disallowance. This written notification would also include the information specified in § 430.42(a), as appropriate, including notice of the State's ability to seek reconsideration or appeal under proposed § 455.806 and § 430.42. We

[71] See, for example, the previously referenced PERM rulemaking at 82 FR 31158 (''We will grant a good faith waiver only if a State both participates in the MEQC pilot program and implements PERM CAPs.'')

believe that providing States with a single written notification would promote transparency, ensure States would clearly understand the basis for CMS' determination, reduce administrative burden, and provide the information necessary to make timely and informed decisions about whether to pursue reconsideration or appeal.

Proposed § 455.806 sets forth the process by which a State could appeal a disallowance imposed under §§ 455.802 and 430.42. Under this provision, a State that disagreed with a disallowance determination could seek CMS reconsideration or appeal the decision to the DAB within 60 calendar days after receipt of the CMS' final disallowance notice. We propose that all processes outlined in § 430.42 would govern disallowances issued under this section, including the processes for notice of disallowance, reconsideration, retention of funds during the pendency of an appeal, and appeals to the DAB in accordance with 1116(e) of the Act and § 430.42.

We explicitly seek comment on this proposed eligibility-related disallowance framework and new good faith waiver criteria.

I. Payment Error Rate Measurement (PERM) Corrective Action Plans (CAPs)

The PERM program measures and reports a national improper payment rate for Medicaid and CHIP in accordance with the requirements of the PIIA, which requires government agencies to identify, report, and reduce improper payments in the government's programs and activities. The implementation guidance in Appendix C of the Office of Management and Budget (OMB) Circular No. A–123 [72] requires executive branch agency heads to review their programs and activities annually and identify those that may be susceptible to significant improper payments. For programs under our purview deemed susceptible to significant improper payments, we must obtain a statistically valid estimate of the annual amount of improper payments, implement a plan to reduce improper payments, and report annually in the Agency Financial Report. Through the measurement of three components, FFS, managed care, and eligibility, the PERM program annually yields estimates of Medicaid and CHIP improper payments via a longstanding 17-State-per-year,[73] 3-year rotation whereby each State is measured once every 3 years, not every year. All 50 States and the District of Columbia are reflected in the national Medicaid and CHIP improper payment rates from the most recent three years of measurements. In FY 2025, the Medicaid and CHIP overall improper payment rates were 6.12 percent and 7.05 percent, respectively.

We take broad steps to reduce Medicaid and CHIP improper payments at the Federal level, but Medicaid and CHIP are Federal-State partnerships and States administer their Medicaid programs, therefore bearing primary responsibility to minimize and adequately address improper payments and their root causes. States, for example, must develop and implement State-specific PERM CAPs, with the existing process described at § 431.992. In accordance with the requirements at § 431.992(a), States are required to develop a separate CAP for Medicaid and CHIP for each improper payment rate measurement. Each CAP must be designed to reduce improper payments in the respective program based on the State's analysis of the causes of improper payments in the FFS, managed care, and eligibility components. Paragraphs (a)(1) and (2) require each plan to address all errors included in the State improper payment rate and all deficiencies and, for eligibility, to evaluate whether actions intended to reduce eligibility errors will also avoid increases in improper denials.

To meet the requirements at § 431.992(b), States' CAPs are required to include, at a minimum: (1) an analysis of errors associated with improper payments, (2) the corrective actions to be implemented to address the root causes of improper payments, (3) an implementation schedule for each corrective action that must include a plan for monitoring the effectiveness of corrective actions, and (4) an evaluation of the previous PERM-related corrective actions.

To meet the requirements at § 431.992(c), a State must submit a CAP to CMS following a PERM review, and implement it no later than 90 calendar days after CMS posts its Medicaid or CHIP improper payment rates on the CMS contractor's website. Section 431.992(d) requires a State to provide CMS annually, and upon request, CAP implementation progress updates. Section 431.992(e) requires that each State with an eligibility improper payment rate over the allowable threshold of 3 percent for consecutive PERM years submit updates on the status of corrective action implementation to us every other month. Status updates must include, but are not limited to the following: (1) details on any setbacks along with an alternate corrective action or workaround; (2) actual examples of how the corrective actions have led to improvements in operations, and explanations for how the improvements will lead to a reduction in the number of errors and in the State's next PERM eligibility improper payment rate; and (3) an overall summary on the status of corrective actions, planning, and implementation that demonstrates how the corrective actions will provide the State with the ability to meet the 3 percent threshold.

As discussed previously in this proposed rule, § 431.1010 outlines the criteria States must meet to be eligible for a good faith waiver of a disallowance under section 1903(u) of the Act when a State's PERM eligibility improper payment rate exceeds the 3-percent threshold. Section § 457.628(a) applies the PERM requirements, including the good faith waiver framework to CHIP in the same manner as Medicaid. These include implementation of PERM CAPs in accordance with § 431.992 and participation in the MEQC program in accordance with subpart P (§§ 431.800 through 431.820). As discussed elsewhere in this proposed rule, we propose to replace § 431.1010 with § 455.804. The proposed § 455.804 would establish the good faith waiver framework for disallowances arising from the proposed beneficiary eligibility audits. Under proposed § 455.804(b)(1) CMS would assess whether the State implemented the eligibility-related elements of its most recent CMS approved PERM CAPs in accordance with § 431.992.

1. State Submission of a Combined Medicaid and CHIP PERM CAP

Current PERM CAP regulations at § 431.992(a) require States to develop separate CAPs for Medicaid and CHIP errors and deficiencies (§ 431.992 applies to both programs). Through our experience administering PERM CAPs and working with States throughout the CAP development and review process, we have found the separate CAP submission requirement creates inefficiencies for States and for CMS. We believe a more streamlined approach would reduce administrative burden and more effectively achieve PERM CAP goals.

[72] *https://www.whitehouse.gov/wp-content/uploads/2021/03/M-21-19.pdf.*

[73] Beginning with 2027 PERM reporting year (RY), Puerto Rico will participate in PERM's 3-year rotation used to measure improper payments. Cycle 3, including Puerto Rico, consists of 18 States (16 States, the District of Columbia, and the territory of Puerto Rico). The other two cycles consist of 17 States.

The PERM program produces separate Medicaid and CHIP improper payment rates and there may be differences between a State's Medicaid and CHIP errors. Nevertheless, we have generally found that many State errors, root causes, corrective actions, implementation activities, and evaluation methods are either identical or share sufficient commonality that could be captured in a single PERM CAP. We have long observed that in many States the same staff develop, coordinate review, clear, and submit both plans. Our current process often requires States to enter the same background information in two plans, conduct separate internal clearance processes, and respond separately to similar CMS questions on materially similar submissions.

A combined submission would allow States to complete shared administrative information once, draft common corrective actions a single time, conduct one internal clearance process rather than two sequential ones, and present related corrective actions in a coordinated manner. We acknowledge that States with fully separate Medicaid and CHIP staff may realize more modest burden reduction. For those States, the combined format would be designed so that program-specific findings and corrective actions would be presented in clearly delineated separate sections, allowing each team to identify and work within their respective program's content without having to parse an undifferentiated document. We believe this structure would preserve the benefit of a single submission while minimizing the coordination burden on States with distinct program offices.

For CMS, a single submission would streamline receipt, tracking, review, and follow-up. It would also reduce duplicative requests for information and make it easier to assess whether corrective actions are being implemented consistently across Medicaid and CHIP. A consolidated format would continue to identify Medicaid and CHIP specific findings and corrective actions in separate sections, as appropriate, so that CMS could independently evaluate compliance with the requirements applicable to each program.

We recognize the risk that a combined document could cause CMS or State staff to conflate Medicaid and CHIP requirements, findings, or corrective actions. To prevent that, the combined CAP format would require States to present Medicaid and CHIP specific findings and corrective actions in clearly labeled, separate sections. Where corrective actions would apply to both programs, States would be required to explicitly identify them as shared and confirm their applicability to each program independently. CMS reviewers would evaluate each program's section against the distinct statutory and regulatory requirements applicable to that program. We would provide States with a standardized template and accompanying guidance reinforcing that structure, and CMS staff would review combined submissions in a manner preserving independent program-level evaluation. These structural and procedural safeguards would be designed to ensure that consolidation of the submission format would not result in consolidation or confusion of the underlying program requirements. Accordingly, combining the plans would be an administrative simplification only, and would not merge, reduce, or otherwise modify the distinct statutory and regulatory obligations for Medicaid and CHIP.

We thus propose to amend § 431.992(a) to require States to submit a combined PERM CAP that would address, as applicable, Medicaid and CHIP PERM errors and deficiencies. The combined CAP would remain subject to all existing substantive requirements, including those at § 431.992(a)(1) and (2). We also propose a technical correction in paragraph (a)(1) to replace the cross-reference to § 431.960(f)(1) with § 431.960(f), which identifies the errors included in State improper payment rates.

Should our proposal be finalized as proposed, we would issue future operational guidance providing States with technical assistance for combining Medicaid and CHIP PERM CAPs, including examples.

2. Monitoring Implementation Progress and Evaluating the Effectiveness of Each Corrective Action

Current regulations at § 431.992(b)(3)(ii)(E) require that States' PERM CAPs include a plan to monitor the effectiveness of the corrective action. Under § 431.992(b)(4), States are required to submit an evaluation of the CAP from the previous measurement cycle that addresses the effectiveness of corrective actions by assessing improvements in operations, efficiencies, error rates, improper payments, and the ability to meet our assigned improper payment rate targets. In practice, we request implementation and evaluation updates from States approximately every 6 months, consistent with § 431.992(d), which requires States to provide updates at least annually, and more frequently if requested, on CAP implementation progress.

Through our experience administering the PERM CAP process, we have found that States' CAP submissions and subsequent evaluation submissions frequently fail to adequately detail how States will evaluate individual corrective actions for effectiveness and monitor implementation progress. Without a clear evaluation plan for each corrective action, we are unable to assess whether States' corrective actions are appropriately designed to address identified errors and States are unable to demonstrate measurable progress of their corrective actions over time. This limitation has resulted in recurring findings across PERM cycles, as States have implemented corrective actions that appeared responsive to identified errors but were not designed or evaluated in a manner that enabled us or the State to determine whether they were effective. Aiming to rectify that, we have issued PERM CAP guidance through templates and technical assistance, but those efforts have been inadequate to address this gap.

Accordingly, we are proposing two amendments to § 431.992(b)(3)(ii) to address these deficiencies. First, to clarify that the monitoring plan required for each corrective action must be designed to assess the progress of its implementation, not merely its effectiveness in the abstract, we propose to amend § 431.992(b)(3)(ii)(E) to read ''A monitoring plan to monitor the progress of implementation of the corrective action.'' Second, we propose to amend § 431.992(b)(3)(ii) by adding a new paragraph (F) to read: ''A plan for evaluating the effectiveness of each corrective action that includes at a minimum the following: (1) Number of samples used for each evaluation; and (2) Frequency of each evaluation.'' Codifying these requirements in regulation would ensure that they apply uniformly across all State submissions and provide CMS with a clear regulatory basis to require States to revise CAP submissions that would not include adequate monitoring or evaluation plans. We believe it essential to add these requirements to ensure that States actively measure their CAPs' effectiveness and take steps to reduce future improper payments.

The proposed prospective evaluation plan would complement the retrospective evaluation required under § 431.992(b)(4). Paragraph (b)(3)(ii)(F) would require the State to explain at the outset how it intends to evaluate each corrective action, while paragraph (b)(4) would continue to require the State to

report the results of its evaluation of the prior measurement's corrective actions. We are not proposing a separate submission or reporting process for the new evaluation plan requirement. Instead, we propose requiring this information as part of the CAP, enabling us and the State to identify any gaps early in the process. We believe this limited upfront requirement would represent the minimum information necessary to distinguish implementation monitoring from effectiveness evaluation and reduce the need for subsequent clarification and rework.

We believe that our proposals would clarify expectations, reduce administrative burden, and reinforce the intent of the PERM CAP framework of assisting States in developing, implementing, and evaluating effective corrective actions.

3. CMS Approval, Revision, Disapproval, and Implementation of State-Specific PERM CAPs

Our experience overseeing States' efforts to reduce Medicaid and CHIP improper payment rates across the PERM fee-for-service, managed care, and eligibility components has demonstrated that effective State implementation of PERM CAPs is critical to strengthening Medicaid and CHIP program integrity by identifying and addressing the root causes of improper payments. Throughout the CAP development process, we provide guidance and work collaboratively with States to strengthen their understanding of PERM findings and the underlying causes of payment errors. We also provide States guidance on how to develop specific actions aimed at eliminating or reducing major errors, error trends, and repeat errors.

Notwithstanding our guidance describing the information States should include in their PERM CAPs, the existing regulatory framework does not establish a formal CMS approval process, uniform minimum standards for determining whether each required CAP element under § 431.992 has been sufficiently addressed, or process for requiring States to revise submissions that are incomplete, insufficient, or contain information requiring revision. In administering the PERM CAP process, we have encountered submissions that did not fully address one or more required elements or provide sufficient information to evaluate whether the proposed corrective actions were appropriately targeted and capable of being assessed for effectiveness. We recognize that this variation does not necessarily reflect a lack of State commitment to reduce improper payments. States vary in their program structures, available personnel and resources, information systems, and statutory and regulatory authorities. Moreover, certain corrective actions, particularly those requiring systems or legislative changes, may take substantial time to implement. Nevertheless, absent clear regulatory authority to review and approve PERM CAPs and require revisions when necessary, we cannot consistently ensure that each CAP meets a minimum standard to support meaningful corrective action and effective Federal oversight.

Accordingly, we propose to revise § 431.992(c) to establish a uniform approval and revision process that would set a minimum floor for the completeness and sufficiency of PERM CAP submissions while preserving State flexibility to develop and implement corrective actions that are appropriate to their unique circumstances. The proposed approval process would serve the purpose of ensuring that each CAP contains adequate information to support appropriately targeted corrective actions and meaningful Federal oversight. It would also establish a consistent process for determining whether each component-specific portion was approved, still under review, or deemed disapproved. Specifically, proposed § 431.992 would govern CAP submission, review, approval, revision, and implementation, while proposed § 455.804(b)(1) would govern how CMS considers approval of the applicable eligibility portion and implementation of its corrective actions when assessing the PERM CAP condition for a good faith waiver. CMS would make these assessments separately for Medicaid and CHIP.

Under proposed § 431.992(c)(1), a State would be required to submit its combined Medicaid and CHIP CAP to CMS for approval and begin implementing corrective actions no later than 90 calendar days after CMS posts its Medicaid and CHIP improper payment rates on the CMS contractor's website. Because CMS posts both program rates on the same date, that date would start the initial submission and implementation period. This initial period is distinct from the 90-calendar day revision period that would begin with CMS' initial written notice of CAP issues under proposed § 431.992(c)(2)(i), discussed below. CMS would separately review the Medicaid and CHIP portions of the combined CAP and, within each program, separately review the eligibility and non-eligibility (fee-for-service and managed care) portions. CMS would approve each portion meeting the requirements of proposed § 431.992(a) and (b) and would notify the State in writing of each approval. CMS would follow the applicable procedures in proposed § 431.992(c)(2) before disapproving a portion. This component-specific structure would permit CMS to approve compliant portions independently and preserve separate program level review.

Under proposed § 431.992(c)(2)(i), if we determined that any portion of a State's proposed CAP failed to meet the criteria of proposed § 431.992(a) or (b), we would provide the State with an initial written notice identifying the issues in the CAP to be resolved. Such notice would include, for example, a request for additional information or other written communication clearly identifying the issues and revisions needed. The notice would identify the deadline for submission of the revisions and explain the approval and disapproval procedures applicable to that portion. For an eligibility portion, the notice would explain both the deemed disapproval rule and the exception for a timely revised portion that remains under CMS review (described below). This initial written notice would be provided to the State even in those circumstances where no separate written determination would be required for deemed disapproval. The State would be required to revise and resubmit the affected plan or program specific portion, as requested by CMS, until attaining CMS' approval.

Under proposed § 431.992(c)(2)(ii), a State would have 90 calendar days from the date of CMS' initial written notification identifying issues under paragraph (c)(2)(i) to submit a revised CAP, or affected portion of the CAP, addressing the identified issues and satisfying the applicable requirements in proposed § 431.992(a) and (b). A revised submission would not restart the 90-day revision period. CMS would work with the State during that period and communicate in writing any remaining issues identified through its review. The State would be responsible for submitting an approvable revised portion by the deadline. The pending review exception described below would protect a timely revised eligibility portion that CMS had not finished reviewing from being deemed as disapproved. We anticipate that many States would be able to obtain CAP approval well before the end of the 90-day period, and would strongly encourage that, while the full timeframe would provide additional time for States to resolve more complex issues.

- *Eligibility portions.* Under proposed § 431.992(c)(2)(iii)(A), an eligibility portion not approved by the end of the

90-calendar day revision period would be deemed disapproved for the applicable PERM year, except when CMS review of the most recent revision submitted within that period would remain pending. When the exception would not apply, deemed disapproval would occur at the end of the correction period, without separate written notice of disapproval determination. Following a deemed disapproval, States would be required to continue working toward submission of an approvable eligibility portion of the CAP that meets the applicable requirements of proposed § 431.992(a) and (b) after the 90-day period had ended. CMS' subsequent written approval would supersede the earlier deemed disapproval of that portion for the applicable PERM review year, as provided in proposed § 431.992(c)(2)(v). Such approval status would inform CMS' assessment under proposed under proposed § 455.804(b)(1).

- *Pending CMS review exception.* Under proposed § 431.992(c)(2)(iii)(B), CMS would communicate in writing when review of a timely revised eligibility portion remained pending at the correction deadline. That portion would remain under review, rather than be deemed disapproved, whether or not CMS had issued the status communication by the deadline. The status communication would neither approve nor disapprove the portion.
- *Completion of pending CMS review.* Under proposed § 431.992(c)(2)(iii)(C), CMS would approve the eligibility portion if it met the applicable requirements of proposed § 431.992(a) and (b). Otherwise, CMS would issue a written disapproval identifying the unmet requirements. The disapproval determination would take effect when CMS issued the written notice.
- *Non-eligibility portions.* Under proposed § 431.992(c)(2)(iv), fee-for-service and managed care portions would remain subject to CMS review and approval, but the eligibility-specific deemed disapproval rule would not apply. After the revision period and completion of its review, CMS would issue a written disapproval identifying the unmet requirements for any non-eligibility portion that does not meet proposed § 431.992(a) and (b). The disapproval would take effect when CMS issued the notice. The failure to obtain approval of a non-eligibility portion of the combined CAP within the 90-calendar day revision period would not affect whether the State satisfied the Medicaid and CHIP eligibility portion of the PERM CAP condition for a good faith waiver under proposed § 455.804(b)(1).
- *Continuing obligation and later approval.* Under proposed § 431.992(c)(2)(v), a State would remain required to revise and resubmit each unapproved CAP portion until CMS approval, including after the revision period or a deemed or written disapproval. This continuing obligation would apply to both eligibility and non-eligibility portions.

We also propose to clarify States' implementation obligations before and after CMS approval. Under proposed § 431.992(c)(3), a State would be required to begin implementing the corrective actions within the initial submission period and follow the implementation schedule in its most recently submitted, unapproved CAP while CMS review was pending, including during the revision period and after a disapproval unless CMS directed the State in writing to defer, modify, or discontinue a specific action. Revision or disapproval of one portion would not, by itself, require the State to restart corrective work in another portion or repeat work consistent with the approved CAP. CMS would request additional information or revisions to an affected CAP portion as necessary to address the identified issues and determine whether that portion meets the requirements of proposed § 431.992(a) and (b). This would limit requests to information needed for review while allowing changes to an action CMS finds insufficient or inappropriate.

Together, the initial written notice, defined revision period, independent approval of compliant portions, pending-review protection, and continuing revision and implementation requirements would make the process more predictable and limit unnecessary work. Deemed disapproval would apply only to eligibility portions as provided in proposed § 431.992(c)(2)(iii)(A). A timely revised eligibility portion still under review at the revision deadline would remain pending until CMS approved it or issued the written disapproval described in proposed § 431.992(c)(2)(iii)(C).

We seek comment on the proposed approval, revision, disapproval, and implementation process, including the 90-calendar-day revision period, the distinction between deemed and written disapproval, the pending-review exception and status communication, and the treatment of later approval in the good faith waiver assessment. We also seek comment on whether the requirements of § 431.992(a) and (b) provide States sufficient clarity to develop approvable CAPs. Should there be such need, we may address any such concerns through future rulemaking or the issuance of additional guidance.

4. Semi-Annual Reporting Requirements for States With an Eligibility Improper Payment Rate Above 3 Percent for Consecutive Cycles

Current PERM CAP regulations at § 431.992(e) require States with a Medicaid and/or CHIP eligibility improper payment rate over the 3 percent allowable threshold for consecutive PERM years to submit updates to CMS every other month on the status of eligibility-related corrective action implementation. Sections 431.992(e)(1) through (3) require States to provide the following information: (1) details on any setbacks along with an alternate corrective action or workaround; (2) examples of how the corrective actions have led to improvements in operations, and explanations for how the improvements will lead to a reduction in the number of errors and the State's next PERM eligibility improper payment rate; and (3) an overall summary on the status of corrective actions, planning, and implementation that demonstrates how the corrective actions will provide the State with the ability to meet the 3 percent threshold.

We have found over time that this every other month reporting cadence is excessive, as it does not permit States the necessary time to implement and evaluate corrective action effectiveness in a meaningful way. We believe we could better attain the goals of an enhanced reporting requirement while reducing State and CMS burden with a less frequent reporting cadence that would allow States longer to evaluate the effectiveness of corrective actions and report on their status and outcome.

Accordingly, we propose to implement a biannual (every 6 months) reporting requirement for States with a Medicaid and/or CHIP eligibility improper payment rate over the 3 percent allowable threshold for consecutive PERM years, which would begin 2 months after our formally approving a State's PERM CAP. We believe that new reporting cadence would be a more rational approach better reflecting operational realities within a State. We also believe that the 2-month interval before the first report needs to be submitted would provide States a reasonable period to begin implementing approved corrective actions before the first status update would be due, rather than requiring a report before implementation had meaningfully begun. We further propose to end a States' reporting obligation before we post the State's improper

payment rate for the next applicable PERM cycle, reflecting the inherent lag between the conclusion of corrective action reporting and the availability of new rate data that would determine whether the State had met the 3 percent threshold. We believe that anchoring the start and end of the reporting obligation to these two events—formal CAP approval and the posting of the next cycle's improper payment rate—would provide States an attainable timeline and avoid a reporting requirement extending into a period when new performance data would better demonstrate a State's progress than would status updates.

We recognize that States may face consecutive PERM cycles in which their eligibility improper payment rate remains over the 3 percent threshold, requiring approval of a new or updated CAP for each subsequent cycle. We propose that each such reporting window be cycle-specific, meaning that a new 6-month reporting period would begin based on CMS' approval of the CAP for that subsequent cycle, rather than treating reporting as a single continuous obligation spanning multiple PERM cycles. This approach would ensure that each reporting window would reflect the specific corrective actions approved for that cycle, and avoid confusion where a State's reporting obligations might otherwise overlap or become disconnected from the CAP actually in effect.

We also propose to clarify the scope of the required status updates when only one program would exceed the 3 percent threshold. Because § 431.992(e) would apply when a State's Medicaid and/or CHIP eligibility improper payment rate would exceed the allowable threshold, a State could exceed the threshold with respect to just one program. In such a circumstance, we propose to require that the State's status updates address only the program exceeding the threshold, irrespective whether both are out of compliance. We believe this approach would appropriately focus the reporting requirement on the program for which corrective action would be needed while avoiding the unnecessary reporting burden for a program whose improper payment rate would be within the allowable threshold. We seek comments on whether the every 6 months reporting period is an appropriate length of time or if the time period should be decreased.

J. Program Integrity CAPs

Several provisions of section 1902 of the Act address States' responsibilities related to Medicaid program integrity, including requirements concerning the proper and efficient administration of the State plan and safeguards against unnecessary utilization and inappropriate payments. Section 1936 of the Act established the MIP, authorizing the Secretary to contract with eligible entities to conduct audits, investigations, education, and training in support of State anti-fraud efforts. Through these authorities, CMS conducts audits of various areas of risk or vulnerability, including State program integrity audits of high-risk service areas, beneficiary eligibility audits, and Medical Loss Ratio (MLR) audits, all of which may result in findings and recommendations requiring States to take specific corrective actions. Currently, when a program integrity audit identifies a State as out of compliance with Federal Medicaid requirements, CMS issues a final audit report describing the findings of noncompliance and recommended corrective actions for the State to address and correct the identified deficiencies. As part of such CMS oversight activities, we often request that States develop and submit CAPs to address identified findings. CMS also works collaboratively with States to provide technical assistance and education, including through the Medicaid Integrity Institute (MII), and works with States to develop and oversee their CAPs at the conclusion of PERM reviews.

Despite our robust Medicaid and CHIP oversight and continuous improvement efforts, we continue to identify recurring State program integrity operation errors that manifest in repeat audit findings.[74] For example, our State Program Integrity Audits have historically assessed States' compliance with Federal Medicaid FFS (part 455, subparts A to F) and managed care (part 438, subparts A to K) program integrity standards. Even in States that have previously developed and implemented CAPs, too often these State Program Integrity Audits identify significant and repeat findings. Common areas of regulatory non-compliance include managed care contract compliance, high-risk provider identification, lapses in conducting independent audits, managed care overpayment reporting requirements, payment suspension policies/procedures, and verification of beneficiary services. In addition, we have encountered challenges obtaining timely and complete corrective action from States following State Program Integrity Audits. For example, States have sometimes failed to submit or revise CAPs in a timely fashion, provide requested information regarding implementation progress, or meet timelines established through the audit follow-up process. Our existing regulations do not establish a uniform mechanism for requiring and overseeing CAPs in such situations. Recurring audit findings, particularly when States fail to adequately take corrective action, underscore our need for a clearer and more consistent regulatory framework defining State obligations to develop and implement CAPs in response to CMS audit findings and providing specific regulatory requirements against which to assess States' compliance.

Accordingly, pursuant to the Secretary's general rulemaking authority under section 1102 of the Act and the Medicaid administrative authority under section 1902(a)(4) of the Act, we propose to establish standardized regulatory requirements governing program integrity CAPs to ensure that States identify and address programmatic vulnerabilities and findings of regulatory non-compliance identified through CMS oversight activities. Specifically, we propose to amend 42 CFR part 455 by adding a new subpart G (§ 455.600, *et seq.*), titled Requirements for Program Integrity Corrective Action Plans. These proposed requirements would be intended to promote greater consistency, transparency, and accountability in how States identify and correct deficiencies identified in the Medicaid program through CMS program integrity oversight activities. The proposals in this Subpart would apply exclusively to Medicaid; CHIP corrective action would continue to be governed by applicable provisions of part 457.

We propose to add a new § 455.602 establishing standardized requirements governing Program Integrity CAPs, including when a CAP would be required, the information it would be required to contain, CMS review and approval procedures, and State implementation and monitoring responsibilities. Under proposed § 455.602(a), when a CMS State Program Integrity Audit identifies Medicaid statutory or regulatory requirement noncompliance, our final audit report would identify the findings, if any, for which the State would be required to develop a Program Integrity CAP. Not every finding of noncompliance in every audit would necessarily require a CAP.

[74] CMS' State Program Integrity Review reports are available on the CMS website, here: *https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.*

For example, we may determine that a CAP is unnecessary when a State demonstrates that it has fully corrected the identified deficiency before issuance of the final audit report and no further corrective action or monitoring is necessary to bring the State into and maintain compliance with the applicable Federal requirement. Where we would determine that a CAP was necessary for one or more findings, our final audit report would identify those findings and the State would be required to develop a single program integrity CAP addressing each finding for which corrective action was required.

We propose in new § 455.602(b) to define four criteria that States would have to include in each Program Integrity CAP and that would serve as a basis for us to evaluate its appropriateness. Satisfying these four criteria would be necessary to ensure that implementation of the Program Integrity CAP could meaningfully and effectively mitigate the identified program integrity risks, with the ultimate goal of reducing future Medicaid improper payments and fraud, waste, and abuse. Similar to the PERM CAP requirements specified at § 431.992(b), we propose at § 455.602(b) that each program integrity CAP would be required to include the following elements: (1) a root cause analysis to identify the specific programmatic causes to which each finding of noncompliance would be attributed; (2) the specific corrective action(s) that would be implemented to address each finding of noncompliance and bring the State into compliance; (3) an implementation schedule for each corrective action that would have to include an estimated timeline for implementation, contact information for key personnel responsible for implementation, and a monitoring plan to track the status and progress of implementation of the corrective action; and (4) a plan for evaluation of the effectiveness of each corrective action and how it would rectify the finding(s) of non-compliance.

We propose at § 455.602(c) that if the final audit report requires a program integrity CAP under paragraph (a) of this section, the State would be required to submit the CAP to CMS no later than 30 calendar days after the date of the final audit report, unless we were to grant a good-cause extension. While the proposed 30-day timeframe would be shorter than the 90-day PERM CAP timeframe under § 431.992(b), the program integrity audit and review process would differ from the PERM review process as the audit and review topics would be much narrower and States would review and provide responses to draft audit reports in advance of the issuance of final audit reports. As such, we believe States would be able to submit any required program integrity CAP within 30 calendar days of the date on the final audit report. We seek comment on this proposed timeframe, including whether and in what circumstances an extension might be appropriate.

Based on our experience with implementing PERM program corrective actions and other oversight efforts, we believe a CAP approval process would strengthen the CAP framework by helping ensure that CMS and States have a shared understanding of how findings and vulnerabilities would be addressed and mitigated. We propose to include a new § 455.602(c)(1) that would require States to submit program integrity CAPs to CMS for review and approval. Should CMS determine that a submitted CAP would not adequately address the audit findings or otherwise fail to satisfy the requirements of § 455.602(b), CMS would return the CAP to the State for revision and resubmission. We believe this review process would help ensure that approved CAPs were sufficient to address the deficiencies identified in the audit.

Further, to ensure that States would satisfactorily implement and execute the actions described in their approved program integrity CAPs, we propose at new § 455.602(c)(2) that States would be required to provide updates and verify the effectiveness of their CAP implementation at every milestone deadline established in the approved CAP and upon request by CMS. We would establish that frequency in our notice of approval of the State's CAP.

Finally, we propose at § 455.602(d) to clarify that the proposed Program Integrity CAP framework would not limit, delay, or condition CMS' exercise of any administrative action otherwise authorized under Federal law. Accordingly, where the applicable requirements for another administrative action are satisfied, CMS could, as appropriate, pursue such an action before, concurrent with, or after requiring a Program Integrity CAP. For example, section 1904 of the Act authorizes the Secretary, after reasonable notice and opportunity for hearing, to withhold further payments to a State upon determining that the State plan no longer complies with the requirements of Section 1902 of the Act or that the State's administration of the plan fails to comply substantially with those requirements. Accordingly, were CMS to determine that the applicable requirements for a withholding under section 1904 of the Act and § 430.35 were satisfied, the proposed Program Integrity CAP process would not require CMS to await completion or failure of a CAP before pursuing withholding. This proposal would not expand or otherwise modify the Secretary's existing withholding authority under section 1904 of the Act, § 430.35, or any other existing authorities. We seek comment on these proposals.

K. Medicaid Fee-for-Service (FFS) Overpayment Reporting (60-Day Rule)

Section 1128J(d)(1) of the Act requires a person who has received an overpayment to report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate. The Act also requires that person to notify, in writing, the entity to which it returns the overpayment of the reason for the overpayment. Section 1128J(d)(2) of the Act requires individuals receiving overpayments under Medicaid or Medicare to report and return the overpayment by the later of (i) 60 days after the date on which the overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. Section 1128J(d)(3) of the Act specifies that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation subject to enforcement under the False Claims Act (FCA) (as defined in 31 U.S.C. 3729(b)(3)). Under section 1128J(d)(4)(C)(i) of the Act, the term ''person'' refers to any provider of services, supplier, Medicaid managed care organization, Medicare Advantage organization, or Prescription Drug Plan sponsor. Section 1128J(d)(4)(C)(ii) of the Act excludes beneficiaries from the definition of person.

Section 1903(d)(2) of the Act and § 433.312 outline States' obligations, with certain exceptions, to return the FFP associated with provider overpayments within a specified timeframe, regardless of whether they have successfully recovered those overpayments. This regulatory framework ensures State accountability and the appropriate management of Federal funds.

This proposed rule would implement the requirements of section 1128J(d) of the Act for the reporting and returning of overpayments in Medicaid FFS, the remaining CMS program to which this statutory provision applies for which regulatory requirements have not been issued. We previously issued rules implementing the requirements of

section 1128J(d) of the Act in the Original Medicare (42 CFR part 401, subpart D), Medicare Part C & D Risk Adjustment Data (§ 422.326), Medicare Part D (§ 423.360), and Medicaid Managed Care (§ 438.608) programs. To best ensure consistent application of the same provision of law across CMS programs, these proposed policies are modeled upon the Medicare FFS regulations found at § 401.305.

Consistent with this statutory requirement that arises outside of the Medicaid Act (instead, at Title XI of the Act), this proposal would establish direct requirements on Medicaid providers (which is atypical for our Medicaid regulations) by specifying a timeframe by which a person must report and return overpayments to the State and establish a standard for when an individual has identified an overpayment. Consistent with regulations at §§ 433.320 and 433.322, our proposal would also require that States keep account of the overpayments identified and returned by providers, produce those records to us upon request, and report to us the amounts of returned overpayments to us on the CMS–64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) for purposes of adjusting the State's claims for FFP. The proposed requirements would be intended to ensure compliance with applicable statutes and protect the Medicaid program against fraud and other improper payments. To implement these requirements, we propose to create a new part 455 subpart J (§ 455.900, *et seq.*), titled Reporting and Returning of Overpayments in Medicaid Fee-for-Service. Section 1128J(d) is limited to overpayments under titles XVIII and XIX, so the requirements of this proposed rule would not apply to CHIP.

Mirroring the statutory definition, we propose at new § 455.902 to define an ''overpayment'' as any funds that a person received or retained under title XIX of the Act to which the person is not entitled under such title after applicable reconciliation. Also consistent with the statute at section 1128J(d)(4)(C), we propose to define ''person'' as a provider of services or a supplier that participates under a State plan (or waiver of such plan) established under title XIX of the Act, thus excluding Medicaid beneficiaries from the definition. Although the term 'supplier' is not commonly used in Medicaid, we propose to include it in the definition of 'person' to track the statutory language at section 1128J(d)(4)(C) of the Act.

Consistent with the statutory requirements in section 1128J(d)(1)(A) and (B) of the Act, we propose at new § 455.904(a)(1) that a person that has received an overpayment must report and return it to, and in a form and manner specified by, the State, and include a written reason for the overpayment. Similar to Original Medicare regulations at § 401.305, we propose at new § 455.904(a)(2) that a person has identified an overpayment when the person knowingly receives or retains an overpayment, and that the term ''knowingly'' has the meaning set forth in 31 U.S.C. 3729(b)(1). Specifically, under the proposed rule, a person would have identified an overpayment if they had actual knowledge of the existence of the overpayment or acted in reckless disregard or deliberate ignorance of the overpayment. This proposed standard for an ''identified overpayment'' would align with the statutory obligation in section 1128J(d)(4)(A) of the Act, which provides that the terms ''knowing'' and ''knowingly'' have the meaning given those terms at section 31 U.S.C. 3729(b)(1) of the Federal civil False Claims Act.

Also similar to Medicare FFS regulations at § 401.305(b), we propose at new § 455.904(b) that a person who has received an overpayment from a Medicaid FFS program must report and return the overpayment to the State by the later of: (i) 60 days after the date on which the overpayment was identified, or (ii) the date any corresponding cost report is due, if applicable. These proposed timeframes mirror the statutory requirements at section 1128J(d)(2) of the Act.

Additionally, we propose at new § 455.904(c)(1) that States would be required to establish a mechanism for a person to report to the State when an overpayment was identified. We also propose to specify at new § 455.904(c)(2) that States would be required to return the Federal share of the overpayments to us on the CMS–64 for purposes of adjusting the State's claims for FFP consistent with current requirements. Because overpayments are not eligible for FFP, the Federal share of any identified overpayments would need to be refunded to us and adjusted through the State's normal financial adjustment process. Under existing regulations at part 433, subpart F, and subject to limited exception, a State has 1 year from the date of discovery of an overpayment to recover or seek to recover the overpayment before the Federal share must be refunded to us, and importantly the State must refund the Federal share of the overpayment to us irrespective of whether the State has recovered the overpayment from the provider. This proposed rule would not alter these existing requirements. Similar to regulations at § 433.322, we also propose at new § 455.904(c)(3) that States would be required to maintain all records related to overpayments. We also propose at new § 455.904(d) that a person would be required to use the reporting mechanism established by the State to report and return an identified overpayment. Similar to related Original Medicare regulations, we propose that any person reporting and returning an overpayment calculated via a statistical sampling methodology and extrapolation would be required to describe that statistically valid sampling and extrapolation methodology in their report to the State, which the State would be required to maintain and make available to CMS upon request pursuant to paragraph (c)(3).

In addition, consistent with section 1128J(d)(3) of the Act, we propose at new § 455.904(e) that any overpayment retained by a person after the deadline for reporting and returning it would be considered an obligation for the purposes of the False Claims Act (FCA) at 31 U.S.C. 3729(b)(3).

Finally, we propose at new § 455.904(f) that overpayments would be required to be reported and returned to the State only if a person identifies the overpayment within 6 years of the date the overpayment was received. This limitation on the lookback period would be necessary to avoid imposing an unreasonable burden or cost on providers and would be consistent with related Original Medicare regulations at § 401.305(f). We seek comment on this lookback period and whether a longer or shorter lookback period would be more appropriate to address State-specific processes, such as whether there are claim/cost-report reopening limitations that could impact overpayments that would otherwise be required to be reported and returned.

Importantly, and notwithstanding our proposal to codify statutory requirements, Medicaid providers are, and since its enactment have been, subject to section 1128J(d) of the Act's statutory overpayment report and return provisions and could face potential FCA liability, Civil Monetary Penalties Law (CMPL) liability, and exclusion from Federal health care programs for failing to report and return an overpayment. Additionally, Medicaid FFS providers must continue to comply with States' current procedures when States identify an overpayment and issue a demand letter. Medicaid FFS providers are also

responsible for ensuring their Medicaid claims are accurate and proper and are encouraged to have effective compliance programs to avoid receiving or retaining overpayments. Should this rule be finalized as proposed, the overpayment-related requirements would be applicable to States 6 months after publication of the final rule. We invite comment on these proposals.

L. Medicaid and CHIP Managed Care Oversight Policies

1. Background

Beneficiaries enrolled in Medicaid managed care plans receive part or all of their Medicaid services from health care providers that are paid by managed care plans under contract with the State. In return, the managed care plan usually receives a per member per month (PMPM) payment, commonly referred to as a capitation payment, from the SMA for providing a specified benefit package. These are known as risk-based arrangements, where the capitation payment rate must be actuarially sound and projected to provide for all reasonable, appropriate, and attainable costs as required by the terms of the contract (438.4(a)). Managed care plans receive capitation payments, usually monthly, for each ''Medicaid-eligible enrollee'' (§ 438.3(c)(2)) regardless of whether the enrollee utilizes services that month. Capitation rates also account for certain administrative costs, including program integrity operations. States are required to specify in their contracts with managed care plans the applicable policies governing the disposition of recovered overpayments, including whether a plan may retain a recovered overpayment or must remit it to the State.[75] Those retention policies do not apply to recoveries retained under the FCA or through other Federal investigations, including other investigations by CMS and its contractors where the Federal government retains any recovered FFP.[76]

As part of our ongoing efforts to strengthen Medicaid program integrity, we have identified several risks and vulnerabilities that may contribute to Medicaid managed care overpayments. These include issues related to the definition of ''Medicaid-eligible enrollee,'' the requirements and timeframes for managed care plans to report changes in enrollee circumstances to the State, and the circumstances under which States must return the Federal share of Medicaid managed care overpayments to CMS. Having identified these issues, we propose rulemaking here to address these risk and vulnerabilities.

a. Medicaid and CHIP Eligibility Determination Requirements for Beneficiary Residency and Death

For most beneficiaries, under titles XIX and XXI of the Act and implementing regulations, Medicaid and CHIP eligibility is subject to periodic renewal, generally on an annual basis or every six months depending on eligibility category.[77] Separately, States conduct eligibility redeterminations when there is a change in a beneficiary's circumstances that may affect eligibility. For example, a beneficiary moving out of a State or dying would prompt an SMA to redetermine eligibility.[78] States may learn of such change in circumstance through a variety of sources, including Federal and State databases, another SMA, a managed care plan, or, with respect to an out-of-State move, possibly a beneficiary him or herself.

Managed care plans in Medicaid and CHIP are subject to reporting requirements under § 438.608(a)(3) to promptly notify the State when they receive information about changes in an enrollee's circumstances that may affect eligibility. Once notified, the State must redetermine the beneficiaries' eligibility, which involves multiple steps and sometimes may be a multi-month process. Based on the type of reported change, the State may require additional information from a beneficiary (or their family or representative) and must provide them with a reasonable time to respond. Should a State determine that a beneficiary is ineligible, it must provide the beneficiary advance notice and fair hearing rights as appropriate under §§ 435.917 and 918; § 435.952(d), as applicable; and Part 431 Subpart E, including the 10-day advance notice requirement in § 431.211, subject to applicable exceptions. Because the State must consider eligibility on all bases before determining ineligibility under § 435.916(f)(1) and must continue to furnish Medicaid to eligible individuals until they are found to be ineligible under § 435.930(b), the State may keep the enrollee in a managed care plan and continue to make capitation payments until the beneficiary's eligibility is terminated[79] or they are disenrolled from the plan and enrolled in the State's FFS program.

States have the option to contract with a managed care plan to cover beneficiaries in the entire State or to cover only those within a certain geographical area within the State. This creates State-specific circumstances where a change in address may impact a beneficiary's enrollment in managed care. For this reason, SMAs must clearly communicate to beneficiaries the importance of timely reporting changes in residence and must promptly act on reported changes to maintain accurate managed care enrollment and ensure that capitation payments align with applicable service area requirements when the change would trigger a redetermination of Medicaid eligibility. However, typically, moving within a State would not be considered a ''change in circumstance'' resulting in a redetermination of eligibility. However, as stated earlier, managed care enrollment may be affected by an in-State move, and therefore, may require the SMA to change a beneficiary's enrollment in a managed care plan if they are unable to access their existing provider network and covered services, or no longer live within the managed care plan's contracted service area.

States have broad flexibility to determine how they identify beneficiaries who are deceased. Currently, Federal requirements do not mandate that SMAs' eligibility systems routinely interface with a specific source to obtain death data; however, many States rely on Federal, State, or local databases that contain death data, such as State or local vital records systems. The Social Security Administration maintains a national record of death, the Death Master File (DMF), which is updated monthly with beneficiary death information. In 2024, to facilitate timely redeterminations based on death and reduce the risk of improper FFS and capitation payments, we reminded States of availability of data sources[80] that interface with the DMF and may be used to conduct regular, including monthly, matches against enrollment and payment data.[81]

[75] § 438.608(d)(1).

[76] § 438.608(d)(1)(iv).

[77] *https://www.federalregister.gov/d/2026-11094.* For the period until October 1, 2034, this IFC restores the following regulations as they existed before the 2024 Eligibility and Enrollment final rule: §§ 431.213(d), 431.231(d), 435.907, 435.911(c), 435.912, 435.916, 435.919, 457.340(d)(1), 457.344, and 457.960

[78] § 435.916(d).

[79] §§ 435.912(c)(5)(i) through (iii) (Medicaid); § 457.343 (CHIP) (incorporating § 435.916 and associated Medicaid eligibility renewal and redetermination timeliness standards).

[80] Specifically, the Enumeration Verification System (EVS), State Data Exchange (SDX), Beneficiary and Earnings Data Exchange (BENDEX), State Online Query (SOLQ), State Online Query internet (SOLQ–I), and Unemployment Insurance Query (UIQ) Type 2.

[81] CMS Guidance. ''Identifying Deceased Medicaid Enrollees.'' April 25, 2024. *https://*

Continued

In the final rule titled ''Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability'' (81 FR 27498) (''2016 Managed Care final rule''), we strengthened managed care plans' responsibilities to protect against overpayments due to enrollees' loss of Medicaid eligibility, such as through death or other changes in circumstances. Revisions made there to § 438.3(c)(2) clarified that MCOs, PIHPs, and PAHPs) may only retain capitation payments for ''Medicaid-eligible enrollees,'' which excludes deceased individuals.[82] That rule also finalized § 438.608(a)(3), which required States to include managed care contract provisions mandating that managed care plans promptly report to SMAs changes in an enrollee's circumstances—specifically death [83] or a change in residence—that may affect the enrollee's eligibility [84] to enable SMAs to promptly redetermine and, when appropriate, terminate eligibility.

The 2016 Managed Care final rule finalized § 438.608(a)(3) because we recognized that managed care plans are a valuable source for beneficiary information, such as current address and date of death.[85] We have encouraged States to increase their reliance on managed care plans for updating beneficiary information to prevent procedural terminations as they resumed normal eligibility operations following the COVID–19 Public Health Emergency (PHE).[86] [87] To mitigate the risk of beneficiaries inappropriately losing Medicaid coverage, we suggested that States consider partnering with managed care plans to verify and update beneficiary contact information, including addresses.[88] We believe many SMAs and managed care plans have sufficient experience and procedures in place to continue reporting and monitoring address changes, consistent with § 438.608(a)(3).

b. Overpayments for Ineligible Enrollees

Various CMS oversight and technical assistance efforts discussed later in this section have demonstrated that changes in residence or death are not always promptly reported to the State, preventing timely redetermination of Medicaid eligibility and, when appropriate, termination of Medicaid coverage. We also reviewed 2024 Medicaid enrollment data and estimated that an average of approximately 1.2 million Americans per month were concurrently enrolled in two or more State Medicaid or CHIP programs.[89] As a result of delays in the identification and reporting of these changes and concurrent enrollments, SMAs may continue making capitation payments for individuals who are no longer Medicaid-eligible and would not reasonably be expected to utilize any Medicaid services due to time and distance.

A 2022 HHS–OIG study on multi-State enrollment found that nearly all States made capitation payments for beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States.[90] The OIG's analysis found that in August 2019 payments were made for 208,254 concurrently-enrolled beneficiaries, generating Medicaid program costs of approximately $72.9 million for capitation payments associated with beneficiaries in one of the two concurrently enrolled States, and in August 2020 payments were made for 327,497 concurrently-enrolled beneficiaries at a cost of $117.1 million. Additionally, the OIG released a report in 2023 summarizing findings from 14 State audits that assessed death data between July 1, 2009 and December 31, 2019 where the OIG identified more than $249 million ($172 million Federal share) in unallowable Medicaid capitation payments that States made to managed care plans on behalf of deceased enrollees across 14 States. Of that, over $41 million (Federal share) remained uncollected as of November 2022.[91] [92] [93] [94] [95]

Our Federal oversight experience has identified a variety of causes for these overpayments, including limited access to death data (especially for deaths that occur outside of the State or territory), reliance on manual processes to terminate eligibility, data interface errors, and claims processing errors. To mitigate these overpayments, some SMAs have developed procedures to obtain death data directly from managed care plans, in accordance § 438.608(a)(3). For example, one State required that managed care plan provider network agreements include a requirement for providers to notify the managed care plan when they learn of an enrollee's death, which the plan then reports to the SMA. To ensure that States are timely made aware of relevant changes, § 438.608(a)(3) requires managed care plans to provide ''prompt'' reporting of these changes; however, we did not define prompt, nor did we require States to specify how notifications were to be received.

Enhanced reporting alone will not address all causes of these overpayments, which is why we believe clearer recovery provisions are also necessary. In response to reports that managed care plans were retaining capitation payments for deceased individuals, the 2016 Managed Care final rule added § 438.3(c)(2), which establishes that ''capitation payments may only be retained by the MCO, PIHP, or PAHP for Medicaid-eligible enrollees''. In the preamble, we explained that this limitation was

www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/AID/guidance-04252024.pdf.

[82] 81 FR 27537.

[83] § 438.608(a)(3)(ii).

[84] § 438.608(a)(3)(i).

[85] 81 FR 27607.

[86] CMS: ''Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations''. March 2024 Update. *https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf.*

[87] CMCS Informational Bulletin: Ensuring Eligible Children Maintain Medicaid and Children's Health Insurance Program Coverage. December 18, 2023. *https://www.medicaid.gov/federal-policy-guidance/downloads/cib12182023.pdf.*

[88] CMCS presentation of ''Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations''. March 2024 Update. *https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf.*

[89] *https://www.cms.gov/newsroom/press-releases/cms-finds-28-million-americans-potentially-enrolled-two-or-more-medicaid/aca-exchange-plans.*

[90] *Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States* (HHS–OIG A–05–20–00025). *https://oig.hhs.gov/documents/audit/7881/A-05-20-00025-Complete%20Report.pdf.*

[91] *Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths* (HHS–OIG A–04–21–09005). *https://oig.hhs.gov/documents/audit/7406/A-04-21-09005-Complete%20Report.pdf.*

[92] *Colorado made at least $3.8 million (Federal share) in unallowable capitation payments to MCOs on behalf of deceased enrollees between January 2018 and December 2020* (HHS–OIG A–07–21–05132). *https://oig.hhs.gov/documents/audit/10197/A-07-21-05132.pdf.*

[93] *Delaware made unallowable capitation payments totaling at least $4.2 million (over $3.4 million Federal share) to MCOs on behalf of the 409 deceased enrollees between calendar years 2019 and 2021.* (HHS–OIG A–03–22–00205). *https://oig.hhs.gov/documents/audit/9827/A-03-22-00205.pdf.*

[94] *Virginia made unallowable capitation payments totaling at least $21.8 million ($15.7 million Federal share) to MCOs on behalf of 12,054 deceased enrollees between calendar years 2019 and 2021.* (HHS–OIG A–03–22–00203). *https://oig.hhs.gov/documents/audit/6873/A-03-22-00203-Report%20in%20Brief.pdf.*

[95] *Puerto Rico claimed at least $6,979,822 in unallowable Federal Medicaid funds for capitation payments made on behalf of deceased enrollees between April 2018 and September 2020.* (HHS–OIG A–02–21–01005). *https://oig.hhs.gov/documents/audit/6529/A-02-21-01005-Complete%20Report.pdf.*

implicit in the existing regulation and that capitation payments are developed based on the services and populations that are authorized for Medicaid coverage and services covered under the contract between the State and managed care plans, and that capitation payments are made for Medicaid-eligible enrollees, which would not include deceased individuals or individuals who are no longer Medicaid-eligible.[96] However, as discussed previously, our audits and data analyses have demonstrated that, in some cases, SMAs continue to improperly pay capitation payments for individuals residing in another State and therefore ineligible for coverage, or were deceased.

c. WFTC Legislation (Pub. L. 119–21) and Capitation Overpayments

Beginning in FY 2026, section 71103 of the WFTC legislation appropriates funding to establish, by October 1, 2029, a system that CMS and States will use to prevent an individual from being simultaneously enrolled under the State plans (or waivers of such plans) of multiple States. States will be required to submit data to the system at least monthly and during each eligibility determination and redetermination. Currently, States continue to be required to participate with the Public Assistance Reporting Information System (PARIS) as required by § 435.945(d). States may elect whether to utilize interstate match results as part of their program integrity activities. To ensure States have more complete address information, sections 71103(a)(2)(B) and 71103(b)(2) of the WFTC legislation amend sections 1932 and 2103(f)(3) of the Act, respectively, to require that, beginning January 1, 2027, each contract under a State plan that a State has with MCOs, primary care case managers (PCCMs), PIHPs, or PAHPs include a provision requiring the entity or plan to promptly transmit to the State any address information received directly from enrollees or verified by the entity or plan directly with the enrollee.

Also, effective January 1, 2027, section 71104 of the WFTC legislation requires that States and the District of Columbia, but not territories, screen all Medicaid enrollees against the Death Master File (DMF) (or a successor system) no less than quarterly to determine whether Medicaid enrollees are deceased. States will be required to treat such information as factual, disenroll deceased beneficiaries with notice of fair hearing rights provided no later than the date of action consistent with 42 CFR part 431 subpart E, and discontinue any payments for medical assistance on the individual's behalf. Prior to the provisions of the WFTC legislation becoming effective on January 1, 2027, pursuant to eligibility verification regulations at §§ 435.945 and 435.952, SMAs are prohibited from acting on DMF data alone and must seek to independently verify a beneficiary's death prior to disenrollment. Once verified, an SMA can terminate coverage immediately, but not retroactively to the date of death and not for items or services furnished prior to death. Section 71104 of the WFTC legislation removes the requirement for additional verification beyond the DMF effective January 1, 2027; however, if an SMA determines that an individual was misidentified as deceased, the SMAs must reenroll the individual immediately and reinstate coverage retroactive to the date of disenrollment.

2. Proposed Policies

a. Standard Contract Requirements Relating to Capitation Payments Retention

Authority for the contracting requirements at § 438.3 is based on section 1903(m)(2)(A)(iii) of the Act (for MCOs) and section 1902(a)(4) of the Act (for PIHPs and PAHPs). Section 1903(m)(2)(A)(iii) of the Act permits Federal matching dollars for State expenditures to a risk-bearing entity for Medicaid services when ''such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which the prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts.'' We are proposing to amend § 438.3(c)(2) to retain the requirement that capitation payments may only be made by States and retained by MCOs, PIHPs, or PAHPs for Medicaid-eligible enrollees, while adding provisions that would permit States to recover capitation payments made for certain periods following an individuals' death or out-of-State relocation. We propose to add § 438.3(c)(2)(i) providing that, following the provision of notice of action with fair hearing rights in accordance with §§ 435.917 and 435.918 and part 431 subpart E, a State must recover capitation payments from MCOs, PIHPs, or PAHPs for any payment periods following the death of an enrollee when verified through the DMF, and may recover capitation payments from MCOs, PIHPs, or PAHPs for any payment periods following the date of out-of-State relocation of an individual. We note that these recovery actions would be limited to financial transactions between the State and the managed care plan and would not create any liability for Medicaid beneficiaries. At § 438.3(c)(2)(ii), we propose to add that States would be required to reimburse CMS an amount equal to the Federal share of all capitation payments subject to recovery described in proposed § 438.3(c)(2)(i), taking into account applicable differences in the Federal matching rate(s) applicable to the population, benefit, and Federal Fiscal Year. We note that under § 438.3(c)(2)(ii) States would be required to return the Federal share of capitation payments for any payment periods following the enrollee's death or date of relocation regardless of whether the State elects to recover or require the plan to return the capitation payment. The CHIP regulations at §§ 457.1201(c) and 457.1285 require CHIP managed care plans to comply with all Medicaid managed care rules established within § 438.3(c); therefore, the proposed changes to § 438.3(c)(2), if finalized, would apply to CHIP managed care plans.

This proposal would ensure that States have clear authority to recover capitation payments attributed to individuals who are deceased or who have relocated out-of-State, while the contractual provisions would establish the operational mechanism for implementing those recoveries, regardless of when the State ultimately terminated Medicaid eligibility. This proposal would make clear that existing notice, fair hearing, and eligibility-redetermination requirements would continue to apply before a State may terminate coverage and initiate capitation payment recovery from a managed care plan. As such, States would have to continue to redetermine eligibility in accordance with requirements at §§ 435.916(d) and 457.343, consider all bases of eligibility before making a determination of ineligibility as required by § 435.916(f), and furnish benefits until the individual is found to be ineligible for Medicaid and provided advance notice, as applicable, as described in §§ 431.211 and 435.930(b). Following completion of notice of action with fair hearing rights and termination of coverage,

[96] ''It is implicit in the [2016 Final Rule], and we did not propose to change, that capitation payments are developed based on the services and populations that are authorized for Medicaid coverage under the State plan which are covered under the contract between the State and the managed care plan and that capitation payments are made for Medicaid-eligible enrollees. This would not include deceased individuals or individuals who are no longer Medicaid-eligible.'' 81 FR 27537.

States would initiate recovery actions from the applicable managed care plan.

Since the 2016 Managed Care final rule, most States have included sufficiently robust contract language to adequately recover capitation payments associated with deceased individuals, but some States have shared with us that they experience challenges recovering capitation payments from managed care plans for enrollees who have relocated out-of-State. When an enrollee has relocated out-of-State, and the State makes a determination of ineligibility and disenrolls the individual after providing advance notice, covered services under the managed care plan's contract should no longer be available to the enrollee because the enrollee is no longer eligible for Medicaid within the original State. Similarly, associated capitation payments would not be consistent with the requirement that capitation rates reflect reasonable, appropriate, and attainable costs under the contract (§ 438.4(a)) because a State may only make payment to a managed care plan for ''covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements'' (§ 438.3(c)(1)(ii)). Therefore, a payment made for an ineligible enrollee would not be compliant with the contract between the State and the managed care plan. While most SMAs recover capitation overpayments from plans when they are identified, some SMAs are unable to recover such payments because of insufficiently robust managed care contract language.

These challenges are largely related to an inability to identify a date on which to base the recovery. Unlike a date of death, which is recorded in national or State-based sources, such as the Social Security Administration's DMF or States' Departments of Vital Statistics, residential address changes are not routinely tracked and reported. PARIS alerts notify States when a beneficiary has relocated to another State by matching certain State and Federal data, but such alerts are generated quarterly and only if the individual interacts with certain entities in that new State such as the SMA or the Department of Motor Vehicles. In addition, States have reported challenges using PARIS because they may receive a high volume of false positive alerts,[97] the alerts may be based on delayed data,[98] or the PARIS system does not retain accessible historical data. All SMAs are required to conduct PARIS data matches, but data matching agreements do not prescribe which of the three PARIS matches (the Veterans Administration Match, Department of Defense/Office of Personnel Management Match, and the Interstate Match) SMAs must conduct, nor the frequency with which any match must be conducted.[99]

Prior to initiating capitation payment recoveries based on an out-of-State relocation, States must first define feasible policies and procedures within their managed care contracts for how they will identify when an out-of-State residential change occurs, what documentation sources can be used to establish a relocation date, and how they will resolve cases of disputed residency. The ''date of out-of-State relocation'' means the date the State determines, consistent with § 435.403 and applicable State residency requirements that the individual ceased to be a resident of the State. States would also need to include clear terms in their managed care contracts that would define how they would determine which capitation payments would be subject to recovery in instances where individuals would not report the timing of their relocation. Further, these policies should align with the Federal requirements regarding State residency at § 435.403(d), and any applicable State-based residency requirements.

SMAs must treat these types of recoveries like all other recovered overpayments resulting from situations other than fraud as outlined generally at § 433.300, which is to refund all recoveries, including ones relating to changes in circumstance, to CMS within 1 year from the date of discovery.

We believe adding a new paragraph (i) to § 438.3(c)(2) within the standard contract requirements provisions would clarify States' obligation to recover capitation payments for any payment periods following a beneficiary's date of death and States' ability to recover capitation payments for any payment periods following the date of out-of-State relocation—after making a determination of ineligibility and the provision of notice of action with fair hearing rights—and would ensure that SMAs update their managed care contract terms to clearly specify their intent to recover inappropriate capitation payments. We invite comment on these proposals.

b. Prompt Reporting of Beneficiary Changes in Circumstances (§ 438.608(a)(3))

The provision added by the 2016 Managed Care final rule at § 438.608(a)(3) did not define ''prompt'' reporting or specify how changes should be reported, and we subsequently observed considerable variation in how States implemented the regulation. To ensure uniformity, we propose to amend § 438.608(a)(3) to require that Medicaid and CHIP managed care plans and Primary Care Case Management (PCCMs) report to a State changes in an enrollee's circumstances (specifically including enrollee deaths and all verified address changes) within 30 calendar days of when a plan receives information about a change that may affect the enrollee's eligibility for or access to services covered under the contract. We also propose to amend § 438.608(a)(3)(i) to require managed care plans and PCCMs to report residence changes if provided by the enrollee or verified directly with the enrollee, including both out-of-State and in-State address changes, which would protect from improper disenrollment. In the 2016 Final Rule, we finalized ''§ 438.608(a)(3) so that managed care plans *would* notify the State of changes in the enrollee's residence and death,'' in an effort to not trigger a required notification by the managed care plan when returned mail is received because the administrative burden on States outweighed the value.[100] At the same time, we acknowledged that managed care plans ''have more direct communication with enrollees than the State and can serve as valuable sources of information relevant to the enrollee's eligibility for Medicaid.'' [101] In the decade since the 2016 Final Rule, managed care plans have expanded communication from mail and telephone to text messages, email, and member portals and mobile applications. With these additional means of communication, managed care plans and PCCMs are in a better position to verify changes in residence with less burden than the State, thus making notification to the State of the verified change in residence beneficial without being overly burdensome.

The proposed change to § 438.608(a)(3) would also implement sections 71103(a)(2)(B) and 71103(b)(2)

[97] California Verification Plan (*medicaid.gov*). *https://www.medicaid.gov/sites/default/files/2021-06/california-verification-plan-final.pdf.*

[98] *https://www.medicaid.gov/sites/default/files/2019-12/new-hampshire-verification-plan-template-final.pdf.*

[99] *Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States* (HHS–OIG A–05–20–00025). *https://oig.hhs.gov/documents/audit/7881/A-05-20-00025-Complete%20Report.pdf.*

[100] *https://www.federalregister.gov/d/2016-09581/p-1477.* (emphasis added).

[101] *https://www.federalregister.gov/d/2016-09581/p-1478.*

of the WFTC legislation, which mandates that States include a provision in their managed care plan and PCCM contracts that requires managed care plans to promptly transmit to the State any address information for Medicaid and CHIP enrollees that is provided to the managed care plan or PCCM directly from, or that the managed care plan or PCCM verified directly with, the enrollee. We propose to amend § 438.608(a)(3) to define this prompt-transmission requirement as requiring transmission within 30 calendar days of when a managed care plan or PCCM receives information about a change in an enrollee's circumstances, which would add clarity and consistency to the implementation of the provisions in section 71103. The CHIP regulations at §§ 457.1201(c) and 457.1285 already require CHIP managed care plans to comply with all Medicaid managed care rules established within §§ 438.3(c) and 438.608, respectively; therefore, no additional regulatory changes would be necessary to implement such changes within CHIP.

In addition, we are proposing to revise § 438.608(a)(3) to require SMAs to define the procedures for prompt notification to the State when changes in an enrollee's circumstances are to be reported, which would ensure that managed care plans and PCCMs report such changes consistently to the appropriate contacts within the SMA or delegated entity. We believe that establishing a uniform timeframe of 30 calendar days would adequately position States and managed care plans and PCCMs to comply with section 71103(a)(2)(B) and 71103(b)(2) of the WFTC legislation, which requires States to include within the managed care contract a requirement that the MCOs, PIHPs, PAHPs, and PCCMs promptly transmit verified address information for enrollees. When a State receives information indicating an enrollee may have moved out-of-State through this process, it must treat such information as a potential change in circumstances and promptly redetermine eligibility in accordance with §§ 435.916(d), 457.343, and 435.952(d). We believe 30 calendar days is a reasonable amount of time for a managed care plan or PCCM to transmit any new address information to the State and would allow States to initiate timely redetermination procedures and potentially prevent transmitting to managed care plans and PCCMs inappropriate capitation payments for enrollees who have a change that may affect their eligibility, or to facilitate enrollment into a new plan for enrollees who continue to be State residents but have moved out of their current plan's service area. However, we are seeking comments on whether 30 calendar days is an appropriate length of time or if the time period should be increased or decreased. In addition, we interpret section 71103(a)(2)(B) of the WFTC legislation's use of ''promptly'' to apply this reporting rule to enrollees with new address information that differs from prior address information, and we would encourage States to leverage their experience from unwinding the Medicaid continuous enrollment provision at the end of the COVID–19 PHE to inform the development of these procedures and protocols.

Prompt reporting of an enrollee's death by managed care plans would also support provisions included within section 71104 of the WFTC legislation. Beginning January 1, 2027, section 71104 of the WFTC legislation requires States on at least a quarterly basis to review the DMF, or a successor system that provides beneficiary death data, and disenroll any deceased beneficiaries. The WFTC legislation also requires that States reinstate Medicaid coverage for a beneficiary who was erroneously disenrolled. We believe that managed care plans may learn of potential deaths or erroneous disenrollments before State or Federal entities. However, Section 71104 of the WFTC does not permit States to treat death information from managed care plans as factual, and States will still be required to verify beneficiary death consistent with § 435.952(d).

Section 438.608(a)(3) currently requires States to require managed care plans' prompt reporting to them when the managed care plan receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility, including change of address and death. We believe that adding a 30-calendar-day timeframe to report out-of-State moves and deceased beneficiary status would strengthen existing requirements and enhance program integrity and eligibility verification in Medicaid.

We propose that these revisions would be applicable for rating periods beginning on or after January 1, 2027. We believe this would also provide sufficient opportunity for States to include these new reporting requirements and recovery provisions in their new or renewed managed care contracts. We invite comment on these proposals.

c. Standard Contract Requirements Relating to Overpayments

We also propose to revise § 438.608(d)(1)(iv) to clarify that the overpayment retention policies specified under § 438.608(d)(1) do not apply to amounts recovered and retained under the False Claims Act or through other Federal or State audits or investigations, including those conducted by Federal agencies, such as CMS, or their contractors. This clarification is intended to ensure that recoveries resulting from fraud, waste, or abuse audits and investigations are treated consistently with existing authorities governing such actions and are not subject to duplicative recovery or return requirements under this section. As stated in the 2016 final rule, ''[a]lthough States have the flexibility to implement overpayment retention contract provisions, the policies in the contract would not prohibit the Federal government from retaining the appropriate share of recoveries of overpayments due to their own audits and investigations''.[102] We seek comment on this this proposed revision.

M. Request for Information on Payment Deductions Under 42 CFR 447.10(i)

CMS is issuing this request for information (RFI) to solicit public input on strengthening consent, documentation, and recordkeeping requirements related to payment deductions made under 42 CFR 447.10(i). This regulation governs deductions from certain Medicaid provider payments to make payments to third-parties, including labor unions, on behalf of the provider. CMS is concerned that existing State practices for obtaining and documenting practitioner consent to such deductions may be insufficient to protect practitioners' First Amendment rights and the financial integrity of the Medicaid program. CMS is also considering how to implement a related statutory prohibition enacted under section 71121 of Pub. L 119–21, the WFTC legislation. The information received in response to this RFI could inform potential future agency action.

1. Background

Section 1902(a)(32) of the Act generally prohibits Medicaid payment for care or services furnished to an individual to anyone other than the individual or the provider furnishing the care or services, unless a statutory exception applies. CMS' implementing regulation at § 447.10 identifies the

[102] *https://www.federalregister.gov/d/2016-09581/p-1523.*

persons to whom State Medicaid payments may be made and the limited circumstances under which payment may be made to others.

Under CMS' current interpretation of section 1902(a)(32) of the Act, as established in a 2022 final rule [103] and pursuant to regulations at § 447.10(i), the payment prohibition in section 1902(a)(32) of the Act does not apply to State payments to third-parties on behalf of individual practitioners for those individual practitioners' health insurance and welfare benefits, skills training, and other benefits customary for employees, in the case of a class of practitioners for which the Medicaid program is the primary source of revenue, if the individual practitioner voluntarily consents to such payments on their behalf.

The preamble to the 2022 final rule noted that ''most commenters stated support for the 2021 proposed rule.'' *See* 87 FR 29675, 29679 (May 16, 2022). But, at the same time, the 2022 final rule also noted that, in response to the 2021 proposed rule,[104] some commenters expressed concerns about bad actors and questionable practices for diverting Medicaid money to unions without providers' express consent, as the agency noted and described in the 2022 final rule, and argued that the consent requirements in § 447.10(i) were insufficient to protect practitioners and the financial integrity of the Medicaid program. *See* 87 FR at 29682–29683, 29686. Some commenters raised concerns about the potential for what they called the practice of ''dues skimming,'' in which a State automatically deducts union dues from a practitioner's Medicaid payment without the practitioner's affirmative consent. *Id.* at 29686. Some commenters cited *Harris* v. *Quinn,* 573 U.S. 616 (2014), and *Janus* v. *American Federation of State, County, & Municipal Employees, Council 31,* 585 U.S. 878 (2018), as examples supporting their view that such practices are impermissible and raise First Amendment concerns. *Id.*

Some commenters further described specific practices they viewed as coercive or inconsistent with the consent standard articulated in *Janus,* including so-called ''captive audience'' meetings, high-pressure tactics associated with union enrollment, and limited ability to disenroll from the union. *Id.* Commenters also expressed concern that finalizing the rule could permit States to divert Medicaid payments to unions and political campaigns. *Id.*

Despite these comments, at the time of the 2022 final rule, CMS believed the requirements at § 447.10(i), particularly the voluntary consent requirement, were sufficient from the Federal perspective and deferred to States to oversee and operationalize this requirement. *See, for example,* 87 FR at 29682–29686, 29689. Specifically, we declined to prescribe in regulation a uniform method for obtaining or documenting consent, including a written consent requirement, out of concern that doing so could conflict with State law, and we deferred to States regarding which methods of obtaining and documenting consent are sufficient. *Id.* However, since the 2022 final rule took effect, CMS has received reports suggesting that these concerns have materialized in practice. In June 2026, CMS sent letters to nine SMAs reminding them of their obligations under § 447.10(i) and of the Supreme Court's holding in *Janus.* In those letters, CMS stated that deductions made without a practitioner's voluntary and affirmative consent are inconsistent with *Janus* and may violate § 447.10. CMS directed States to review their Medicaid payment arrangements involving union dues and requested documentation sufficient to allow CMS to assess compliance.

Although the Supreme Court has not reached the specific question, the First Amendment principles articulated in *Harris* and *Janus* would appear to apply to union deductions from Medicaid payments to homecare workers and would appear to bind States in that context independently of any Federal regulation. Assuming that our understanding of the decisions is correct in this regard, any rule CMS issues with respect to union dues deductions from Medicaid payments must be consistent with those decisions and States' existing constitutional obligations are not optional: that is to say that a State's deduction of union dues from a practitioner's Medicaid payment without the practitioner's clear and affirmative prior and voluntary consent is unconstitutional regardless of whether CMS' regulations separately require it.

We are concerned that current practices in some States may not reliably ensure that consent to the deduction of union dues is obtained in a manner free from coercion or pressure. We note that § 447.10(i) applies broadly to deductions for a range of benefits, not solely union dues, but CMS believes that in the context of union dues, greater regulatory specificity regarding consent, documentation, and recordkeeping may be warranted to ensure voluntary and verifiable consent from practitioners, consistent with applicable First Amendment principles, and to ensure consistent Federal oversight across States.

Separately, section 71121 of the WFTC legislation amended section 1915(c) of the Act by adding a new paragraph (11), which establishes a new HCBS waiver option, available to States beginning July 1, 2028, under which States may provide HCBS to individuals without requiring them to meet the institutional level-of-care requirement otherwise applicable under section 1915(c). Section 1915(c)(11)(C) of the Act provides that no payments made to carry out that paragraph may be used by a State to make payments to a third-party on behalf of an individual practitioner for benefits such as health insurance, skills training, and other benefits customary for employees, in the case of a class of practitioners for which the Medicaid program is the primary source of revenue. CMS is using this RFI, in part, to inform implementation of this statutory provision.

2. Issues for Public Input

CMS continues to receive reports from practitioners and other stakeholders raising concerns regarding compliance with § 447.10(i) and applicable First Amendment principles, including practitioners reporting that consent to union dues deductions was obtained as a condition of provider enrollment, and practitioners reporting difficulty withdrawing previously given consent. These reports, together with the responses to CMS' June 2026 compliance letters, raise questions regarding whether existing State oversight and implementation of § 447.10(i) consistently ensures compliance with the voluntary consent requirement.

CMS is concerned that deduction of union dues, or other third-party payment under § 447.10(i) may in some circumstances occur without the practitioner's voluntary consent. CMS is considering whether more prescriptive Federal requirements addressing how consent to such deductions must be obtained, documented, and maintained, and how States must demonstrate compliance to CMS, are necessary to ensure the financial integrity of the Medicaid program and to safeguard practitioners' constitutional rights, consistent with *Harris* and *Janus.*

CMS is seeking additional information from States, practitioners, beneficiaries, unions, and other stakeholders to better understand current practices, the scope of the

[103] 87 FR 29675, May 16, 2022.

[104] 86 FR 41803, August 3, 2021.

potential problem, and the range of approaches that could address it, including in the context of consumer-directed service programs, where the beneficiary rather than a traditional employer may perform functions relevant to consent and payment.

3. Request for Information

CMS invites public comment on the following questions. Commenters need not respond to every question and are encouraged to provide data, examples, and supporting documentation where available. CMS is not proposing specific regulatory provisions related to this issue in this proposed rule, and nothing in this RFI should be construed as reflecting a predetermined outcome regarding any future policy development.

- What specific practices do States currently use to obtain, verify, and document practitioner consent to deductions under § 447.10(i), including deductions for union dues? How do these practices vary across States and program types (for example, fee-for-service, managed care, consumer-directed HCBS programs)?
- What roles do fiscal intermediaries, financial management services (FMS) entities, and other agents or vendors perform in administering practitioner payments, third-party deductions, and practitioner consent? On whose behalf does each entity act, who receives the Medicaid payment, and in whose name is the payment received? How do these arrangements relate to the payment arrangements addressed in § 447.10(f) and/or (i)?
- How are the respective roles of the State, the employer of record, and the fiscal intermediary defined and enforced? Who is the employer of record for self-directed or independent practitioners? What functions, including data sharing, does the fiscal intermediary perform, and under what authority?
- How do States conduct oversight (including, for example, through audits) of the fiscal intermediaries, or similar agents, as it relates to third-party payments or deductions? What oversight approaches are used, what information is collected, how frequently, and how do States act on the findings? States that have recently audited their fiscal intermediaries are encouraged to describe relevant findings from their most recent audit.
- How are the terms of collective bargaining agreements covering Medicaid practitioners relevant to State administration of deductions and payment of union dues? How would a State conduct a review, including legal review as appropriate, of such collective bargaining agreements to identify provisions that may conflict with § 447.10 or with *Janus*? What data and information would be collected, and how would a State act on the findings? States that have conducted this type of review are encouraged to describe their most recent process and findings.
- In consumer-directed service models in which the Medicaid beneficiary performs employer-related functions, what unique challenges or considerations arise in ensuring that practitioners' consent to third-party deductions under § 447.10 is voluntary? Are there additional considerations for union dues deductions?
- What processes or safeguards, if any, do States have in place to ensure that practitioners can make voluntary decisions concerning whether or not to agree to union dues deductions without coercion or improper pressure from anyone, whether in favor of or opposed to such deductions? Which individuals or entities may be involved in those interactions, and what barriers or pressures, if any, do practitioners face in exercising their choices?
- What processes or mechanisms, if any, do States have in place to: (1) allow a worker who never consented to dues deductions to avoid paying such dues; and (2) allow a worker who previously consented to union dues deductions to request revocation, subject to any applicable contractual obligations or agreed-upon revocation periods? How are disputes regarding the existence, validity, or effective date of consent or revocation resolved?
- What documentation or recordkeeping requirements would allow CMS to effectively assess State compliance with the voluntary consent requirement in § 447.10(i), without imposing unnecessary administrative burden on States or practitioners?
- What safeguards should CMS consider to ensure that consent is voluntary and not made a condition of provider enrollment or other program participation requirements?
- What data exist, or could reasonably be collected, regarding the frequency, scope, or financial magnitude of deductions made under § 447.10(i) without the voluntary consent required by that provision, or where the existence or validity of consent is disputed?
- What categories of third parties receive payments under § 447.10(i) (such as unions, benefit administrators, or other organizations), and should any future consent, documentation, or recordkeeping requirements distinguish among those categories?
- What implementation questions arise under section 1915(c)(11)(C) of the Act? What guidance, if any, would assist States in identifying payments made to carry out section 1915(c)(11) and the classes of practitioners for which the Medicaid program is the primary source of revenue, and what operational issues should CMS consider?
- What impact, including administrative, operational, or financial, might enhanced Federal consent and documentation requirements have on States, managed care plans, practitioners, fiscal intermediaries, FMS entities, and beneficiaries, particularly in consumer-directed programs?
- Are there alternative regulatory or sub-regulatory approaches that CMS should consider to address the concerns described in this RFI?
- Does the deduction of union dues from Medicaid payments to individual home care workers, with or without adequate consent, positively or negatively affect the financial integrity of the Medicaid program? If so, in what way? What evidence is there of this connection or these effects?

IV. Medicare Advantage and Medicare Part D Proposals

The Balanced Budget Act of 1997 (BBA), Pub. L. 105–33, established a new Part C of the Medicare program, known then as the Medicare+Choice (M+C) program, which became effective in January 1999. As part of the M+C program, the BBA authorized CMS to contract with public or private organizations to offer a variety of health plan options for Medicare beneficiaries. These health plans provide all Medicare Part A and Part B (also known as ''Original Medicare,'' or ''Medicare Fee-for-Service (FFS)'') benefits, and most offer additional benefits beyond those covered under the Medicare FFS program. The M+C program in Part C of Medicare was renamed the Medicare Advantage (MA) program under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), enacted in December 2003. The MMA updated and improved the choice of plans for beneficiaries under Part C and changed the way benefits are established and payments are made. As of calendar year 2025, over 34 million individuals receive their Medicare benefits through MA, which represents over half of the total Medicare beneficiary population.[105]

[105] CMS, *CMS Fast Facts, April 2026 Edition,* pg.1, *https://data.cms.gov/sites/default/files/2026-04/CMSFastFacts2026_508.pdf.*

The MMA also established the Medicare Prescription Drug Benefit under Part D, which began providing prescription drug coverage to Medicare beneficiaries in 2006. The Part D program operates through private plan sponsors that contract with CMS, offering coverage either through stand-alone prescription drug plans (PDPs) to supplement Original Medicare, or through Medicare Advantage prescription drug (MA–PD) plans that integrate drug coverage with all other Medicare-covered benefits. The original Part D benefit design included risk-abating mechanisms—including direct subsidy risk corridors, risk adjustment, and Federal reinsurance—enabling CMS to implement a market-based program that maintained affordable premiums over time and promoted high enrollee satisfaction. The Inflation Reduction Act of 2022 (IRA) subsequently made significant structural changes to the Part D benefit, including establishing a hard cap on annual out-of-pocket spending and authorizing the Federal Government to negotiate certain drug prices directly with manufacturers, with those changes being phased in through 2026.

Program integrity is fundamental to the proper administration of both the Part C and Part D programs. While CMS has robust program integrity controls in place, bad actors continue to find the Medicare program a financially lucrative target and use creative tactics to evade detection and adverse consequences. Accordingly, the potential for fraud, waste, and abuse (FWA) is significant, making rigorous oversight of MA organizations and Part D plan sponsors, providers, and suppliers essential to protecting both the Medicare Trust Funds and the beneficiaries who depend on these programs. Compliance oversight of our partners is also important to ensure appropriate expenditures of taxpayer dollars. For example, CMS conducts ongoing oversight of MA organizations and Part D plan sponsors through audits, monitoring, data analysis, and other program integrity activities to ensure compliance with Federal requirements and identify program vulnerabilities. In accordance with 42 CFR 422.504(h)(1) and 423.505(h)(1), MA organizations, Part D plan sponsors, and their employees, governing body members, and first-tier, downstream, and related entities agree to comply with Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse. Through these oversight activities and its experience administering the Part C and Part D programs, CMS has identified opportunities to strengthen existing regulatory requirements to improve accountability and clarify program integrity standards.

A. Overview of Proposed Policies

In this proposed rule, CMS proposes to expand its implementation of the requirements set forth in Sections 2008 and 6063 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Public Law 115–271 (2018), previously implemented through the Contract Year 2022 Medicare Advantage and Part D Final Rule, which appeared in the **Federal Register** on January 19, 2021 (86 FR 5864). CMS further relies on the authority provided under section 1857(e)(1) of the Act, which authorizes the Secretary to include in an MA organization contract such other terms and conditions as the Secretary finds necessary and appropriate. In addition, pursuant to section 1856(b)(1) of the Act, the Secretary may establish, through regulation, other standards for MA organizations necessary to carry out the program. Pursuant to section 1860D–12(b)(3) of the Act, the provisions of section 1857—including section 1857(e)(1)—apply to Part D plan sponsor contracts in the same manner as they apply to MA organizations. Specifically, CMS relies on these provisions for its proposed expansion of mandatory fraud, waste, and abuse reporting requirements, and for the requirement to report all payment suspensions based on credible allegations of fraud. Under existing requirements at §§ 422.503(b)(4)(vi)(G)(*4*)–(*7*) and 423.504(b)(4)(vi)(G)(*4*)–(*7*), MA organizations and Part D plan sponsors are required, in accordance with §§ 422.503(b)(4)(vi)(G)(*5*) and 423.504(b)(4)(vi)(G)(*5*), to report information concerning: (1) any payment suspensions implemented by a plan sponsor, pending the investigation of credible allegations of fraud by a pharmacy, which must be implemented in the same manner as the Secretary's implementation under section 1862(o)(1) of the Act; and (2) investigations, credible evidence of suspicious activities of a provider of services (including a prescriber) or supplier, and other actions taken by the plan sponsor related to the inappropriate prescribing of opioids to the Health Plan Management System (HPMS) Fraud, Waste, and Abuse (FWA) Reporting Module. While CMS currently encourages plan sponsors to report referrals of substantiated or suspicious fraud, waste, or abuse to CMS, it is not mandatory. CMS is now proposing to make referrals of substantiated or suspicious fraud, waste, and abuse a mandatory reporting requirement, to expand plan sponsors' required reporting of payment suspensions of credible allegations of fraud against pharmacies to other provider and supplier types, and to add the definition of ''credible allegation of fraud'' to § 422.500 to ensure the Medicare Advantage program requirements align with the current definitions §§ 405.370, 423.4, and 455.2. If finalized as proposed, the requirements for mandatory reporting of fraud, waste and abuse would become effective 60 days after publication of the final rule and would be applicable January 1, 2028.

In addition, CMS is proposing changes to the regulation in Part 422 governing the MA RADV Program. These proposals include: applying extrapolation to plan year audits for payment year 2018 forward; requiring MA organizations to remit improper payments based on RADV audits, in a manner specified by CMS; and allowing MA organizations to request a hardship exception, as prescribed by CMS, if they cannot submit medical records timely as required.

B. Mandatory Reporting of Fraud, Waste, and Abuse

1. Introduction

All MA organizations (including MA organizations offering prescription drug plans (MA–PD plans)) and standalone Part D plan sponsors (collectively referred to herein as ''plan sponsors'') are required to adopt and implement effective compliance programs to oversee provider networks, benefits, and payments. Compliance programs must include measures that prevent, detect, and correct non-compliance with CMS' program requirements, as well as measures that prevent, detect, and correct fraud, waste, and abuse.[106] As part of these requirements, plan sponsors must establish and implement procedures and systems for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.

An important part of plan sponsors' fraud, waste, and abuse initiatives involves sharing potential leads, trends,

[106] *See* Section 1860D–4(c)(1)(D) of the Act and §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi).

or schemes resulting from the plan sponsors' own data analytics and investigative findings through referrals to CMS, which helps accomplish the following objectives:

- Enables CMS to perform data analysis to identify fraud schemes;
- Facilitates and increases transparency among CMS and plan sponsors through the exchange of information;
- Provides information and education to plan sponsors on potential fraud, waste, and abuse issues, enabling plan sponsors to investigate and take action based on such data;
- Improves fraud detection across the Medicare program, allowing for increased recovery of taxpayer dollars and enrollee expenditures (for example, premiums, co-insurance, other plan cost-sharing);
- Provides more effective support, including fraud leads, to plan sponsors and law enforcement; and
- Increases beneficiary safety through increased oversight measures.

In this proposed rule, CMS proposes to expand upon the existing requirements in sections 2008 and 6063 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act that CMS previously addressed in the Contract Year 2022 Medicare Advantage and Part D Final Rule (referred to as the ''January 2021 final rule'' (CMS–4190–F2)). Beginning January 1, 2022, the requirements finalized in the January 2021 Final Rule allowed CMS and plan sponsors to share data and information regarding unscrupulous actors, take swift action based on such data and information, and achieve enhanced outcomes in our efforts to fight the opioid crisis. In addition, the January 2021 Final Rule paved the way for more effective referrals to law enforcement based on plan sponsor reporting, ultimately resulting in reduced beneficiary harm and greater savings for the Medicare program.

2. SUPPORT Act Sections 2008 and 6063

The SUPPORT Act was signed into law on October 24, 2018, and amended sections 1860D–12(b) and 1859 of the Act to alleviate the nationwide opioid crisis by: (1) reducing the abuse and supply of opioids; (2) helping individuals recover from opioid addiction and supporting the families of these persons; and (3) establishing innovative and long-term solutions to the crisis. Part of CMS' role in overseeing the Medicare program is to ensure that payments are made correctly and that fraud, waste, and abuse is stemmed; failing to do so endangers the Trust Funds and can result in harm to beneficiaries. For example, a practitioner engaging in abusive behavior by prescribing unnecessary opioids to Medicare patients poses a threat to the health and safety of the affected beneficiaries, and Trust Fund dollars paid for drugs that were not needed. As a result, several of the SUPPORT Act provisions addressed important program integrity and payment safeguard topics.

Sections 2008 and 6063 of the SUPPORT Act authorized plan sponsors to suspend payments to pharmacies based on credible allegations of fraud; required plan sponsors to report such payment suspensions to CMS through a secure program integrity portal; and clarified that a fraud hotline tip, without further evidence, does not constitute sufficient evidence of a credible allegation of fraud. The SUPPORT Act also required CMS to establish a secure program integrity portal to facilitate referrals and data sharing related to fraud, waste, and abuse among CMS, plan sponsors, and Medicare program integrity contractors; define, through rulemaking, substantiated or suspicious activities of fraud, waste, or abuse and inappropriate opioid prescribing; establish reporting requirements for plan sponsors related to fraud investigations and inappropriate opioid prescribing; and provide plan sponsors with regular program integrity information and fraud, waste, and abuse trend reports.

3. CMS Actions and Contract Year 2022 Medicare Advantage and Part D Final Rule (January 2021 Final Rule)

In accordance with the requirements of sections 2008 and 6063 of the SUPPORT Act, CMS established a secure web-based program integrity portal for plan sponsor reporting in the HPMS FWA Reporting Module in the Contract Year 2022 Medicare Advantage and Part D Final Rule (January 2021 Final Rule) (86 FR 5864). Since January 1, 2022, under §§ 422.503(b)(4)(vi)(G)(*4*)–(*5*) and 423.504(b)(4)(vi)(G)(*4*)–(*5*) and the associated timelines for reporting found at §§ 422.503(b)(4)(vi)(G)(*6*) and 423.504(b)(4)(vi)(G)(*6*), plan sponsors must report to CMS: (1) payment suspensions pending investigations of credible allegations of fraud by pharmacies; and (2) information concerning investigations, credible evidence of suspicious activities of a provider (including a prescriber) or supplier related to the inappropriate prescribing of opioids, and other actions taken by the plan sponsor related to the inappropriate prescribing of opioids. In addition, under §§ 422.503(b)(4)(vi)(G)(*3*) and 423.504(b)(4)(vi)(G)(*3*), plan sponsors should have procedures to voluntarily self-report potential fraud or misconduct in the MA or Part D programs to CMS. When plan sponsors choose to report a referral of substantiated or suspicious activities of a provider or supplier related to fraud, waste, or abuse, they must also use the HPMS FWA Reporting Module to do so in accordance with §§ 422.503(b)(4)(vi)(G)(*5*) and 423.504(b)(4)(vi)(G)(*5*). In the January 2021 Final Rule, CMS also defined (or, for ''credible allegation of fraud'' in § 405.370, updated the definition for) the following terms:

- ''Substantiated or Suspicious Activities of Fraud, Waste, or Abuse'' (§ 422.500 and 423.4)
- ''Inappropriate Prescribing'' (§§ 422.500 and 423.4)
- ''Credible Allegation of Fraud'' (§§ 405.370, 423.4, and 455.2)
- ''Fraud Hotline Tip'' (§§ 405.370, 422.500, 423.4, and 455.2)

Lastly, in accordance with §§ 422.503(b)(4)(vi)(G)(*7*) and 423.504(b)(4)(vi)(G)(*7*), CMS provides a quarterly report to plan sponsors of data or information reported under these provisions.

4. Proposals To Strengthen the Reporting Requirements

In its July 2018 report, ''The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness,'' [107] the HHS–OIG recommended that CMS require plan sponsors to report Part C and Part D fraud and abuse incidents and the corrective actions taken to a centralized system. The OIG added that requiring plan sponsors to use some centralized system to report suspect providers and pharmacies, investigative information, and corrective actions would provide the Medicare Drug Integrity Contractor (MEDIC) and plan sponsors with valuable information to use in their fraud-fighting efforts. The report also stated this would enhance CMS oversight by providing transparency into the plan sponsors' efforts to protect the program from fraud, waste, and abuse.

[107] Department of Health and Human Service, Office of the Inspector General, ''The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness'' (2018), *https://oig.hhs.gov/reports/all/2018/the-medic-produced-some-positive-results-but-more-could-be-done-to-enhance-its-effectiveness/*.

The OIG recommendation for CMS to require plan sponsors to report Part C and Part D fraud and abuse incidents and the corrective actions taken to address them to a centralized system has remained an open recommendation since the release of the 2018 report, which means that it is considered by the OIG to be unimplemented. Through the authority given in the SUPPORT Act, CMS has taken steps to address the OIG's recommendations to require plan sponsor reporting, establish a centralized reporting system, and increase transparency in the Medicare Part C and Part D program, measures that are outlined in the current regulations for plan sponsors in §§ 422.503(b)(4)(vi)(G)(*4*) though (*6*) and 423.504(b)(4)(vi)(G)(*4*) though (*6*). But while plan sponsors are required to report certain information to CMS under these regulations, plan sponsors retain discretion to report referrals involving substantiated or suspicious activities of a provider (including a prescriber) or supplier related to fraud, waste, and abuse. In fact, CMS has found that less than half (46 percent in CY 2025) of Medicare Part C and Part D plan contracts reported referrals of substantiated or suspicious fraud, waste, and abuse to CMS. Additionally, while plan sponsors are required to report payment suspensions based on credible allegations of fraud by pharmacies, only 19 percent of Medicare Part C and Part D plan contracts reported any payment suspensions based on credible allegations of fraud to CMS in CY 2025, including both pharmacies and other provider and supplier types.[108] The low reporting rates for these two measures suggest there may be a significant number of additional substantiated or suspicious FWA referrals and payment suspensions for other provider or supplier types that are not being reported to CMS, severely limiting CMS' visibility into potential program integrity risks.

CMS believes that maximized reporting is essential to the oversight of the Medicare Part C and Part D programs, as this information is valuable to CMS and assists with investigations, referrals to law enforcement, and trend monitoring. In addition, more stringent reporting requirements would allow CMS to appropriately share the more robust data on referred providers or suppliers with other MA organizations and Part D contracts on a quarterly basis to assist in their own internal fraud, waste, and abuse efforts. Data transparency and information sharing with our partners are at the core of CMS' strategy to crush fraud. Therefore, CMS is proposing to: (1) require all plan sponsors to report all referrals of substantiated or suspicious fraud, waste, and abuse to CMS through the HPMS FWA Reporting Module; and (2) expand plan sponsor reporting of payment suspensions based on credible allegations of fraud by pharmacies to all provider and supplier types. As CMS is proposing to expand the reporting of payment suspensions for credible allegations of fraud beyond pharmacies, CMS is also proposing to add the definition of ''credible allegation of fraud'' to § 422.500, to ensure the Medicare Part C program requirements align with the current definitions at §§ 405.370, 423.4, and 455.2.

CMS is also proposing to specify that plan sponsors must report any inappropriate opioid prescribing to CMS no later than 30 days after the closing of the previous quarter. Based on our Part C and Part D program integrity audits and questions submitted to the HPMS FWA Reporting Module mailbox, we have determined that plan sponsors have some misperception regarding the expectations for the requirements at §§ 422.503(b)(4)(vi)(G)(*6*)(*ii*) and 423.504(b)(4)(vi)(G)(*6*)(*ii*). When the HPMS FWA Reporting Module was first launched, consistent with these regulations, plan sponsors were required to submit referrals related to inappropriate opioid prescribing, and, at their discretion, submit separate referrals involving substantiated or suspicious fraud, waste, and abuse. Feedback from plan sponsors indicated that these requirements imposed a burden because referrals related to inappropriate opioid prescribing were often part of a larger referral of substantiated or suspicious fraud, waste, and abuse. As such, CMS updated the HPMS FWA Reporting Module, beginning November 17, 2023,[109] to include a new question regarding referrals for substantiated or suspicious fraud, waste, and abuse. The new question allows plan sponsors to indicate whether the referral relates to the inappropriate prescribing of opioids. If the plan sponsor indicates that a referral is related to the inappropriate prescribing of opioids, the system will automatically mark the contracts as having submitted a referral of inappropriate prescribing of opioids for that quarter and no further action is needed by the plan sponsor. But when a plan sponsor has not submitted a referral of substantiated or suspicious fraud, waste, and abuse related to inappropriate prescribing of opioids, the system requires the plan sponsor to submit a ''No'' response as a quarterly attestation to satisfy the quarterly reporting requirement. Ultimately, this system action is meant to ensure (and allow CMS to ensure) that plan sponsors are actively aware they are submitting no referrals of inappropriate prescribing for a given quarter. However, to best ensure that plan sponsors report any inappropriate opioid prescribing to CMS no later than 30 days after the closing of the previous quarter, CMS is also proposing to specify this submission requirement.

Consistent with the previous discussion, we are also proposing the following regulatory provisions to implement mandatory reporting of referrals of substantiated or suspicious fraud, waste, and abuse and to expand the reporting of payment suspensions based on credible allegations of fraud. Our proposals modify or supplement existing regulations, while others establish new regulatory subparagraphs altogether. Regulations related to Part C are addressed in 42 CFR part 422; those pertaining to Part D are addressed in 42 CFR part 423.

CMS is also proposing to add the definition of ''credible allegation of fraud'' to § 422.500. This term is already defined in §§ 405.370, 423.4, and 455.2. Consistent with those regulations, we propose ''credible allegation of fraud'' under § 422.500 to mean an allegation from any source, including but not limited to any of the following: (1) fraud hotline tips verified by further evidence; (2) claims data mining; and (3) patterns identified thorough provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability.

Current §§ 422.503(b)(4)(vi)(G)(*3*) and 423.504(b)(4)(vi)(G)(*3*) state that plan sponsors should have procedures to voluntarily self-report potential fraud or misconduct related to MA organizations and Part D programs, respectively, to CMS or its designee. To mitigate terminology confusion among plan sponsors and align regulatory language with what is currently reported to CMS via the HPMS FWA Reporting Module, CMS proposes to remove the existing language at §§ 422.503(b)(4)(vi)(G)(*3*) and 423.504(b)(4)(vi)(G)(*3*). The existing language at §§ 422.503(b)(4)(vi)(G)(*4*) and 423.504(b)(4)(vi)(G)(*4*), which

[108] Plan sponsors that do not report referrals or payment suspensions as required to the HPMS FWA Reporting Module may be subject to a CMS audit or compliance action in accordance with §§ 422.504(e)(2) and 423.505(e)(2) and sections 1857(c) and (h) of the Act, respectively.

[109] November 3, 2023, HPMS Memo titled ''Health Plan Management System (HPMS) Program Integrity (PI) Portal for Fraud, Waste, and Abuse (FWA) Reporting Module Enhancements.''

require reporting of payment suspensions and credible evidence of suspicious activities, would be redesignated as §§ 422.503(b)(4)(vi)(G)(*3*) and 423.504(b)(4)(vi)(G)(*3*), respectively. CMS proposes to modify subparagraph (i) to the redesignated §§ 422.503(b)(4)(vi)(G)(*3*) and 423.504(b)(4)(vi)(G)(*3*) to remove the reference to ''by a pharmacy,'' to allow for and require reporting for all payment suspensions implemented based on credible allegations of fraud. In addition, CMS proposes to add a subparagraph (iii) to the redesignated §§ 422.503(b)(4)(vi)(G)(*3*) and 423.504(b)(4)(vi)(G)(*3*) to include the new mandatory requirement for plan sponsors to report any referrals of substantiated or suspicious activities of a provider of services (including a prescriber) or a supplier related to fraud, waste, and abuse for initiating or assisting investigations conducted by CMS, or its designee, a Medicare program integrity contractor, or law enforcement partners.

Specifically, the redesignated §§ 422.503(b)(4)(vi)(G)(*3*) and 423.504(b)(4)(vi)(G)(*3*) would state that the MA organization or Part D plan sponsor, respectively, ''must have procedures to identify, and must report to CMS or its designee, any of the following in the manner described in paragraphs (b)(4)(vi)(G)(*3*) and (*4*) of this section,'' and would read and require as follows in subsections (*i*) through (*iii*):

- Any payment suspension implemented by a MA organization or Part D plan sponsor, pending investigation of credible allegations of fraud, which must be implemented in the same manner as the Secretary's requirement under section 1862(o)(1) of the Act.
- Any information concerning investigations, credible evidence of suspicious activities of a provider of services (including a prescriber) or supplier, and other actions taken by the MA organization or Part D plan sponsor related to the inappropriate prescribing of opioids.
- Any substantiated or suspicious activities of a provider of services (including a prescriber) or a supplier related to fraud, waste, or abuse for initiating or assisting investigations conducted by CMS, or its designee, a Medicare program integrity contractor, or law enforcement partners.

Secondly, we propose to redesignate §§ 422.503(b)(4)(vi)(G)(*5*) and 423.504(b)(4)(vi)(G)(*5*), which currently describe the location where the data must be submitted, as §§ 422.503(b)(4)(vi)(G)(*4*) and 423.504(b)(4)(vi)(G)(*4*), respectively, and modify the language of the redesignated provisions by replacing the individual reporting requirements language in the current §§ 422.503(b)(4)(vi)(G)(*5*) and 423.504(b)(4)(vi)(G)(*5*) with citation to the associated reporting requirements in redesignated §§ 422.503(b)(4)(vi)(G)(*3*) and 423.504(b)(4)(vi)(G)(*3*) described earlier. Because referrals of substantiated or suspicious fraud, waste, and abuse would be mandatory reporting requirements, there would be no need to distinguish between which referrals were required and which were voluntary. Removing this language streamlines the citation and makes it clearer for the reader. In addition, we propose to redesignate §§ 422.503(b)(4)(vi)(G)(*6*)(*i*)–(*ii*) and 423.504(b)(4)(vi)(G)(*6*)(*i*)–(*ii*), which require plan sponsors to report information within certain timeframes, as subsections (*i*) and (*ii*) at §§ 422.503(b)(4)(vi)(G)(*4*) and 423.504(b)(4)(vi)(G)(*4*), respectively. The reporting timeframes at §§ 422.503(b)(4)(vi)(G)(*6*)(*i*)–(*ii*) and 423.504(b)(4)(vi)(G)(*6*)(*i*)–(*ii*) are identified separately in the current regulation; however, for clarity, CMS believes it is logical to instead list the timeframes plan sponsors must report the data within as subsections to §§ 422.503(b)(4)(vi)(G)(*4*) and 423.504(b)(4)(vi)(G)(*4*), which specify where the data must be submitted. We also propose the following in these redesignated provisions: correcting a missing space in ''7day'' at § 423.504(b)(4)(vi)(G)(*6*)(*i*); updating referenced citations to align with the proposed redesignations and revisions; updating references from ''plan'' to ''MA organization'' or ''Part D plan sponsor,'' as applicable, to ensure consistency with the existing terminology used at §§ 422.503 and 423.504; adding the timeframe for reporting referrals of substantiated or suspicious fraud, waste, and abuse to match the existing timeframes for reporting inappropriate opioid prescribing; and removing information regarding the first data reporting period, as it is now outdated. Specifically, these proposed changes at redesignated §§ 422.503(b)(4)(vi)(G)(*4*) and 423.504(b)(4)(vi)(G)(*4*) would state that the MA organization or Part D plan sponsor, respectively, ''must submit data, as specified in this section, in the program integrity portal when reporting the referrals described in paragraph (b)(4)(vi)(G)(*3*) of this section. The data categories, as applicable, include referral information and actions taken by the ''MA organization,'' or ''Part D plan sponsor,'' as appropriate, ''on the referral.'' In addition, §§ 422.503(b)(4)(vi)(G)(*4*)(*i*)–(*ii*) and 423.504(b)(4)(vi)(G)(*4*)(*i*)–(*ii*) would read as follows:

- The MA organization or Part D plan sponsor is required to notify the Secretary, or the Secretary's designee, of a payment suspension described in paragraph (b)(4)(vi)(G)(*3*)(*i*) of this section 7 days prior to implementation of the payment suspension. The MA organization or Part D plan sponsor may request an exception to the 7-day prior notification to the Secretary, or the Secretary's designee, if circumstances warrant a reduced reporting time frame, such as potential beneficiary harm.
- The MA organization or Part D plan sponsor is required to submit the information described in paragraph (b)(4)(vi)(G)(*3*)(*ii*) and (*iii*) of this section, or the absence of any information, no later than January 30, April 30, July 30, and October 30 of each year for the preceding periods, respectively, of October 1 through December 31, January 1 through March 31, April 1 through June 30, and July 1 through September 30.

Lastly, we propose to redesignate §§ 422.503(b)(4)(vi)(G)(*7*)(*i*) and 423.504(b)(4)(vi)(G)(*7*)(*i*), which refer to CMS' requirements for providing plan sponsors a data report, as §§ 422.503(b)(4)(vi)(G)(*5*) and 423.504(b)(4)(vi)(G)(*5*), respectively. In addition, we propose to modify the language in redesignated (b)(4)(vi)(G)(*5*) to update the citation reference. We also propose to redesignate §§ 422.503(b)(4)(vi)(G)(*7*)(*ii*) and (*iii*) and 423.504(b)(4)(vi)(G)(*7*)(*ii*) and (*iii*), which describe requirements of the data report, as §§ 422.503(b)(4)(vi)(G)(*5*)(*i*) and (*ii*) and 423.504(b)(4)(vi)(G)(*5*)(*i*) and (*ii*). In addition, we propose to delete the existing subparagraph (iv) as it is no longer relevant. The language at §§ 422.503(b)(4)(vi)(G)(*5*) and 423.504(b)(4)(vi)(G)(*5*) would state that CMS provides MA organizations or Part D plan sponsors, respectively, ''with data report(s) or links to the information described in paragraphs (b)(4)(vi)(G)(*3*)(*i*) through (*iii*) of this section no later than April 15, July 15, October 15, and January 15 of each year based on the information in the portal, respectively, as of the preceding October 1 through December 31, January 1 through March 31, April 1 through June 30, and July 1 through September 30.'' In addition, (*i*) and (*ii*) of the redesignated regulation would read:

- Include administrative actions, pertinent information related to opioid overprescribing, and other data determined appropriate by the Secretary in consultation with stakeholders.

• Are anonymized information submitted by MA organizations or Part D plan sponsors without identifying the source of such information.

C. Medicare Advantage Risk Adjustment Data Validation (RADV) Reforms

In this proposed rule, we discuss the proposed changes to the regulations in Part 422 governing the MA program. We are proposing to reissue provisions concerning the use of extrapolation in RADV audits and our decision not to apply an FFS Adjuster when calculating RADV overpayments due to a U.S. District Court for the Northern District of Texas vacating, for procedural reasons, similar provisions of a CMS final rule published February 1, 2023.[110] We are also proposing new provisions related to improvements to the hardship exception process in RADV audits.

The following is a summary of the proposed changes included in this proposed rule:

• We propose to reissue § 422.300 as it currently appears including the phrase ''collection of improper payments.''

• We propose to reissue and amend § 422.310(e) Validation of risk adjustment data, to: (1) apply extrapolation in RADV audits for payment year 2018 and subsequent payment years, using CMS published payment error calculation methodologies; (2) require MA organizations to remit improper payments identified through RADV audits, in a manner specified by CMS and consistent with applicable HHS and CMS overpayment collection regulations; and (3) allow MA organizations to request a hardship exception, subject to CMS' discretionary review, when they are unable to timely submit medical records as required.

• We propose to reissue § 422.311 RADV Audit Dispute and Appeal Processes, to apply revised audit requirements and methodologies.

1. Introduction

a. General Overview of Risk Adjustment Payments in the MA Program

Section 1853(a)(1)(C) of the Act requires that CMS adjust payments made to MA organizations based on risk. Risk adjustment ensures that CMS is able to make appropriate and accurate payments for enrollees with differences in costs. Making accurate payments to MA organizations also ensures we are safeguarding Federal taxpayer dollars.

The risk adjustment model employed to adjust MA payments is known as the CMS Hierarchical Condition Category (CMS–HCC) model. This model functions by categorizing the International Classification of Disease, Clinical Modification (ICD–CM)[111] diagnosis codes into disease groups called Hierarchical Condition Categories, or HCCs. Each HCC includes diagnosis codes that are related clinically and have similar cost implications. MA enrollee HCCs are assigned based on data submitted to CMS by MA organizations. The HCCs contribute to an enrollee's risk score, which is used to adjust a base payment rate. Essentially, the higher the risk score for an enrollee, the higher the expected health care cost for the enrollee and the greater payment that is received by the MA organization.

The CMS–HCC model was first used for payment in 2004 and has been recalibrated numerous times since then. When CMS recalibrates the CMS–HCC risk adjustment model, it uses data from Medicare FFS claims, using diagnoses in one year to predict the following year's expenditures. Claims data from beneficiaries enrolled in the Medicare FFS program are used to calibrate the CMS–HCC model, which produces a set of coefficients that represent the marginal (additional) cost of each medical condition and demographic factor reported for a given beneficiary. (For additional information, see the Medicare Managed Care Manual, CMS Pub. 100–16, Chapter 7, section 70.1.)[112] These coefficients are then divided by the average predicted expenditure for the population, also known as the model denominator, to generate relative factors that reflect expected costs relative to the average cost FFS beneficiary. Each beneficiary's relative factors are added together to yield a risk score for that beneficiary that is used to adjust the base payment rate for that beneficiary.

For a diagnosis to be acceptable for risk adjustment, it must be from an acceptable provider type (that is, hospital inpatient facilities, hospital outpatient facilities, or physicians), coded in accordance with ICD–CM coding guidelines, result from a face-to-face visit, and be documented in a medical record, and MA organizations are required to ensure the accuracy and integrity of risk adjustment data submitted to CMS.[113]

CMS uses diagnostic information submitted by MA organizations to calculate risk scores. MA organizations are required to submit data that is accurate, complete, and truthful to the best of their knowledge. CMS pays prospectively and issues final payment through a reconciliation run. As such, the diagnosis data the MA organizations submit do not undergo CMS validation prior to use for risk score calculation and payment. CMS validation audits occur post payment reconciliation. CMS conducts post-payment audits of MA organization-submitted diagnosis data from a selection of MA organizations for specific payment years to ensure that the diagnoses they submitted are supported by their enrollees' medical records. These audits are called contract-specific MA RADV program audits. While RADV audits are intended to identify improper risk adjustment payments, they are not specifically designed to detect fraud,[114] nor are they intended to identify all improper diagnosis submissions made by MA organizations for risk adjustment payment.[115]

b. Purpose and Description of Contract-Specific RADV Audits

The improper payment measurements conducted each year by CMS that are included in the HHS Agency Financial Report, as well as audits conducted by the HHS–OIG, have demonstrated that the MA program is at high risk of improper payments. In Fiscal Year (FY) 2025 (based on calendar year 2023

[110] *Humana Inc.* v. *Becerra,* 801 F.Supp.3d 624 (N.D. Tex. 2025), *appeal docketed sub nom. Humana Inc.* v. *Kennedy,* No. 25–11082 (5th Cir. Nov. 21, 2025).

[111] The ICD–CM is a modification of the ICD, authorized by the World Health Organization, used as a source for diagnosis codes in the United States. The ICD–CM has been adopted by the Secretary as the standard medical data code set. *See* 45 CFR 162.1002.

[112] *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf.*

[113] Medicare Managed Care Manual, CMS Public Law 100–16, chapter 7, section 40 (2014).

[114] For example, the Department of Justice is responsible for pursuing potential violations of the False Claims Act, which includes certain elements of knowledge.

[115] CMS contract-specific RADV audits focus on specific MA organization contracts to determine and recoup improper payments. The HHS–OIG also undertakes audits of MA organizations, similar to RADV audits, as part of its oversight functions. CMS can collect the improper payments identified during those HHS–OIG audits, including the extrapolated amounts calculated by the OIG. CMS also oversees the Part C Improper Payment Measurement, previously referred to as ''national RADV,'' to determine a program-wide improper payment rate as required by the Payment Integrity Information Act of 2019 (Pub. L. 116–117). In addition to risk adjustment oversight conducted by CMS, HHS also oversees HHS–RADV, which was created by the Affordable Care Act (Pub. L. 111–148 and Pub. L. 111–152) to strengthen the integrity of the Affordable Care Act Marketplace by validating the accuracy of data submitted by issuers that is used to calculate the amount of funds transferred to insurers based on the actuarial risks of the individuals they enroll. Neither the Part C Improper Payment Measurement nor the HHS–RADV programs are subject to the provisions outlined in this proposed rule.

payments), we estimated that CMS made over $21 billion in Part C overpayments, a figure representing over 5 percent of total Part C payments.[116] The HHS–OIG has also released several reports over the past few years that demonstrate a high risk of improper payments in the MA program,[117] and for several years has identified the MA program as one of the top management and performance challenges facing HHS due to the high amount of improper payments.[118] The Medicare program, including MA, has also been identified by the Government Accountability Office (GAO) as a high-risk program due to the risk of substantial improper payments and actions were needed to reduce these risks.[119]

RADV audits are our main corrective action for overpayments made to MA organizations when there is a lack of documentation in the medical record to support the diagnoses reported for risk adjustment. We select MA organizations for RADV audits using a risk-based approach that focuses on HCCs that are more likely to be in error as identified by prior RADV audits, Part C Improper Payment Measurements, OIG findings, and other vulnerability analyses. RADV audits occur after the final risk adjustment data submission deadline for the MA contract year and after CMS calculates final payments, as described at § 422.310(g).[120]

RADV audits are intended to confirm that risk adjustment conditions (that is, diagnoses that map to HCCs) reported by MA organizations are supported by medical record documentation. RADV audits confirm the presence of the diagnoses related to the enrollee's HCC profile through the review of medical records submitted by the MA organizations for the purpose of a RADV audit; specifically, medical records from hospital inpatient facilities, hospital outpatient facilities, and physicians/practitioners (excluding suppliers of durable medical equipment, prosthetics, orthotics, and supplies). Risk adjustment discrepancies are identified when an enrollee's HCCs used for payment, which are based on MA organization self-reported data, differ from the HCCs assigned based on the medical record review performed by CMS through the RADV audit process. Risk adjustment discrepancies for sampled enrollees can then be aggregated to determine an average change in risk score as a result of RADV for sampled contract enrollees. The average change in risk score can be used to calculate an estimated total payment error amount for the larger universe of enrollees within an MA organization contract from which the sample is drawn, within specified confidence intervals using statistical extrapolation.

c. History of the Contract-Specific RADV Audits

RADV audits have existed in various forms and approaches for over 20 years. RADV audits began for payment year (PY) 1999, when the payment amounts made to MA organizations on a risk-adjusted basis were small (10 percent). During the period from PY 1999 until PY 2003, our RADV activity had an educational focus and was primarily intended to provide information that could be used by MA organizations to improve the accuracy of the risk adjustment data submitted to CMS for payment. Payment adjustments (recoveries) were limited to enrollee-level adjustments for those enrollees sampled in the audits and were not extrapolated to the overall contract. As a result, for the few MA contracts we audited, payment recovery amounts were small.

Risk adjustment payments using the CMS–HCC risk adjustment model began for the first time in PY 2004.[121] Because of various risk adjustment payment methodology changes required in the BBA and the Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), CMS provided a payment ''phase-in'' under the new risk adjustment methodologies from 2000 to 2007, when MA organizations' payments were ultimately 100 percent risk-adjusted using the CMS–HCC risk adjustment model methodology. To prepare for implementation of a risk adjustment model in PY 2004 that was based on multiple sites of care, in 2001 CMS required MA organizations to begin submitting data on enrollees' hospital outpatient and physician office encounters, which increased the administrative data burden on MA organizations. Because of this burden and the associated phase-in of the new methodology, CMS considered PYs 2004 through 2006 as pilot years for the purpose of the RADV program and did not seek to recover improper payments

[116] HHS, FY 2025 HHS Agency Financial Report, pg. 154, *https://www.hhs.gov/sites/default/files/fy-2025-hhs-agency-financial-report.pdf.* As identified in this report, CMS made over $23 billion in total Part C improper payments. The improper payment measurement for the MA program in FY 2025 included both overpayments ($21 billion) and underpayments ($2 billion).

[117] For example, see reports: CMS Potentially Overpaid Medicare Advantage Organizations $462 Million Based on Certain Unsupported Acute Stroke Diagnosis Codes, Issued on May 28, 2026, *https://oig.hhs.gov/reports/all/2026/cms-potentially-overpaid-medicare-advantage-organizations-462-million-based-on-certain-unsupported-acute-stroke-diagnosis-codes/;*

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Priority Health (Contract H2320) Submitted to CMS, Issued March 31, 2026, *https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-priority-health-contract-h2320-submitted-to-cms/;*

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Gateway Health Plan, Inc., (Contract H5932) Submitted to CMS, Issued March 12, 2026, *https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-gateway-health-plan-inc-contract-h5932-submitted-to-cms/;*

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross and Blue Shield of Alabama (Contract H0104) Submitted to CMS, Issued March 10, 2026, *https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-blue-cross-and-blue-shield-of-alabama-contract-h0104-submitted-to-cms/;*

Medicare Advantage Compliance Audit of Specific Diagnosis Codes Humana Health Benefit of Louisiana (Contract H1951) Submitted to CMS, Issued December 18, 2025, *https://oig.hhs.gov/reports/all/2025/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-humana-health-benefit-of-louisiana-contract-h1951-submitted-to-cms/;*

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health and Life Insurance Company (Contract H1608) Submitted to CMS, Issued June 3, 2025, *https://oig.hhs.gov/reports/all/2025/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-coventry-health-and-life-insurance-company-contract-h1608-submitted-to-cms/.*

https://oig.hhs.gov/oas/reports/region7/71901187.asp

https://oig.hhs.gov/oas/reports/region2/21801028.asp.

https://oig.hhs.gov/oas/reports/region3/31900001.asp

https://oig.hhs.gov/oas/reports/region2/22001009.asp

https://oig.hhs.gov/oas/reports/region7/71701169.asp

https://oig.hhs.gov/oas/reports/region7/71601165.asp.

[118] For example, see OIG, 2024 Top Management and Performance Challenges Facing HHS, *https://oig.hhs.gov/reports-and-publications/top-challenges/2021/2021-tmc.pdfhttps://oig.hhs.gov/documents/tmc/10057/2024%20Top%20Management%20and%20Performance%20Challenges%20Facing%20HHS.pdf.*

[119] For example, see reports: GAO, *Medicare Program & Improper Payments, https://www.gao.gov/highrisk/medicare-program-improper-payments;*

Actions Needed to Reduce Improper Payment and Fraud Risks in VA Community Care and Medicare Advantage, GAO–26–107946 (2026), *https://www.gao.gov/products/gao-26-107946.*

[120] Please refer to the May 23, 2014, final rule, ''Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule'' (79 FR 29843, 29926) for a more detailed discussion of the timing and execution of the RADV audit and appeals process.

[121] CMS, *Advance Notice of Methodological Changes for Calendar Year (CY) 2004 Medicare+Choice (M+C) Payment Rates,* 4–5 (March 28, 2003), *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf.*

for those payment years based on the audit results.

Improper payment recovery resumed for PY 2007, when we conducted two sets of RADV audits: (1) Pilot 2007, which involved 5 MA contracts; and (2) Targeted 2007, which involved 32 MA contracts. CMS began with the Pilot 2007 audit to test the methodology and make any changes needed before conducting the Targeted 2007 audit. CMS selected MA contracts after measuring the weighted average change in disease scores (risk scores) over the preceding 3-year period and grouping MA organization contracts as high, medium, or low relative to other MA contracts that were eligible for a RADV audit. Through these two sets of audits, we recouped $13.7 million. Payment adjustments were again limited to enrollee-level adjustments for those enrollees sampled in the audits and not extrapolated to the overall contract error rate. After CMS' findings were reported to each MA organization, any MA organization that disagreed with CMS' determinations could challenge them through an administrative dispute and appeals process that was established by regulation (75 FR 19678). This dispute and appeals process, as subsequently amended (75 FR 32858, 79 FR 29844, and 89 FR 30448), remains in effect and allows for the appeal of the medical record review determination and/or the payment error calculation through a three-level administrative review process, as outlined in § 422.311. To date, CMS has issued audit findings and initiated recovery activities for PYs 2011–2015.[122]

(1) Development of an Audit Methodology (PYs 2007 through 2010)

After the RADV audits were conducted for PY 2007, CMS paused RADV audits for PYs 2008, 2009, and 2010. CMS used those years to continue refining the methodology for the RADV audits, including the consideration of statistical methods to calculate extrapolated overpayments based on the errors identified in the audit sample. The use of extrapolation would enable us to make contract-specific payment adjustments rather than simply adjusting payments for specific enrollees from an audit sample, as we had done previously.

On December 20, 2010, we published an informal proposal on the CMS website that outlined our intended RADV methodology for: (1) selecting a statistically valid sample of enrollees from each audited MA contract; and (2) calculating a contract-specific payment adjustment by extrapolating the results of that sample. We invited public comment on this proposed methodology.

(2) Informal Proposal Comments and the FFS Adjuster

In response to the December 2010 informal proposal, some MA organizations suggested that CMS could not lawfully enforce the requirement of medical record documentation for diagnosis codes while making payments at the published rates. These MA organizations stated that there is a difference in auditing standards between Medicare FFS and MA diagnosis data because, in contrast to the MA organization-submitted diagnoses data, Medicare FFS data is ''unaudited'' by CMS. This difference purportedly exists because most FFS payments are made on the basis of the item or service provided and not the beneficiary's diagnosis or diagnoses. For example, an office visit is paid based on whether the evaluation and management service billed met Medicare coverage and payment rules, not based on what diagnoses are listed on the claim or in the medical record. As a result, they stated, the Medicare FFS data used to calculate MA organization payments will understate the cost of treating various conditions and, because erroneous diagnoses in the FFS claims data are used to calibrate the MA payment model, CMS must either adjust payment rates (by raising them) or adjust documentation standards (by loosening them) to resolve the alleged incompatibility between the payment rates and documentation standards. This proposed adjustment to the MA organization payment rates and/or documentation standard was referred to as an ''FFS Adjuster.''

These MA organizations ground their arguments in section 1853(a)(1)(C)(i) of the Act, which requires the Secretary to adjust payments to MA organizations for demographic and health related risk factors so as to ensure ''actuarial equivalence.'' As described previously, the Act requires that we calculate risk-adjusted payments to MA organizations to ensure that MA organizations are paid appropriately based on the enrollees' health status and demographic characteristics. The current risk adjustment model does this by calculating plan enrollees' risk scores and, in turn, using them to adjust the MA organizations' base payment rates, which are the rates for the average beneficiary.

As noted previously, CMS uses diagnostic information submitted by MA organizations to calculate risk scores using the CMS–HCC risk adjustment model, which is published in the Announcement of Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies each time it is updated (*see* section 1853(b) of the Act).[123] Risk scores are used to adjust payments to MA organizations. MA organizations may only report a diagnosis when that diagnosis is properly supported by the beneficiary's medical records. Medical records properly support a reported diagnosis when they comply with all CMS data and documentation requirements, which are described in current agency policy documents, including the Medicare Managed Care Manual.[124] In their annual contracts with CMS, MA organizations agree to operate in accordance with applicable Federal statutes, regulations, and policies, including policies described in the Medicare Managed Care Manual. MA organizations are also required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS (*see* § 422.310(e)).

(3) The 2012 Notice of Payment Error Calculation Methodology

The feedback received from industry in response to the informal proposal in 2010 was considered by CMS, and on February 24, 2012, we issued on our website[125] what we described as a final methodology for RADV contract-specific payment error calculation, to begin with PY 2011 RADV audits (referred to herein as the ''2012 methodology''). That methodology described sampling techniques and a statistical calculation to extrapolate from the sample selected, as well as the use of an FFS Adjuster.[126] The 2012 methodology included the following components:

- *Sampling Technique:* Under the 2012 methodology, up to 201 enrollees from each audited MA contract would be selected according to certain criteria. These criteria included, but were not limited to, the enrollees': (1) continuous

[122] *https://www.cms.gov/data-research/monitoring-programs/medicare-advantage-risk-adjustment-data-validation-radv-program/radv-documents-data.*

[123] *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.*

[124] *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.*

[125] CMS *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf.*

[126] *Id.* at 4–5.

enrollment in the MA contract for the entire data collection year and January of the payment year; (2) lack of end-stage renal disease (ESRD) or hospice status for the entire data collection year and January of the payment year; (3) enrollment in Medicare Part B coverage for the entire data collection year; and (4) assignment of at least one CMS–HCC based on diagnoses submitted by the MA organization for risk-adjustment payment. The RADV-eligible enrollees would then be ranked by risk score and divided into three equal strata (low risk score, average risk score, and high-risk score), with an equal number of enrollees randomly selected from each stratum (for example, 67 enrollees per stratum in the case of an audit of 201 enrollees).

- *Payment Error Calculation:* After medical records were reviewed, payment errors would be calculated for each selected enrollee based on the number of months the person was enrolled in the selected MA contract (and was not in ESRD or hospice status) during the payment year. A payment error amount for each stratum would be calculated, which could include both RADV-identified overpayments and underpayments, and an overall payment error estimate for the audited contract would be derived, along with a 99 percent confidence interval around the payment error estimate.
- *FFS Adjuster:* As part of the 2012 methodology, we also stated that we would apply a FFS Adjuster before finalizing the overpayment amount. The 2012 methodology stated that the actual value of the FFS Adjuster would be calculated by CMS based on a RADV-like review of medical records submitted to support FFS claims data. CMS never calculated or implemented an FFS adjuster for any RADV audits.

(4) The 2018 RADV Proposed Rule

In the 2018 proposed rule (83 FR 54982), to enhance transparency and provide ample notice to MA organizations, we proposed to codify in regulation our methodological approach to RADV audits that would apply to all the payment year audits that had not yet been finalized. These methodologies would apply to PY 2011 and subsequent years and included our prior proposal to use extrapolation and a new proposal not to apply an FFS Adjuster to calculate RADV audit overpayments.

(5) The 2023 RADV Final Rule

In the February 1, 2023, **Federal Register** (88 FR 6643), we published a final rule. This final rule codified in regulation that, as part of the RADV audit methodology, CMS would extrapolate RADV audit findings beginning with PY 2018 and would not extrapolate RADV audit findings for PYs 2011 through 2017. We also finalized a policy whereby CMS would not apply an FFS Adjuster in RADV audits. We also finalized the requirement that MA organizations remit improper payments in a manner specified by CMS. CMS subsequently issued final, non-extrapolated RADV audit results for PYs 2011–2015 and published audit methodologies for PYs 2018–2021, and PY 2024.

On September 25, 2025, the U.S. District Court for the Northern District of Texas vacated this final rule, and CMS is currently appealing that decision.[127]

2. Discussion of Proposals

a. Extrapolation of RADV Audit Findings

(1) Use of Extrapolation in the Medicare Program

Extrapolation, or the act of estimating a value (such as an overpayment amount for a Medicare provider) based on a statistically valid sample of units (such as Medicare claims), has historically been a standard part of auditing practice at CMS. There is significant guidance, including case law and best practices from HHS and other Federal agencies, stating that extrapolation may be utilized as a valid part of calculating improper payments. Courts have held that sampling and extrapolation is a valid method of calculating improper Medicare payments, so long as statistically valid methods are used. *See United States* v. *Lahey Clinic Hosp., Inc.,* 399 F.3d 1, 18 n.19 (1st Cir. 2005) (noting that ''sampling of similar claims and extrapolation from the sample is a recognized method of proof'' for the United States in an affirmative case seeking recovery under a common-law theory); *see also Ratanasen* v. *California Dep't of Health Servs.,* 11 F.3d 1467, 1469–71 (9th Cir. 1993) (collecting cases in which sampling and extrapolation have been approved in the Medicaid context, and ''join[ing] other circuits in approving the use of sampling and extrapolation as part of audits in connection with Medicare and other similar programs''); *Chaves Cnty. Home Health Serv., Inc.* v. *Sullivan,* 931 F.2d 914, 917–23 (D.C. Cir. 1991). The authority to use sampling and extrapolation in Medicare audits is grounded in our statutory and regulatory authority to audit providers and recoup improper payments. *See Chaves,* 931 F.2d at 919 (interpreting the Medicare statute to allow for a ''sample adjudication procedure'' followed by extrapolation from that sample, which ''is reasonable given the logistical imperatives recognized by courts in other comparable circumstances'').

Sampling and extrapolation have been used to calculate improper payments in Medicare FFS (Part A and Part B) for decades. CMS formally approved of this technique in 1986 (HCFA Ruling 86–1), but Medicare Administrative Contractors (MACs), which are responsible for determining medical necessity and paying Medicare FFS claims, have been using it ''at least since 1972.'' *Chaves,* 931 F.2d at 921; *see also id.* at 913 (explaining that ''sample adjudication has been used in previous instances involving post-payment review of 'coverage determinations' under Part A,'' and that HCFA Ruling 86–1 ''simply reiterated [the agency's] belief that it had the latitude to employ sample audits on post-payment review to efficiently recoup overpayments for non-covered services''). Medicare contractors currently use established sampling and extrapolation techniques when determining overpayments in accordance with Chapter 8 of the Medicare Program Integrity Manual. In 1991, the United States Court of Appeals for the District of Columbia Circuit, in *Chaves,* upheld the use of this audit methodology against arguments that the Medicare statute required individualized review of claims submitted by providers. *Id.* at 922.

The MMA imposed limits on the use of sampling and extrapolation in Medicare payment decisions in the context of Part A and Part B. Since 2003, Medicare Part A and Part B extrapolation under section 1893(f)(3) of the Act has been limited to instances in which the Secretary determines either that ''there is a sustained or high level of payment error'' or that ''documented educational intervention has failed to correct the payment error.'' No similar limitation applies to the MA program, and CMS announced its intention to use extrapolation in RADV audits in the 2012 notice.

As previously discussed, sampling and extrapolation is a generally accepted audit technique in the Medicare context, and the Act does not apply any limits to the use of extrapolation in the MA program. Therefore, we believe that CMS has the authority to implement this audit methodology in RADV audits for any case in which a RADV audit identifies

[127] *Humana Inc.* v. *Becerra,* 801 F.Supp.3d 624 (N.D. Tex. 2025), *appeal docketed sub nom. Humana Inc.* v. *Kennedy,* No. 25–11082 (5th Cir. Nov. 21, 2025).

unsupported medical diagnoses resulting in improper risk-adjusted payments. We further believe that extrapolation is a reasonable approach to our RADV audits, given the sustained and high level of risk adjustment payment errors, as previously described, and volume of diagnosis data submitted by MA organizations.

(2) Extrapolation Proposal

CMS proposes extrapolating contract-specific RADV audit findings using statistically valid random sampling techniques. Given the volume of diagnosis data submitted by MA organizations, amount of improper payments identified under the MA program, interest in determining an accurate recovery amount for each audited MA plan, and importance of protecting the overall integrity of the program, we believe that it is in the public interest for CMS to apply extrapolation to PY 2018 and all subsequent years. Implementation of extrapolation and the other audit methodologies in this proposed rule will allow CMS to act in compliance with the improper payment obligations under the Act (most recently updated as part of the Payment Integrity Information Act of 2019 (PIIA), Pub. L. 116–117, 134 Stat. 113 (2020)), as well as our fiduciary responsibility to recover funds due to the Medicare Trust Funds.

CMS proposes to employ statistical methods to determine statistically valid sample sizes, accurately identify payment error, and extrapolate to the universe of enrollees from which the sample is selected. These statistically valid methods may include applying one or more RADV audit methodologies for any given RADV audit. In addition, while CMS views extrapolation as a statistically valid methodology for RADV audits, the agency may, at times, use its discretion to not utilize extrapolation in a particular instance. For example, there may be unforeseen circumstances in which the statistical validity of the sample is disturbed (such as the need to exclude a large number of cases from the sample due to the loss of medical records in a natural disaster) and extrapolation is no longer possible, despite the initial intent to do so. There may be other limited instances in which CMS seeks to collect overpayments associated only with enrollees in a given sample or wishes to perform only a probe sample of RADV reviews without the use of a statistically valid sample and yet will seek to recover any identified, non-extrapolated overpayments. The OIG may also independently decide not to extrapolate for reasons outside the control of CMS, and CMS will still recover those overpayments in accordance with requirements. To account for this, we are proposing § 422.311(a)(2) to read, ''CMS may apply extrapolation to audits for payment year 2018 and subsequent payment years.'' However, CMS intends for extrapolation to be the standard practice for RADV audits beginning with PY 2018.

Any sampling and extrapolation methodologies adopted by CMS for RADV audits will be focused on MA organization contracts and enrollees' HCCs that, through statistical modeling and/or data analytics, are identified as being at highest risk for improper payments. This is an appropriate approach to any Federal MA audit that seeks to recoup taxpayer dollars that have been inappropriately paid to MA organizations for diagnoses that are not supported in the medical record. This approach was also recommended by the GAO in a 2016 report titled ''Fundamental Improvements Needed in CMS' Effort to Recover Substantial Amounts of Improper Payments.'' [128] The GAO recommended that CMS ''modify [its] selection of contracts for contract-level RADV audits to focus on those contracts most likely to have high rates of improper payments by taking actions such as the following: selecting more contracts with the highest coding intensity scores; excluding contracts with low coding intensity scores; selecting contracts with high rates of unsupported diagnoses in prior contract-level RADV audits; if a contract with a high rate of unsupported diagnoses is no longer in operation, selecting a contract under the same MA organization that includes the service area of the prior contract; and selecting some contracts with high enrollment that also have either high rates of unsupported diagnoses in prior contract-specific RADV audits or high coding intensity scores.'' [129]

CMS is not required to set forth all potential sampling methodologies for calculating an extrapolated payment error through regulatory provisions. However, in the interest of transparency, we are choosing to inform MA organizations about our plans to use various sampling and extrapolation methodologies in RADV audits, as CMS deems appropriate, through rulemaking.

In the 2018 proposed rule, we stated that, given the amount of improper payments identified under the MA program, interest in determining an accurate recovery amount for each audited MA plan, and importance of protecting the overall integrity of the program, we believed that it was in the public interest for CMS to apply the RADV payment error methodology or methodologies adopted through this rulemaking to PY 2011 and all subsequent years. In the 2023 final rule, we announced that extrapolation would instead begin with the PY 2018 RADV audits rather than PY 2011, as proposed. This change was made due to our fiduciary duty to protect taxpayer dollars from overpayments, certain operational considerations, and public comments on the timeliness of RADV audits.

We also note that our publication of audit methodologies for PYs 2018–2021 put MA organizations on further notice that CMS plans to calculate a contract-specific payment error for PY 2018 and subsequent payments year by extrapolating from its review of a statistically valid sample of enrollees, and that MA organizations have never been entitled to receive or retain payments associated with HCCs that cannot be validated by medical records.

In addition to codifying our existing authority to use contract-specific extrapolation techniques in the RADV context, we also propose to use potential methodologies for sampling and extrapolation that are based on a particular sub-cohort or sub-cohorts in a given payment year. For example, a sub-cohort could be the enrollees for whom a particular HCC or one of a related set of HCCs (such as HCCs for diabetes conditions) was reported. After choosing an MA contract and a sub-cohort or sub-cohorts to audit, we would select a statistically significant sample of enrollees in the sub-cohort or sub-cohorts. After reviewing these enrollees' medical records that are submitted by the MA organization, we would use statistical extrapolation to calculate and recoup the improper payments made to the audited MA contract for all enrollees in the sub-cohort or sub-cohorts in that payment year.

Using a sub-cohort methodology, such as one focused on enrollees with high-risk HCCs, would allow us to use a smaller sample size to calculate a statistically valid extrapolated improper payment amount. This is possible because, when selecting a sample from a smaller population (that is, a sub-cohort of enrollees), one can still achieve an acceptable level of statistical confidence with that smaller sample size. This sub-cohort-based audit methodology would also allow us to spread our audit resources across a wider range of MA contracts and focus

[128] GAO, at 26, *https://www.gao.gov/assets/gao-16-76.pdf* (April 2016).

[129] *Id.*

on cohorts of enrollees that raise programmatic concerns, while also reducing operational burden on both CMS and the MA organizations due to the reduced sample size needed to calculate improper payments.

We emphasize that neither proposed methodology is meant to displace our longstanding authority to audit the medical records of specific enrollees who we believe may be associated with improper payments or to use any statistically valid audit methodology on a case-to-case basis. If we finalize one or more sampling and extrapolation methodologies through this rulemaking, we will announce any future changes to that methodology (or those methodologies) through the Health Plan Management System (HPMS) or other appropriate means.

We also propose that MA organizations would be required to remit extrapolated recovery amounts from RADV audit findings in a manner specified by CMS, typically through CMS' payment system, the Medicare Advantage and Prescription Drug system (MARx), as offsets to MA plans' monthly capitation payments. In the event that the recovery amount exceeds the payment in one month, we propose that the recovery be spread across adjustments for multiple months until the full amount plus applicable interest is recouped. In some situations, payment by wire transfer may be necessary. We also propose that CMS might likewise require MA organizations to remit such recovery amounts based upon audit findings by the HHS–OIG.

We also propose to reissue our RADV dispute and appeals regulations in § 422.311, to conform with the proposed audit methodology provisions. Specifically, consistent with our other proposed policies, we propose to reissue § 422.311 by including language to clarify that recovery of improper payments from MA organizations will be conducted according to the Secretary's payment error calculation methodologies and recovery procedures, and that CMS will apply extrapolation to RADV audits beginning with PY 2018.

b. Fee-For-Service Adjuster Concept

(1) Description of an FFS Adjuster

As previously described, risk adjustment ensures that MA organizations are paid appropriately for their plan enrollees, and section 1853(a)(1)(C) of the Act requires that we calculate risk-adjusted payments to MA organizations based on specific criteria, such as age, disability status, sex, institutional status, and health status. As discussed earlier, MA organizations' payments are calculated using the CMS–HCC risk adjustment model, which is published each time it is updated (see section 1853(b) of the Act).[130] Additionally, an MA organization may only report a diagnosis, and claim the associated payment, when that diagnosis is properly supported by the beneficiary's medical records. Medical records properly support a reported diagnosis when they comply with all CMS data and documentation requirements, which are described in current agency regulations and policy documents, including Chapter 7 of the Medicare Managed Care Manual and those on the Customer Service and Support Center website.[131] Plans are also required to submit a sample of medical records for the validation of this risk adjustment data (*see* § 422.310(e)).

Some MA organizations have suggested that CMS cannot lawfully enforce the requirement of medical record documentation for diagnosis codes while making payments at published rates. These MA organizations state that there is a difference in auditing standards between Medicare FFS and MA diagnosis data. In contrast to the MA organization-submitted diagnosis data, these MA organizations claim that Medicare FFS data is ''unaudited'' by CMS and presumably contains erroneous diagnosis codes not properly supported by beneficiaries' medical records. As a result, they state, the Medicare FFS data used to calculate MA organization payments will understate the cost of treating various conditions. MA organizations state that CMS must raise payment rates to MA organizations or relax the documentation standard that CMS applies to reported medical diagnoses to address what they refer to as the presence of erroneous diagnoses in the FFS claims used to calibrate the CMS–HCC model. MA organizations refer to this concept of a proposed adjustment to the payment rates and/or documentation standard for MA organizations as an ''FFS Adjuster.'' These MA organizations ground their arguments in section 1853(a)(1)(C)(i) of the Act, which requires the Secretary to adjust payments to MA organizations for demographic and health related risk factors to ensure ''actuarial equivalence.'' According to these MA organizations, an FFS Adjuster would either adjust payment rates (by raising them) or adjust documentation standards (by loosening them) to resolve the alleged incompatibility between the current rates and current documentation standards. In the 2012 methodology, using the term somewhat differently, CMS said that it would ''apply a Fee-for-Service Adjuster (FFS Adjuster) amount as an offset to the preliminary recovery amount'' calculated for RADV audits under that methodology.

(2) FFS Adjuster Proposal

We are proposing to not apply an FFS Adjuster to RADV audits. The ''actuarial equivalence'' and ''same methodology'' provisions in the statute do not apply to the obligation of an MA organization to report and return improper payments for diagnoses lacking medical record support, including those improper payments identified during a RADV audit, as discussed in detail later. We also believe that it would not be reasonable to interpret the Act as requiring a reduction in payments to MA organizations by at least a statutorily set minimum percentage pursuant to the coding pattern adjustment, while at the same time prohibiting CMS from enforcing longstanding documentation requirements by requiring an offset to the recovery amounts calculated for CMS audits, as discussed in detail as follows.

(3) Actuarial Equivalence

Some MA organizations have contended that an FFS Adjuster is required in RADV audits to ensure ''actuarial equivalence'' between payments to MA plans and payments under the Medicare FFS program. Some have also contended that the ''same methodology'' provision of section 1853(b)(4)(D) of the Act requires the application of an FFS Adjuster in RADV audits.

We believe that the ''actuarial equivalence'' requirement under section 1853(a)(1)(C) of the Act and ''same methodology'' provision under section 1853(b)(4)(D) of the Act do not require the use of an FFS Adjuster in RADV audits. As described by the D.C. Circuit, these provisions do not apply to the obligation to return improper payments for MA organization diagnosis codes that are unsupported by medical records. *See UnitedHealthcare Ins. Co.* v. *Becerra,* 16 F.4th 867, 869, 891–92 (D.C. Cir. 2021), *cert. denied,* 142 S. Ct. 2851 (U.S. June 21, 2022). Although the D.C. Circuit did not address the RADV

[130] *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.*

[131] See the following link to access CMS manuals: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf.* See the following link for the MA Customer Service and Support website: *https://csscoperations.com/.*

audit context in its decision in *UnitedHealthcare,* our position is consistent with the D.C. Circuit's reasoning in that case. *Id.*

In *UnitedHealthcare,* a group of MA organizations challenged the Secretary's Part C Overpayment Rule (the ''Overpayment Rule'') (79 FR 29844), which implemented section 6402 of the Affordable Care Act (Pub. L. 111–148) and required MA organizations to self-report and return payments associated with MA organization diagnosis codes not supported by medical record documentation. The district court invalidated the Overpayment Rule. *See UnitedHealthcare Ins. Co.* v. *Azar,* 330 F. Supp. 3d 173, 192 (D.D.C. 2018).

However, the D.C. Circuit reversed the district court, holding that the actuarial equivalence provision applies only to how CMS risk adjusts the payments it makes to MA organizations, and not to the obligation of MA organizations to return improper payments for diagnosis codes, submitted by MA organizations to CMS, lacking medical record support. *See UnitedHealthcare,* 16 F.4th at 883–887. The D.C. Circuit also held that even if the actuarial equivalence provision applied, plaintiffs' claims would still fail because they did not meet their burden in showing, either through empirical evidence or persuasive logic, that application of the Overpayment Rule would lead to systematic underpayment of MA organizations. *Id.* at 887 through 891.

While the D.C. Circuit decision pertained only to the Overpayment Rule and declined to address RADV audits, its reasoning applies just as strongly in the RADV context and supports our proposed conclusion that an FFS Adjuster is neither required nor appropriate to reduce a RADV audit overpayment. ''The role of the actuarial-equivalence provision is to require CMS to model a demographically and medically analogous beneficiary population in Original Medicare to determine the prospective lump-sum payments to [MA organizations].'' *Id.* at 870. The RADV audit program, like the Overpayment Rule, arises post-payment to require MA organizations to refund any payment to which they are not entitled, based on diagnoses that lack support in the medical record. The purpose of RADV audits is to recover payments that were made improperly based on diagnoses not supported by medical record documentation. If a payment is made to an MA organization based on a diagnosis code not supported by medical record documentation, the entire payment for that code is in error and should be recovered in full because the payment standard has not been met.

We also believe it would be unreasonable to interpret the Act as requiring a minimum reduction in payments in one provision (the coding pattern provision), while at the same time prohibiting CMS in an adjacent provision (the actuarial equivalence provision) from enforcing those longstanding documentation requirements (by requiring a reduction to the recovery amount calculated for CMS audits). To the contrary, because the Act requires CMS to reduce payments to MA organizations by at least a specific minimum percentage, the only reasonable interpretation of the Act is that CMS would pay MA organizations at those reduced rates, under the existing payment model,[132] and enforce the longstanding documentation requirements.

Our proposal is consistent with the conclusion of the D.C. Circuit, which is that the actuarial-equivalence requirement is not an ''entitle[ment] . . . to a precise payment amount'' for a Medicare Advantage insurer, but only ''an instruction to the Secretary regarding the design of the risk adjustment model as a whole . . . describ[ing] the type of 'payment amount[s]' that the risk adjustment model should produce''; ''[i]t does not directly govern how CMS evaluates the validity of diagnoses or defines 'overpayment.'" *UnitedHealthcare,* 16 F.4th at 885–86.

(4) Coding Pattern Adjustment

Section 1853(a)(1)(C)(ii) of the Act requires the implementation of a minimum coding pattern adjustment to reduce risk scores of MA beneficiaries, and therefore MA payment rates, until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data. This minimum coding pattern adjustment accounts for differences in coding patterns between MA and Medicare FFS, given that MA organizations have a greater incentive than FFS providers to report diagnoses. To meet this requirement, each year, CMS has implemented an adjustment to offset the effects on MA risk scores of higher levels of coding patterns in MA relative to FFS. (See section 1853(a)(1)(C)(ii) of the Act.) Under section 1853(a)(1)(C)(ii)(III) of the Act, the minimum adjustment factor for 2019 and each subsequent year is 5.90 percent. CMS has, each year, implemented the minimum coding pattern adjustment reduction required by statute.

Some MA organizations have expressed concern that using extrapolation without applying an FFS Adjuster to payment recoveries achieved through RADV audits will overlap with coding pattern adjustments or create a double recovery by CMS. As CMS has explained in its annual MA Advance Notices and Rate Announcements, the coding pattern adjustment, unlike RADV, is not intended to address unsupported or inaccurate codes reported by MA organizations in particular instances but only the general practice, relative to Medicare FFS, of identifying more diagnosis codes, including codes that are nonetheless accurate.[133] The coding pattern adjustment provision of the statute supports our proposal not to apply an FFS Adjuster. We briefly review the history of that provision.

The coding pattern adjustment was enacted as part of the Deficit Reduction Act of 2005. (Pub. L. 109–171 (February 8, 2006), codified at 42 U.S.C. 1395w–23(a)(1)(C)(ii)(I) and (II).) The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), section 1853(a)(1)(C)(ii) of the Act was amended to require that the adjustment be at least 4.71 percent in 2014, rising annually to at least 5.7 percent in 2019. (Pub. L. 111–152, tit. I, subtit. B, section 1102(e), 124 Stat. 1046.) (For payment years 2010 to 2013, CMS applied a 3.41 percent adjustment.[134]) Section 1853(a)(1)(C)(ii)(III) of the Act was subsequently amended again in the American Taxpayer Relief Act of 2012 to require the Secretary to make a reduction of at least 4.91 percent in 2014, rising to at least 5.9 percent by 2019. (Pub. L. 112–240, tit. VI, subtit. C, section 639, 126 Stat. 2357.) As noted previously, it would be unreasonable to interpret the Act as requiring a minimum reduction in payments in one provision (the coding pattern provision), while at the same time prohibiting CMS in an adjacent provision (the actuarial equivalence provision) from enforcing those longstanding documentation requirements (by requiring an offset to the recovery amount calculated for CMS

[132] Any changes to the CMS–HCC payment model are published in the annual payment notice.

[133] Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter at 19 (April 5, 2010); *see also* Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter at 54 (April 4, 2016); Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter at 37–38 (April 4, 2011).

[134] Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies at 19–29 (April 6, 2009).

audits). Section 1853(a)(1)(C)(ii) of the Act requires a minimum coding pattern adjustment to reduce the risk scores of all MA beneficiaries, and therefore, MA payment rates. Such a minimum coding pattern adjustment accounts for differences in coding patterns between MA and Medicare FFS, given that MA organizations have a greater incentive than FFS providers to report diagnoses.

(5) Documentation Requirements

Some MA organizations have stated in prior rulemaking comments that not using an FFS adjuster imposes new documentation standards on them, but CMS audits reinforce longstanding documentation requirements. The purpose of RADV audits is to recover improper payments resulting from diagnoses that are not supported in the medical record documentation, which is a longstanding documentation standard that applies to all plans equally and regardless of whether the plan is subject to a RADV audit. The objective of an audit is to promote fair and impartial recovery of improper payments due to insufficient documentation in accordance with regulations. This proposal would not impose a new documentation standard on MA organizations, nor is there a distinction in the documentation standards between the MA and FFS Medicare programs. Under section 1857(d)(2), each MA contract provides the Secretary with the right to audit and inspect any books and records of the MA organization that pertain to services performed or determinations of amounts payable under the contract. Similarly, Section 1815(a) of the Act (Medicare Part A) states that ''no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.'' Additionally, section 1833(e) of the Act (Medicare Part B) states that ''[n]o payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.'' Section 1172 of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. 104–191) requires both providers and health plans to use standard content, formats, and coding for health care transactions. Accordingly, all parts of Medicare generally require program participants to submit documentation necessary to support Medicare payments.

As we noted in our April 15, 2022, Health Plan Management System (HPMS) memorandum, *Reminder of Existing Obligation to Submit Accurate Risk Adjustment Data,* MA organizations must submit data that conforms to all relevant national standards, including the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD–10–CM) Guidelines for Coding and Reporting requirement that diagnoses be documented in patients' medical records. (*See* §§ 422.310(d)(1); 45 CFR 162.1002(c)(2), (3).) The diagnosis codes and other risk adjustment information that MA organizations submit directly affect the calculation of CMS payments to the MA organization. A diagnosis code that is not documented in a patient's medical record is not a valid basis for CMS risk adjustment payments to an MA organization. *UnitedHealthcare,* 16 F.4th at 869, 877.

In addition, the Secretary has adopted various organizations' formats and code sets, including the ICD–10 and the ICD Guidelines, which is the national standard for both FFS and MA. See 45 CFR 162.1002. CMS has always required proper medical record documentation in order for any reported diagnosis code or claim to be valid. (*See, for example, UnitedHealthcare,* 16 F. 4th at 869 (''[n]either Congress nor CMS has ever treated an unsupported diagnosis for a beneficiary as valid grounds for payment to a Medicare Advantage insurer''). That is the consistent policy throughout the Medicare program, including MA and FFS.[135] (See § 422.310 (''MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards.'') Thus, we do not believe that RADV audits impose any new level of burden on providers or violate any initiatives to reduce that burden.

As such, we propose to not apply an FFS Adjuster to RADV audit overpayments.

c. Improving the Hardship Exceptions Process

MA record retention requirements incorporated in MA contracts have been in place since the beginning of the MA program. Under § 422.504(d), MA organizations are required to maintain records and other documentation for 10 years to accommodate the periodic auditing of financial records for such purposes as determining Medicare utilization, costs, and amounts payable under the contract. Further, § 422.504(i) extends these record retention requirements to providers of health care services under contract with the MA organization. This regulation further specifies that the Federal Government has the right to audit an MA organization through 10 years from the end of the final contract period.

However, CMS understands that there may be extraordinary circumstances beyond MA organizations' control that may make it difficult to meet medical record submission or other audit requirements. CMS historically implemented a hardship exception process through sub-regulatory guidance for prior payment year audits. We are now proposing to codify this process in regulation by adding a new subparagraph § 422.310(e)(1) to allow MA organizations to request a hardship exception, as prescribed by CMS, if they cannot submit medical records timely as required.

First, we propose that MA organizations may submit a hardship exception request for: (1) the entire MA contract; (2) a sampled enrollee and all the related audited HCCs; or (3) specific audited HCCs. An MA organization may submit multiple hardship exception requests, if necessary, but all supporting documentation must be submitted before the hardship exception request submission deadline. Deadlines to request a hardship exception would be specified in sub-regulatory guidance issued prior to the start of a payment year audit. An MA organization would be required to withdraw a specific hardship exception request before resubmitting it with modifications. For example, if an MA organization submitted a hardship exception request for one or more audited HCCs for a specific enrollee, the MA organization would be required to withdraw that existing hardship exception request submission prior to adding another HCC to the hardship exception request and resubmitting the request to CMS. If an MA organization submits a valid medical record (MR) for an audited HCC(s) for which it has submitted a hardship exception request, then the hardship exception request and any decision made by CMS (for the related audited HCC(s)) for the request would be rendered moot. In other words, the

[135] FFS Medicare claims are subject to error correction and payment adjustment when they are based on diagnosis codes not supported by the medical record. *See* Medicare Program Integrity Manual Ch. 3 & Ch. 6, §§ 3.3.1.1, 3.3.2.1, 3.6.2.4, 6.5.2, 6.5.3., *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs-Items/CMS019033.*

valid MR submission would supersede any hardship exception request.

Second, we propose that an MA organization would be required to submit supporting documentation with a hardship exception request that clearly demonstrates an extraordinary circumstance(s) exists and includes all relevant details required for CMS to comprehensively assess the incident or issue. Supporting documentation includes, but is not limited to, any communications associated with the incident and all available evidence substantiating that the incident occurred. MA organizations still have an obligation to pursue all potential medical record sources before submitting a hardship exception request and should review relevant record retention requirements. MA organizations should actively pursue and submit an alternative medical record that supports an audited HCC(s) when the initial medical record sought is unavailable or insufficient to support the audited HCC(s).

If an MA organization is unable to obtain the relevant medical record(s) and submits a hardship exception request for a sampled enrollee's, or group of sampled enrollees', audited CMS–HCCs, we propose that the MA organization would be required to submit documentation (such as verification of a United States Postal Service certified mail delivery or that a delivery attempt was made, or similar verifiable evidence) that it sought medical record documentation from all providers associated with diagnosis data that the MA organization submitted to CMS for the purpose of receiving risk adjusted payments for the sampled enrollee(s). Additionally, MA organizations should be aware of State requirements for medical records to be placed in the care of a custodian for a period of time when a health care provider's office closes. When a health care provider has closed, retired, passed away, changed ownership, or otherwise undergone a change that, according to State law, should have required their medical records to be placed in the care of a custodian, MA organizations should contact the custodian to request the relevant medical records. We propose that CMS would deny a hardship request if the MA organization failed to submit sufficient supporting documentation, including documentation of the MA organization's pursuit of all possible medical record sources. We also propose that hardship exception requests decisions would be final and not subject to appeal.

The following are examples of extraordinary circumstances that may meet CMS' definition of an extraordinary circumstance that may impede an audited MA organization's timely acquisition of medical records and the types of supporting documentation that CMS would expect to be submitted by the MA organization to substantiate the circumstances:

- *Natural Disaster or Declared Emergency:* Events such as hurricanes, wildfires, floods, or other declared emergencies that disrupt provider operations or access to records. Supporting documentation includes FEMA or State emergency declarations, provider attestations, news releases, and facility closure notices associated with the natural disaster or declared emergency.
- *Public Health Emergency:* Public health events that significantly impact staffing, operations, or access to medical records. Supporting documentation includes government-issued emergency declarations, internal contingency plans, and provider attestations.
- *Legal or Regulatory Restrictions:* Court orders, subpoenas, or legal constraints preventing access to records within required timeframes. Supporting documentation includes court orders, legal correspondence, attestation from legal counsel, and any proof of seizure or unavailability including official documentation showing records were seized.
- *Major System or Technology Failure:* Significant IT outages or cybersecurity incidents. Supporting documentation includes incident reports, vendor outage notices, and other documentation such as system logs, error reports, security audit reports, data recovery attempts, incident documentation, and/or breach or loss of data reports.
- *Provider's Office Closed and Custodial Requirements Lapsed:* A provider retired, sold, or closed their practice preventing access to records within the required timeframe and the State law custodial requirements have lapsed. Supporting documentation includes an announcement, news report, or signed attestation indicating closure. Submissions regarding provider office closures would take into consideration State law custodian of record requirements, and evidence that the enrollee's record cannot be accessed by any other provider or practice.
- *Other Extraordinary Circumstances:* Circumstances beyond the organization's control that materially impact the retrieval of medical record documentation. Supporting documentation includes a detailed written explanation and third-party attestations or corroborating documentation.

These examples are not exhaustive and would not guarantee approval of a submitted hardship exception request. Furthermore, MA organizations failing to submit sufficient supporting documentation, including documentation of the MA organization's pursuit of all possible medical record sources, will result in CMS denying a hardship exception request.

CMS would not consider the following scenarios to be justification for granting a hardship exception:

- Reliance solely on State law record retention periods that are shorter than CMS' 10-year record retention requirement.
- Health care providers not responding to a request.
- Issues related to lost records.
- Provider office closures, or retired or deceased health care providers where State law custodial requirements have not lapsed.
- Medical practice transfers.
- Human resource issues.
- Ordinary IT issues (for example, system upgrade issues, routine data migration issues, incomplete vendor handovers) that result in missing or inaccessible records.

MA organizations are reminded of their obligation to pursue alternative medical records in these situations. We seek comments on the hardship exception request process and MA organizations' requirement to submit supporting documentation.

d. Retroactivity

We do not believe that the RADV audit policies proposed in this rule impose any new requirements on MA organizations that could be construed as retroactive. We may begin to conduct new RADV audits or finalize results from existing audits for multiple payment years before finalizing the policies in this rule, pursuant to our longstanding authority under § 422.310(e) to review the medical records of any MA enrollee and recoup improper payments identified.

As discussed in the Discussion of Proposals section, CMS has a long-established historical record of using extrapolation in the Medicare program. There is significant guidance, including case law and best practices from HHS and other Federal agencies, stating that extrapolation may be utilized as a valid part of calculating improper payments. CMS first announced its intention to use extrapolation in RADV audits with the publication of an informal proposal in 2010 and reaffirmed this intention in

the 2012 methodology.[136] This intention was again announced in the 2018 RADV proposed rule (83 FR 54982) and subsequently finalized in the 2023 RADV final rule (88 FR 6643). CMS has also announced its intention not to apply an FFS adjuster in RADV audits since the 2018 RADV proposed rule and this policy intention was finalized in the 2023 RADV final rule.

Even if our proposal was determined to be a retroactive application of policy, a position with which we do not agree, it is in the public interest for CMS to apply extrapolation to past payment years, and, therefore, is authorized under the Act. CMS has the authority, in accordance with section 1871(e)(1)(A) of the Act, to apply retroactive changes in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability to items and services furnished before the effective date of the change, if the Secretary determines that ''such retroactive application is necessary to comply with statutory requirements or failure to apply the change would be contrary to the public interest.'' Since the early development of RADV, CMS has repeatedly notified MA organizations and the public of its intent to extrapolate RADV audits results and published a methodology in 2012. We believe that recovering extrapolated improper amounts is necessary to comply with statutory requirements and advances the public interest by protecting the overall integrity of the Medicare program. As mentioned earlier, in fiscal year (FY) 2025 (based on calendar year 2023 payments), we estimated that CMS made over $21 billion in Part C overpayments, a figure representing over 5 percent of total Part C payments.[137] Due to significant growth in the MA program and the large volume of diagnosis data submitted by MA organizations, we are unable to recover this significant amount of overpayment without the use of extrapolation. We have a statutory mandate under the PIIA to reduce improper payments and a fiduciary responsibility to recover funds due and owed to the Medicare Trust Funds.

As previously discussed, CMS, HHS–OIG, and the GAO have identified a significant volume of improper payments in the MA program,[138] and RADV audits are the primary way CMS ensures payment accuracy to MA organizations. As further discussed in the Regulatory Impact Analysis section of this proposed rule, CMS estimates extrapolated improper payment recoveries of approximately $9 billion per audit year beginning with the PY 2018 audits. We also believe that extrapolation will foster an additional sentinel effect of RADV audits on the improper payment rate as MA organizations improve their processes to report only those diagnoses that meet CMS requirements to be documented in the medical record in accordance with ICD–CM coding guidelines.

The core component of a RADV audit is to ensure that all diagnoses are properly supported by medical records. We only seek to recover improper payments received by MA organizations for HCCs that are not substantiated by enrollees' medical records. MA organizations have never been entitled to receive or retain payments associated with HCCs that cannot be validated by medical records, and it is impossible for MA organizations to submit, and CMS to audit, every medical record. CMS has never calculated or applied an FFS adjuster to any RADV audit findings and allowing MA organizations to retain Medicare funds for unsubstantiated diagnoses on this basis runs contrary to the statute. Therefore, applying the rule under the public interest exception in section 1871(e)(1)(A) of the Act would not upset any settled or reasonable reliance interests. This all serves the public interest by reducing the improper allocation of taxpayer dollars that can otherwise be used for other purposes within the Federal Government, including solvency of the Medicare Trust Funds. Thus, a retroactive application of the rule is in the public interest within the meaning of section 1871(e)(1)(A) of the Act.

If a court were to find that any provision of this rule is impermissibly retroactive, we believe that the rule should remain in effect for any payment year that has not yet occurred or for other provisions not found to be retroactive. For example, if our proposed use of extrapolation for payment years prior to the publication of a final rule is determined to be impermissibly retroactive, the final regulation would still allow collection of extrapolated recoveries for subsequent payment years depending on what payment year is determined to be the triggering date for retroactive application.

To the extent a court may ultimately enjoin one provision of this section as finalized, CMS proposes that the other provisions should remain in effect, ensuring the continuity of the regulations. We propose that any provision of the requirements of this rule that is held to be invalid or unenforceable by its terms or as applied to any person, entity, or circumstance would be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding is one of utter invalidity or unenforceability, in which event we propose that the provision would be severable from the other provisions of this rulemaking and would not affect the remainder thereof or the application of the provision to persons or entities not similarly situated or to dissimilar circumstances.

We propose that if any section, subsection, sentence, clause, phrase, word, provision, or application of this proposed rule as finalized shall be found to be invalid, illegal, unconstitutional, or unenforceable, that finding shall not affect or undermine the validity of any other section, subsection, sentence, clause, phrase, word, provision, or application which can be enforced without the use of the offending provision. We request comments from the public on severability, particularly which policies could be severable, if finalized, and how the other policies in a final rule would operate absent those particular provisions.

V. Provider Enrollment Proposals

A. Provider Enrollment Background

1. Introduction

Section 1866(j)(1)(A) of the Act requires the Secretary to establish a process for the enrollment of providers and suppliers into the Medicare program. The overarching purpose of the enrollment process is to help confirm that providers and suppliers (hereafter collectively ''providers'' unless otherwise noted) seeking to bill Medicare for services and items furnished to Medicare beneficiaries meet all applicable Federal and State requirements to do so. The process is, to

[136] CMS *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf.*

[137] HHS, FY 2025 HHS Agency Financial Report, pg. 154, *https://www.hhs.gov/sites/default/files/fy-2025-hhs-agency-financial-report.pdf.* CMS made over $23 billion in total Part C improper payments. The improper payment measurement for the MA program in FY 2025 included both overpayments ($21 billion) and underpayments ($2 billion).

[138] For example, the FY 2025 HHS Agency Financial Report, pg. 154, *https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf* states that Part C Improper Payment Measurement (IPM) estimated approximately $21.4 billion in overpayments for reporting year 2025. *https://www.hhs.gov/sites/default/files/fy-2025-hhs-agency-financial-report.pdf.*

an extent, a ''gatekeeper'' that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. It has proven invaluable in this regard and is a vital component of Medicare program integrity.

Under 42 CFR 424.510, a provider or supplier must complete, sign, and submit to its assigned Medicare contractor the appropriate Form CMS–855 (OMB Control No. 09380685) application in order to enroll in the Medicare program and obtain Medicare billing privileges.[139] The Form CMS–855, which can be submitted via paper or electronically through the internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process, captures information about the provider or supplier that is needed for CMS or its contractors to determine whether the provider or supplier meets all Medicare requirements. Data collected during the enrollment process include but are not limited to: (1) general identifying information (for example, legal business name, tax identification number (TIN), and National Provider Identifier (NPI)); (2) licensure data; (3) practice locations; and (4) information regarding the provider's or supplier's owning and managing individuals and organizations.

The application is used for a variety of provider enrollment transactions, including the following:

- *Initial enrollment*—The provider or supplier is: (1) enrolling in Medicare for the first time; (2) enrolling in another Medicare contractor's jurisdiction; or (3) seeking to enroll in Medicare after having previously been enrolled.
- *Change of ownership*—The provider or supplier is reporting a change in its ownership.
- *Revalidation*—The provider or supplier is revalidating its Medicare enrollment information in accordance with § 424.515.
- *Reactivation*—The provider or supplier is seeking to reactivate its Medicare billing privileges after it was deactivated in accordance with § 424.540.
- *Change of information*—The provider or supplier is reporting a change in its existing enrollment information in accordance with § 424.516.

Our provider enrollment regulations are generally codified in 42 CFR part 424, subpart P (currently §§ 424.500 through 424.575 and hereafter occasionally referenced as subpart P). They address, among other things, requirements that providers must meet to obtain and maintain Medicare billing privileges. Since 2006, we have issued numerous final rules designed to strengthen and clarify the provider enrollment process, such as the following:

a. The 2006 Provider Enrollment Final Rule

We published in 2006 a final rule titled, ''Medicare Program; Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment,'' which appeared in the **Federal Register** on April 21, 2006 (71 FR 20754). The final rule set forth certain requirements in 42 CFR part 424, subpart P that providers and suppliers must meet to obtain and maintain Medicare billing privileges.

b. The 2011 Provider Enrollment Final Rule

We published a final rule with comment period in 2011 titled, ''Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers,'' which appeared in the **Federal Register** on February 2, 2011 (76 FR 5862). This final rule with comment period implemented various provisions of the Act, as added by the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111–148) and as amended by the Health Care and Education Reconciliation Act (Pub. L. 111–152). These provisions included, among other things:

- Requiring the submission of application fees by institutional providers and suppliers as part of the Medicare, Medicaid, and CHIP provider enrollment processes.
- Establishing Medicare, Medicaid, and CHIP provider risk-based enrollment screening categories and corresponding screening requirements.
- Authorizing temporary moratoria on the enrollment of new Medicare, Medicaid, and CHIP providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area when necessary to combat fraud, waste, or abuse.

c. The 2019 Provider Enrollment Final Rule

We published in 2019 a final rule with comment period titled ''Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process,'' which appeared in the **Federal Register** on September 10, 2019 (84 FR 47794). This rule implemented section 1866(j)(5) of the Act (as added by the Affordable Care Act), which permitted the Secretary to deny the enrollment of a Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provider or supplier if—

- The provider or supplier has or previously had an affiliation with a provider or supplier that: (1) has uncollected debt; (2) has been or is subject to a payment suspension under a Federal health care program; (3) has been or is excluded by the Office of Inspector General (OIG) from Medicare, Medicaid, or CHIP; or (4) has had its Medicare, Medicaid, or CHIP billing privileges denied or revoked; and
- The Secretary determines that this affiliation presents an undue risk of fraud, waste, or abuse to the Medicare program.

This rule also established additional grounds for denying or revoking a provider's or supplier's Medicare enrollment based, in general, on problematic or otherwise non-compliant conduct by the provider or supplier. These provisions were designed to strengthen the integrity of the Medicare program and to protect Medicare beneficiaries.

Besides these final rules, we have made other regulatory changes to 42 CFR part 424, subpart P—virtually on an annual basis since 2020—to address various payment safeguard issues that have arisen.

Despite these rulemaking efforts, and as later explained in detail, several provider enrollment vulnerabilities remain and certain regulatory clarifications are needed. Therefore, we are proposing a number of provider enrollment provisions that we believe would help resolve these issues. They focus largely on: (1) DMEPOS supplier enrollment, including DMEPOS surety bonds; (2) Medicare Advantage enrollment requirements; and (3) additional denial and revocation grounds. We also are proposing provisions regarding Medicaid provider enrollment, discussed in section V.G of this proposed rule.

2. Legal Authorities

Although additional legal authorities are addressed later in this section V., our principal authorities for this proposed rule are:

- Section 1866(j) of the Act, which furnishes specific authority regarding

[139] Medicare Diabetes Prevention Program (MDPP) suppliers complete the Form CMS–20134 (Medicare Enrollment Application; Medicare Diabetes Prevention Program (MDPP) Suppliers) in lieu of the Form CMS–855. Except as stated otherwise, all references in this proposed rule to the Form CMS–855 include the Form CMS20134.

the enrollment process for providers and suppliers; and

• Sections 1102 and 1871 of the Act, which provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program.

3. Medicaid and CHIP Provider Enrollment

As stated, we are also proposing a number of provider enrollment provisions relating to Medicaid and CHIP. These are addressed in section V.G. of this proposed rule.

B. DMEPOS Supplier Provisions

Among the types of providers and suppliers that must enroll in Medicare to bill the Medicare program are DMEPOS suppliers. Such suppliers include, but are not limited to, the following:

• Medical supply companies that exclusively furnish DME like wheelchairs, walkers, and canes.

• Physicians and practitioners who provide DMEPOS to their own patients.

• Home health agencies (HHAs) and hospitals that provide DMEPOS to their own patients.

• Oxygen and oxygen equipment suppliers.

• Prosthetists and orthotists.

• Pharmacies.

DMEPOS suppliers enroll in Medicare via the Form CMS–855S application (Medicare Enrollment Application—Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); OMB Control No. 0938–1056). Per 42 CFR 424.57(b)(1)—and excluding locations it utilizes solely as warehouses or repair facilities—the supplier must separately enroll each physical location it uses to furnish Medicare-covered DMEPOS.

Suppliers of DMEPOS have long presented to the Medicare program an elevated risk of fraud, waste, and abuse—historically, perhaps the highest of all Medicare provider and supplier types. Numerous HHS–OIG reports since 1998 have noted serious program integrity problems with DMEPOS suppliers, and we recently outlined a significant number of DMEPOS supplier criminal and False Claims Act cases.[140] Recognizing this threat, CMS over the years has established particularly stringent requirements that DMEPOS suppliers must meet to enroll and maintain enrollment in Medicare. To illustrate, DMEPOS suppliers under 42 CFR 424.518(c) are one of only a few provider and supplier types subject to the highest and strictest level of screening during the enrollment process. (In fact, they were one of only two types originally assigned to this high-risk screening category in 2011—the other being HHAs). This level of screening includes: (1) a site visit; and (2) submission of fingerprints of the supplier's 5 percent or greater owners for a Federal Bureau of Investigation (FBI) criminal background check. There are other regulatory provisions besides the basic provider enrollment requirements in 42 CFR part 424, subpart P (§§ 424.500 through 424.575) that DMEPOS suppliers must meet. These requirements include, but are not limited to, the following:

• Compliance with the DMEPOS supplier standards in § 424.57(c).

• Acquisition and maintenance of a surety bond consistent with § 424.57(d).

• Compliance with DMEPOS quality standards.

• Accreditation by a CMS-approved DMEPOS accrediting organization.

The foregoing underscores the serious and continued payment safeguard challenges associated with DMEPOS suppliers. We accordingly propose several regulatory revisions related to DMEPOS supplier enrollment.

1. Medicare Surety Bonds

a. Introduction

On January 2, 2009, we published in the **Federal Register** (74 FR 166) a final rule to implement section 1834(a)(16)(B) of the Act.[3] The rule established a new § 424.57(d) requiring DMEPOS suppliers that were not otherwise exempted to submit a surety bond in the amount of at least $50,000 to the National Supplier Clearinghouse (now the National Provider Enrollment Contractors (NPECs)) to enroll in and maintain their enrollment in the Medicare program. The surety bond requirements of § 424.57(d) have been in effect since 2009. DMEPOS suppliers presently are the only Medicare provider or supplier type required to submit and maintain a surety bond as a condition of enrollment.

Section 6402(g)(1) of the Affordable Care Act amended section 1834(a)(16) of the Act by adding a provision regarding the volume of DMEPOS billing as it relates to the surety bond requirement. Section 1834(a)(16)(B) of the Act now provides that a DMEPOS supplier must furnish a surety bond of at least $50,000 that the Secretary determines is commensurate with the volume of the supplier's billing. Consistent therewith, and as discussed further, we are proposing changes to § 424.57(d) to improve the overall surety bond process.

b. Issues With Existing § 424.57(d)

In general, a surety bond—in the context of Medicare DMEPOS supplier enrollment—represents a promise by a surety that it will pay CMS a certain sum amount if the DMEPOS supplier to whom the surety issued the bond fails to repay a debt it owes to CMS; these debts include overpayments, civil money penalties, and assessments. Indeed, debt recoupment is the principal goal of CMS' surety bond requirement. The bond requirement has other benefits, too. One is that it facilitates additional screening of the DMEPOS supplier beyond that performed under § 424.518(c). Before deciding whether to issue a surety bond, the surety reviews the finances and other aspects of the DMEPOS supplier that CMS may currently lack the means to assess. This is critical given the program integrity threats that DMEPOS suppliers pose. The other is that suppliers may learn that CMS has referred their unpaid debt to the surety. Concerned that the surety might cancel the supplier's bond if the surety has to pay the debt to CMS—leaving the supplier at risk of revocation if it is unbonded—the supplier finally pays the debt. Since 2012, in fact, two of CMS' DME Medicare Administrative Contractor (MAC) jurisdictions have collected a combined $171.3 million in DMEPOS supplier payments in this manner. Hence, § 424.57(d) is not only a means of collection from sureties but also from the suppliers themselves.

Over the years, though, our surety bond collection efforts have encountered challenges. A particular difficulty has been that sureties sometimes do not make payment to CMS notwithstanding their obligation to do so under both § 424.57(d) and the surety bond's terms. To illustrate, of the approximately $32 million in DMEPOS supplier debts that CMS referred to sureties for payment between CY 2016

[140] See the proposed rule titled, ''Medicare and Medicaid Programs; Calendar Year (CY) 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies'' (90 FR 29108), published in the **Federal Register** on July 2, 2025. CMS on February 27, 2026, also imposed a nationwide temporary moratorium on the enrollment of DMEPOS medical supply companies due to fraud, waste, and abuse concerns. *See* ''Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Medical Supply Companies'' (91 FR 9855), which appeared in the **Federal Register** on February 27, 2026.

and CY 2018, CMS collected only $2.85 million from the sureties.[141] To help address this issue, we proposed in a March 1, 2016, provider enrollment rule that CMS could reject an enrolling or enrolled DMEPOS supplier's surety bond if the surety that issued the bond failed to make a required payment to CMS pursuant to § 424.57(d).[142] Though we did not finalize this provision, the problem remains very serious. To illustrate:

- CMS data from 2025 showed that a combined $37.5 million in DMEPOS supplier debts had been referred to seven sureties for payment. The sureties collectively paid only $540,000. Although the affected suppliers paid about $5.5 million of the $37.5 million amount once their debts were referred to the sureties, it is extremely disconcerting that the sureties—despite their obligation to do so under the bond's terms—paid no more than 1.5 percent of the amount of debt referred to them.
- The two previous-referenced DME MAC jurisdictions also informed CMS that since 2012 they have referred a combined $229.2 million in DMEPOS supplier debts to sureties. Of this total, sureties paid only $35.7 million.

In sum, sureties' failures to make required payments to CMS have resulted in hundreds of millions of dollars in unpaid DMEPOS supplier debts. Sureties should not be able to avoid fulfilling their legal and financial obligations to CMS. Given the resulting harm to American taxpayers and the need to protect the Trust Funds, we propose the following changes to § 424.57(d).

c. ''Sufficient Evidence'' Standard and Review of Overpayment Calculations

Section 424.57(d)(5)(i) states that the DMEPOS surety bond must guarantee that the surety will—within 30 days of receiving written notice from CMS containing ''sufficient evidence'' to establish the surety's liability under the bond of unpaid claims, civil money penalties (CMPs), or assessments—pay CMS a total of up to the full penal amount of the bond. Section 424.57(a) defines ''sufficient evidence'' as documents CMS may supply to the surety to establish that the supplier had received Medicare funds exceeding the amount due and payable under the statute and regulations, the amount of a CMP, or the amount of some other assessment against the DMEPOS supplier.

One reason a surety sometimes cites for refusing to pay CMS is that, in the surety's view, CMS did not furnish ''sufficient evidence'' that the surety is, in fact, liable for payment. This, in many cases, is incorrect, and there have been numerous instances where no matter how many documents CMS furnishes to the surety that conclusively establish the supplier's debt and the surety's obligation, the surety continuously—and, we believe, inappropriately—maintains that the evidence is insufficient. Nonetheless, and to clarify its scope, we propose to revise the ''sufficient evidence'' definition such that the term would mean that CMS has furnished documentation to the surety that establishes all of the following:

- The amount and basis of the overpayment, CMP, or assessment that the DMEPOS supplier owes.
- That it is an unpaid claim.
- A valid surety bond exists.
- The request to the surety for payment satisfies the surety bond requirements, specifically:

++ When a bond is in effect, that the unpaid claim, CMP, or assessment occurred during the term of the bond. This includes when a DMEPOS supplier changes its surety during the term of a bond; or

++ When the DMEPOS supplier fails to furnish a bond, submit a rider[143] when required, or if the DMEPOS supplier's billing privileges are revoked, that the unpaid claims, CMPs, or assessments are asserted or imposed against the DMEPOS supplier during the 2 years following, and they are based on overpayments or other events that took place during the term of the bond or rider.

This clarification is not intended to change which surety is responsible when a DMEPOS supplier obtains a bond from a new surety; in that circumstance, 42 CFR 424.57(d)(9) determines which surety is responsible. Rather, we believe these revisions would remove any ambiguity about the surety's responsibility to make payment to CMS, and we expect sureties to do precisely this after receipt of this documentation.

In addition, some sureties have declined to make required payments to CMS because: (1) CMS did not furnish documentation to the surety as to how CMS calculated the overpayment, CMP, or assessment; or (2) the supplier's appeal rights regarding the overpayment have not been exhausted. This is improper because neither the existing definition of ''sufficient evidence'' nor any other provision in current § 424.57(d) (including paragraph (d)'s required bond terms) have ever required such documentation or the exhaustion of appeal rights. Regarding the former, ''sufficient evidence'' only requires documentation ''that the DMEPOS supplier had received Medicare funds in excess of the amount due and payable under the statute and regulations, the amount of a CMP, or the amount of some other assessment against the DMEPOS supplier.'' The surety's obligation under the bond to make payment is the critical consideration, not the details of how CMS calculated the debt amount. As for appeals, CMS in the aforementioned January 2, 2009, final rule—in response to a public comment recommending that CMS not request surety payment before appeals are exhausted—was clear that: ''We do not agree that we should be prohibited from seeking payment from a surety until all supplier appeals have been exhausted. In addition, we believe that it is appropriate for the surety to pay CMS a total of up to the full penal amount of the bond when sufficient evidence is presented.'' [144]

While the foregoing reflects longstanding policy, we propose to reiterate this by revising existing paragraph (d)(5)(ii). Said paragraph currently states that the surety bond ''must provide the following: The surety is liable for unpaid claims, CMPs, or assessments that occur during the term of the bond.'' We propose to designate the clause beginning with ''The surety is liable. . . . . .'' as new paragraph (d)(5)(ii)(A). New paragraphs (d)(5)(ii)(B) and (C) would require the bond to provide that:

- The surety agrees not to challenge or dispute the amount CMS determines is owed from the obligor, the underlying calculations, or the basis for overpayment.
- The surety must make payment to CMS as required under the bond and this paragraph (d) regardless of whether the obligor has available options to appeal, or pending appeals of, the overpayment, CMP, or assessment.

d. Decline To Accept Bonds From Noncompliant Sureties

Notwithstanding the aforementioned non-finalization of our surety bond rejection proposal in 2019, we maintain that CMS should not be required to

[141] The remainder (which could not be collected) was referred to the Department of Treasury consistent with existing CMS procedures.

[142] Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process'' (81 FR 10720).

[143] Section 424.57(a) defines ''rider'' as a notice issued by a surety that a change in the bond has occurred or will occur.

[144] 74 FR 174.

accept bonds from non-compliant sureties. Again, the bond requirement's central purpose is to help CMS recoup monies it is owed. Sureties' failure to make required payments harms the Trust Funds and taxpayers, and CMS' continued acceptance of bonds from such sureties exacerbates said harm. Measures to hold such sureties accountable are therefore needed.

A non-exempt DMEPOS supplier must obtain and maintain a surety bond from an ''authorized surety.'' The latter term is defined in part in § 424.57(a) as a surety ''that has been issued a Certificate of Authority [COA] by the U.S. Department of the Treasury [DoT] as an acceptable surety on Federal bonds . . .''. DoT is the principal overseer of processes involving surety companies that do business with the United States; indeed, 31 CFR 223.1(a) states that the regulations in 31 CFR part 223 ''govern the issuance, renewal, and revocation by the Secretary of the Treasury,'' acting through the DoT, Bureau of the Fiscal Service, of COAs ''to bonding companies to do business with the United States as sureties on, or reinsurers of, Federal surety bonds'' under 31 U.S.C. 9304–9308 and Part 223, ''and the acceptance of such obligations.'' COAs are addressed at 31 CFR 223.16. This regulatory provision states in part that a list of certificate holding companies is published annually in Department Circular No. 570 (Companies Holding Certificates of Authority as Acceptable Sureties on Federal Bonds and as Acceptable Reinsuring Companies). Per 31 CFR 223.17(a), a bond underwritten by a certified company on the 31 CFR 223.16 Department Circular No. 570 list may be presented to any agency-bond approving official for acceptance, and such agency bond-approving official may accept such bonds. To furnish DMEPOS surety bonds, a surety must be on this list as an acceptable surety.

Section 223.17(b)(1), though, states that an agency bond-approving official may decline to accept bonds underwritten by a certified company for cause if the company has been given advance written notice by said agency. The written notice must do all of the following:

- State the agency's intention to decline bonds underwritten by the company.
- State the reasons for or cause of the proposed declination of such bonds.
- Give the company an opportunity to rebut and to cure the stated reasons or cause.

Under section 223.17(b)(2), the agency may decline to accept the bonds if—after considering the company's submission under 223.17(b)(1) (or its failure to respond to the paragraph (b)(1) notice)—it issues a written determination that the bonds should not be accepted.

We believe section 223.17 is clear on its face that CMS may decline bonds in the circumstances described in said section. To this end, we propose to outline procedures for doing so in new § 424.57(d)(16). These procedures would include section 223.17(b)'s requirements (such as describing what qualifies as ''for cause''), tailored to the specifics of the DMEPOS surety bond requirements.

In new § 424.57(d)(16)(i), we propose to mirror section 223.17(b)(2)'s language for purposes of consistency. We would state that CMS may decline to accept from an authorized surety any DMEPOS supplier surety bonds required under § 424.57(d) if: (i) the ''for cause'' standard in paragraph (d)(16)(ii) is met; and (2) the written notice and opportunity for rebuttal requirements in paragraph (d)(16)(iii) are met.

In new § 424.57(d)(16)(ii), we propose that CMS' declination to accept DMEPOS surety bonds from a particular surety must be ''for cause.'' For purposes of § 424.57(d)(16), ''for cause'' would involve circumstances ''when a surety under paragraph (d) has not paid or satisfied an administratively final bond obligation'' that is owed to CMS. This latter quoted language is in section 223.17(b)(2). Section 223.17(b)(3), meanwhile, states that the agency must define when a bond obligation becomes administratively final. We propose that this occurs when: (1) CMS has furnished ''sufficient evidence'' (as that term would be defined in our proposed revision thereto) to the surety of its obligation to make payment under the bond; and (2) the surety fails to make the required payment within 30 calendar days of receiving notice from CMS or its contractor to do so. This is consistent with current CMS practice.

New § 424.57(d)(16)(iii) would outline the procedures for furnishing written notice to the surety of our intention to decline to accept its DMEPOS supplier bonds. This paragraph would state that CMS sends, via certified mail, written notice to the surety of said intention. The notice must: (1) state the intention to decline bonds underwritten by the company; (2) list the reason(s) or cause for CMS' intention; (3) identify the instance(s) in which the surety failed to make the required payment(s); (4) describe the surety's rebuttal rights; and (5) provide the surety a 30-day opportunity to cure the stated reasons for declination. These requirements would help ensure that the surety received the notice and understands the basis for CMS' action.

In new § 424.57(d)(16)(iv), we propose a process by which the surety can rebut CMS' conclusions in the § 424.57(d)(16)(iii) notice it received. This process would be similar to rebuttals in § 424.541(b) for stays of enrollment and in § 424.546 for enrollment deactivations. This approach is appropriate for three reasons. First, it has been used for many years in provider enrollment and the processes are well-established. It can hence be expeditiously expanded to include surety rebuttals. Second, section 223.17 specifically uses the term ''rebut'' as opposed to ''appeal'' or ''reconsideration''; the latter two terms represent processes addressed in 42 CFR part 498. Using a rebuttal process for section § 424.57(d)(16)(iv) would accordingly be consistent with section 223.17's ''rebut'' terminology. Third, our existing rebuttal process for enrollment affords providers and suppliers ample opportunity to be heard. We believe the same would hold true for sureties.

In paragraph (d)(16)(iv)(A)(*1*), we propose that when a surety receives the notice specified in (d)(16)(iii), the surety has 30 calendar days from the date of the notice to submit a rebuttal to CMS' intention to decline to accept DMEPOS surety bonds from the surety. Although the rebuttal timeframe for stay and deactivation rebuttals is 15 days, we believe 30 days is appropriate for sureties since this process would presumably be new to them.

In paragraph (d)(16)(iv)(A*)(2),* we propose that CMS may, at its discretion, extend the 30-day time-period referenced in paragraph (d)(16)(iv)(A)*(1).*

In paragraphs (d)(16)(iv)(B)(*1*) through (*4*), we propose that the rebuttal must meet all of the following:

- Be in writing.
- Specify the facts or issues about which the surety disagrees with CMS' intention to decline to accept bonds.
- Submit all documentation the surety wants CMS to consider in its review of the rebuttal.
- Be submitted in the form of a letter that is signed and dated by:

++ The surety's chief executive officer, chief operating officer, general partner, or equivalent official who is a W–2 employee of the surety with the authority to legally and financially bind the surety to Federal and State laws; or

++ A representative (as defined in § 498.10). If the legal representative is an attorney, the attorney must include a statement that he or she has the authority to represent the surety; this statement is sufficient to constitute

notice of such authority. If the legal representative is not an attorney, the surety must file with CMS written notice of the appointment of a representative; this notice of appointment must be signed and dated by, as applicable, the official in the previous paragraph or a legal representative.

In paragraph (d)(16)(iv)(C), we propose that the surety's failure to submit a rebuttal that is both timely under paragraph (d)(16)(iv)(A) and fully compliant with all of paragraph (d)(16)(iv)(B)'s requirements constitutes a waiver of all rebuttal rights under this section. If the surety fails to timely submit a compliant rebuttal, CMS would issue a subsequent written determination that it will not accept bonds underwritten by the surety and state the declination's effective date, which would not be before the date of this written determination.

In paragraph (d)(16)(iv)(D), we propose that upon receipt of a timely and compliant rebuttal, CMS reviews the rebuttal to determine whether to proceed with its intended declination of surety bonds from the surety.

In paragraph (d)(16)(iv)(E), we propose that after its receipt of any timely and compliant rebuttal, CMS notifies the surety in writing of the following—

- Its review of the rebuttal;
- Its decision as to whether to proceed with its intended declination to accept DMEPOS surety bonds from the surety and the basis for that decision; and
- Any such declination's effective date, which would not be before the date of the notice described in paragraph (d)(16)(iv)(E).

Although enrollment stays and deactivations can be implemented and become effective before the stay or deactivation letter is sent to the provider, we wish to give the surety an opportunity to submit the rebuttal and for CMS to consider it before deciding whether to proceed with any declination. We also believe this approach is more consistent with section 223.17(b) than one that would permit declination before CMS' completes its review of the rebuttal. In addition, a determination made under paragraph (d)(iv)(E) is not an initial determination under § 498.3(b), and, therefore, is not appealable.

Under new paragraph (d)(16)(v)(A), and as previously indicated, the surety would have a 30-day opportunity to remedy the issues leading to CMS' intention to decline to accept the surety's bonds. CMS would have the discretion to extend this 30-day period.

Under new paragraph (d)(16)(v)(B), we propose the following:

- The surety, within the required timeframe, would have to submit written proof that it has cured all the deficiencies in question. This proof could include, for example, documentation that it has fully paid or satisfied all outstanding financial obligations forming the bases of CMS' intended declination. It would not be enough for the surety to merely state that it has cured the stated reasons or cause.
- CMS would decide whether the submitted written proof is adequate and whether all deficiencies have been corrected. If the surety submitted a timely and compliant rebuttal, CMS would include its decision on the cure matter in the rebuttal decision letter described in proposed (d)(16)(v)(A). If the surety does not submit a timely and complete rebuttal, CMS would include its decision on the cure issue in a final letter to the surety confirming whether CMS will decline to accept surety bonds issued by the surety.

In paragraph (d)(16)(vi)(A), and consistent with 31 CFR 223.17(b)(4), we propose to maintain a list of sureties from which CMS would not accept DMEPOS surety bonds under paragraph (d)(16). This list would be made public on CMS' website and updated as needed so that DMEPOS suppliers understand which sureties they may and may not use for purposes of the surety bond requirement.

In paragraph (d)(16)(vi)(B), we propose that CMS may, in its discretion, at any time remove a surety from the list described in paragraph (d)(16)(vi). CMS would notify the surety in writing of said removal and the effective date thereof. This would give CMS flexibility to again accept bonds from the surety should, in CMS' judgment, circumstances warrant.

2. Medicare DMEPOS Supplier Relationship Reporting

A significant challenge CMS has faced in stemming DMEPOS fraud, waste, and abuse has been our lack of upfront knowledge of certain outside entities with which the supplier may have business relationships. While DMEPOS suppliers have for decades been required to report on the Form CMS–855S their 5 percent or greater owners, general and limited partners, managing employees and organizations, and corporate officers and directors, the supplier need not disclose various other parties with which they are associated, such as the following:

- Marketing companies, which perform services for the supplier such as advertising, mail and email solicitation to beneficiaries, and generating leads.
- Wholesalers that purchase supplies from manufacturers and then sell them to the supplier.
- Fulfillment companies, which generally are entities with which the supplier contracts to deliver items to beneficiaries (rather than the supplier directly delivering them).

Considering the excessive program integrity risk DMEPOS suppliers have long posed and the need to ensure that the products they distribute to beneficiaries are quality items, we believe we must understand the full chain of the supplier's acquisition and eventual distribution and delivery of these goods. Without knowing, for instance, the entity from which the supplier purchased its products, we may lack important information to help us ascertain the seller's credentials. Indeed, we have seen instances where certain wholesalers distribute low-quality supplies that can harm beneficiaries, sometimes with the knowledge of questionable DMEPOS suppliers seeking to limit costs at the expense of patient care. In a similar context, it can be difficult for us to verify whether a supplier will properly deliver supplies to beneficiaries if we do not know whether the supplier uses a fulfillment company for this function and, if it does, which company. Some fulfillment entities may have poor records regarding supply delivery (with beneficiaries sometimes never receiving needed items) or have participated in fraud schemes.

Awareness of these companies' identities would help CMS: (1) safeguard beneficiaries; (2) validate the supplier's compliance with the enrollment standards in § 424.57(c); (3) vet these entities for program integrity risks; and (4) ascertain whether the supplier may be acting with other entities in a larger fraud scheme, an especially important consideration given that we have seen an alarming number of such instances over the years. We also note that some of these entities may have as much (or more) involvement with the supplier's regular operations as certain parties that must currently be reported, such as indirect owners and various members of boards of directors. This, in our view, further warrants the collection of data about wholesalers and fulfillment companies.

Marketing entities are of particular concern to us. Section 424.57(c)(11) currently states that—with three exceptions outlined in § 424.57(c)(11)(i) through (iii)—suppliers may not contact a beneficiary by telephone when supplying a Medicare-covered item.

This also applies to companies with which the supplier contracts to perform marketing services on the supplier's behalf. Some suppliers have used marketing entities to convince beneficiaries that they need certain DMEPOS items when, in fact, they do not. There have been instances where a marketing company cold-calls Medicare beneficiaries to obtain their personal data (sometimes promising the beneficiary free items in return); it will then use this information to: (1) prepare orders for certain DMEPOS items; and (2) pay physicians to sign them regardless of whether the patient requested the product. The following reports and cases—some of which were outlined earlier in the cited CY 2026 Home Health Prospective Payment System (HH PPS) proposed rule (90 FR 29108)—are illustrative of this behavior:

- A May 2024 OIG report stated that Medicare paid for off-the-shelf braces marketed to beneficiaries by telemarketers using prohibited direct solicitation.[145]
- Also in May 2024, a Florida man was sentenced to 96 months in prison for his role in a DMEPOS kickback scheme. He and others owned and operated marketing call centers and telemedicine companies through which they secured physicians' orders for DMEPOS for Medicare beneficiaries without regard to medical necessity.[146]
- A California woman was sentenced in December 2023 to 15 years in prison for billing Medicare for over $24 million by submitting fraudulent claims for medically unnecessary DME—mostly power wheelchairs (PWC)—and PWC repairs. As the *de facto* owner of two DMEPOS supplier companies (both of which were Medicare-enrolled in the names of her out-of-state relatives), the individual orchestrated a scheme in which she paid marketers for patient referrals and then directed them to take patients to physicians, who prescribed medically unnecessary DME (including PWCs) that her companies used to submit fraudulent claims to Medicare.[147]
- In September 2023, a Federal district court entered a judgment against a Virginia DMEPOS supplier for damages and penalties under the False Claims Act for over $12 million. In its complaint filed in district court, the United States alleged that over a nearly 6-year period, Medicare paid the supplier over $600,000 for medical braces furnished to Medicare beneficiaries related to DMEPOS prescriptions that the supplier illegally purchased from marketing companies. The DMEPOS supplier paid a fee for each prescription that it purchased and then used these prescriptions (along with personal and medical data provided by the marketing companies) to submit 923 fraudulent Medicare claims.[148]
- A Georgia woman pled guilty in June 2024 to an information charging her with conspiracy to commit health care fraud. The individual and her conspirators owned, operated, and had a financial interest in DMEPOS companies through which they obtained physicians' orders for DMEPOS for Medicare beneficiaries without regard to medical necessity. They obtained the DMEPOS orders using marketing call centers and telemedicine companies, caused the submission of false and fraudulent Medicare claims, and paid illegal kickbacks.[149]
- A South Carolina man was sentenced to 9 years in prison in March 2024 for his role in a nearly $100 million healthcare fraud scheme. The individual controlled and operated at least 10 DMEPOS companies located throughout the United States. The companies entered into agreements with an offshore, advertised call center to purchase physicians' orders so the DMEPOS companies could bill Medicare. When a Medicare beneficiary called the applicable number, the beneficiary would be screened for eligibility and then convinced that the beneficiary needed a brace and oftentimes upsold on other braces. The call center would then contact a telemedicine company whose physician or nurse practitioner would issue a prescription without regard to the medical necessity. Beneficiaries were prescribed braces without ever being examined by, seeing, or, in some instances, even speaking to a medical professional.[150]
- A Texas man in March 2026 was sentenced to 150 months in prison for organizing and leading a $61.5 million health care fraud and wire fraud conspiracy in which thousands of Medicare beneficiaries who were the victims of deceptive telemarketing were sent thousands of orthotic braces, foot baths, and genetic tests they did not need. The defendant—who owned seven DMEPOS supply companies—owned a marketing company, too. Working with an offshore call center located in the Philippines, the defendant and others peddled medically unnecessary orthotic braces, foot baths, and genetic tests to Medicare beneficiaries nationwide. In audio recordings presented at trial, the defendant was heard pressuring beneficiaries to accept these products even after the beneficiaries protested that they did not need or want them.[151]
- A Mississippi man who owned a marketing company and was the beneficial owner of eight DMEPOS companies was sentenced in May 2026 to 196 months in prison for his role in a scheme to bilk Medicare (and another Federal health program) out of nearly $200 million by selling patient information and sham doctors' orders for orthotic braces that patients did not want or need. According to court documents and evidence presented at trial, the defendant worked with overseas telemarketing call centers that pressured elderly Americans to provide their personal and health insurance information and agree to accept medically unnecessary orthotic braces; in certain instances, the call centers altered call recordings to make it seem like Medicare patients agreed to the braces when they did not.[152]

As we have noted in prior provider enrollment rules, our goal is to stop fraud before it begins and to depart from the ''pay and chase'' model, whereby we take action only after the fraud commences. The earlier we learn of any marketing companies (domestic or foreign) the supplier uses, the sooner we can screen them and determine whether they present payment safeguard threats to the Medicare program.

In light of all these concerns, we propose the following provisions.

First, new § 424.57(i) would require all DMEPOS suppliers to report on the Form CMS–855S application (or its successor form), in a complete and accurate manner (including any documentation requested by CMS under § 424.510(d)(2)(iii)(C) to verify or explain the furnished information), all

[145] ''Medicare Remains Vulnerable to Fraud, Waste, and Abuse Related to Off-the-Shelf Orthotic Braces, Which May Result in Improper Payments and Impact the Health of Enrollees'' (A–09–21–03019).

[146] *https://www.justice.gov/usao-nj/pr/florida-man-sentenced-96-months-prison-role-multimillion-dollar-health-care-kickback.*

[147] *https://www.justice.gov/usao-cdca/pr/redondo-beach-woman-sentenced-15-years-prison-leading-24-million-scam-billed-medicare.*

[148] *https://www.justice.gov/usao-edva/pr/virginia-medical-equipment-provider-ordered-pay-12-m-medicare-fraud-scheme-civil.*

[149] *https://www.justice.gov/usao-nj/pr/georgia-chiropractor-admits-149-million-health-care-fraud-and-kickback-scheme-related.*

[150] *https://www.justice.gov/usao-sc/pr/mt-pleasant-man-sentenced-nine-years-federal-prison-role-one-largest-medicare-fraud.*

[151] *https://www.justice.gov/opa/pr/texas-fugitive-apprehended-and-sentenced-over-12-years-prison-61m-telemarketing-fraud-scheme.*

[152] *https://www.justice.gov/opa/pr/former-nfl-player-sentenced-over-16-years-prison-197m-medicare-fraud.*

domestic and foreign entities and individuals that do any of the following:

- Perform any marketing service of any type for the supplier.
- Furnish DMEPOS items or services to beneficiaries on the supplier's behalf, such as fulfillment companies.
- Are wholesalers from which the supplier purchases DMEPOS items for provision to the supplier's beneficiaries.

CMS would revise the Form CMS–855S via a separate Paperwork Reduction Act (PRA) package to collect this data. Stakeholders may submit comments on these form revisions during the eventual PRA notice-and-comment process.

Second, we propose in new §§ 424.530(a)(26) and 424.535(a)(31) that we may deny or revoke the DMEPOS supplier's enrollment if CMS determines that any entity or individual reported pursuant to § 424.57(i)—or the relationship or business arrangement the entity or individual has with the supplier—poses an undue risk of fraud, waste, or abuse, or of beneficiary harm. This provision would give us the ability and flexibility to address program integrity threats based on the reported information. However, CMS would not deny or revoke enrollment under these provisions as a matter of course but only when justified after carefully considering the facts and circumstances. We also propose that the effective date of a revocation under § 424.535(a)(31) would be the date on which CMS determines that a supplier should be revoked pursuant to § 424.535(a)(31). This would conform to CMS' proposal in the CY 2027 HH PPS proposed rule (placed on display at the **Federal Register** on July 1, 2026 (91 FR 41216)) [153] to make all of our revocation effective dates retroactive rather than keep some of them prospective (that is, effective 30 days after the date on which the revocation letter is mailed to the provider). As that proposed rule would designate all revocation effective dates therein as § 424.535(g)(1)(i) through (xxvi), we propose that § 424.535(a)(31)'s effective date would be designated as new § 424.535(g)(1)(xxxi).

3. Beneficiary Consent for Items

An especially disturbing DMEPOS supplier practice over the years has been the shipping of supplies to beneficiaries without the latter having requested them, followed by the supplier billing Medicare for the items. Indeed, we have seen fraud schemes involving stolen beneficiary information, which enables the supplier to report a beneficiary's data on the claim with a fictitious diagnosis and date of service and a random referring provider's information; in some cases, the supplier never even sent the item to the beneficiary. The following are several recent examples of this conduct (as noted previously, we generally use the term ''supplier'' to refer to DMEPOS suppliers and the term ''provider'' to refer to other provider and supplier types):

- A supplier submitted approximately a dozen claims for items it claimed to have sent to various beneficiaries. All of the beneficiaries: (1) denied the diagnoses the supplier reported; (2) confirmed that they never received the items; and (3) denied knowing the supplier or the referring provider.
- A beneficiary received orthotics from a supplier via shipment. The beneficiary stated that he did not know why he received the items, and that the reported diagnosis was incorrect. While he stated that he was scheduled for an appointment with the reported referring provider, he had not yet seen said provider.
- A beneficiary received a call from a party identifying itself as Medicare, advising her that she would receive orthotics for free. The beneficiary informed the caller that she did not need them, but she ultimately received the supplies. The beneficiary later told CMS that she never saw or spoke with the referring provider and had never used the services of the supplier listed on the claim.
- Another beneficiary received a call from a supplier: (1) asking her questions about her medical diagnosis; and (2) stating that she was qualified to receive DMEPOS items at no cost to her. She received the items but informed CMS that she had neither requested nor needed them; she also had never discussed needing the items with her primary care provider.

We believe that requiring prior confirmation from the beneficiary that the item was requested and needed before it is sent to the beneficiary would help stem this improper activity. Suppliers could not simply send unauthorized items to patients and receive payment for them. To this end, we propose an additional DMEPOS supplier standard in new § 424.57(c)(32) that would require DMEPOS suppliers to have a process for obtaining prior beneficiary consent for items the supplier sends to the beneficiary at their home or residence. For purposes of this standard:

- The standard only applies to the initial order the supplier receives, not to refills.
- The process must, at a minimum, include the following:

++ After receiving a valid order for the item from the ordering or prescribing provider (for example, physician), the supplier must telephone or email the beneficiary (or, if applicable, their representative (such as a caretaker or guardian)) and ask whether the beneficiary or representative: (1) is aware of the order or prescription; (2) whether the beneficiary needs the item; and (3) consents to receiving the item. The item cannot be delivered until these three conditions are met, even if the beneficiary or representative cannot be reached. If only the representative can satisfy the requirements, the supplier's process must include a means of confirming that said individual is authorized to act on the beneficiary's behalf.

++ For each such item, the supplier must document in a written log: (1) the beneficiary's or representative's name and either their phone number or email address (whichever means of communication was used); (2) time(s) and date(s) of the contact(s); and (3) a statement that the three conditions were met.

We solicit comments on any additional minimum requirements that should be included in this process.

4. Surveys and Accreditations

Section 424.58(e)(8)(i)(A) states that a DMEPOS accreditation organization (AO) must perform a survey of all DMEPOS supplier locations for which the supplier seeks accreditation or reaccreditation with the AO. (This includes, but is not limited to, accreditations: (i) for a new item type the supplier has not previously furnished; or (ii) as required under § 424.551.) Surveys help determine whether the supplier meets the DMEPOS quality standards. These standards address matters such as: (1) administration; (2) financial, human resources, and information management; (3) equipment and item delivery and set-up; (4) patient and caregiver training and instruction; and (5) patient follow-up. The standards are both extensive and detailed because of the need to confirm the supplier's legitimacy. Compliance with the quality

[153] ''Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; and Other Medicare and Medicaid Policies''.

standards is necessary for the supplier to enroll in Medicare.[154]

Given the importance of DMEPOS supplier surveys in protecting beneficiaries and facilitating program integrity, the following proposed changes to § 424.58(e)(8)(i)(A) would expand the instances in which a survey must be performed.

First, § 424.551 states that a DMEPOS supplier undergoing a CIMO—which is defined as an individual or organization acquiring more than a 50 percent direct ownership interest in the supplier within 36 months of its initial enrollment (or within 36 months of its most recent CIMO)—must enroll as a new DMEPOS supplier, undergo a survey, and obtain a new accreditation. There are three supplier exceptions to this ''36-month rule'' in § 424.551: (1) the supplier's parent company is undergoing an internal corporate restructuring; (2) the supplier's owners are changing the supplier's business structure, and the owners remain the same; and (3) an individual owner of the supplier dies. We are concerned that the lack of a supplier survey in these three exempted situations—as well as with suppliers that undergo CIMOs beyond the 36-month window—leaves CMS unable to confirm whether the supplier under its new majority ownership is compliant with the quality standards and is committed to patient care. To us, the central issues are the change in the supplier's controlling interest itself and the potential involvement of the new majority owner(s)—rather than the timing (for instance, more than 36 months after initial enrollment) or whether an exception applies.

We therefore propose to revise § 424.58(e)(8)(i)(A) such that any DMEPOS supplier in which an individual or organization acquires more than a 50 percent direct ownership interest requires a survey. This survey requirement would thus apply a modified version of the definition of CIMO in § 424.551(a); that is, it would apply even if the CIMO: (1) occurred more than 36 months after initial enrollment or the supplier's most recent CIMO; or (2) qualifies for an exception under § 424.551(c). We note that this change would only involve the performance of a survey. A supplier undergoing a CIMO that is excepted or occurs outside the 36-month period would not have to enroll as a new supplier or receive a new accreditation based solely on the CIMO.

[154] The quality standards can be found at *https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/downloads/final-dmepos-quality-standards-eff-01-09-2018.pdf.*

Second, we propose to also include practice location changes within § 424.58(e)(8)(i)(A). If a supplier moves to another site, we have no means of ascertaining whether it is compliant with the quality standards in that new physical environment. To illustrate, several standards pertain to personnel qualifications. Since the new location may result in new employees, we must ensure that said personnel meet, for instance, licensure or certification requirements. Accordingly, we believe this proposed revision is needed to help safeguard beneficiaries.

Regarding paragraph structure, new § 424.58(e)(8)(i)(A)*(1)* and *(2)* would include the situations currently described in § 424.58(e)(8)(i)(A) as well as our two proposed new scenarios.

5. Ordering Unnecessary DMEPOS Services or Items

Several of the criminal cases cited earlier—as well as other criminal cases and situations we have seen—involve physicians ordering DMEPOS services and items that were either not reasonable or not necessary. This is sometimes done as part of a fraud scheme, with the physician receiving remuneration from the supplier that will be providing the services and items. Millions of Medicare dollars are at risk from such behavior. While we have various means of addressing these situations, a significant program integrity gap remains; specifically, our existing authority to immediately revoke the physician is limited in certain circumstances. To illustrate, under § 424.535(a)(8)(i) and (a)(21), respectively, we can revoke:

- A provider or supplier that submits a claim or claims for services that could not have been furnished to a specific individual on the date of service.
- A physician or eligible professional who has a pattern or practice of ordering, certifying, referring, or prescribing Medicare Part A or B services, items, or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements.

In our aforementioned scenario, though, § 424.535(a)(8)(i) could only apply to the DMEPOS supplier (that is, the supplier submitting the claim), not to the doctor who ordered the item (Dr. X). While § 424.535(a)(21) could apply to Dr. X as the ordering physician, it may require multiple instances of Dr. X's non-compliant ordering. This effectively means we might have to wait until Dr. X engages in this behavior a second or third time (or more) before we can take revocation action, thus allowing Dr. X to continue said misconduct and threaten the Trust Funds. This would run counter to our obligation to protect taxpayer dollars and, equally important, Medicare beneficiaries from unnecessary and potentially dangerous services and items. We must be able to take swift action on the physician's enrollment. We thus propose in new § 424.535(a)(29) that CMS have the authority to revoke a physician's or practitioner's enrollment if the individual ordered a DMEPOS item or service that was not reasonable or not necessary. The revocation effective date under proposed new § 424.535(g)(1)(xxix) would be the date on which CMS determines that the supplier should be revoked under § 424.535(a)(29).

We stress that this proposed revocation ground is not restricted to demonstrated DMEPOS fraud schemes. No prior finding of fraud would be required. On the other hand, stakeholders should not assume that CMS intends to revoke every physician or practitioner who orders a DMEPOS service or item that is later determined not to be reasonable or necessary. CMS would only take revocation action when, after careful consideration of the facts and circumstances, said action is warranted. In addition, § 424.535(a)(29) would be limited to the ordering of DMEPOS items or services, in large part because of the longstanding program integrity threat that DMEPOS suppliers have posed—higher, perhaps, than any other Medicare provider or supplier type.

C. Factors for Consideration for Denial and Revocation Decisions

As already alluded to, CMS under § 424.535(a) may revoke a provider's enrollment for any reason specified in that paragraph. These reasons include, for instance, the provider's: (i) failure to adhere to Medicare enrollment requirements; (ii) exclusion by the HHS OIG; (iii) felony conviction within the previous 10 years; (iv) pattern of improper or abusive billing; and (v) termination by another Federal health care program. A revocation helps safeguard the Medicare program, the Trust Funds, and beneficiaries by removing (and preventing payment to) Medicare providers that have engaged in problematic or otherwise non-compliant behavior. When a provider is revoked, it is generally barred from reenrolling in Medicare for a period of 1 to 10 years. The length of this ''reenrollment bar'' is determined based upon the severity of the basis of the revocation.

CMS also has reasons in § 424.530(a) for which it can deny a provider's enrollment application, some of which duplicate our revocation grounds in § 424.535(a) (for instance, OIG exclusion). The general rationale for a denial mirrors that for a revocation: to protect the Medicare program and its beneficiaries from potentially fraudulent or abusive activity.

For several of our denial and revocation grounds, CMS in its determination must consider various criteria outlined within the applicable denial/revocation reason in §§ 424.530 and 424.535. As an example, § 424.535(a)(9) permits revocation if the provider fails to report a change in their enrollment information (such as a change in practice location) within the required timeframe. Section 424.535(a)(9)(i) through (iv) lists the following factors that CMS must consider in its decision: (i) whether the data in question was reported; (ii) if the data was reported, how belatedly; (iii) the data's materiality; and (iv) any other information that CMS deems relevant to its determination.

Such specified criteria have, in our view, hindered CMS' denial and revocation authority—even to the point where we could not deny or revoke the provider in a particular instance even though CMS believed that it was justified under the circumstances. Consider these two § 424.535(a)(9) scenarios:

Scenario 1—A provider was required to report a certain change to us within 30 days but did not do so until Day 50.

Scenario 2—A supplier failed to report a change involving information that, on the surface, might not appear as crucial as that in Scenario 1.

Revocation might prove challenging in both situations. In the former, the data was ultimately submitted 20 days after the deadline. This may weigh against a revocation per § 424.535(a)(9)(i) and (ii)—even if the information was material. The end result could be incorrect payments being made to the provider due to the lack of timely, updated information. For Scenario 2, an apparent lack of materiality per § 424.535(a)(9)(iii) could, in some circumstances, override the failure to disclose the change.

We outlined our concerns regarding factors in the aforementioned CY 2027 HH PPS proposed rule (91 FR 72022). One particular concern we discussed involved the criterion in several of our denial and revocation grounds that requires CMS to consider whether the provider has any history of final adverse actions as defined in § 424.502 (such as felony convictions). We stated that most aberrant billing we have seen is done by providers with no history of adverse actions. Yet the adverse action factor essentially requires us to weigh against a denial or revocation for such providers. It aids non-compliant providers so long as the provider lacks an adverse history (which it often will), hence obstructing our program integrity efforts.

The point is that the facts of every potential denial and revocation case are very different. We must accordingly have the maximum possible flexibility to address them without criteria that might effectively compel us to enroll (or maintain the enrollment of) a non-compliant provider—something that could seriously harm the Trust Funds, the taxpayers, and beneficiaries.

We proposed in the CY 2027 HH PPS proposed rule to remove the factors in § 424.535(a)(8)(ii) and § 424.530(f) (the latter addresses reapplication bars). Given the scope of the foregoing problem, though, we believe we must go much further and remove all factors from our denial and revocation reasons. Our proposed regulatory revisions would be as follows:

- In § 424.530(a)(6)(ii)(C), deleting—
  - ++ The second sentence of the opening paragraph.
  - ++ Paragraphs *(1)* through *(5).*
- In § 424.530(a)(7), deleting paragraphs (iii), (iii)(A), (iii)(B), and (iii)(C).
- In § 424.530(a)(12), deleting—
  - ++ The second sentence of the opening paragraph.
  - ++ Paragraphs (i) through (v).
- In § 424.530(a)(14), deleting—
  - ++ The second sentence of paragraph (i).
  - ++ Paragraphs (i)(A) through (C).
- In § 424.530(a)(15), deleting—
  - ++ he second sentence of paragraph (i).
  - ++ Paragraphs (i)(A) through (E);
  - ++ (i)(C)*(1)* through *(3).*
- In § 424.530(a)(17)—
  - ++ Deleting paragraphs (ii) and (ii)(A) through (F).
  - ++ Redesignating paragraph (i) as the only sentence in (a)(17).
- In § 424.535(a)(9), deleting—
  - ++ The second sentence of paragraph (a)(9)'s opening paragraph.
  - ++ Paragraphs (i) through (iv).
- In § 424.535(a)(12), deleting—
  - ++ The second sentence of paragraph (a)(12)(i)'s opening paragraph.
  - ++ Paragraphs (a)(12)(i)(A) through (C).
- In § 424.535(a)(14)—
  - ++ Revising (a)(14)'s opening paragraph to read: ''CMS determines that the physician or eligible professional has a pattern or practice of prescribing Medicare-covered drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries or both, or fails to meet Medicare requirements.''
  - ++ Deleting paragraphs (i), (i)(A) through (H), (ii), and (ii)(A) through (C).
- In § 424.535(a)(15)—
  - ++ Deleting paragraphs (ii) and (ii)(A) through (F).
  - ++ Redesignating paragraph (i) as paragraph (a)(15)'s only sentence.
- In § 424.535(a)(17), deleting—
  - ++ The second sentence of paragraph (a)(17)(i)'s opening paragraph.
  - ++ Paragraphs (a)(17)(i)(A) through (F).
- In § 424.535(a)(18), deleting—
  - ++ The second sentence of paragraph (a)(18)'s opening paragraph.
  - ++ Paragraphs (a)(18)(i) through (v).
- In § 424.535(a)(20), deleting—
  - ++ The second sentence of paragraph (a)(20)'s opening paragraph.
  - ++ Paragraphs (a)(20)(i) through (vii).
- In § 424.535(a)(21), deleting—
  - ++ The second sentence of paragraph (a)(21)'s opening paragraph.
  - ++ Paragraphs (a)(21)(i) through (ix).
- In § 424.535(a)(22), deleting—
  - ++ The second sentence of paragraph (a)(22)(i)'s opening paragraph.
  - ++ Paragraphs (a)(22)(i)(A) through (E).
  - ++ Paragraphs (a)(22)(i)(C)(*1*) through (*5*).
- In § 424.535(c)(3), which lists factors for consideration in determining the reenrollment bar length for a provider's second revocation, deleting—
  - ++ The second sentence of paragraph (c)(3)'s opening paragraph.
  - ++ Paragraphs (c)(3)(i) through (iv).
- In § 424.535(i)—
  - ++ Deleting paragraphs (i)(2) and (i)(2)(i) through (iv).
  - ++ Redesignating paragraph (i)(1) as the only sentence in paragraph (i).
- In § 424.535(j)—
  - ++ The second sentence of paragraph (j)'s opening paragraph.
  - ++ Paragraphs (j)(1)(i) through (iv).

D. Faster Enrollment Change Reporting for Medicare Providers

Providers must report changes to their enrollment data within the timeframes specified in our regulations. DMEPOS suppliers under § 424.57(c)(2) must disclose all such changes within 30 days of the change. All other provider and supplier types must report changes within 30 days or 90 days, depending on the data involved. Changes in ownership, practice location, and final adverse actions are typically subject to a 30-day timeframe, with 90 days for most others.

We propose to require that all changes of information—regardless of the type of

data involved or the provider or supplier type—be reported within 30 days. While ownership, practice location, and final adverse action changes are important (hence their general 30-day timeframes), other data changes are, too. A failure to timely report a new managing employee or corporate officer, for example, could result in CMS unknowingly paying a provider with a high-level official who poses a program integrity risk based on past or current conduct. Too, if we do not timely learn of a provider's new bank, billing agency, doing business as name, or correspondence address, CMS risks sending funds or information to—or receiving claims from—the wrong entity or individual; this could lead to incorrect payments or the inadvertent release of confidential data. In short, any outdated or erroneous enrollment information can threaten the Trust Funds, making, in our view, a 90-day reporting period much too long. We believe that a shorter, across-the-board reporting timeframe would help ensure more accurate data. It would also eliminate uncertainty as to whether a particular data element is subject to the 30-day period or, instead, the 90-day period. We note that DMEPOS suppliers are well-accustomed to the 30-day period, and we believe all other provider and supplier types will also become accustomed; this has been our past experience when we have reduced certain reporting timeframes from 90 to 30 days.

This proposal does not mean that CMS now intends to revoke every provider that fails to meet these reporting timeframes. Our authority to revoke enrollment under § 424.535(a)(9) for failing to timely report changed data is discretionary (not mandatory), and we sometimes use other vehicles to address failures to timely disclose changes, such as stays of enrollment under § 424.541 and deactivations under § 424.540.

Our specific regulatory revisions are as follows:

In § 410.33(g)(2), which pertains to independent diagnostic testing facilities, we propose to delete the existing second and third sentences. The new second sentence would state that all changes in enrollment information must be reported within 30 days of the change.

In § 424.205(c)(5), which addresses Medicare diabetes prevention programs, we would remove the current language and state that all changes in enrollment information must be reported within 30 days of the change.

Sections 424.516(d)(1), (d)(2), (e), (e)(1) and (e)(2) address reporting requirements for other provider and supplier types. We propose to delete all these paragraphs and revise § 424.516(d)'s lone sentence such that all changes in enrollment information must be reported within 30 days of the change. We would also change the title of paragraph (d) from ''Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations'' to ''Reporting requirements for all other provider and supplier types''.

Section 424.516(e)(3) addresses requirements for ambulance suppliers to report license or certification revocations or suspensions. We propose to re-designate paragraphs (e)(3), (e)(3)(i), and (e)(3)(ii) as new paragraphs (e), (e)(1), and (e)(2), respectively. In addition, we would change paragraph (e)'s title from ''Reporting requirements for all other providers and suppliers'' to ''Special air ambulance supplier reporting requirements.''

E. New Bases for Medicare Provider Enrollment Denial/Revocation

1. CY 2027 HH PPS Proposed Rule Grounds

Among the denial and revocation reasons we proposed in the CY 2027 HH PPS proposed rule were the following—

- Proposed new § 424.535(a)(24) would permit CMS to revoke enrollment if the provider's or supplier's enrollment presents a high risk of fraud, waste, or abuse due to the provider's or supplier's location within a limited geographic area that has an excessive number of providers and suppliers.
- Proposed new § 424.530(a)(19) would allow denial of enrollment if the provider's or supplier's practice location is in the same suite or office as another provider or supplier whose Medicare enrollment has been revoked or denied under § 424.535 or § 424.530.
- Proposed new § 424.530(a)(20) would permit denial of a hospice's enrollment if any of the following apply—

++ The hospice's medical director: (1) is the medical director of multiple other hospices; or (2) practices at such a distance (for example, in a different State) from the enrolling hospice that the medical director cannot realistically perform all medical director functions required under 42 CFR part 418.

++ The hospice's administrator: (1) is the administrator of multiple other hospices; or (2) practices at such a distance (for example, in a different State) from the enrolling hospice that the administrator cannot realistically perform all administrator functions required under 42 CFR part 418.

++ The hospice's medical director does not have an active physician medical license in the State in which they are practicing.

We explained at great length in the proposed rule the reasons for these provisions and briefly summarize them here.

Regarding proposed § 424.535(a)(24), we noted the alarming increase in situations where numerous providers and suppliers—sometimes of the same type—are simultaneously operating within a very small geographic area (for instance, a multi-block sector), the same complex or building, or even the same office. We cited as examples: (1) 18 HHAs operating within the same building in Columbus, Ohio; and (2) hundreds of HHAs and hospices having enrolled in Los Angeles County over the span of several years. There was no medical need for such increases, which were entirely out of proportion with any increase in the region's beneficiary population and could be a strong indicator of fraud. As for proposed § 424.530(a)(19), sharing a suite or office with a provider who has been deemed non-compliant with Medicare enrollment requirements could spur concerns about the newly enrolling provider's own willingness to maintain compliance if enrolled. This is particularly true when—in cases we have seen—several providers in the same suite engage (or seek to engage) in a fraud scheme, have their Medicare enrollments revoked or denied, and another provider aims to enroll in that same office. Proposed § 424.530(a)(20), meanwhile, reflected the longstanding program integrity issues involving hospices. Of special concern were instances where an individual is a medical director or administrator of numerous hospices, sometimes at a great distance from the hospice location. This raises questions as to whether such persons are actually fulfilling these roles consistent with our regulations.

We recognized in the proposed rule—and do so again here—that some of these situations do not automatically mean fraud, waste, and abuse is occurring. Many medical facilities and complexes have a large number of providers and suppliers located therein. For example, a medical center comprising of three adjacent buildings may have seven physician practices with different specialties, two laboratories, etc.; some neighborhoods may have several types of providers and suppliers within them. Too, a physician operating in the same suite as a revoked provider is not automatically indicative of fraud. Nevertheless, some of the fraud schemes we have encountered have similarities to the situations addressed in these three proposed provisions.

Considering the hundreds of millions of taxpayer dollars that such schemes can threaten, we need the discretion to deny or revoke providers and suppliers in the three proposed circumstances if warranted. So concerned are we about such situations that we believe these three denial or revocation grounds should be both denial and revocation bases, rather than only a denial reason or only a revocation reason (for instance, the § 424.535(a)(24) scenario only permits revocation).

Thus, we propose the following provisions. First, proposed new § 424.530(a)(23) would permit denial in the circumstances described in § 424.535(a)(24) in the July 1, 2026, proposed rule. Second, proposed new revocation grounds in § 424.535(a)(26) and (27) would duplicate the §§ 424.530(a)(19) and (20) denial grounds in the July 1, 2026, proposed rule. Third, the effective dates of proposed new § 424.535(a)(26) and (27) would, under proposed new § 424.535(g)(1)(xxxiii) and (xxvii) be the date on which CMS determines that the provider should be revoked under these paragraphs; said date would align with our previously mentioned proposal in the CY 2027 HH PPS to make the remainder of our prospective revocation grounds retroactive.

2. Change in Hospice Administrators

We have already noted in the present and the CY 2027 HH PPS proposed rules the serious program integrity risks posed by hospices in recent years. Among the hospice fraud schemes we have seen involves administrators opening clusters of hospices within a small geographic area—sometimes even in the same building—without any corresponding need for such an increase in hospice services. The administrator inappropriately bills Medicare through these hospices, departs the hospices, and then repeats the pattern as administrator of other hospices the individual opens. Even if the administrator does not start up the hospices, the person may engage in misconduct at several hospices, and his or her successors as administrator may do the same. Constant changes of administrators can raise questions as to the hospice's legitimacy and stability and, more importantly, whether the provider is engaged in fraud, waste, or abuse.

While we acknowledge that administrators may depart hospices for entirely legitimate reasons (for example, retirement, taking a different position, etc.), we must protect the Medicare program against situations where the administrator turnover reflects improper conduct. We hence propose in new §§ 424.530(a)(24) and 424.535(a)(28) to have the authority to deny or revoke a hospice's enrollment if the hospice changes its administrator within 36 months following the hospice's initial enrollment or its most recent change in administrator. The revocation effective date under § 424.535(g)(1)(xxviii) would be the date on which CMS determines that the hospice should be revoked under § 424.535(a)(28). We emphasize that our proposal would not represent an across-the-board prohibition against administrator changes within 36 months, for, again, we recognize that many such changes have no nefarious intent. It would simply afford us the authority to take measures should the situation warrant it.

3. Denial and/or Revocation of Old and New Owner in Ownership Changes

We earlier referenced § 424.551, which requires DMEPOS suppliers to enroll as a new supplier and obtain a survey and accreditation if they undergo a non-exempt CIMO. A similar 36-month CIMO provision is in § 424.550(b)(1) for hospices and HHAs. The main purposes of this ''36-month rule'' are twofold. First, it helps prevent ''flipping'', whereby a provider enrolls in Medicare after receiving a survey and/or accreditation and then promptly sells the business to another party such that the latter need not receive a survey/accreditation. This makes it harder for CMS to confirm that the provider under its new ownership meets all Medicare requirements. Second, and even if ''flipping'' is not involved, the 36-month rule enables CMS to fully scrutinize the provider and the new owner via the initial enrollment and survey/accreditation processes.

Considering the failures of some providers to comply with the 36-month rule as well as efforts to circumvent it (such as by concealing the ownership change from CMS), we proposed in the CY 2027 HH PPS proposed rule to give CMS the authority to deny or revoke enrollment under §§ 424.530(a)(22) or 424.535(a)(25) if the provider does not comply with the provisions of, as applicable, § 424.550(b)(1) or § 424.551. Yet other ownership changes—depending on their particular facts—can at times pose program integrity risks, such as: (1) HHA, hospice, and DMEPOS supplier CIMOs occurring outside the 36-month period; and (2) CIMOs involving provider types that are not subject to a 36-month rule (such as skilled nursing facilities). Of considerable concern to us are situations where the owner of a provider that presents serious program integrity risks attempts to sell the business to another party, perhaps as part of a larger fraud operation. The following examples are illustrative:

Example 1—U owns Ambulance Supplier V, which has 20 employees. V was recently reactivated after having been deactivated for non-compliance with enrollment requirements. Both U and V are now under investigation for potential fraud. U decides to sell the company to W, who has previously been revoked from Medicare and intends to change V's name but retain its employees. A Form CMS–855B enrollment application is submitted to report the planned sale, though the sale is not scheduled to occur for another 60 days.

Example 2—X has owned Hospice Y for 5 years (outside of § 424.550(b)'s 36-month window). X sells Y to Z, but neither X nor Z report the sale to CMS, in violation of the requirement to report ownership changes within 30 days. X thus remains on record with CMS as the owner even though Z is the actual owner.

Both scenarios are disconcerting. In the first: (i) U might be selling V in hopes that doing so would end the investigation of U's activities; and (ii) the company—which remains under investigation—is being sold to a party with a prior revocation. In the second, the failure to report means that Medicare monies may be going to an entity whose new owner has not been vetted by CMS—at potentially significant risk to the Medicare program. The apparent risks that U, V, and W (for W, based on its prior revocation) pose and the non-compliance of X and Z raise serious questions as to whether any of them can be relied upon as current or future partners of the Medicare program. Since neither of these two situations is directly covered by §§ 424.550(b) or 424.551, we believe additional safeguards are needed to address problematic ownership changes. We accordingly propose the following in new § 424.536.

In paragraph (a), we propose that CMS, as applicable to the situation, may deny or revoke the enrollment of any provider or supplier involved in a change in majority ownership if CMS determines that the—

- The seller, buyer, or any provider or supplier involved in the change in majority ownership failed to comply with Medicare enrollment requirements; or
- The change in majority ownership, the seller, the buyer, or any provider or supplier involved in the change of majority ownership poses an undue risk

of fraud, waste, and abuse to the Medicare program.

Using our two examples, CMS could revoke V's enrollment due to U's attempt to forestall the investigation into U's activities if CMS determines this presents an undue fraud, waste, or abuse risk; if the sale of the business to W proceeds and W tries to reenroll V, CMS could deny the enrollment on the same ''undue risk'' basis. Regarding the second, neither the seller nor the buyer reported the change. This means that Y's enrollment could be revoked. Too, if Z tries to reenroll Y, CMS could deny the enrollment: (1) because Medicare requirements involving the CIMO were not met; and/or (ii) if CMS determines that an undue risk exists.

We recognize that previously proposed §§ 424.530(a)(22) and 424.535(a)(25)—as well as existing § 424.535(a)(9), which permits revocation for failing to timely report changes in ownership—may address some problematic CIMO situations. Yet proposed § 424.536 would go further in two ways. First, and unlike §§ 424.530(a)(22) and 424.535(a)(25), it would cover all CIMOs regardless of the provider or supplier type or the sale's timing. Second, denial or revocation under § 424.536 would be permitted based on an undue risk of fraud, waste, and abuse. Section 424.536 would hence enable CMS to address a greater number of circumstances surrounding a CIMO, although CMS could still utilize §§ 424.530(a)(22), 424.535(a)(9), or 424.535(a)(25) in lieu of or in conjunction with § 424.536 if the conditions for invoking any of the three former provisions exist.

In new § 424.536(b), we propose that paragraph (a) could be applied regardless of whether the provider's or supplier's name, identity, or location changes due to the CIMO. While CIMOs are sometimes accompanied by such changes, this does not negate the risk or non-compliance involved. Indeed, if we exempted § 424.536's application if the buyer changed the entity's name or identity, buyers might do precisely this to avoid a § 424.536 revocation. This concern of ours is why a number of our current denial and revocation reasons permit revocation under any of the provider's current or former names, numerical identifiers, or business identities.

In paragraph (c), we propose that a CIMO under § 424.536 occurs when a party acquires more than a 50 percent direct ownership interest in a provider (including via the cumulative effect of asset sales, stock transfers, consolidations, or mergers); this comports with the general CIMO definition in § 424.502. However, and consistent with our prior discussion, a § 424.536 CIMO could take place regardless of the provider type involved (for example, ambulance suppliers, HHAs), whether the CIMO occurred within 36 months of initial enrollment or the most recent CIMO, or whether the change in majority ownership requires a new, initial enrollment.

In paragraph (d), we propose that nothing in § 424.536 would negate the requirement that an HHA, hospice, or DMEPOS supplier enroll as a new provider or supplier and be surveyed/accredited if §§ 424.550(b) or 424.551 applies. This would merely remind stakeholders that the latter two provisions are separate and distinct from proposed § 424.536's denial and revocation authority.

Sections 424.530 and 424.535 contain procedures for denials and revocations (in addition to the denial and revocation grounds listed in §§ 424.530(a) and 424.535(a)). These procedures include, for example, reapplication and reenrollment bars, revocation effective dates, and specifications for submitting claims for services furnished before a revocation. To ensure these procedures apply to § 424.536 actions—that is, to directly tie § 424.536 to §§ 424.530 and 424.535, we propose to add new §§ 424.530(a)(27) and § 424.535(a)(32) by which CMS could deny or revoke under § 424.530 or § 424.535 if it determines that denial or revocation (as applicable) is warranted under § 424.536; the revocation effective date per new § 424.535(g)(1)(xxxii) would be the date on which CMS determines that the provider should be revoked under § 424.535(a)(32). Due to the breadth of § 424.536's provisions (such as its distinct definition of change in majority ownership), we believe our proposed approach is sounder than including all of § 424.536 within § 424.530 and § 424.535.

4. Other Improper Activity

Section 424.535(a)(7) permits revocation if the provider knowingly sells to or allows another individual or entity to use its billing number. (This does not include providers or suppliers who enter into a valid § 424.80 reassignment of benefits or a § 489.18 change of ownership.) While this provision has existed for many years, we have long been concerned about its narrowness. It only addresses a specific, unique scenario without capturing other very concerning situations directly or indirectly related to the provider's improper use of its enrollment, billing number, electronic funds transfer (EFT) arrangement, or other aspect of its relationship with Medicare. For example, there have been instances where an enrolled provider secures access to Medicare Beneficiary Identifiers and sells them to outside parties for nefarious purposes. Yet no existing revocation reason explicitly addresses such behavior. We believe § 424.535(a)(7) must be expanded to incorporate a wider range of inappropriate conduct. We thus propose to revise this paragraph to permit revocation if the provider engages in improper activity related to its Medicare enrollment, any billing number or identifier, or EFT arrangement. We would also change the paragraph title from ''Misuse of billing number'' to simply ''Improper activity.'' (For purposes of § 424.535(a)(7), the term ''improper'' would have its plain language meaning.) In addition, the § 424.535(a)(7) effective date would be that which we proposed in the CY 2027 HH PPS proposed rule at revised § 424.535(g)(1)(vii)—namely, the date on which the conduct resulting in the revocation occurred.

We acknowledge that this is a broad expansion of § 424.535(a)(7). We do not intend for this provision to supplant other current revocation grounds addressing inappropriate conduct (for example, abusive or non-compliant prescribing under § 424.535(a)(14)). In fact, we expect to utilize revised § 424.535(a)(7) only in exceptional circumstances. Nonetheless, the vast array of potential scenarios involving such conduct requires that we close all regulatory gaps that could permit the provider to remain enrolled and continue its behavior, hence the need for § 424.535(a)(7).

F. Verification of Identity and Risk Posed by Foreign and Domestic Owners and Managing Employees

Although CMS has means of validating the identities of enrolling physicians, enrolling practitioners, and an organizational provider's individual owners and managing employees, such means are mostly limited to reviewing the individual's legal name and social security number (SSN) against the Social Security Number Verification Service (SSNVN). This presents two significant problems.

One is that we have seen a disturbing increase in Medicare provider identity theft. Unscrupulous individuals and entities have attempted to: (1) enroll in and bill Medicare using the SSNs (and other identifiers) of bona fide physicians and practitioners; and (2) shield their actual (and problematic) owners and managing employees by instead listing on the Form CMS–855 application the

stolen identities of other persons as their owning and managing individuals. This has in certain instances permitted nefarious parties to enroll in Medicare—either directly or through an organization in which the party is the actual owner—and commit fraud because CMS' identity verification vehicles are limited.

The second dilemma is that providers sometimes list foreign owners and managing employees/organizations on the Form CMS–855. While there is no existing Medicare provider enrollment prohibition against a provider having a foreign owning or managing party, validation of the party's identity becomes difficult if no SSN or tax identification number (TIN) is included as many foreign parties lack one. The foreign status of such parties also makes it hard to confirm their specific location and any adverse legal history the party has (such as a criminal conviction or sanction). All this, in turn, can leave us unable to ascertain whether said foreign party poses a program integrity risk to Medicare—a vital consideration given the Medicare fraud schemes we have seen involving foreign nationals. Accordingly, although we are not seeking to bar foreign ownership or management of Medicare providers at this time, we still must strive to prevent potential threats to Medicare.

We believe the foregoing situations require that CMS have additional means of validating domestic and foreign identities and of reviewing possible risks posed by such parties. We hence propose the following regulatory revisions.

First, § 424.510(d)(2) outlines documentation that providers must submit as part of the enrollment process. Paragraph (d)(2)(ii) addresses documents that may be needed to uniquely identify the provider (though specific types of documents are not listed). To ensure our ability to verify the provider's identity and other data beyond what we currently require (such as the IRS CP–575 for TINs and legal business names), we propose the following:

- A new provision in paragraph (d)(2)(ii) by which CMS could require an individual provider, owner, managing employee, general or limited partner, or corporate officer or director to submit a copy of their driver's license, passport, social security card, birth certificate, or similar documentation if CMS determines it is needed to validate their identity. We emphasize that we would not ask for any of these documents as a matter of course but only if: (1) other verification means are unsuccessful; or (2) we suspect a possible case of identity theft. The overwhelming majority of providers would not have to submit them.
- To revise paragraph (d)(2)(iii), which permits CMS to require any other documentation needed to validate the data on the enrollment application, including, but not limited to, ''documentation regarding the provider's or supplier's ownership or management.'' In paragraph (C) thereof, we would insert ''domestic or foreign'' between ''provider's or supplier's'' and ''ownership.'' This would supplement our change to paragraph (d)(2)(ii) by reiterating our ability to request any documentation needed to validate ownership or management, including foreign.

Second, we propose in new §§ 424.530(a)(25) and 424.535(a)(30) that we may deny or revoke a provider's enrollment if the provider has a domestic or foreign owner, managing employee, managing organization, general or limited partner, or corporate officer or director: (1) whose identity or location cannot be confirmed; or (2) that CMS determines poses an undue risk of fraud, waste, or abuse to Medicare. An example of such a risk might be that the foreign party is based in a nation in which other persons and entities have been (or suspected to have been) involved in Federal health care program (including Medicare) fraud—though we emphasize that there are other factual scenarios in which an undue risk could arise, including with respect to domestic owners, managers, etc., as well as situations not involving identity verification. To a degree, our proposal is similar to existing §§ 424.530(a)(13) and 424.535(a)(19), albeit perhaps with a greater emphasis on risks posed by owners and managers themselves than on affiliations involving those parties. Indeed, it would be somewhat illogical to permit denial or revocation based on affiliations but not on individual threats that the parties in those relationships might present.

The effective date of a § 424.535(a)(30) revocation would, under § 424.535(g)(1)(xxx), be the date on which CMS determines that the provider should be revoked under this paragraph.

G. Medicaid and CHIP Provider Enrollment Reforms

As previously described, the Medicaid program (title XIX of the Act) is a joint Federal and State health care program that covers approximately 67 million low income-individuals.

States have considerable flexibility when administering their Medicaid programs within a broad Federal framework, and programs vary from State to State. CHIP (title XXI of the Act) is a joint Federal and State health care program that provides health care coverage to over 7 million children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.

In operating Medicaid and CHIP, and as required by sections 1902(a)(78) and 2107(e)(1)(D) of the Act, respectively, each State requires providers to enroll in order to furnish, order, prescribe, refer, or certify eligibility for Medicaid or CHIP items or services in that State.[155] States may also establish their own provider enrollment requirements, which must be met in addition to the applicable Federal provider enrollment requirements. Similar to Medicare provider enrollment, the purposes of the Medicaid and CHIP provider enrollment processes are to ensure that providers: (1) meet all Medicaid or CHIP requirements (and any other State-specific or Federal requirements); (2) are qualified to furnish, order, prescribe, refer, or certify Medicaid and CHIP services, items, and drugs; and (3) are eligible to receive payment, where applicable.

Different States may have different provider enrollment processes in operating their Medicaid and CHIP programs. However, all States must comply with Federal Medicaid and CHIP provider enrollment statutory and regulatory requirements, including those in part 455, subparts B and E.[156]

1. Principal Purposes of Medicaid and CHIP Provider Enrollment Proposals

There are several key reasons for our proposed Medicaid and CHIP provider enrollment revisions in this proposed rule.

First, we have not updated part 455's provider enrollment provisions in a comprehensive, wide-ranging fashion since the previously noted February 2, 2011, final rule. As certain enrollment terminology and requirements have become outdated or otherwise need enhancement given this long passage of time, we believe revisions to part 455 are warranted.

Second, the February 2, 2011, final rule emphasized the value of consistency between programs by establishing, for all three programs,

[155] Section 1902(kk)(7) of the Act also requires physicians and other eligible professionals who order or refer Medicaid services and items to be enrolled in Medicaid. This requirement is made applicable to CHIP via section 2107(e)(1)(G) of the Act.

[156] All of subpart E, and 42 CFR 455.107 in Subpart B, are applicable to CHIP in accordance with § 457.990.

common provider enrollment screening levels (limited, moderate and high) and application fee requirements. We also in that rule based other new Medicaid enrollment provisions partly on our stated desire for greater conformity to Medicare enrollment requirements. This included, for example, § 455.104(b)(1)(ii), in which we required disclosing entities, fiscal agents, and managed care entities to disclose the date of birth (DOB) and social security number (SSN) of any person with an ownership or control interest in the entity. (We similarly require owning and managing individuals of Medicare providers and suppliers to disclose their DOBs and SSNs.)

Various statutory provisions also emphasize consistency among programs. For example, under section 1902(kk)(3) of the Act, States must require providers to comply with the same requirements regarding disclosure of certain affiliations that also apply to Medicare under section 1866(j)(5) of the Act. Section 2107(e)(1) of the Act, meanwhile, makes the requirements of section 1902(kk) of the Act—including the screening, enrollment, and disclosure requirements—applicable to CHIP.

Yet the issue is not merely consistency between Medicare and Medicaid/CHIP. As already noted, and while all States must comply with the enrollment provisions in part 455, States often have different State-based Medicaid and CHIP provider enrollment requirements and processes. This can prove challenging for providers located in multiple States, for this could necessitate adherence to different requirements for many different State programs. We believe that harmonizing certain requirements via updates to part 455 could ease the burden on providers enrolling in (or enrolled in) multiple States' Medicaid programs and CHIPs. We emphasize, though, that our revisions are not intended to remove the States' traditional and general discretion over the requirements and operations of these programs.

Third, we believe it is critical to provide States with further means of preventing and combating potential and actual fraud, waste, and abuse. We presently have numerous grounds for which we can deny or revoke a Medicare provider's enrollment under §§ 424.530 and 424.535, respectively. These grounds address a broader range of circumstances than the Medicaid and CHIP denial and termination reasons specified at § 455.416. While some States may have State-specific denial and termination grounds beyond those in § 455.416, we are uncertain whether they adequately cover the many situations that could justify taking denial or termination action against a provider. To help States address such cases and protect Medicaid and CHIP monies and beneficiaries, we are proposing additional grounds for the State to deny or terminate a provider's Medicaid or CHIP enrollment, most of which mirror the existing Medicare grounds in §§ 424.530 and 424.535.

The proposed changes in section V.G. of this proposed rule are generally discussed in the numerical order of the applicable regulatory provision in part 455. Unless noted otherwise, all references to Medicaid (for example, ''Medicaid provider enrollments'') should be read to include CHIP.

2. Legal Authorities

Our principal authorities for our Medicaid and CHIP provider enrollment proposals are as follows:

- Section 1102 of the Act provides general authority for the Secretary to prescribe regulations for the efficient administration of the Medicaid program and CHIP.
- Section 1902(kk)(1), under which the State must comply with the process for screening providers and suppliers under this title, as established by the Secretary under section 1866(j)(2) of the Act.
- Section 1902(a)(27) of the Act provides general authority for the Secretary to require provider agreements under the Medicaid State Plans with every person or institution providing services under the State plan. Under these agreements, the Secretary may require information regarding any payments claimed by such person or institution for providing services under the State plan.
- Section 4313 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and SSN of each provider or supplier, each person with an ownership or control interest in the provider or supplier, any subcontractor in which the provider or supplier directly or indirectly has a 5 percent or more ownership interest, and any managing employees, including directors and officers of corporations and non-profit organizations and charities.
- Section 2107(e) of the Act, which provides that certain title XIX and title XI provisions apply to States under title XXI.

3. Definitions (§§ 455.2 and 455.101)

We propose to: (1) revise several definitions in §§ 455.2 and 455.101 to clarify existing processes and enhance conformity to Medicare enrollment definitions; and (2) add several definitions to § 455.101.

a. ''Conviction or Convicted''

The current definition of ''Conviction or Convicted'' in § 455.2 reads, ''a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.'' We propose to change this to, ''has the same meaning as the definition of 'convicted' in 42 CFR 1001.2.'' That definition states:

- A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether—

++ There is a post-trial motion or an appeal pending; or

++ The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

- A Federal, State or local court has made a finding of guilt against an individual or entity;
- A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
- An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

We believe this definition is more detailed, thorough, and robust than that currently in § 455.2; it would accordingly provide greater clarity as to the types of convictions falling within § 455.2's purview. Moreover, we reference the § 1001.2 definition in §§ 424.530(a)(3) and 424.535(a)(3), which permit, respectively, denial or revocation of Medicare enrollment based on a felony conviction. Since, as we discuss later, we are proposing similar felony provisions in this rule, we believe that a concomitant definition of ''Conviction or Convicted'' in part 455 is warranted.

b. Definitions Related to Disclosures

As later addressed in greater detail, a ''disclosing entity'' is required under § 455.104(b) to report certain information to the State. These data include but are not limited to:

- Any person (individual or corporation) with an ownership or control interest in the disclosing entity.
- Whether the person (individual or corporation) disclosed in the previous

bullet is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

• Any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

• Any managing employee of the disclosing entity.

A central purpose of this information is to help the State confirm that the provider is not under the direct or indirect control of an excluded party. Various definitions in current § 455.101 apply to this disclosure requirement. These include:

• ''*Disclosing entity,*'' which means ''a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.''

• ''*Other disclosing entity,*'' which means ''any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under titles V, XVIII, or XX of the Act.'' This includes:—

++ Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII of the Act);

++ Any Medicare intermediary or carrier; and

++ Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

• ''*Person with an ownership or control interest,*'' which means a person or corporation that:

++ Has an ownership interest totaling 5 percent or more in a disclosing entity;

++ Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

++ Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

++ Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

++ Is an officer or director of a disclosing entity that is organized as a corporation; or

++ Is a partner in a disclosing entity that is organized as a partnership.

We propose to revise or supplement several of these definitions as follows:

c. Addition of ''Managing Organization''

We propose to add a definition of ''managing organization'' to § 455.101 that states: ''Managing organization means an entity that exercises operational or managerial control over or that directly or indirectly conducts the day-to-day operations of a provider, either under contract or through some other arrangement.'' This definition, which mirrors § 424.502's definition of this term, would be used for our proposed requirement (discussed later) that providers furnish data on entities that manage them.

d. Revisions to the Definition of ''Person with an Ownership or Control Interest''

The opening language of this definition states: ''Person with an ownership or control interest means a person or corporation that . . . .'' We propose to change this to read: ''Person or organization with an ownership or control interest is one that . . . .'' We do not believe organizational interests should be limited to corporations; any organizational interest in a provider is pertinent regardless of whether it is a corporation, partnership, limited liability company, etc.

We are not proposing to concomitantly revise paragraph (e) of this definition, which includes officers and directors of disclosing entities that are corporations as ''person[s] with an ownership or control interest''. As previously noted, sections 1124 and 1124A of the Act require providers to disclose certain information about various persons and entities associated with the provider. Per section 1124(a)(3)(B) of the Act, this includes ''officer[s] or [director[s] of the entity if the entity is organized as a corporation.'' To remain consistent with section 1124(a)(3)(B) of the Act, only officers and directors of corporations (rather than, for example, of limited liability companies) would fall within paragraph (e).

4. Expanded Medicaid and CHIP Provider Enrollment Disclosure Requirements

We propose the following changes to § 455.104:

• The current version of § 455.104(b)(1)(i) requires the disclosure of the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The addresses for corporate entities must include (as applicable) the primary business address, every business location, and P.O. Box address. We propose two changes to this paragraph.

First, we would change the language that reads ''any person (individual or corporation) with an ownership or control interest'' to ''any person or organization with an ownership or control interest.'' We believe that disclosures of owning or controlling organizations should be made irrespective of whether the entity is a corporation, partnership, limited liability company, or other form of organization. It is important that States can screen all owning and controlling parties for potential program integrity issues. Second, we propose to remove the word ''corporate'' from the second sentence of paragraph (b)(1)(i). This is to clarify that the addresses of any organization under paragraph (b)(1), regardless of the entity's structure, must be disclosed.

• Section 455.104(b)(1)(iii) requires in part the disclosure of an ''Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) . . .'' We propose to change this to reference the tax identification number of any organization with an ownership or control interest in, or that serves as a managing organization of, the disclosing entity (or fiscal agent or managed care entity). This revision would: (1) accord with our proposed change to § 455.104(b)(1)(i) by removing the reference to corporations so that the paragraph applies to all organizations, regardless of type; and (2) add managing organizations to the paragraph's purview.

As we stated in the earlier noted September 10, 2019, final rule, a managing entity often has as much (or more) day-to-day control over a provider or supplier as an owner. Given the important roles that managing organizations have over providers' operations, we believe that States must know the organizations' identities to help ensure that Medicaid and CHIP program integrity is maintained. We note that Medicare providers and suppliers have long been required to disclose managing organizations as part of the enrollment process.

• Section 455.104(b)(2) generally requires disclosure of the identities of persons reported per paragraph (b)(1) who are related to each other. We propose to change the language ''person (individual or corporation) with an ownership or control interest'' in that paragraph to ''person or organization with an ownership or control interest.'' This change would conform to our proposed revision of the definition of ''person with an ownership or control interest'' in § 455.101.

• Section 455.104(b)(4) requires the disclosure of ''the name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).'' We propose to redesignate this as new § 455.104(b)(4)(i) and to add new § 455.104(b)(4)(ii) to read: ''The name, address, and tax identification number of any managing organization of the disclosing entity (or fiscal agent or managed care entity).'' This is consistent with our proposed revisions to § 455.104(b)(1) involving managing entities.

Meanwhile, paragraph (a) of § 455.106 states that before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

• Has ownership or control interest in the provider, or is an agent or managing employee of the provider (§ 455.106(a)(1)); and

• Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs (§ 455.106(a)(2)).

We propose to revise paragraph (a) to expand the types of adverse actions that must be reported to the State. We would require that before the State enters into or renews a provider agreement, or at any time upon written request by the State, the provider must identify whether the provider, any person or organization with an ownership or control interest in the provider, or any agent, managing employee or managing organization of the provider, under any current or former name, numerical identifier, or business identity—

• Was, within the preceding 10 years, convicted of a Federal or State felony offense (regardless of type);

• Has been revoked or terminated, or is currently suspended, from participation in any State Medicaid program, CHIP, Medicare, or any other Federal health care program;

• Is currently subject to a payment suspension under § 455.23 or under CHIP or Medicare; or

• Has had its health care license revoked—or whose license is currently suspended—in any State. (This includes situations where the individual or entity voluntarily surrendered the license in lieu of disciplinary action.)

These four actions would be included in revised paragraph (a)(1) and new paragraphs (a)(3), (4), and (5). We also would expand existing paragraph (a)(2)'s scope to include misdemeanors involving sexual assault or financial misconduct; this is because we proposed in the CY 2027 HH PPS proposed rule to permit denial or revocation of a provider's enrollment based on a misdemeanor conviction involving sexual assault or financial misconduct.

There are two main reasons for this proposal. First, these data—some of which, in the Medicare context, must currently be reported on the applicable Medicare provider enrollment application (OMB Control No.: 0938–0685)—would give States greater insight into potential program integrity threats that the disclosed party may pose. This, in turn, could further safeguard the Medicaid program, CHIP, and their beneficiaries. Second, and as already noted and discussed in more detail later, we are proposing a number of new Medicaid and CHIP provider enrollment denial and termination reasons. Since several of these grounds involve the reportable actions under proposed revised § 455.106(a), we believe this information would help the States determine whether a denial or termination is warranted.

We particularly note the proposed addition of the language ''under any current or former name, numerical identifier, or business identity.'' This language has been used with several existing Medicare denial and revocation reasons in §§ 424.530 and 424.535 for a number of years. The purpose is to enable us to take action against problematic parties notwithstanding any identity change. We believe States must have the same ability. We do not believe a party's demonstrated program integrity risk disappears upon a mere change in name, especially when the entity or person makes this change to circumvent an existing adverse action. Indeed, we previously saw situations where a revoked Medicare provider changed its name to evade its revocation and subsequent bar against reenrolling in Medicare. In our view, the party's risk remains, and States must base their payment safeguard actions more on said risk than on the party's current name or identity.

Existing § 455.106(c) states that the Medicaid agency may refuse—

• To enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the title XX Services Program; or

• To enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under § 455.106(a).

We propose to delete this paragraph because these and all other denial and termination reasons in subpart B would, per this proposed rule, be included in revised § 455.416. This would ensure that all denials and terminations are addressed in one section rather than split between multiple sections.

5. New Bases for Medicaid and CHIP Provider Enrollment Denial and Termination

a. Introduction

Pursuant to the Secretary's general authority under section 1102 of the Act to prescribe regulations for the efficient administration of the Medicaid program and CHIP, we are proposing a number of additional denial and termination reasons. Our proposed grounds would—

• Be mandatory, meaning the State (except as discussed in the next bullet) would be required to deny or terminate enrollment if the facts of the case fall within those covered by the applicable denial or termination reason; and

• Permit the State in most cases to forgo mandatory denial or termination if the State determines that the denial or termination would not be in the best interests of its Medicaid program or CHIP.

We recognize that virtually all of our Medicare denial and termination grounds are discretionary. Yet we believe that making our proposed Medicaid denial and termination reasons mandatory—with the best interests exception—is advisable, in part because it would be consistent with the mandatory nature of (and best interests exceptions within) most of 42 CFR part 455's existing denial and termination grounds. Moreover, and notwithstanding our desire for greater consistency between Medicare and State Medicaid provider enrollment programs, we maintain that substantial conformity between States in how they interpret and carry out Part 455's denial and termination reasons is also important. Indeed, this was a principal consideration behind the aforementioned February 2, 2011, final rule's establishment of additional provider enrollment requirements in subparts B and E of Part 455. We believe that having consistent, uniform interpretations of Federal Medicaid provider enrollment provisions in Part 455 is preferable to inconsistent ones and would reduce provider uncertainty

regarding the meaning of these requirements.

b. Listing of Current Denial and Termination Reasons in § 455.416

The following denial and termination reasons are in existing § 455.416:

- Under paragraph (a), the State must terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under this subpart.
- Under paragraph (b), the State must deny or terminate enrollment if a person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with Medicare, Medicaid, or title XXI of the Act in the last 10 years.
- Under paragraph (c), the State must deny or terminate enrollment of any provider that is terminated under Medicare or under the Medicaid program or CHIP of any other State and is currently included in the termination database under § 455.417.
- Under paragraph (d), the State must deny or terminate enrollment if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information.
- Under paragraph (e), the State must deny or terminate enrollment if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or State Medicaid agency request.
- Under paragraph (f), the State must deny or terminate enrollment if the provider fails to permit access to provider locations for any site visits under § 455.432.
- Under paragraphs (g)(1) and (2), the State may deny or terminate enrollment if CMS or the State Medicaid agency—

++ Determines that the provider has falsified any information provided on the application; or

++ Cannot verify the identity of any provider applicant.

Paragraphs (b), (d), (e) and (f) state, however, that the State is not required to deny or terminate enrollment if it determines that denial or termination of enrollment is not in the best interests of the Medicaid program, and the State documents that determination in writing.

Also, under § 455.107(g), the State must deny a provider's enrollment if it determines under § 455.107 that a particular affiliation (as that term is defined under § 455.101) poses an undue risk of fraud, waste, or abuse.

We are proposing to delete existing § 455.416(a) through (g). This is primarily because some of these provisions fall within the larger scope of our proposed grounds. To avoid duplication and confusion by having two separate reasons involving similar conduct, we would incorporate the existing grounds within the proposed ones to the maximum extent possible. Those current § 455.416 grounds not falling within one of our proposed reasons would remain in § 455.416, though under a different paragraph designation and, in some cases, with revisions.

To summarize, revised § 455.416 would include: (1) the incorporation of several existing provisions within our proposed reasons; (2) the retention of several existing grounds with modifications; (3) the transfer of several denial and termination reasons from §§ 455.104, 455.106, and 455.107 to § 455.416; and (4) the incorporation of a number of Medicare denial and revocation grounds into Medicaid within § 455.416, though in most cases with the former's required factors and discretionary application replaced by the ''best interests'' exception referenced in current § 455.416.

c. Revised § 455.416

(1) Exclusion (§ 455.416)(a))

In paragraph (a), we propose that the State must deny or terminate enrollment if a provider, person or organization with an ownership or control interest in the provider, managing employee or managing organization or agent of the provider, or other health care or administrative or management services personnel furnishing services payable by a Federal health care program of the provider, is either—

- Excluded from Medicare, Medicaid, and any other Federal health care program, as defined in § 1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867, or 1892 of the Act.
- Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement activity in accordance with section 2455 of the Federal Acquisition Streamlining Act (FASA).

States are already required to deny Medicaid participation for: (1) certain exclusions under section 1128 of the Act; and (2) government-wide debarments in accordance with section 2455 of the Federal Acquisition Streamlining Act. However, there is no explicit regulatory provision in subparts B and E of part 455 to this effect. Proposed § 455.416(a), which mirrors §§ 424.530(a)(2) and 424.535(a)(2) regarding denials and revocations of Medicare enrollment based on an exclusion or debarment, would address this. Also, we propose to include in § 455.416(a) the language in § 424.530(a)(2)(ii) stating that the former would include individuals and organizations that are either W–2 employees or contracted individuals and organizations of the provider. We believe the risk from excluded or debarred parties is no less with contracted parties than with W–2 employees.

As this is a mandatory denial and revocation reason under §§ 424.530 and 424.535, and because States are generally prohibited from making payments to excluded (42 CFR 1001.1901(b)) or debarred (2 CFR 180.305(a), 2 CFR part 376) providers, revised § 455.416(a) would not contain the aforementioned ''best interests'' exception.

(2) Affiliation Posing Undue Risk (§ 455.416(b))

As mentioned previously, the State, in consultation with us, must under § 455.107(g) deny or terminate a provider's enrollment if it determines under § 455.107 that a particular affiliation poses an undue risk of fraud, waste, or abuse. To ensure that all denial and termination reasons are included within one section, we propose to delete § 455.107(g) and designate this provision as revised § 455.416(b). No ''best interests'' exception would be included, for none exists in current § 455.107(g) and because States should consider the best interests of their programs in making the determination as to whether a particular affiliation poses an ''undue risk'' of fraud, waste, or abuse.

As part of this change, existing § 455.107(h) would be redesignated as § 455.107(g).

(3) Medicare/Medicaid/CHIP Termination (§ 455.416(c))

We previously noted current § 455.416(c), which requires denial or termination based on a Medicare, Medicaid, or CHIP termination and the provider currently being in the termination database. We propose to retain this provision essentially as is, including its present paragraph designation and its existing lack of a ''best interests'' exception; we would,

though, remove the now-unnecessary qualification that the requirement applies to terminations on or after January 1, 2011.

(4) Misdemeanor Conviction (§ 455.416(d))

We propose to redesignate existing § 455.416(b) (which addresses criminal offenses related to Medicare, Medicaid, or CHIP) as revised § 455.416(d), with the ''best interests'' caveat included. Yet we also propose two other changes to redesignated § 455.416(d):

- We would restrict this denial or termination reason to misdemeanor convictions. Since felony convictions would, as discussed shortly, be addressed elsewhere in § 455.416, paragraph (d)'s limitation to misdemeanors would help prevent overlap.
- In the CY 2027 HH PPS proposed rule, we proposed in new §§ 424.530(a)(16) and 424.535(a)(16) that CMS could deny or revoke enrollment if the provider or supplier—or any owner, managing employee, managing organization, officer, or director thereof—was convicted of a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. We propose to add this reason to revised § 455.416(d). This would not only facilitate consistency with proposed new §§ 424.530(a)(16) and 424.535(a)(16) but also allow the State to take action against problematic parties beyond those currently addressed in § 455.416(b).

As with most other existing and proposed Medicaid enrollment denial and termination reasons in Part 455, redesignated § 455.416(d) would include the previously discussed ''best interests'' exception. Too, the misdemeanor conviction would have to be detrimental to the best interests of the Medicaid program or CHIP (rather than those of the Medicare program).

(5) General Non-Compliance (New § 455.416(e))

Sections 424.530(a)(1) and 424.535(a)(1) state in part that we may deny or revoke Medicare enrollment if the provider is not in compliance with the Medicare enrollment requirements in title 42 or in the enrollment application applicable for its provider or supplier type. We propose a similar reason in revised § 455.416(e) whereby the State must deny or terminate enrollment if the provider is non-compliant with any requirement described in subpart B or E of part 455, though it may utilize the ''best interests'' exception.

We recognize that there could be some overlap between revised § 455.416(e) and certain other § 455.416 provisions. To illustrate, some providers must submit sets of fingerprints as part of the enrollment process consistent with subpart 455, subpart E. Failure to do could result in denial under existing § 455.416(e). Yet this could also fall within the scope of revised § 455.416(e) due to the provider's non-compliance with subpart E. To avoid duplicative application, we also propose to include existing § 455.416(a), (d), (e), (f), and (g)(2) within revised § 455.416(e) as examples of subpart B or E non-compliance; we would, though, combine existing paragraphs (a) and (e) due to their similarities. In addition, revised § 455.416(e) would effectively incorporate existing § 455.106(c)(2), which permits denial or termination if the provider fails to make a required disclosure under § 455.106(a).

(6) Felony Convictions (§ 455.416(f))

In revised paragraph (f), we would mirror the current Medicare denial and revocation reasons in §§ 424.530(a)(3) and 424.535(a)(3) regarding felony convictions. We propose that the State must deny or terminate enrollment if the provider, any person or organization with an ownership or control interest in the provider, or any managing employee or managing organization of the provider was, within the preceding 10 years, convicted (as that term is defined in § 1001.2) of a Federal or State felony offense that the State determines is detrimental to the best interests of its Medicaid program or CHIP and their beneficiaries. Offenses would include, but not be limited in scope or severity to—

- Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted;
- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted;
- Any felony that placed the Medicaid program or CHIP or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct; and
- Any felony that would result in mandatory exclusion under section 1128(a) of the Act.

We have long believed that any felony conviction, regardless of the type, raises questions as to whether the provider can be a reliable participant in Medicare. We believe the same concern would apply in the Medicaid program or CHIP. States thus must do whatever possible to prevent unnecessary risks to Medicaid or CHIP and those programs' beneficiaries. Nonetheless, under our proposal the State would have discretion to determine what types of convictions are ''detrimental to the best interest of the Medicaid program or CHIP or their beneficiaries'' and could utilize the ''best interests'' exception if it deems warranted.

(7) False or Misleading Information (§ 455.416(g))

Under existing § 455.416(g)(1), the State may deny Medicaid or CHIP enrollment if CMS or the State determines that the provider has falsified any information provided on the application. Per existing § 424.530(a)(4), we can deny Medicare enrollment if the provider or supplier has submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program; offenders may be referred to the OIG for investigation and possible criminal, civil, or administrative sanctions.

We propose to redesignate § 455.416(g)(1) as revised § 455.416(g), combine it with § 424.530(a)(4)'s language, and add further clarification. Under revised § 455.416(g), the State must deny or terminate Medicaid or CHIP enrollment if the provider submits false or misleading information to (or omits information from) the Medicaid program or CHIP to gain or maintain enrollment.

We believe that providers submitting false or misleading data or omitting data to become or remain enrolled in Medicaid or CHIP potentially pose the same level of risk to these two programs as they do to Medicare. The language ''in order to gain or maintain enrollment'' is particularly important because it clarifies two aspects of existing practice in the Medicare context. First, the requirement to submit complete and truthful information is not restricted to initial applications but also applies to revalidations, changes of information, and all other application types. Our proposed inclusion of ''maintain'' (as opposed to merely gaining enrollment, which implies initial submissions) is therefore necessary; providers must always submit truthful and accurate information to Medicaid and CHIP. Second, we believe that any false, misleading, or omissive submission to Medicaid or CHIP—regardless of whether it was made via the enrollment application, supporting documentation,

or otherwise—should constitute grounds for denial or termination. The specific format of submission, in our view, is less crucial than the actual submission.

Under current § 455.416(g)(2), States may deny or terminate the provider's Medicaid or CHIP enrollment if CMS or the State Medicaid agency cannot verify the identity of any provider applicant. We propose to delete this provision because we would include it within the general ''Non-compliance'' category in § 455.416(e)(1)(iv)).

We note that while current paragraph (g)(1) is discretionary, we propose to make revised paragraph (g) mandatory (though with the ''best interests'' provision in proposed (g)(2)) to be consistent with most of our other proposed denial and termination grounds.

(8) Drug Enforcement Administration Certificates (§ 455.416(h))

The DEA implements and enforces titles II and III of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and the Controlled Substances Import and Export Act, as amended, and collectively referred to as the Controlled Substances Act (CSA) (21 U.S.C. 801–971); the implementing regulations for these statutes are in 21 CFR parts 1300 through 1321. The CSA makes possession of authority under State law to dispense controlled substances a requirement for both obtaining and maintaining a DEA Certificate of Registration.

Sections 424.530(a)(11) and 424.535(a)(13) state, in part, that we may deny or revoke a physician's or eligible professional's Medicare enrollment if the individual's DEA Certificate of Registration to dispense a controlled substance is currently suspended or revoked or is surrendered in response to an order to show cause. We believe that a DEA Certificate of Registration to prescribe controlled substances is akin to a State's requirement that a physician or eligible professional be licensed or certified by the State to furnish health care services. The loss of the ability to prescribe drugs via a suspension or revocation of a DEA Certificate indicates that the physician or eligible professional may be misusing or abusing their authority to prescribe such substances.

Yet those concerns are not limited to Medicare. Improper prescribing activities can harm Medicaid and CHIP beneficiaries and program integrity as much as Medicare patients and program integrity. Hence, we propose in new § 455.416(h) that a State must deny or terminate enrollment if the physician's or practitioner's DEA certificate is currently suspended or revoked or is surrendered in response to an order to show cause, with the ''best interests'' provision included. The only difference would involve our use in § 455.416(h) of ''practitioner'' instead of ''eligible professional,'' since the former term is broader than 42 U.S.C. 1396b(t)(3)(B)'s somewhat narrow definition of the latter.

(9) Misuse of Enrollment (§ 455.416(i))

Under current § 424.535(a)(7), we may revoke Medicare enrollment if the provider or supplier knowingly sells to or allows another individual or entity to use its billing number. (This does not apply to providers or suppliers who enter into a valid reassignment of benefits as specified in § 424.80 or a change of ownership outlined in § 489.18.) This provision is meant to prevent providers from permitting others to utilize their Medicare enrollment. A provider's enrollment is restricted and unique to that provider. Each provider must individually meet and maintain compliance with the legal requirements specific to it and cannot use the credentials of other providers, suppliers, or other parties to do so. To permit another party to bill Medicare via the provider's enrollment would entirely undercut this principle; it could lead to fraudulent individuals and entities (or other parties that Medicare has not screened) billing the program and receiving payment under the provider's enrollment.

We have the same concerns regarding Medicaid and CHIP. Each Medicaid or CHIP enrollment is specific to the enrolled provider and does not extend to any other party. To help protect against the improper use of a provider's enrollment by other persons or entities, we propose in new § 455.416(i) that the State must terminate enrollment if the provider knowingly sells or allows another individual or entity to use its enrollment to bill Medicaid or CHIP. We believe the language ''use its enrollment to bill Medicaid or CHIP'' is more appropriate than ''use its billing number.'' The former is broader and can encompass any activity by which the other party bills Medicaid or CHIP via the provider's enrollment.

As with § 424.535(a)(7), there would be two exceptions to § 455.416(i). One would be for Medicaid and CHIP assignments of payment. Under § 447.10(g), payment for services provided by an individual practitioner may be made to—

- The employer of the practitioner, if the practitioner is required as a condition of employment to turn over the practitioner's fees to the employer;
- The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or
- A foundation, plan or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

We believe these provisions are akin to those under § 424.80, whereby the physician or practitioner permits a party with whom it has an employment or contractual relationship to bill for and collect payment for the services the individual provides. We thus conclude that an exception for payments permitted under § 447.10(g) is appropriate.

The second exception involves changes of ownership. Because State laws vary regarding: (1) what constitutes a change of ownership; (2) the consequences of such a change; and (3) the vetting and screening process for ownership changes, we propose that a State would not be required to terminate a provider under § 455.416(i) if State law permits another individual or entity to bill Medicaid or CHIP under the provider's enrollment in a change of ownership situation.

As with most of our other proposed grounds, the ''best interests'' exception would be included within § 455.416(i).

(10) Abusive Prescribing or Ordering of Services, Items, or Drugs (New §§ 455.416(j) and (k))

Existing §§ 424.535(a)(14) and (21) permit revocation of Medicare enrollment if we determine that the physician or eligible professional has a pattern or practice of—

- Prescribing Medicare-covered drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or fails to meet Medicare requirements. (§ 424.535(a)(14)); or
- Ordering, certifying, referring, or prescribing Medicare Part A or B services, items, or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements (§ 424.535(a)(21)).

We outlined our concerns about improper prescribing in our discussion of proposed § 455.416(h). The inappropriate ordering, certifying, or referring of services and items is equally concerning to us. If a physician or practitioner is improperly performing these activities, patient harm can ensue. For instance, a physician ordering tests that patients do not require could subject beneficiaries to dangerous and

unnecessary procedures. Moreover, Medicaid and CHIP funds would be unnecessarily spent on these tests.

We believe States should take action against these individuals, not only to protect Medicaid and CHIP beneficiaries but also to safeguard the financial integrity of these programs. Accordingly, we propose to duplicate existing §§ 424.535(a)(14) and (21) in new § 455.416(j) and (k), though we note the following. First, all references in §§ 424.535(a)(14) and (21) to Medicare would be changed to ''Medicaid or CHIP.'' Second, to avoid overlap, we would not include improper prescribing within new § 455.416(k) because we believe § 455.416(j) would adequately address this situation. Section 455.416(k) would be limited to services and items. Third, any references in §§ 424.535(a)(14) and (21) to eligible professionals would be changed in § 455.416(j) and (k) to physician or practitioner. Fourth, both paragraphs would include the ''best interests'' exception.

6. Additional Medicaid and CHIP Provider Enrollment Proposals

a. Database Reviews (§ 455.436)

Section 455.436 lists databases that States must review when (1) enrolling Medicaid and CHIP providers and (2) confirming their eligibility to remain enrolled. Section 455.436(b) lists the Excluded Parties List System (EPLS) as one of these databases. As this database is now named the System for Award Management (SAM), we propose in § 455.436(b) to replace ''Excluded Parties List System'' with the former term. For the same reason, we propose to change ''EPLS'' in § 455.436(c) to ''SAM.''

b. Screening Levels (§ 455.450)

Section 424.518 discusses the different levels at which Medicare must screen initial applications, revalidation applications, and other application submissions. The levels are limited, moderate, and high. The categories are generally based on the assessed degree of program integrity risk each provider or supplier type poses; those types presenting the highest risk (for example, hospices) are in the ''high'' category.

Section 455.450 addresses the screening levels applicable to Medicaid enrollment. The first sentence in its opening paragraph states: ''A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of 'limited,' 'moderate,' or 'high.'' Consistent with section 1902(kk)(1) of the Act—and as explained in the preamble to the aforementioned February 2, 2011, final rule—for provider types that exist in both Medicare and Medicaid, the State must assign providers to the same or higher risk category applicable under Medicare in accordance with § 424.518. To codify this requirement in regulatory text, we propose to amend the opening paragraph of § 455.450 to add the following language between this paragraph's two existing sentences: ''For provider types that also exist in Medicare, the State must assign such providers to the same or higher risk category applicable under Medicare in accordance with § 424.518.''

c. Application Fees (§ 455.460)

Under § 455.460(a), the State must ''collect the applicable application fee prior to executing a provider agreement from a prospective or reenrolling provider other than either of the following'' persons or entities, which are listed in § 455.460(a)(1) and (2). We propose several changes to this section.

First, we propose to change the language ''a prospective or re-enrolling provider'' in paragraph (a) to ''a prospective, revalidating or re-enrolling provider'' to clarify that revalidating institutional providers, consistent with section 1866(j)(2)(C) of the Act and current practice, must pay an application fee.

Second, we propose to remove the language ''either of'' in paragraph (a) because all parties listed in paragraph (2) are, as applicable, exempt from the fee.

Third, the purpose of the application fee is to cover the costs of screening provider applications under subpart E. As already noted, States must screen a provider's application at the same or a higher level than we use for that same provider type in Medicare and as prescribed in § 424.518. For instance, hospitals under § 424.518(a)(1) are subject to the ''limited'' risk category of screening; under § 455.450, States, too, typically screen hospital applications using the ''limited'' risk category procedures. However, States have the discretion under § 455.452 to screen an application using additional or more stringent methods than those required by subpart E. This helps States address local or statewide conditions involving provider types that may present a higher risk of fraud, waste or abuse and thus require stricter screening.

Section 455.460(a)(2)(ii) states that providers that have already paid the application fee to a Medicare contractor or to another State are exempt from paying a second fee to the State. This is because the State may rely on the screening results of the Medicare enrollment or the other State enrollment. Yet this becomes problematic when the State believes that a higher level of screening is warranted with respect to the provider's Medicaid or CHIP enrollment. Some States have expressed reluctance to screen at higher levels under § 455.452 because of the inability to collect an application fee under § 455.460(a)(2) to cover the costs of such screening. This has led to instances where the State has been unable, for financial reasons, to use enhanced screening methods when the State believed they were necessary. We are concerned that this has resulted in certain Medicaid providers having been insufficiently screened.

Section 455.460(a)(2)(ii) contains the language ''(p)roviders that have paid the applicable application fee to (A) a Medicare contractor, or (B) (a)nother State''. To address the previously mentioned concerns, we propose the following:

- Redesignating paragraphs (a)(2)(ii), (a)(2)(ii)(A), and (a)(2)(ii)(B) as, respectively, paragraphs (a)(2)(ii)(A), (a)(2)(ii)(A)(*1*), and (a)(2)(ii)(A)(*2*);
- Changing ''providers that have paid the applicable application fee'' to ''Subject to paragraph (2)(ii)(B), providers that have paid the applicable fee. . .''; and
- Establishing a revised paragraph (ii)(B) that reads: ''Paragraphs (2)(ii)(A)(*1*) and (*2*) do not apply if the State is screening the provider at a higher level under § 455.450 than the Medicare contractor or other State to which the provider paid the fee. In this situation, the State may collect a fee from the provider that represents the cost of this additional screening above and beyond the level of screening the Medicare contractor or State performed under § 455.450. However, the State shall document the reason(s) for the enhanced screening.''

To illustrate how revised paragraph (ii)(B) would work, assume State A screened a fee-paying enrolling provider at the ''moderate'' level. Said provider now submits an enrollment application to State B, which believes the provider should be screened at the ''high'' level. State B's ''high'' level screening typically costs Y dollars and its ''moderate'' level screening X dollars. State B could require the provider to pay the difference between Y and X to reflect the additional screening activities; States would have the discretion to determine the cost of this additional screening. We believe that

payment of the difference between the two screening levels' costs would be fairer to the provider than requiring payment of another full application fee. We also note that revised paragraph (ii)(B) would only apply to providers that have paid the applicable fee to the Medicare contractor or other State. Providers that, for example, received a hardship exception from paying the fee to the Medicare contractor or other State would not have the pay the costs of the additional screening.

In summary, we believe that revised paragraph (ii)(B) would assist the States in their efforts to appropriately screen Medicaid and CHIP providers by removing the disincentive for elevated screening. This would, in turn, enhance Medicaid and CHIP program integrity. To ensure that States have sufficient grounds for requiring a fee under (ii)(B), though, we believe that States should document the need for the enhanced screening.

d. Monthly Reporting of Denials and Terminations to CMS

Consistent with sections 1902(kk)(8) and 1902(ll) of the Act as well as § 455.417, CMS operates a ''termination database.'' This database contains information on certain Medicaid and CHIP terminations and Medicare revocations. Per Sections 1902(kk)(8) and 1902(a)(41) of the Act, the State must report to the Secretary all its provider terminations under Medicaid and CHIP that are ''for cause'' (as defined in § 455.101) within 30 days after the effective date of the termination, which is the later of the effective date specified in the termination notice or the date appeal rights have been exhausted. Although CMS reviews these terminations in the database, the latter does not capture: (1) denials of Medicaid or CHIP enrollment; or (2) situations where the State chose not to deny or terminate enrollment based on a best interests determination. We believe that despite the termination database's usefulness, the lack of certain information about the State's denial and termination decisions hinders our ability to detect and address vulnerabilities in the Medicaid and CHIP provider enrollment processes.

To address this gap, we propose in new § 455.418 that each State must submit to CMS on a monthly basis—and in a format required by CMS—the legal business and doing business names, address, TIN, and NPI of each provider (Medicaid or CHIP) whose enrollment, within the applicable monthly period, the State—

- Denied or terminated under § 455.416. This must include—

++ The regulatory basis for the denial or termination.

++ The facts of the case and an explanation of how the State reached its decision.

- Was required to deny or terminate under § 455.416 but declined to do so based on a best interests finding. This must include—

++ The regulatory basis for the prospective denial or termination; and

++ The facts of the case, an explanation of how the State reached its decision, and reasons for the State's best interests determination.

CMS would issue guidance to States on the required format should this provision be finalized.

In new paragraph (b), we would remind stakeholders that the requirements of § 455.418 would be in addition to, and not in lieu of, the reporting requirement under sections 1902(kk)(8) and 1902(a)(41). That said, they would only apply to denials or terminations pursuant to § 455.416 and not those under separate State authority that might meet the definition of ''for cause'' for purposes of those provisions.

H. Medicare Advantage Original Medicare Provider Enrollment Requirements

1. Background

a. General Overview

The Balanced Budget Act of 1997 (BBA) established a new Part C of the Medicare program, known as Medicare+Choice (M+C), effective January 1999. As part of the M+C program, the BBA authorized CMS to contract with public or private organizations to offer a variety of health plan options for enrollees, including both traditional managed care plans (such as those offered by HMOs, as defined in section 1876 of the Act) and new options not previously authorized. The M+C program was renamed the Medicare Advantage (MA) program under Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), which was enacted on December 8, 2003. The MMA changed how benefits are established and payments are made; under the MMA, enrollees were able to choose from additional plan options. Also, Title I of the MMA established the Medicare prescription drug benefit (Part D) program and amended the MA program to allow most MA plans to offer prescription drug coverage.

All Medicare health plans (but not Program of All-inclusive Care for the Elderly (PACE) organizations) that specify networks of providers from whom enrollees may obtain services must develop a network of qualified providers that meets CMS network adequacy standards as detailed in § 422.116. CMS reviews MA organizations' network of contracted providers on a routine basis, unless there is a triggering event that would require an expedited formal network review, such as a significant provider termination.

b. The 2016 and 2018 Part C Provider Enrollment Regulations

In November 2016, CMS issued a final rule (81 FR 80170) containing various requirements related to provider enrollment,[157] including the addition of § 422.222. This section required providers and suppliers that furnish health care items or services to a Medicare enrollee who receives their Medicare benefit through an MA organization to be enrolled in Original Medicare (also known as Medicare fee-for-service (FFS)) in an approved status no later than January 1, 2019. (The term ''MA organization'' refers to both organizations offering stand-alone MA plans and MA plans that provide drug coverage, otherwise known as MA–PD plans.)

The general purpose of this requirement was to ensure that MA providers and suppliers (hereafter collectively ''providers'' unless otherwise noted) were fully screened via the provider enrollment process used for Original Medicare Part A and Part B providers. As previously noted in this proposed rule, Original Medicare Part A and Part B provider enrollment screening is comprehensive. It involves the collection and verification of critical data such as the provider's identity, address, licensure and other qualifications, practice location, owners, managing employees, and adverse legal history. Depending on the provider type, it can also include site visits and fingerprint-based criminal background checks. The thoroughness of this process was invaluable in protecting the Medicare program from fraud, waste, and abuse as well as Medicare beneficiaries from unqualified providers. Given that many providers at the time underwent less robust screening by their prospective MA organizations before becoming MA

[157] ''Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements''

providers, we believed that our requirement would help safeguard the MA program and its beneficiaries (hereafter occasionally ''enrollees'').

We began outreach efforts shortly after the November 2016, final rule's publication. We communicated with provider associations and MA organizations regarding, among other things, the purpose of the enrollment process, the rationale for the new enrollment requirement, and the mechanisms of completing and submitting an enrollment application. While the vast majority of MA providers and suppliers were already enrolled in Original Medicare and thus met the new MA provider enrollment requirement, over 100,000 were not. This led the MA community to raise concerns about the potential burden of this requirement, especially since MA providers also must undergo credentialing by their respective MA organizations.

In response to these concerns, we issued a final rule in April 2018 (83 FR 16440) that eliminated the MA provider enrollment requirement at § 422.222.[158] In its place, we established in § 422.222 a ''preclusion list.'' The preclusion list for contracted and non-contracted individuals and entities is a list of providers that are precluded from receiving payment for MA services and items they furnish. Per the definition of ''preclusion list'' in § 422.2, there are three ways individuals and entities can be added to the list:

- The individual or entity is currently revoked from Medicare, is currently under a reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
- The individual or entity has engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Regardless of whether they are or were enrolled in Medicare, the individual or entity has been convicted of a felony under Federal or State law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program. (We proposed in the CY 2027 HH PPS proposed rule (91 FR 41216) to expand this to include felony convictions against the individual or entity or an owner, managing employee, managing organization, director, or officer (as those terms are defined in § 424.502) thereof.))

For purposes of burden reduction, the April 2018 final rule also replaced the requirement that prescribers of Medicare Part D drugs be enrolled in Original Medicare with a preclusion list for Part D prescribers, addressed in § 423.120(c)(6).

c. Preclusion List and Part C Program Integrity Issues

The preclusion list for MA providers has been in effect since 2019. For several reasons, though, we are reevaluating its effectiveness in stemming MA fraud, waste, and abuse in comparison to the proven program integrity safeguards of our existing Medicare provider enrollment process.

First, while many MA organizations require providers to be enrolled in Original Medicare as a condition of contracting,[159] well over 100,000 in-network providers remain unenrolled. In certain cases, a particular MA organization's credentialing process may not be as comprehensive as Original Medicare enrollment screening. The latter, for example, contains the following verification mechanisms that do not necessarily exist in the MA organizations' internal process:

- Reviewing the provider and its owners and managing employees against the System for Award Management, which lists debarment actions taken by various Federal agencies.
- Reviewing the provider's adverse legal history, such as criminal convictions, health care program revocations and suspensions, and adverse State licensure actions.
- Fingerprint-based criminal background checks for 5 percent or greater owners of provider types designated as high-risk under § 424.518.
- Reviewing the Medicaid Termination Database under § 455.417 to ascertain whether the provider is terminated under Medicaid or CHIP.
- Monthly monitoring to ensure the provider's continued compliance with licensure and other enrollment requirements.
- Verifying the validity of the provider's practice location.
- Requiring the provider to revalidate its Medicare enrollment information (including upon a CMS request) by submitting a complete Medicare enrollment application.

Most disconcerting of all is that out-of-network providers that bill MA may not be credentialed by any MA organization, meaning they receive little, if any, screening. This leaves the MA program vulnerable to fraud, waste, and abuse.

As noted, Original Medicare enrollment is the front line of Medicare program integrity. It enables us to detect and stop non-compliant and potentially fraudulent parties from billing MA at the start, rather than after they begin doing so. Without this important vetting, we have limited means of preventing unqualified providers from entering MA and possibly harming the Trust Funds and MA enrollees.

Second, and in this same vein, we see the preclusion list as more of a reactive program integrity measure than a proactive one. For MA providers that are not enrolled in Original Medicare, we sometimes do not learn that the provider has engaged in fraudulent or other improper conduct until the MA organization itself discovers this and informs us. Only then can we begin the process of placing the provider on the preclusion list. By the time all this occurs, many months may have passed, hundreds of thousands of MA organization dollars may have been paid to the provider, and considerable harm to MA enrollees may have taken place. In other words, in such cases CMS effectively must wait: (1) for the inappropriate activity to happen; (2) for the inappropriate activity to be discovered by the MA organization (potentially months after it occurred); and (3) to be notified by the MA organization before CMS can commence action against the provider. This directly contradicts our stated objective of moving away from the ''pay-and-chase'' program integrity model and towards the far better approach of halting fraud before it begins.

Third, pursuant to § 422.222(a)(3), the following timing conditions apply to the addition of an individual or entity (other than an OIG-excluded party) to the MA preclusion list:

- If the individual or entity (hereafter occasionally and collectively referenced as ''party'') does not file a reconsideration request under § 498.5(n)(1), the party is added to the preclusion list upon the expiration of the 60-day period in which the party may request a reconsideration; or
- If the party files such a reconsideration request, they are added to the list effective the date on which CMS, if applicable, denies reconsideration. OIG-excluded parties

[158] ''Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program''.

[159] Recent CMS data indicates that approximately 90 percent of in-network MA providers—over one million—are enrolled, meaning that they are already subject to the strict screening of Original Medicare enrollment.

are added to the preclusion list effective on the date of the exclusion.

This means that even though CMS believes an individual or entity has, for instance, engaged in fraud, beneficiary harm, or felonious conduct, CMS cannot take any action against that individual or entity via the preclusion list for at least 60 days—and if said party files a reconsideration request, CMS action could take considerably longer. Yet with Original Medicare provider enrollment, CMS can immediately revoke the provider's enrollment without having to wait for the expiration of any appeals process, thus providing further protection for Medicare funds and beneficiaries. In addition, many of the Medicare enrollment revocation reasons in § 424.535(a) are retroactive, meaning the revocation effective date—in general and with variations—essentially goes back to the date the provider's non-compliance with Original Medicare enrollment requirements began. This enables CMS to recoup monies paid to the provider while they were non-compliant.[160] (We also proposed in the CY 2027 HH PPS proposed rule to make the remainder of our Medicare revocation reasons retroactive.) Accordingly, requiring providers that bill MA to enroll in Original Medicare, and hence be subject to retroactive revocations in cases of non-compliance, would likely go further in the MA realm in safeguarding taxpayer monies and protecting MA enrollees than the preclusion list.

Too, we have seen a growing trend of providers foregoing Original Medicare enrollment and instead billing MA organizations as out-of-network providers. This only enhances the need for the comprehensive, up-front screening process that Medicare provider enrollment furnishes.

We recognize that proposing to require MA providers (both in-network and out-of-network) to be Original Medicare-enrolled would, if finalized, be a change in position from our prior decision to have the preclusion list replace the enrollment requirement. We also appreciate providers' likely concerns about the potential burden of having to enroll. Yet we note two things.

One is that several of the aforementioned issues concerning the preclusion list–such as the time it can take for CMS to learn of an MA provider's misconduct–were not as apparent as they are now. In fact, in September 2026, as part of the White House Anti-Fraud Task Force's ongoing efforts to crush fraud in the healthcare system and protect taxpayer dollars, CMS identified and barred via the preclusion list 11 DME companies with more than $3.4 billion in suspected fraudulent billing practices in 2025 and 2026 from receiving future Part C and Part D payments. These 11 DMEPOS suppliers: (1) had submitted no claims prior to 2025; (2) used improper billing practices for their claims; (3) had billed for medical equipment to beneficiaries already deceased; and (4) supplied equipment to beneficiaries who never requested or received it. Four of the suppliers had already been revoked from Original Medicare and began billing MA organizations instead.[161] This is one illustration of how the preclusion list is a useful tool once potential fraud has been identified but can fall short when fraud is being targeted at MA plans instead of Original Medicare, especially when those targeting MA are out-of-network providers. MA credentialing by itself is often not as rigorous as the Medicare provider enrollment process (as previously shown in the bulleted list of verification activities that some MA plans do not undertake), and the lack of screening for out-of-network providers is an extremely serious vulnerability; the increasing number of out-of-network providers greatly heightens this risk to the MA program. Circumstances have changed, and our obligation to protect the Trust Funds requires us to be flexible in our program integrity activities and to modify them as warranted.

As discussed in more detail in this proposed rule's ICR section, roughly 150,000 MA providers (many being out-of-network) would have to enroll in Medicare. While we again acknowledge this burden, we stress that the payment of MA dollars to fraudulent or otherwise unqualified providers burdens all Americans, including legitimate MA providers. Indeed, a single fraud scheme involving several MA providers that had not been adequately vetted before they began providing MA services—when strict enrollment screening might have kept them out of the MA program—could alone result in tens of millions of dollars in lost taxpayer monies. The point is that the cost burden of MA provider enrollment would, we believe, ultimately be far less than the savings to bona fide MA providers and all other Americans from MA fraud and abuse prevention.

For all these reasons, we propose to require that all providers that bill MA be enrolled in Original Medicare. This proposal is aligned with Department of Health and Human Services Office of Inspector General's September 2026 report on CMS actions to prevent durable medical equipment fraud in MA.[162] The proposed regulatory changes that follow largely mirror those we finalized in the previously mentioned November 2016 final rule. An important modification, though, would be our proposal to expand the enrollment requirement to include out-of-network MA providers, which were not required to enroll under the November 2016 final rule. CMS is proposing to include out-of-network MA providers in this requirement to address the earlier noted program integrity threats associated with these parties.

To give unenrolled MA providers adequate time to enroll in Original Medicare and MA organizations adequate time to operationalize this requirement, our changes, if finalized, would not become applicable until January 1, 2030. This timeframe is somewhat akin to that which we finalized in November 2016 final rule, which was the first day of the next plan year that begins 2 years after the date of publication of that final rule. Until this January 1, 2030, applicability date, the MA preclusion list requirements would remain in effect.

We are not at this time proposing that Part D prescribers be required to enroll in Original Medicare in lieu of the preclusion list. We may consider doing so in future rulemaking.

d. Statutory Authority

The following are the principal legal authorities for our proposed MA enrollment requirement:

- Section 1856(b) of the Act, which provides that the Secretary shall establish by regulation other standards for Medicare+Choice organizations and plans consistent with, and to carry out, Part C.
- Section 1857(e)(1), which gives CMS the authority to implement additional MA contract terms and conditions not inconsistent with Part C as the Secretary may find necessary and appropriate.
- Sections 1102 and 1871 of the Act, which provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program.
- Section 1866(j) of the Act, which provides specific authority with respect

[160] We are also proposing in the CY 2027 HH PPS proposed rule to make the remainder of our Medicare revocation reasons retroactive.

[161] *https://www.cms.gov/newsroom/press-releases/cms-cracks-down-massive-3-4-billion-medical-equipment-supplier-fraud-scheme.*

[162] Medicare Advantage Organizations and CMS Can Do More To Prevent Durable Medical Equipment Fraud in Medicare Advantage.

to the enrollment process for providers and suppliers in the Medicare program.

2. Specific Regulatory Changes

We propose the following regulatory revisions:

a. Proposed Provisions ''Preclusion List'' Definition (§ 422.2)

In light of the foregoing, we propose the following regulatory revisions. Note that a number of these reflect that our existing MA preclusion list provisions would remain in effect up to December 31, 2029. Also, the MA definition of ''providers'' in § 422.2 includes individuals and entities that would be considered either providers or suppliers in original Medicare; we will hence use the term ''provider'' in our proposed regulatory provisions except as other noted.

In the opening clause of this definition, we propose to replace the language that reads ''means a CMS compiled list'' with ''means, before January 1, 2030, and with respect to this part, a CMS compiled list''. This would clarify that the definition only applies to Part 422 through December 31, 2029, after which the enrollment requirement would replace the preclusion list for MA.[163]

b. Documented Process (§ 422.204(c))

Section 422.204(c) states that an MA organization must follow a documented process that ensures compliance with the preclusion list provisions in § 422.222. We propose to redesignate this paragraph as new § 422.204(c)(1) and to insert ''Before January 1, 2030,'' at the beginning of the paragraph. This would elucidate that § 422.204(c)(1) only applies through December 31, 2029.

New § 422.204(c)(2) would state that beginning January 1, 2030, an MA organization must follow a documented process that ensures compliance with the provider enrollment provisions in § 422.223 (addressed shortly). We believe this would help facilitate MA organizations' verification of the provider's Original Medicare enrollment status.

c. Various Preclusion List Requirements (§ 422.222)

Section 422.222 outlines a number of provisions and requirements regarding the preclusion list for contracted and non-contracted entities and individuals. We propose to add the following language immediately prior to subsection (a): ''The provisions of this section apply before January 1, 2030.''

d. New Enrollment Section (§ 422.223)

To address some of our new enrollment requirements (including outlining the parties to which they apply), we propose to establish a new § 422.223. We believe that promulgating a new, separate section would be clearer for stakeholders than attempting to incorporate our new provider enrollment provisions within § 422.222. Section 422.223's opening paragraph would state that beginning January 1, 2030, providers that are types of individuals or entities that can enroll in Original Medicare (in accordance with section 1861 of the Act) must be so enrolled in Original Medicare in an approved status to receive payment from an MA organization for health care items or services provided to a Medicare enrollee who receives their Medicare benefit through the MA organization. (For purposes of this requirement, ''approved status'' means the provider is neither revoked from Medicare under § 424.535 nor deactivated under § 424.540.) As outlined in new § 422.223(a)(1) through (6), this would include the following providers and suppliers:

- In-network and out-of-network MA providers.
- First-tier, downstream, and related entities (FDR), as these are defined at § 422.2.[164]
- Providers in Health Maintenance Organizations (HMOs) or Competitive Medical Plans that contract with CMS under section 1876 of the Act.
- Providers participating in demonstration programs or in pilot programs.[165]
- Locum tenens providers.
- Incident-to providers.

With the exception of out-of-network MA providers, these six provider categories were included within our MA enrollment requirement in the November 2016 final rule. Both then and now, we believe that patients of these providers should benefit from the protections afforded by the very thorough and comprehensive provider screening processes in 42 CFR part 424, subpart P. Existing § 422.222(b) states that an MA organization that does not comply with § 422.222(a) may be subject to sanctions under § 422.750 and termination under § 422.510. We propose a similar provision in new § 422.223(b) regarding our enrollment requirement. Considering the serious risks to the Medicare program and its beneficiaries from fraudulent or otherwise unqualified providers, it is necessary to stress to MA organizations the consequences of non-adherence to § 422.223(a).

e. Excluded, Revoked, and Precluded Providers

Section 422.224(a) states, in part, that an MA organization may not pay for items or services furnished to a Medicare enrollee by an individual or entity that is OIG excluded or on the preclusion list. Section 422.224(b) states, also in part, that if the MA organization receives a request for payment by, or on behalf of, such an excluded or precluded individual or entity, the MA organization must notify the enrollee and the excluded or precluded party that payment will not be made; the paragraph adds that payment cannot be made to, or on behalf of, an excluded or precluded person or entity. We propose to re-designate these paragraphs as new § 422.224(a)(1) and (a)(2). Consistent with our aforementioned revisions, we would also add the following after the paragraph (a) designation: ''Before January 1, 2030''. This will clarify these paragraphs' applicability. In new paragraph (b), we would largely duplicate proposed new §§ 422.224(a)(1) and (a)(2) but with two modifications. First, the requirements would apply beginning January 1, 2030. Second, we would leave precluded parties within the scope of these sections but change it to refer to Part D prescribers that are on the preclusion list as defined in § 423.100 and as described in § 423.120(c)(6). We believe that the program integrity risk that all parties on the preclusion list pose—be they MA or Part D—warrants the inclusion of the latter within § 422.224(b). (The existing reference in § 422.224 to precluded MA providers, though, would not be retained in § 422.224(b) because the preclusion list will not be applicable to MA providers beginning January 1, 2030.)

We also would include the language ''revoked from Medicare'' in revised § 422.224(b). As we stated in the November 2016 final rule and have reiterated in others since then, revoked providers and suppliers pose a significant risk to Medicare beneficiaries

[163] In the CY 2027 HH PPS proposed rule, we proposed to expand the preclusion list's breadth to include felony convictions against the provider/prescriber's owner, managing employee, managing organization, corporate director, or corporate officer.

[164] Current rules allow MA organizations to contract with different entities to provide services to beneficiaries. These contracted entities are referred to as first-tier, downstream, and related entities or FDRs, as defined in § 422.500.

[165] Demonstrations and pilot programs, also called research studies, are special projects that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time for a specific group of people and/or are offered only in specific areas.

and the Trust Funds and should not receive Federal dollars. This is why we originally included revoked providers within the scope of § 422.224(a) in the November 2016 final rule and propose to do so in revised § 422.224(b). For this same reason, we are not proposing a ''first-time allowance'' (FTA)—similar to what we did in the April 2018 MA preclusion list final rule with respect to precluded providers—in which payment could be made the first time the revoked provider submits a claim but not thereafter. The objective behind any FTA would be to prevent beneficiaries from being liable for payment when the first claim is denied due to the provider's revocation. The beneficiary is notified that while payment will be made in this instance, future payments to the provider will not be; this means the beneficiary should seek a different provider to ensure that the beneficiary's services are covered. However, we explained in the November 2016, final rule that beneficiaries would already be protected in these situations per 42 CFR 1001.1901(b) and § 424.555(b), which prevent OIG-excluded individuals and entities (as well as revoked, deactivated, and denied providers) from recouping payment from beneficiaries. There is accordingly no need for an FTA.

f. HMOs and Competitive Medical Plans

Sections 417.478(e)(1) and (2) state, in part, that the prohibitions, procedures, and requirements relating to payment to individuals and entities on the preclusion list apply to HMO and Competitive Medical Plans that contract with CMS under section 1876 of the Act. We propose to redesignate these paragraphs as new § 417.478(e)(1)(i) and (ii) with the ''Before January 1, 2030'' caveat. Proposed new § 417.478(e)(2)(i) and (ii), meanwhile, would mostly duplicate new § 417.478(e)(1)(i) and (ii), though with (1) applicability beginning on January 1, 2030, and (2) all MA preclusion list references changed to the enrollment (and the non-payment to an unenrolled, excluded, revoked, or § 423.120(c)(6) precluded provider) requirements in §§ 422.223 and 422.224. This would make clear that these provisions, as noted, apply to HMOs and Competitive Medical Plans that contract with CMS under section 1876 of the Act.

g. Additional Regulatory Revisions To Accommodate Our Proposed Enrollment Requirements

• Under §§ 422.510(a)(4)(xiii) and 422.752(a)(13), CMS may sanction or terminate an MA organization for failure to comply with the preclusion list requirements at § 422.222 or § 422.224, such as by making payment to parties on the preclusion list. We propose to re-designate these provisions as new §§ 422.510(a)(4)(xiii)(A) and 422.752(a)(13)(i) with an applicability date before January 1, 2030. In new §§ 422.510(a)(4)(xiii)(B) and 422.752(a)(13)(ii), which would apply beginning January 1, 2030, the former would reference non-compliance with the requirements of §§ 422.223 and 422.224(b) instead of compliance with the preclusion list requirements. For § 422.752(a)(13)(ii), we propose to reference the MA organization's failure to comply with §§ 422.223 and 422.224(b), which require the MA organization not to make payment to providers that are OIG-excluded, revoked from Medicare, precluded under § 423.120(c)(6), or that can enroll in Medicare under section 1861 of the Act but are not so enrolled in an approved status.

• Sections 422.501(c)(1)(iv) and (2) state that in completing an application to become an MA organization under § 422.510, an entity must, among other things, furnish documentation that ''payment for health care services or items is not being and will not be made to individuals and entities included on the preclusion list, defined in § 422.2.'' We would redesignate these paragraphs as new §§ 422.501(c)(1)(iv)(A) and (2)(i) with a ''before January 1, 2030'' applicability date. In new §§ 422.501(c)(1)(iv)(B) and (2)(ii), which would apply beginning January 1, 2030, we proposed to reference the need for documentation demonstrating and verifying that payment for health care services and items is not being and will not be made to providers and suppliers that can enroll in Medicare in accordance with section 1861 of the Act but that are not enrolled in an approved status. These changes would align with our proposed enrollment requirement, and the addition of ''demonstrating and verifying'' will help clarify the scope of the required documentation.

• Sections 422.504(a)(6), (g)(1)(iv), (g)(1)(v)(B), and (i)(2)(v) describe several of the required terms of a CMS contract with an MA organization with respect to the preclusion list. Specifically, the MA organization must:

++ Agree under (a)(6) to comply with the preclusion list requirements in §§ 422.222 and 422.224.

++ Ensure under (g)(1)(iv) that the enrollee does not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to the enrollee by an MA contracted individual or entity on the preclusion list.

++ Ensure under (g)(1)(v) that the plan's provider agreement contains the provisions in paragraphs (g)(1)(v)(A) and (B) regarding provider payment and financial liability after the expiration of the 60-day period specified in § 422.222.

++ Agree under § 422.504(i)(2)(v) to require all FDR entities to ensure that payments are not made to individuals and entities on the preclusion list.

We propose the following revisions to these paragraphs. First, we would clarify in paragraph (a)(6) that the preclusion references therein only apply before January 1, 2030. Second, new paragraph (a)(22) would require compliance with the requirements of §§ 422.223 and 422.224(b) beginning January 1, 2030. Third, we would split paragraph (g)(1)(iv) into new paragraphs (g)(1)(iv)(A) and (B). Paragraph (g)(1)(iv)(A) would consist of existing paragraph (g)(1)(iv) with the ''Before January 1, 2030'' caveat. Paragraph (g)(1)(iv)(B) would include the ''Beginning January 1, 2030'' language and replace references to the preclusion list with references to unenrolled MA providers. Fourth, we would add ''Before January 1, 2030'' at the beginning of paragraph (g)(1)(v). Lastly, we would redesignate paragraph (i)(2)(v) as new paragraph (i)(2)(v)(A) with the ''before January 1, 2030'' qualifier. In new paragraph (i)(2)(v)(B) we would include the language ''providers that are eligible to enroll in Medicare under section 1861 of the Act but that are not enrolled in Medicare in an approved status'', with an effective date of January 1, 2030.

• Section 422.2267(e) lists certain communications materials that must be provided to prospective or current MA plan enrollees. Paragraph (e)(15) references an ''excluded provider notice'' whereby plans must notify enrollees when a provider they visit or consult is OIG-excluded or is on the preclusion list. We propose to redesignate paragraph (e)(15) as new paragraph (e)(15)(i) with the ''before January 1, 2030'' caveat. In new paragraph (e)(15)(ii)-applicable beginning January 1, 2030, and consistent with our other proposed changes—we would include unenrolled, excluded, revoked, and § 423.120(c)(6) precluded providers within this notification requirement.

• Section 417.484(b)(3) pertains to ''related entities'', which is defined in paragraph (a) as any entity that is related to the HMO or Comprehensive Medical Plan by common ownership or control and meets the requirements of paragraphs (a)(1) through (3). Section (b)(3) states that the contract must provide that the HMO or

Comprehensive Medical Plan agrees to require all related entities to agree that payments must not be made to parties on the preclusion list as defined in § 422.2. We propose to redesignate this paragraph as new paragraph (b)(3)(i) with the ''before January 1, 2030'' qualifier. New paragraph (b)(3)(ii) would apply beginning January 1, 2030, regarding providers that are eligible to enroll in Medicare in accordance with section 1861 of the Act but are not enrolled in Medicare in an approved status.

• Part 498 of Title 42 addresses certain appeal rights. Section 498.3(b)(20) includes a party's placement on the preclusion list (as defined in §§ 422.2 or 423.100) as an initial determination. Section 498.5(n)(1)(i) outlines appeal rights for these parties. We propose to divide § 498.3(b)(20) into subparagraphs (i) and (ii). Sub-paragraph (i) will be limited to parties on the preclusion list as defined in § 423.100—that is, Part D prescribers; sub-paragraph (ii) will apply to precluded individuals and entities per § 422.2 before January 1, 2030. We propose the same for paragraph § 498.5(n)(1)(i), which would be split into paragraphs (n)(1)(i)(A) and (B) with the former applying to Part D precluded parties, and the latter to MA parties before January 1, 2030.

3. Solicitation of Comments

We recognize that there are certain circumstances in which an MA organization is obligated to pay a provider regardless of that party's contract status with the plan or for a benefit that is not covered under Original Medicare. The following are illustrative.

First, under § 422.113, an MA organization must cover and pay for emergency and urgently needed services, regardless of whether the provider has a contractual relationship with the plan.

Second, MA organizations are required to pay for out-of-network services in certain circumstances, such as:

• When an MA organization's provider network is insufficient to furnish a covered service (such that an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs), the organization must arrange for, and pay for, that service from an out-of-network provider; and

• When the enrollee is in a PPO plan, which is required to reimburse for covered services obtained out-of-network.

Third, supplemental benefits that MA organizations may offer under section 1852(a)(3) of the Act are, by definition, items and services not covered under Original Medicare Parts A and B; providers furnishing these benefits may not have a basis to maintain Medicare FFS enrollment.

We also recognize that while we believe our proposed provisions are very much necessary, stakeholders—as after the November 2016 final rule was issued—may be concerned about certain aspects of these requirements. These could involve, for example, the potential burden, impact on beneficiary financial liability and access to care, and whether certain provisions might or should be inapplicable to certain situations. We wish to be as responsive as possible to such concerns within the parameters of our program integrity objectives. Accordingly, we welcome and encourage public comments on our proposed provisions, especially concerning the following issues:

• Whether § 422.222 should include an exception for providers furnishing: (1) emergency or urgently needed services under § 422.113; (2) services furnished when the MA organization is required under § 422.112(a)(1)(iii) and § 422.4(a)(1)(v)(B) to cover or arrange for out-of-network coverage; and (3) supplemental benefits not covered under Original Medicare. In Moreover, we request feedback on how any such exception should be structured to avoid creating a loophole that could be exploited to circumvent the enrollment requirement's program integrity purpose.

• Whether the payment safeguards proposed at § 422.224 should still apply to these three aforementioned illustrations.

• Whether there should be any other exceptions to our enrollment requirements and, if so—

++ The reason(s) for the exception(s);

++ The situations in which they should or should not apply; and

++ The sub-category or sub-categories of MA providers to which they should apply.

• Whether any of our proposed six categories of applicability in proposed § 422.223 should or should not be included therein—as well as any clarification needed regarding the scopes and meanings of said categories (for example, the scope of the locum tenens and incident-to categories). Conversely, we ask stakeholders whether any provider types not listed in § 422.223—such as PACE providers—should be subject to our enrollment requirements.

We ask stakeholders to be as specific and detailed as possible in describing their recommended exemptions, requested clarifications, etc. Suggested regulatory text—and its location within the CFR—would be appreciated, as well as recommended limitations or clarifications on the scope of any of the proposed categories.

• The network adequacy requirements in § 422.116, including whether our provider enrollment proposals would impact the ability of MA organizations to meet network adequacy standards, especially in Rural or Counties with Extreme Access Considerations (CEAC) areas.

• The extent of any access to care issues that stakeholders believe might arise, where and why they may occur, and recommendations on how they could be alleviated within the context of our proposal, including any recommended regulatory text.

• Suggestions regarding the limitation of beneficiary financial liability for services performed by unenrolled providers—for instance:

++ Whether enrollee liability should be capped at normal in-network cost-sharing whenever the plan is barred from paying a provider under § 422.224 for services the enrollee was otherwise permitted to receive under §§ 422.4, 422.112, or 422.113.

++ Whether and how MA organizations should ensure the MA enrollee is not liable for care provided by unenrolled providers.

++ Additional situations where stakeholders believe that beneficiary liability should be restricted, including suggested regulatory text and their locations with the CFR.

• Requested CMS educational activities concerning our proposed requirements (such as those we performed following the November 2016 final rule).

• Costs that MA organizations might incur in implementing our provisions.

• Any other CFR sections that stakeholders believe should be added, revised, or updated to accommodate our proposed MA enrollment requirements.

VI. Marketplace

In recent years, there has been a substantial increase in complaints from consumers who reported that they were unaware they had been enrolled in Exchange coverage or that their Exchange plan had been switched without their consent by an agent, broker, or web-broker. From 2023 through 2025, CMS received over 624,000 consumer complaints attesting to unauthorized Exchange

enrollments [166] or unauthorized plan switching [167] by agents, brokers, or web-brokers and confirmed by issuer and CMS review; 300,000 of the 624,000 were received in 2025 alone.[168] These improper enrollments constitute abusive conduct that costs Federal taxpayers billions of dollars. For example, the HHS Agency Financial Report for Fiscal Year 2025 estimates improper payments of Premium Tax Credits totaled about $1.13 billion.[169]

Abusive conduct by agents, brokers, and web-brokers, such as unauthorized enrollments and unauthorized plan switching, can cause significant medical or financial harm to consumers. For example, enrolling consumers in Exchange plans or changing a consumer's Exchange plan without their consent can cause financial harm, such as unexpected tax liabilities and higher copayments and deductibles. It can also cause physical harm by interrupting their access to medical care when an unauthorized new plan does not cover their medications or include their established providers in-network.[170] CMS has identified an ongoing pattern of unauthorized enrollment, unauthorized plan switching, and other fraudulent, unauthorized, or noncompliant enrollment activity involving a subset of agents, brokers, and web-brokers participating in the Federally-facilitated Exchange (FFEs) and State-based Exchanges on the Federal platform (SBE–FPs).[171] While CMS has taken a number of steps to address this conduct, the conduct has persisted. For example, on August 31, 2026, CMS canceled approximately 315,000 enrollments covering over 760,000 consumers after following its standard issuer investigation process to confirm that these enrollments were unauthorized. Similarly, CMS is also holding agents, brokers, and web-brokers accountable for violating Marketplace standards. Since January 2026, CMS has issued termination notices to more than 200 non-compliant agents and brokers. Furthermore, in the summer of 2026, CMS issued 569 notices of intent to terminate to agents and brokers who submitted 2026 applications without key-identifying applicant information, such as Social Security Numbers (SSN).

When an agent, broker, or web-broker enrolls someone in a Marketplace health plan without their knowledge or consent, or switches plans without their knowledge or consent, that action can trigger Advance Premium Tax Credit (APTC) payments on behalf of a person who never actually agreed to the coverage — resulting in improper payments, because the subsidy is based on an eligibility determination tied to an application the enrollee did not knowingly submit or a plan the person did not select. These improper payments can result in the improper disbursement of taxpayer dollars. Accordingly, we propose to strengthen the integrity of the vetting and oversight processes for agents, brokers, and web-brokers participating in the FFEs and SBE–FPs to reduce waste, fraud, and abuse, protect Exchange consumers, and safeguard Exchange systems.

A. Statutory and Regulatory Authority

Section 1312(e) of the Patient Protection and Affordable Care Act (the Affordable Care Act) provides the Secretary with the authority to establish procedures under which a State may allow agents or brokers to: (1) enroll qualified individuals and qualified employers in qualified health plans (QHPs) offered through Exchanges; and (2) assist individuals in applying for premium tax credits and cost-sharing reductions (CSRs) for QHPs sold through an Exchange. Section 1313(a)(5) of the Affordable Care Act provides that, with respect to activities carried out under Title I of the Affordable Care Act, the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that— (A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of Title I; and (B) the Secretary has authority to implement under Title I or any other Act. Section 1321 of the Affordable Care Act also authorizes the Secretary to issue regulations setting standards for meeting the requirements under Title I of the Affordable Care Act with respect to the establishment and operation of Exchanges (including Small Business Health Options Program), the offering of QHPs through such Exchanges, and such other requirements as the Secretary determines appropriate.

Regulations at 45 CFR 155.220 implement the statutory requirements in section 1312(e) of the Affordable Care Act, establishing standards governing Exchange participation by agents, brokers, and web-brokers, including Exchange Agreement(s) requirements, standards of conduct, and enforcement authorities. The proposals in this rule would revise these existing requirements and strengthen oversight, improve enforcement procedures, and better protect consumers and taxpayer dollars.

B. Overview of Proposed Policies

These proposed policies would improve CMS' [172] ability to prevent abusive conduct by agents, brokers, and web-brokers, better protect consumers within the FFEs and SBE–FPs, and support the efficient, non-discriminatory administration of the FFEs and SBE–FPs. First, this proposed rule would add participation standards to 45 CFR 155.220(g)(3) that would prevent agents, brokers, and web-brokers from participating in the FFEs and SBE–FPs in the circumstances described below, which CMS believes present an unacceptable risk because continued participation may pose a substantial likelihood of consumer harm, improper enrollment activity, misuse of Exchange information, or material program integrity concerns (defined in section VI.B. of this proposed rule). Specifically, agents, brokers, and web-brokers that CMS determines pose such an unacceptable risk would not be permitted to register, complete training, or enter into agreements with the FFEs and SBE–FPs as described in § 155.220(d) (hereinafter referred to as ''Exchange agreement(s)''), preventing them from assisting

[166] An unauthorized enrollment is when an enrollment occurred in Exchange coverage without consumer consent.

[167] An unauthorized plan switch is when an Exchange plan was changed without consumer consent.

[168] *See* U.S. Government Accountability Office. (2025 December) *Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist,* (Publication No. GAO–26–108742). *https://www.gao.gov/products/gao-26-108742* (explaining, ''Based on our preliminary analyses, we identified at least 30,000 applications in plan year 2023 and at least 160,000 applications in plan year 2024 that had likely unauthorized changes.''). *See also* U.S. Government Accountability Office. (2026 July) *Health Insurance Marketplaces: CMS Needs Stronger Controls to Prevent Unauthorized Actions by Agents and Brokers,* (Publication No. GAO–26–108297). *https://www.gao.gov/products/gao-26-108297.*

[169] U.S. Department of Health and Human Services. (2025). *FY 2025 agency financial report (p. 157). https://www.hhs.gov/sites/default/files/fy-2025-hhs-agency-financial-report.pdf.*

[170] U.S. Government Accountability Office. (2025). *Patient Protection and Affordable Care Act: Preliminary results from ongoing review suggest fraud risks in the Advance Premium Tax Credit persist* (Publication No. GAO–26–108742) (Pg. 2). *https://www.gao.gov/products/gao-26-108742.*

[171] *See supra note 3.* From 2023 through 2025, CMS received over 624,000 consumer complaints attesting to unauthorized enrollments or unauthorized plan switching in the Federally-facilitated Exchanges by agents or brokers and confirmed by issuer review; approximately 300,000 of the 624,000 consumer complaints were received in 2025 alone (web-brokers are excluded from this count).

[172] Although 45 CFR 155.220 references ''HHS,'' CMS is the agency taking the actions discussed, therefore ''CMS'' will be used throughout this preamble when referencing the agency administering this regulatory framework.

consumers with enrolling in Exchange coverage, including insurance affordability programs, through the FFEs and SBE–FPs. Additionally, this proposed rule would update § 155.220(g)(3) to allow CMS to immediately terminate agents, brokers, and web-brokers who the agency determines pose such an unacceptable risk from participating in the FFEs and SBE–FPs, without waiting 30 calendar days from the date of notice.

To strengthen oversight and improve fairness in enforcement proceedings arising from findings of agent, broker, and web-broker noncompliance under § 155.220(g)(2), we propose additional revisions to § 155.220. Specifically, we propose to amend § 155.220(g)(3)(i) to replace the existing opportunity for agents, brokers, and web-brokers to ''resolve'' a noncompliance determination with an opportunity to ''refute'' before CMS terminates their Exchange agreement(s) for cause or imposes other penalties. As discussed in section VI.C.1. of this proposed rule, this change would clarify that the 30-calendar day period is primarily for submitting information to dispute or rebut a noncompliance determination.

We also propose to codify the factors that CMS would consider when determining whether to terminate an agent, broker, or web-broker's Exchange agreement(s) with the FFEs and SBE–FPs for cause and to impose other penalties under § 155.220(k)(1) after making a noncompliance determination. In addition, we propose to amend § 155.220(h) to clarify that agents, brokers, or web-brokers may request reconsideration when CMS denies them the right to enter into Exchange Agreement(s) in addition to when CMS terminates their Exchange Agreement(s) for cause.

We also propose to add a new standard in § 155.220(j) to codify a term in the existing FFEs and SBE–FP Exchange agreement(s) requiring agents, brokers, and web-brokers to implement and maintain reasonable safeguards to ensure that access and attempted access to the FFEs and SBE–FPs, systems that support the FFEs and SBE–FPs, and consumer personally identifiable information (PII) obtained through those Exchanges only occur from locations within the United States.

We have also determined changes to § 155.220(g)(5) are necessary and appropriate to enhance transparency measures (for example, the public registration termination list) around program integrity oversight of the FFEs and SBE–FPs and further strengthen our administrative actions against suspected bad actors. Specifically, this proposed rule would make several amendments to § 155.220(g)(5), including moving from a fraud-based standard to an abusive conduct-based framework. This proposed rule would also adjust the standard of proof CMS would apply to suspensions and terminations for cause of an agent, broker, or web-broker's Exchange agreement(s) under § 155.220(g)(5). Specifically, under § 155.220(g)(5)(ii), CMS could suspend an agent's, broker's, or web-broker's agreements if CMS finds that there is a credible allegation of abusive conduct. Under § 155.220(g)(5)(iii), CMS could terminate those agreements if CMS determines, by a preponderance of the evidence, that abusive conduct occurred. Furthermore, this proposed rule would amend § 155.220(j)(2)(i) and (ii) by adding illustrative, non-exhaustive examples of agent, broker, and web-broker behavior that CMS has observed and considers harmful. CMS would also amend § 155.220(j)(4) to limit its scope as applied to abusive conduct as proposed in § 155.220(g)(5)(1). We seek comment on these proposals.

C. Expand Authority To Deny and Terminate Agents, Brokers, and Web-brokers' Exchange Participation

There are certain instances in which participation by an agent, broker, or web-broker can pose an unacceptable risk to the FFEs and SBE–FPs, including when certain administrative actions have been taken by Federal programs and State licensure authorities, as well as when an agent, broker, or web-broker has been convicted of a Federal or State misdemeanor or felony offense that CMS determines is detrimental to the best interests of the FFEs, SBE–FPs, and their consumers. Similar authorities regarding providers or suppliers with felony convictions have long existed in the Original Medicare program, also known as Medicare fee-for-service.[173] Medicare suppliers and providers, as well as agents, brokers and web-brokers in the Exchange, are entrusted with safeguarding program integrity, public health, and taxpayer money. Better alignment between the Federal Exchange platform approach with similar longstanding authorities that exist in the Medicare program would create consistency and strength through a unified voice and are necessary to increase program integrity and better protect consumers and taxpayer dollars by preventing agents, brokers, and web-brokers that pose unacceptable risk from participating in the FFEs and SBE–FPs.

[173] 42 CFR 424.535(a)(3), 424.535(a)(19).

1. Suspension, Termination, or Debarment From Any Federal Program, or Suspension or Revocation of State Licensure in Any State (§ 155.220(g)(3)(iii))

We propose to add § 155.220(g)(3)(iii) to provide that CMS may deny registration for, or immediately terminate the Exchange Agreement(s) of, any agent, broker, or web-broker who is currently terminated, suspended, revoked, debarred, or excluded from participation in any Federal program, or whose license is currently revoked or suspended for conduct that may cause harm to consumers or program integrity in a State other than that in which the agent, broker, or web-broker is enrolling consumers, regardless of whether any appeals are pending. If the appeal is successful and no other grounds for denial of registration exist, CMS would allow the agent, broker, or web-broker to register (or re-register if they were terminated) with the FFEs and SBE–FPs. Agents, brokers, and web-brokers with a history of these adverse actions imposed by a Federal program or a State licensing entity pose an unacceptable risk for the FFEs, SBE–FPs, and their consumers because they have demonstrated an inability to abide by the rules of other programs to such an extent that serious sanctions were warranted. Accordingly, if codified, we believe this proposal would better protect the FFEs, SBE–FPs, and consumers by preventing agents, brokers, and web-brokers who have a track record of misconduct from participating in the Exchange agent-broker program. We seek comment on the potential need for any exceptions to this proposed bar on participation, as well as if there are any reasons why an agent, broker, or web-broker who is currently terminated, suspended, revoked, debarred, or excluded from participation in a Federal program should not also be barred from participation in the FFEs and SBE–FPs. CMS also believes it is prudent to take such action even if an appeal, which can take months if not years to complete, is pending, and seeks public comment on whether any exceptions to this approach are warranted.

Additionally, CMS seeks comment on whether agents, brokers, and web-brokers who are terminated for noncompliance on the Exchanges should also be referred for nonprocurement suspension and debarment. HHS has adopted OMB's guidelines (2 CFR 180) for nonprocurement suspension and debarment at 2 CFR 376, but CMS does not currently refer terminated agents,

brokers, and web-brokers for suspension or debarment.

Agents, brokers, and web-brokers enter into public agreements with the Federal Government in order to gain access to the Exchanges where they enroll consumers in QHPs and earn commissions on such enrollments. Such commissions are paid to these agents, brokers, and web-brokers by QHP issuers who, in turn, receive PTC subsidy funding from the Federal Government for eligible enrollments. Per 2 CFR 180.970, a nonprocurement transaction means any transaction, regardless of type (except procurement contracts), including, but not limited to, subsidies, § 180.970(a)(8), and insurances, § 180.970(a)(9). As specified in 2 CFR 180.970(b) a nonprocurement transaction at any tier does not require the direct transfer of Federal funds. Therefore, the actions of an agent, broker, or web-broker enrolling a consumer in a QHP could constitute nonprocurement transactions under this meaning and these regulations.

If CMS were to implement such a policy, when we have adequate evidence that there may be a cause for debarment of an agent, broker, or web-broker and conclude that immediate action is necessary to protect the Federal interest, we could impose a 12-month suspension and initiate proceedings for debarment. Because the standard of proof for pursuing debarment is the same as the standard of proof for pursuing termination (*i.e.,* the preponderance of the evidence, 45 CFR 155.220(g)(2); 2 CFR 180.850(a)), CMS could impose suspension and consider debarment for all agents, brokers, and web-brokers that are terminated for noncompliance. Suspension could occur immediately upon effectuation of agent, broker, or web-broker termination. If such a termination were to be reversed upon reconsideration per 45 CFR 155.220(h), then this suspension would be lifted. If such a termination were to be sustained upon reconsideration or no request for reconsideration were submitted, then proceedings for debarment could be initiated where the grounds for termination meets the criteria for debarment specified at 2 CFR 180.800(b)(2) (that is, a history of failure to perform or of unsatisfactory performance of one or more public agreements or transactions). Generally, debarment cannot exceed three years, however, if circumstances warrant, an agency may impose a longer period of debarment (2 CFR 180.865). If CMS were to implement such a policy, therefore, we could pursue a term of debarment that mirrors the length of the penalty imposed under 45 CFR 155.220(k)(1)(i) (that is, the period that a terminated agent, broker, or web-broker may be denied the right to enter into agreements with the Exchanges in future years). If CMS were to implement such a policy, then updates to the forms completed by agents, brokers, and web-brokers (for example, OMB Control Nos. 0938–1204 and 0938–1463) as well as all relevant enforcement notices (for example, Notices of Intent to Terminate, Final Notices of Termination, and Final Agency Determinations after reconsideration) could be necessary. The Final Notice of Termination could constitute the Notice of Proposed Debarment (2 CFR 180.805), and the process to appeal such nonprocurement suspension and debarment actions could occur through a process similar to that used to appeal the termination action (that is, the request for reconsideration under 45 CFR 155.220(h)).

We seek comment on all aspects of this discussion of nonprocurement suspension and debarment for agents, brokers, and web-brokers who are terminated for noncompliance on the Exchanges, including the potential need for any exceptions, as well as if there are any reasons why an agent, broker, or web-broker who is terminated should not be referred for non-procurement suspension or debarment.

In addition, while § 155.220(g)(3)(ii) already authorizes CMS to immediately terminate an agent, broker, or web-broker's Exchange Agreement(s) if the agent, broker, or web-broker fails to maintain the appropriate license in every State in which they actively assist consumers with applying for the APTC or enrolling in a QHP through the FFEs or SBE–FPs, no comparable regulatory authority currently exists to deny registration for, or terminate the agreement of, an agent, broker, or web-broker whose license has been suspended or revoked in a State in which the agent, broker, or web-broker is not currently enrolling consumers. This gap is problematic because health insurance license reciprocity derives from an agent, broker, or web-broker's resident State, and disciplinary actions in non-resident States may not affect an agent, broker, or web-broker's ability to continue to enroll consumers in other States. Under our current authority, an agent, broker, or web-broker whose license has been revoked for misconduct in one State could potentially continue enrolling consumers in QHPs through the Exchanges and pose a risk to consumers in other States where the agent, broker, or web-broker is still licensed. Under these proposed regulatory changes, we would be able to better protect consumers in States with FFEs or SBE–FPs from agents, brokers, or web-brokers that pose unacceptable risk due to their suspension or revocation of a license in a State where they are not enrolling consumers, or their suspension, termination, or debarment from a Federal program.

Also, we propose to update § 155.220(g)(3)(i), which currently provides agents, brokers, and web-brokers with 30 calendar days after the date of notice to rebut a noncompliance determination prior to termination. The update to § 155.220(g)(3)(i) would allow CMS to immediately terminate agents, brokers, and web-brokers that pose unacceptable risk from participating in the FFEs and SBE–FPs due to suspension, termination, or debarment from any Federal program, or suspension or revocation of State licensure in any State.

2. Misdemeanor and Felony Convictions (§ 155.220(g)(3)(iv))

We also propose to add § 155.220(g)(3)(iv) to provide CMS with the ability to deny registration to, or immediately terminate the agreement for cause with, any agent, broker, or web-broker who was convicted of a Federal or State misdemeanor or felony offense that HHS determines is detrimental to the best interests of the FFEs, SBE–FPs, or their consumers.

Similar authorities already exist with respect to felonies in the Original Medicare program related to provider and supplier enrollment.[174] Similar to the rationale for imposing these requirements in Original Medicare, we believe that certain misdemeanor and felony offenses indicate a history of conduct that could undermine the integrity of Exchange operations or Exchange information systems, or place consumers and their PII at heightened risk of harm. Codifying this change would also better align the FFEs and SBE–FPs participation standards with similar longstanding authorities that exist in the Original Medicare program, ensuring consistency across CMS programs.

We also propose adding 45 CFR 155.220(g)(3)(iv)(A)(1) through (4) to clarify that misdemeanor and felony offenses detrimental to the best interests of the FFEs, SBE–FPs and their consumers include, but are not limited in scope or severity to: (1) misdemeanor and felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted,; (2) financial crimes,

[174] 42 CFR 424.530(a)(3); 42 CFR 424.535(a)(3).

such as extortion, embezzlement, income tax evasion, insurance fraud, identity theft, forgery, bribery, falsification or destruction of records, receiving stolen property, making false statements or claims, violation of consumer protection laws, and other similar crimes for which the individual was convicted; (3) any misdemeanor or felony that places the FFE program or its consumers at immediate risk, such as a conviction for criminal neglect or misconduct; and (4) any misdemeanor or felony that would result in mandatory exclusion under section 1128(a) of the Act.[175] If CMS denies an agent, broker, or web-broker registration or terminates their Exchange agreement(s) under § 155.220(g)(3)(iv), CMS will provide the agent, broker, or web-broker with notice of the decision, and the agent, broker, or web-broker may request reconsideration as described under § 155.220(h). We also propose amending 45 CFR 155.20 to add a definition of ''convicted,'' defining it to mean: (1) a judgment of conviction has been entered against an individual or entity by a Federal or State court, regardless of whether there is a post-trial motion or an appeal pending, or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed; (2) a Federal, State, or local court has accepted a plea of guilty or *nolo contendere* or an Alford plea by an individual or entity; or (3) an individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld. This definition closely mirrors Medicare's definition of conviction. The underlying conduct is the primary risk; thus, this definition is intended to protect consumers medically and financially as well as the FFE's and SBE–FPs' program integrity. If the appeal is successful and no other grounds for denial of registration exist, CMS would allow the agent, broker, or web-broker to register with the Exchange.

In addition, we propose to update § 155.220(g)(3)(i) to include paragraph (g)(3)(iv) as an exception to the requirement of providing 30 calendar days from the date of notice prior to termination of the agreement. This would allow CMS to immediately terminate agents, brokers, and web-brokers who pose unacceptable risk from participating in the FFEs and SBE–FPs due to certain misdemeanor and felony convictions.

We believe these policies are appropriate and necessary to strengthen program integrity, better protect consumers and taxpayer dollars, and better align the FFEs and SBE–FPs with longstanding Medicare program integrity authorities. More specifically, these policies would strengthen the vetting and oversight processes for agents, brokers, and web-brokers participating in FFEs and SBE–FPs to reduce waste, fraud, and abuse; support transparency around program integrity oversight of the FFEs and SBE–FPs to further strengthen our administrative actions against suspected bad actors; better protect consumers and taxpayer dollars by preventing agents, brokers, and web-brokers that pose unacceptable risk from participating in the FFEs and SBE–FPs; and better align the Federal Exchange platform approach with similar longstanding authorities that exist in Original Medicare.

D. Strengthen CMS' Authority To Terminate an Agent, Broker, or Web-Broker for Cause

1. Opportunity To Refute Determinations of Noncompliance (45 CFR 155.220(g)(3)(i))

We propose to revise § 155.220(g)(3)(i) to provide agents, brokers, and web-brokers with an opportunity to refute determinations of noncompliance prior to the termination of their Exchange agreement(s) for cause[176] and imposition of other penalties under § 155.220(k)(1), which would replace the existing opportunity to ''resolve'' identified noncompliance. Specifically, we propose that, except as provided in proposed paragraphs (g)(3)(ii) through (g)(3)(iv),[177] when CMS issues a determination of noncompliance against an agent, broker, or web-broker in accordance with § 155.220(g)(1), CMS would provide the agent, broker, or web-broker with 30 calendar days to submit information to refute the non-compliance determination. Further, we propose to provide that after reviewing any rebuttal evidence submitted, CMS may terminate the agent, broker, or web-broker's agreements required under §§ 155.220(d) and 155.260(b), for cause, if CMS determines, based on the evidence available to CMS, that a preponderance of the evidence establishes that noncompliance occurred. The failure to submit evidence to refute would not preclude CMS from making such a determination based on the evidence otherwise available to CMS. We also propose to make corresponding edits to the heading of paragraph (g) and to paragraphs (g)(3)(ii), (g)(4), (k)(1), and (k)(2) to reflect this change. For purposes of this provision, ''refute'' means to submit information, documentation, or explanation disputing or rebutting a determination of noncompliance, which CMS would consider in determining whether termination and imposition of other penalties is appropriate. This opportunity to refute would not apply to findings of abusive conduct as proposed to be defined at § 155.20 and subsequent enforcement actions carried out under proposed § 155.220(g)(5), discussed later in this preamble.

The current regulation at § 155.220(g)(3)(i) governing termination for cause of agent, broker, and web-broker Exchange agreement(s) in FFEs and SBE–FPs for noncompliance states that CMS will notify the agent, broker, or web-broker of the specific finding of noncompliance or pattern of noncompliance made under § 155.220(g)(1), and after 30 calendar days from the date of the notice, may terminate their Exchange agreement(s) if the matter is not resolved to the satisfaction of CMS. Many agents, brokers, and web-brokers have interpreted this 30-calendar day period to mean that if the agent, broker, or web-broker takes corrective action or makes assurances that they will maintain compliance moving forward, that CMS may not proceed with termination. This interpretation is not consistent with our original intent with this regulation: to take enforcement action, as appropriate, in response to noncompliance notwithstanding corrective action or assurances by the agent, broker, or web-broker.[178] Further, if agents, brokers, and web-brokers continue to have this belief, they may not be incentivized to refrain from noncompliant behavior and may instead believe that they can correct it before they are subject to any

[175] Section 1128(a) of the Act calls for the mandatory exclusion of the following individuals and entities from participation in any Federal healthcare program: (1) conviction of program-related crimes; (2) conviction relating to patient abuse; (3) felony conviction relating to health care fraud; and (4) felony conviction relating to controlled substance.

[176] Section 155.220(f) establishes the framework for an agent, broker, or web-broker to terminate an agent's, broker's, or web-broker's Exchange agreement(s) with HHS. We are not proposing any changes with respect to the terminations under § 155.220(f).

[177] *See* § 155.220(g)(3)(ii), which provides that HHS may immediately terminate Exchange Agreement(s) upon notice to the agent or broker if they fail to maintain the appropriate license under State law, and § 155.220(g)(3)(iii) and (iv) in this proposed rule, which propose additional exceptions and allows for immediate termination without any further opportunity to refute the noncompliance determination.

[178] *See* Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals final rule (78 FR 54080).

negative consequences. Therefore, we are proposing to reframe the 30-calendar day period as a time for the agent, broker and web-broker to refute the noncompliance rather than resolve the noncompliance, to clarify that nothing prevents CMS from terminating an agent, broker, or web-broker's Exchange agreement(s) where the agency makes a finding of noncompliance, even if the agent, broker, or web-broker takes corrective action or makes assurances that they will maintain compliance moving forward. Compliance with all terms and conditions of Exchange agreement(s), any State law applicable to agents, brokers or web-brokers, and any Federal law, including HHS regulations implementing those laws, is required at all times under § 155.220. Further, CMS expects compliance at all times with CMS' regulatory enforcement framework.

Further, by framing the 30-calendar-day period primarily as a time to *resolve* the matter to CMS' satisfaction, agents, brokers, and web-brokers have expressed concerns that they cannot refute the noncompliance finding or determination prior to a termination action going into effect. Instead, they can only do so after a termination action goes into effect and the agent, broker, or web-broker is offered a reconsideration in accordance with § 155.220(h). This belief is based on an incorrect reading of the current regulatory text. The existing language at § 155.220(g)(3)(i) frames the 30-calendar-day period as a time to resolve the matter ''to the satisfaction of HHS,'' which some agents, brokers, and web-brokers have interpreted as being limited to corrective action or assurances of future compliance rather than as a time to dispute the underlying findings of noncompliance. Because the current regulatory text does not explicitly specify this 30-calendar-day period as a time to refute whether noncompliance occurred, agents, brokers, and web-brokers have mistakenly concluded that the reconsideration process under § 155.220(h), which occurs after a termination action goes into effect, is their first meaningful chance to refute the findings themselves.

As such, we have seen that some agents, brokers, and web-brokers choose not to respond during the 30-calendar-day notice period but will request reconsideration to dispute the findings. The intent of the 30-calendar-day notice period is to provide agents, brokers, and web-brokers the chance to provide CMS with information to inform a decision on whether the alleged noncompliance actually occurred. Bypassing this 30-calendar-day period to engage with CMS subverts the intent of the review and enforcement processes and wastes the time and resources of both CMS and agent, broker, and web-broker. If agents, brokers, and web-brokers have information that can refute a noncompliance determination, and they submit that information within the 30-calendar-day period, CMS would be able to make more fully informed decisions on the front end of the process and reduce resources expended on imposing enforcement actions, conducting reconsideration reviews, and in some instances, rescinding previously imposed terminations. This would also protect agents, brokers, and web-brokers from interruptions to their ability to assist consumers with enrollment through the FFEs or SBE–FPs as a result of an avoidable termination that was imposed due, in part, to their failure to refute during the 30-calendar-day period.

While CMS may consider any actions the agent, broker, or web-broker has taken to address or correct the identified noncompliance, these actions alone may not be determinative of whether CMS may proceed to terminate an agent, broker, or web-broker's Exchange agreement(s) and impose a penalty other than termination. As explained in section VI.D.2. of this proposed rule, under proposed § 155.220(g)(1)(i), CMS may consider the nonexclusive factors identified in § 155.285(b)(1) and (2), to the extent relevant to the facts and circumstances of the particular case, to assess the nature and circumstances of the noncompliance and the impact of that noncompliance before deciding whether termination, another penalty under § 155.220(k)(1), or both are appropriate. This approach would preserve CMS' flexibility to account for unusual circumstances. For example, analysis under the non-exclusive factors would allow CMS to consider an individual's history with the FFEs and SBE–FPs, which could include consideration of any proactive actions taken to address or correct identified noncompliance. CMS may determine, based on consideration of the factors proposed in section VI.D.2. of this proposed rule, that despite corrective action, the noncompliance warrants enforcement action under § 155.220(g)(1) and (k)(1).

In summary, by aligning the regulation text to clarify and mirror the original intent of the policy, this proposed approach would protect the integrity of the FFEs and SBE–FPs and the interests of consumers; clarify that agents, brokers, and web-brokers have an opportunity to refute findings of noncompliance before termination goes into effect or CMS imposes a penalty; and help to ensure that enforcement decisions are based on a complete and accurate assessment of the noncompliance. We seek comment on these proposals.

2. Factors CMS May Consider in Enforcement Determinations (45 CFR 155.220(g)(1)(i))

We propose to revise § 155.220(g)(1) and add a new paragraph at § 155.220(g)(1)(i) to specify how CMS would determine whether to terminate an agent, broker, or web-broker's Exchange agreement(s) and impose a penalty under § 155.220(k)(1) when CMS has made a determination of noncompliance under § 155.220(g)(1).

Specifically, we propose to remove the ''sufficiently severe'' language in § 155.220(g)(1) and replace it with a new framework under proposed § 155.220(g)(1)(i). The removal of the ''sufficiently severe'' language is intended to reduce ambiguity regarding what is sufficient to trigger termination and instead replace it with explicit factors CMS would consider that are clear and transparent. The proposed framework would provide that, except for terminations made in accordance with paragraphs (g)(3)(ii) through (g)(3)(iv) of this section, when CMS makes a noncompliance determination under paragraph (g)(1), CMS would consider the factors identified in § 155.285(b)(1) and (2) to the extent relevant to the facts and circumstances of each case, as well as any additional relevant factors supported by the evidence when it: (A) decides whether to terminate an agent, broker, or web-broker's Exchange agreement(s) for cause; or (B) selects among the penalties identified in paragraph (k)(1) of this section, including the length of the penalty imposed under paragraph (k)(1)(i) of this section.

The factors listed under § 155.285(b)(1) and (2) are the factors that CMS has established for consideration in determining the amount of a civil money penalty (CMP) imposed against an individual for providing false or fraudulent information to an Exchange. CMPs, terminations, and the imposition of other penalties are all enforcement mechanisms that aim to address and correct noncompliance. Thus, utilizing these factors when making determinations on whether to terminate for cause an agent, broker, or web-broker's Exchange agreement(s) and the imposition of penalties other than terminations, when relevant, would help to ensure consistency throughout CMS' enforcement mechanisms. Use of

a single, nonexclusive factor framework across related enforcement decisions would reduce divergence in factors considered, increase consistency in decision making, and promote transparency while preserving CMS' flexibility to terminate Exchange agreement(s) and impose other penalties when supported by the facts of the identified noncompliance. The factors listed under § 155.285(b)(1) and (2) reflect the considerations most relevant to the full range of noncompliance CMS has encountered in overseeing the FFEs and SBE–FPs and are expected to apply in the vast majority of enforcement actions. The nonexclusive nature of the list preserves CMS' flexibility to account for case-specific circumstances not captured by the codified factors. We propose that CMS would consider additional factors to the extent they are relevant to the particular case and supported by the evidence. These additional factors could include, but would not be limited to, failure to cooperate with CMS monitoring, audit, or enforcement activities, or the submission of incomplete, inaccurate, or misleading information to CMS.

As explained in section VI.C.1. of this proposed rule, if CMS were to find that a preponderance of available evidence supports a finding that an agent, broker, or web-broker violated a standard under this section, an applicable Exchange agreement term, or Federal or State law, and that such noncompliance justifies termination of the agent, broker, or web-broker's Exchange agreement(s), or imposition of other penalties based on an assessment of the proposed factors in § 155.285(b)(1) and (2), CMS will make a refutable determination of noncompliance under § 155.220(g)(3)(i). In accordance with proposed § 155.220(g)(3)(i), following the 30-calendar-day refutation period, CMS would review all refutation evidence provided and reassess whether a preponderance of the evidence still supports a finding of noncompliance that, based on an assessment of the proposed relevant factors in § 155.285(b)(1) and (2), justifies termination or imposition of other penalties under § 155.220(k)(1) before moving forward. If the information provided does not refute the noncompliance, meaning that a preponderance of the evidence still supports the noncompliance determination based on CMS' assessment of the proposed factors in § 155.285(b)(1) and (2), CMS may proceed to terminate an agent, broker, or web-broker's Exchange agreement(s) and impose other penalties. This approach aligns with § 155.285(b)(1)(vii) that contemplates evaluating ''any additional information provided by the individual to refute performing the violation.''

Under this proposal, CMS would weigh both mitigating and aggravating facts, but would retain discretion to weigh the proposed factors as appropriate and would not be required to consider all of the factors in every case. CMS would only consider a factor listed in § 155.285(b)(1) and (2) if the factor is relevant to the noncompliance at issue and applicable to the facts and circumstances of the particular case, and would consider both the presence and absence of a relevant factor when making a termination decision and selecting penalties. For example, not all findings of noncompliance as described in § 155.220(g)(2) involve the disclosure of false or fraudulent information as referenced in § 155.285(b)(2)(v). A finding of noncompliance may instead involve, for example, an agent, broker, or web broker's failure to obtain or maintain required consumer consent documentation. Similarly, even if an agent, broker, or web-broker did not receive compensation associated with the violation as described in § 155.285(b)(1)(vi), or CMS is not able to determine whether the agent, broker, or web-broker received compensation, assessment of other relevant factors may still support termination and imposition of a penalty other than termination. In such circumstances, CMS may determine that enforcement action is appropriate based on its assessment of the other factors relevant to the particular case. We have determined that codifying these factors would provide greater transparency into CMS' enforcement decision-making under § 155.220(g)(1) and reflect that enforcement determinations are based on the totality of the circumstances.

Section 155.285(b)(1) provides that CMS may take into account the nature and circumstances of the conduct, including, but not limited to: the number of violations; the severity of the violations; the individual's history with the Exchange, including any prior violations that would indicate whether the violation is an isolated occurrence or represents a pattern of behavior; the length of time of the violation; the number of individuals affected or potentially affected; the extent to which a person received compensation or other consideration associated with the violation; any documentation provided in any complaint or other information, as well as any additional information provided by the person alleged to have committed the violation to refute performing the violation; and whether other remedies or penalties have been imposed on the person alleged to have committed the violation for the same conduct or occurrence.

When considering the number of and length of time of violations, as described in § 155.285(b)(1)(i) and (iv), CMS may look at, among other things, the number of regulatory requirements the agent, broker, or web-broker violated; the number of times CMS identified the agent, broker, or web-broker violated such requirements; compliance with previously provided technical assistance; and for how long the agent, broker, and web-broker sustained the noncompliance. For example, if an audit or other oversight action results in findings of many instances in which an agent, broker, or web-broker failed to document consumer consent and eligibility application information review in accordance with § 155.220(j)(2)(iii) and (j)(2)(ii)(A) for a large number of different consumers and applications, CMS may consider this more significant than an audit that identifies only a few instances of failure to document consumer consent across a small number of consumers and applications.

Similarly, in considering an agent, broker, or web-broker's history with the Exchange, as described in § 155.285(b)(1)(iii), CMS would consider any previously identified violations of agency regulatory requirements, such as those described in §§ 155.220 and 155.221, to assess whether the violation is an isolated occurrence or represents a pattern of behavior. However, the absence of a documented history of noncompliance would not preclude CMS from taking enforcement action as appropriate, including termination of an Exchange agreement required under § 155.220(d), against an agent, broker, or web-broker. If, after assessment of the other factors described in § 155.285(b)(1) and (2), CMS determines that totality of the circumstances warrants enforcement action, CMS would retain authority to terminate the Exchange agreement required under § 155.220(d) and impose a penalty other than termination under § 155.220(k)(1), regardless of whether the agent, broker, or web-broker had a prior history of noncompliance.

In considering the severity of any identified noncompliance with regulatory requirements, as described in § 155.285(b)(1)(ii), CMS would assess the nature and degree to which the agent, broker, or web-broker violated the regulatory requirement(s) at issue, including the extent to which the violation departed from the applicable requirement and whether the

documented facts reflect a partial or complete failure to meet the requirement. Using noncompliance with the consent documentation requirements at § 155.220(j)(2)(iii) as an example, CMS would likely consider less severe a procedural or technical noncompliance in which an agent, broker, or web-broker clearly obtained and documented consumer consent, but the documentation did not include an adequate description of the process by which the consumer or their authorized representative may rescind the consent, as required by § 155.220(j)(2)(iii)(B). This type of violation would likely be considered less severe because the documentation demonstrated that the consumer knowingly consented to the enrollment, which is the core purpose of the consent requirement, and the deficiency was limited to an incomplete description of a procedural right.

In contrast, CMS would likely consider noncompliance with regulatory requirements to be more severe if it impacted the enrollee's ability to provide actual, informed consent before the agent, broker, or web-broker enrolled them in coverage through the FFEs or SBE–FPs, as we would not be able to determine if the consumer named on the application provided such consent. This uncertainty directly undermines the core purpose of the consent requirement to ensure that enrollments are made with the consumer's knowing and voluntary authorization. Another example of a severe violation might include an instance in which an agent, broker, or web-broker failed to document the name of the consumer or consumer's authorized representative providing consent to be enrolled, creating a situation where we cannot determine if the consumer named on the application provided consent to the agent, broker, or web-broker's assistance with this enrollment. As a further example, CMS would likely consider enrolling a consumer in a health plan without *any* documented evidence that the consumer authorized the enrollment to be a severe violation because, as previously described, the consent requirement is a fundamental safeguard that helps ensure enrollments and application updates are authorized by the consumer. Failure to obtain or maintain any consent documentation prevents CMS from verifying that consumer authorization was obtained, undermines the integrity of the FFE and SBE–FP enrollment process, and increases the risk of consumer financial and medical harm. Because maintaining adequate consent documentation is a condition of participation in the FFEs and SBE–FPs, agents, brokers, and web brokers are responsible for retaining records sufficient to demonstrate compliance.

In considering the number of individuals affected by the noncompliance, as described in § 155.285(b)(1)(v), for instances in which the number of affected individuals cannot be readily determined from the documented instances of noncompliance, CMS could, for example, consider the total number of applications submitted by the agent, broker, or web-broker during the relevant period to determine the number of affected individuals should findings suggest a pattern of noncompliance likely existed across a large portion of the agent, broker, or web-broker's book of business. CMS may also consider the nature of the noncompliance because certain types of noncompliance may affect a broader population of consumers than others. For example, if CMS finds that an agent, broker, or web-broker engaged in misleading marketing in violation of § 155.220(j)(3), CMS may consider the potential reach and impact of the misleading marketing to estimate the number of people affected, including the number of advertisements publicly posted, the number and type of platforms on which the advertisements were posted, the length of time the postings were made public or how often they were posted, available information regarding consumer exposure or engagement, complaints or referrals that mention the misleading marketing, and any related application or enrollment activity. CMS would consider such information, as available and appropriate, in assessing the number of individuals potentially affected and may not necessarily presume that all individuals who may have been exposed to a misleading advertisement were actually impacted by the advertisement.

In considering the extent to which a person received compensation or other consideration associated with the violation as an aggravating factor, as described in § 155.285(b)(1)(vi), CMS could, for example, weigh whether an agent, broker, or web-broker received commissions from QHP issuers for enrollments the agent, broker, or web-broker assisted with or facilitated while engaging in noncompliance.

In considering any additional information provided by the agents, brokers, and web-brokers to refute performing the violation, as described in § 155.285(b)(1)(vii), CMS would consider any information the agent, broker, or web-broker submits to refute a determination of noncompliance as described in proposed § 155.220(g)(3)(i). CMS could consider events or conditions outside the control of the agent, broker, or web-broker that affected their ability to comply with applicable requirements, such as a natural disaster that limits the agent, broker, or web-broker's access to records described under § 155.220(j)(2)(ii) and (iii) requested during a compliance an investigation. However, CMS would not consider a claim that an agent, broker, or web-broker is unable to produce documentation requested during an investigation, for example, because it is maintained by a former employer, as a mitigating factor in assessing noncompliance with the requirements to produce documentation of consent or eligibility application review upon request. This is because, as required in §§ 155.220(j)(2)(ii)(A)(3) and (j)(2)(iii)(D), the individual or entity that assists with or facilitates enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through a FFEs or SBE–FPs, or assists individuals in applying for APTC and CSRs for QHPs sold through a FFEs or SBE–FPs, is responsible for maintaining the required documentation and providing it to HHS upon request.[179]

Further, we clarify that § 155.285(b)(1)(viii), which provides that CMS may consider whether other remedies or penalties have been imposed for the same conduct or occurrence, would not prevent CMS from terminating an agent, broker, or web-broker's Exchange agreement(s) or imposing a penalty under § 155.220(k)(1) should CMS identify new conduct that constitutes noncompliance with regulatory requirements, even after previously identifying or imposing penalties for noncompliance with the same regulatory requirements. Repeated noncompliance could be viewed as an aggravating factor and may weigh in favor of more significant enforcement action, such as the imposition of other penalties under § 155.220(k)(1). However, CMS would evaluate each instance of noncompliance based on the facts and circumstances and the

[179] *See 45 CFR 155.220(j)(2)(iii)(C). See also* CMS, *Frequently Asked Questions: Consumer Consent & Application Review Requirements,* Question 35 (Oct. 28, 2024) *available at https://www.cms.gov/marketplace/agents-brokers/files/frequently-asked-questions-consumer-consent-application-review-requirements.pdf* providing that an agent, broker, or web-broker must maintain documentation of consumer consent and review of eligibility application information for a minimum of 10 years for all Marketplace consumers even if they stopped working for their former employer.

applicable factors described in § 155.285(b)(1).

Section 155.285(b)(2) provides that CMS may also consider the nature of the harm resulting from, or reasonably expected to result from, a violation, including but not limited to: whether the violation resulted in actual or potential financial harm, such as unexpected tax liabilities for an individual; whether there was actual or potential harm to an individual's reputation; whether the violation hindered or could have hindered an individual's ability to obtain health insurance coverage; whether there was actual or potential harm resulting from providing false or fraudulent information or from the improper use or disclosure of the information; and whether any person received a more favorable eligibility determination for enrollment in a QHP or insurance affordability program, such as greater APTCs or CSRs than they would have been eligible for if the correct information had been provided. In the context of determining whether to terminate an agent's, broker's, or web-broker's Exchange agreement(s) and impose a penalty other than termination under § 155.220(k)(1), it would be within CMS' discretion to assess whether the identified noncompliance resulted in actual or potential financial harm to an individual applicant or to taxpayers should CMS find that the agent, broker, or web-broker's noncompliance resulted in payment of APTCs or CSRs on behalf of individuals who were ineligible or who did not consent to enrollment in coverage through the FFEs or SBE–FPs with the assistance of the agent, broker, or web-broker. CMS may also consider other circumstances in which the noncompliance resulted in, or created a significant risk of, financial harm to consumers or to the Federal Government, based on the facts and circumstances of the particular case.

We note that our proposal to cross-reference only § 155.285(b)(1) and (2) would adopt the nonexclusive factor list in § 155.285(b)(1) and (2) but would not incorporate the CMP procedures outlined in § 155.285(c) through (f) because those procedures apply only when CMS imposes CMPs under § 155.285 and there are existing adequate procedures under § 155.220(g) and (k) that govern terminations and the imposition of other penalties. For termination and other penalties for noncompliance under § 155.220(g)(1) and (2), excluding CMPs, CMS would continue to follow the procedures described in proposed § 155.220(g)(1) through (4) and (k), and, for CMPs, CMS would continue to follow the procedures in § 155.285(c) through (f). Further, if CMS makes a finding or determination by a preponderance of the evidence under § 155.220(g)(5)(iii), CMS would terminate an agent's, broker's, or web-broker's Exchange agreement(s) and impose any penalties deemed appropriate consistent with that provision. For suspensions under § 155.220(g)(5)(ii), CMS would evaluate any rebuttal evidence submitted during the suspension period. The factor list would not apply to the suspension decision. Additionally, in cases that fall under § 155.220(g)(3)(ii) and proposed paragraphs (g)(3)(iii) and (iv), CMS may immediately terminate Exchange agreements and impose additional penalties without the 30-day notice period in § 155.220(g)(3)(i) or consideration of the factor list.

When the factor assessment would apply to selection of penalties and CMS determines that it is appropriate to impose a denial of the right to enter into Exchange agreement(s), we are proposing that the length of such denial would be based on the totality of the circumstances and an assessment of the proposed factors. For example, denial of the right to enter future agreements for one year may be appropriate for violations with several mitigating factors or of lesser severity, such as deficiencies limited to an incomplete description of a procedural right rather than a failure to obtain or record meaningful consumer consent. More severe noncompliance and violations with several aggravating factors, such as noncompliance that likely impacted the enrollee's ability to provide actual, informed consent before the agent, broker, or web-broker enrolled them in coverage, would generally support a longer denial of right to enter into agreements with the FFEs and SBE–FPs. While the duration of the denial of right to enter into agreements with the FFEs and SBE–FPs would vary based on the totality of the circumstances and evidence, denial for a period of 10 years or more may be appropriate for the most severe violations with several aggravating factors. We also propose a conforming revision to § 155.220(g)(3)(ii) to replace the phrase ''without any further opportunity to resolve the matter'' with ''without any opportunity to refute a finding of noncompliance under § 155.220(g)(1),'' consistent with the proposed revisions to the refutation process under § 155.220(g)(3)(i). In addition, as an alternative, instead of cross referencing the factors in § 155.285(b), CMS is considering reproducing or adapting relevant factors from § 155.285(b) directly into § 155.220 in the final rule. Should CMS finalize regulatory text that reproduces or adapts relevant factors from § 155.285(b) directly into § 155.220, such a list would be nonexclusive and not all factors would apply in every case, as described in this proposal. We invite comment on which factors identified in this proposal should apply and how they should be adapted for § 155.220, if at all. We seek comment on these proposals.

3. Clarification on the Scope of an Agent, Broker, or Web-Broker's Right To Request Reconsideration (45 CFR 155.220(h)(1))

We propose to revise 45 CFR 155.220(h)(1) to state that an agent, broker, or web-broker may request a reconsideration of CMS' decisions to terminate their Exchange agreement(s), deny registration under proposed § 155.220(g)(3)(iii) or (iv), or impose a penalty described in § 155.220(k)(1)(i) in the manner and form established by CMS.

Section 155.220(h)(1) currently provides agents, brokers, and web-brokers with the opportunity to request a reconsideration when HHS terminates an agent, broker, or web-broker's Exchange agreement(s), but does not explicitly address whether agents, brokers, and web-brokers are afforded the same reconsideration opportunity when HHS denies registration under proposed § 155.220(g)(3)(iii) or (iv), or imposes penalties other than termination under § 155.220(k)(1)(i). For example, if CMS determines that an agent, broker, or web-broker has failed to comply with the requirements in § 155.220, CMS may deny the agent broker, or web-broker the right to enter into Exchange agreement(s) as a penalty other than termination under § 155.220(k)(1)(i). Therefore, we propose in § 155.220(h)(1) to outline three instances in which an agent, broker, or web-broker may request reconsideration in the manner and form established by CMS. First, proposed § 155.220(h)(1)(i) would allow an agent, broker, or web-broker to request reconsideration of CMS' decision to terminate the agent, broker, or web-broker's Exchange agreement(s) under § 155.220(g). Second, proposed § 155.220(h)(1)(ii) would allow an agent, broker, or web-broker to request reconsideration of CMS' decision to deny registration with the Exchange under § 155.220(g)(3)(iii) or (iv). Third, proposed § 155.220(h)(1)(iii) would allow an agent, broker, or web-broker to request reconsideration of CMS' decision to

impose a penalty under paragraph (k)(1)(i).

We believe this proposal would help ensure consistency in the application of reconsideration opportunities by expressly providing agents, brokers, and web brokers with the same opportunity to request reconsideration regardless of whether CMS terminates an Exchange agreement, denies registration, or imposes a penalty under 45 CFR 155.220(k)(1)(i). We also believe this would provide greater clarity and predictability regarding the availability of reconsideration and promote uniform administration of CMS' enforcement process.

Along those same lines, we also propose corresponding changes to § 155.220(g)(6) to clarify that CMS would notify the applicable State Department(s) of Insurance or other State agent or broker licensing authority whenever CMS imposes penalties other than termination under § 155.220(k)(1)(i), in addition to suspensions or terminations as stated in the current regulation. Because agents and brokers are licensed and regulated by States, such notifications support coordination between Federal and State regulators and enable State licensing authorities to evaluate whether additional action under State law is appropriate.

Furthermore, we clarify the nature and scope of the existing reconsideration process. Operationally, the form and manner currently specified by CMS is that requests for reconsideration must be handled independently by a separate administrative unit of CMS than that which imposed the original penalty. Specifically, CMS' Center for Consumer Information and Insurance Oversight (CCIIO) and Center for Program Integrity (CPI) handle investigations and imposition of penalties, while CMS' Office of Program Operations and Local Engagement (OPOLE) handles requests for reconsideration. OPOLE adjudication of requests for reconsideration constitutes a *de novo* review of the enforcement action based on the totality of the facts and circumstances of the particular case, including potentially exculpatory information submitted by the agent, broker, or web-broker and verification that all internal CMS enforcement policies and procedures were followed. OPOLE evaluates whether the preponderance of the evidence supports the enforcement action. OPOLE administration of requests for reconsideration generally result in one of three outcomes: sustaining the enforcement action, reversing the enforcement action, or modifying the enforcement action (for example, reducing the duration of the termination imposed).

We seek comment on this proposal.

4. Policies To Address Abusive Conduct

a. Purpose and Description of Abusive Conduct Standards

Abusive conduct by agents, brokers, and web-brokers can adversely impact consumers, resulting in significant medical or financial harm. Consumers enrolled in Exchange QHPs without their knowledge or consent can experience interruptions in access to medical care and unexpected tax liabilities associated with receiving APTCs. Through our investigations and data analytics in the FFEs and SBE–FPs, we have identified specific actions and patterns of inappropriate behavior by agents, brokers, and web-brokers that violate the standards of conduct listed in § 155.220(j)(2). These activities ultimately result in consumers being misled about important aspects of their Exchange coverage, including their eligibility for APTC based on their income, the cost-sharing implications (that is, deductibles and copayments) associated with the insurance plans they sign up for, and other material information necessary to make informed enrollment decisions.

Through our investigations of consumer complaints and analyses of enrollment activity in the FFEs and SBE–FPs, we have found that significant consumer harm arises from abusive conduct by agents, brokers, and web-brokers that may not initially rise to the level of fraud under current § 155.220(g)(5). The proposed standard of abusive conduct would better reflect the nature of the misconduct we are seeing that often involves deceptive or coercive enrollment practices, material misrepresentations, unauthorized application or enrollment activity, or the submission of inaccurate application information that misleads consumers and undermines the integrity of Exchange operations. Under the current regulatory framework, the suspension authority at § 155.220(g)(5) is tied in part to a reasonable suspicion of fraud, which may not capture a significant portion of the types of misconduct CMS encounters through its Marketplace oversight activities. Based on this experience, we have determined it is appropriate to propose revising our regulations to establish an enforcement framework that would more directly address the misconduct we are seeing while applying a clear and transparent evidentiary standard.

Accordingly, we believe revisions to our suspension and termination authorities are necessary to better align our enforcement authorities with the types of abusive conduct encountered through our Marketplace oversight. We therefore propose to amend § 155.220(g)(5) by removing reference to a ''reasonable suspicion of fraud'' in § 155.220(g)(5) and replacing it with a standard under which CMS may suspend an agent, broker, or web-broker when CMS finds there exists a credible allegation of abusive conduct by the agent, broker, or web-broker. We further propose amending § 155.20 to add a definition of ''a credible allegation of abusive conduct,'' defining it to mean: an allegation from any source, including but not limited to the following: (1) consumer, Marketplace call center, or agent, broker, or web-broker complaints verified by further evidence; (2) data or information identified during investigation; or (3) patterns identified through data analysis. Additionally, the definition would state that allegations are considered to be credible when they have indicia of reliability. The presence of one of these sources alone could be sufficient to meet this standard as a credible allegation of abusive conduct, depending on the facts of each individual case.

Unlike a general finding of noncompliance or pattern of noncompliance under § 155.220(g)(1) and (2), enforcement actions under § 155.220(g)(5) would apply to the most egregious behaviors. Specifically, enforcement actions would apply when the conduct is likely to or has caused harm to the Federally facilitated Exchange, SBE–FP, or their consumers. Conduct that does not meet this harm standard, though it may cause harm, would be addressed through enforcement actions authorized under § 155.220(g)(1) through (3). We seek comment on this proposal.

Likewise, we propose to amend § 155.220(g)(5)(ii) and (iii) to establish standards for suspension and termination based on a finding of abusive conduct. Specifically, we propose that CMS may suspend an agent, broker, or web-broker based on a credible allegation of abusive conduct and may terminate the agreement of an agent, broker, or web-broker based on a preponderance of evidence of abusive conduct. We believe the proposed credible allegation of abusive conduct standard for suspensions is consistent with Medicare's payment suspension authority, which uses a credible allegation of fraud standard, and mirroring these standards is appropriate because the resulting impact is similar

between a Marketplace suspension and Medicare payment suspension. We believe the proposed preponderance of the evidence standard for terminations is appropriate because it is the evidentiary standard generally applied in Federal administrative and civil cases, and it would create a fair, well-established, and transparent basis for final enforcement actions. Adopting these standards would better align our enforcement framework with the nature of these administrative proceedings while providing agents, brokers, and web-brokers with greater clarity regarding the evidentiary standard CMS would apply when determining whether termination is warranted. This proposal would also align with the standards we have used for other enforcement actions against agents, brokers, and web-brokers. We seek comment on these standards and alternative standards that could be used for suspensions and terminations.

We also propose to amend § 155.220(g)(5)(i) to define abusive conduct as any conduct that is likely to cause or has caused harm to the Exchange or its consumers that includes, but is not limited to: (1) a violation of the standards of conduct at 45 CFR 155.220(j)(2); (2) providing the Exchange with inaccurate application information related to the consumer's eligibility for Medicaid, CHIP, a QHP offered through the Exchange, advance premium tax credit, or cost-sharing reductions; or (3) a violation of any term or condition of the agreements with the Exchange that relates to the agent, broker, or web-broker's conduct toward consumers.

This would incorporate the proposed examples of violations of the existing standard of conduct to provide consumers with correct information by adding § 155.220(j)(2)(i)(A) and (B). These include:

- Having a website that HHS determines could mislead a consumer into believing the consumer is visiting *HealthCare.gov,* an official Marketplace, Affordable Care Act or Exchange enrollment website, certified Exchange enrollment partner website, or any other official website of the Federal or a State government. To do this, we would move the existing parenthetical in the current § 155.220(j)(2)(i) that states: ''including by having a direct enrollment website that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*'' to a new paragraph (A).
- Falsely claiming to represent the FFE or SBE–FPs or falsely suggesting that coverage from the FFE or SBE–FP is free. We would do this by creating a new paragraph (B).

The proposed definition of abusive conduct at § 155.220(g)(5)(i) would also incorporate the proposed amendments to § 155.220(j)(2)(ii)(E) through (K):

- Paragraph (E)*(1)* would state: An agent, broker, or web-broker may not project, or mislead or coerce a consumer to project, one of the following:

++ An annual income that is not based on any actual or reasonably expected source of income.

++ Income the consumer is unlikely to earn.

++ Income that omits one or more tax household members.

++ Income based on inappropriate modified adjusted gross income calculations, such as projecting income based on income after income tax withholding.

++ A predetermined income amount that the consumer is coached, targeted, or steered towards by the agent, broker, or web-broker.

- Paragraph (F) would state: Submitting application and enrollment data only for consumers who are not deceased at the time of enrollment.
- Paragraph (G) would state: Accurately entering information provided and confirmed by the consumer pertaining to any existing minimum essential coverage as defined by 45 CFR part 156 Subpart G, that the consumer is eligible for or enrolled in.
- Paragraph (H) would state: Accurately entering information provided and confirmed by the consumer pertaining to all tax household members. Agents, brokers, and web-brokers must ask consumers about their household composition to the same extent consumers are asked about household composition on the Exchange eligibility application and accurately report each consumer response.
- Paragraph (I) would state: Accurately entering information provided and confirmed by the consumer regarding residence address in accordance with § 155.305(a)(3).
- Paragraph (J) would state: Accurately entering information provided and confirmed by the consumer regarding household contact information including names, phone number and mailing address, and if the consumer chooses to provide them, accurate email address and mobile phone number for text messages. Consumer contact information must only be the consumer's personal contact information and cannot be contact information accessible or controlled by an agent, broker, web-broker or any other non-consumer persons or entities.
- Paragraph (K) would state: Using customer service channels that HHS determines do not mislead a consumer into believing the consumer is providing information to or enrolling through an official Exchange, Marketplace, or Affordable Care Act customer service pathway or representative, or through certified Exchange enrollment partners.

In addition, we propose to amend § 155.220(j)(4) to provide that conduct resulting solely from inadvertent error notwithstanding reasonable compliance measures does not constitute abusive conduct. We believe the abusive conduct under § 155.220(g)(5)(i) poses an unacceptably high risk to the Exchanges and their consumers. Therefore, conduct resulting solely from an inadvertent error, notwithstanding reasonable compliance measures, does not rise to the level of unacceptable high risk for abusive conduct. In cases where abusive conduct is credibly alleged or found, regardless if an agent, broker, or web-broker has and follows reasonable compliance measures to prevent abusive conduct, CMS would still take suspension and/or termination action under § 155.220(g)(5) given the likelihood of harm arising from such conduct. We have provided a non-exhaustive list of examples of conduct that would fall into this category later in this proposed rule as part of our proposed changes to § 155.220(j)(2), below. This would ensure CMS retains the ability to take appropriate enforcement action against conduct that poses a high risk to the Exchanges and their consumers.

We also propose to amend the rebuttal review period within § 155.220(g)(5) from 45 calendar days to at least 60 calendar days to allow CMS more time to review submitted evidence and make a more informed decision. Under proposed § 155.220(g)(5)(ii)(B), agents, brokers, and web-brokers subject to suspension in accordance with § 155.220(g)(5) would have 30 calendar days to submit rebuttal evidence after which CMS would review that evidence and make a determination on lifting the suspension or pursuing termination in accordance with § 155.220(g)(5)(iii) within 90 calendar days of the suspension. This would provide CMS at least 60 calendar days for review of evidence submitted by an agent, broker, or web-broker as such evidence must be submitted within the first 30 days of the 90-day suspension period.

We further propose to simplify the structure of § 155.220(g)(5) to more clearly delineate the authorities to suspend or terminate an agent, broker, or web-broker's Exchange Agreements.

While we outline specific behaviors that would be considered abusive conduct, we do not intend for these examples to be an exhaustive list. Rather, we propose at new § 155.220(g)(5)(i)(D) that CMS would maintain the discretion to evaluate each case individually to determine if it is otherwise misleading or coercive conduct that constitutes abusive conduct. This would allow the agency to address unique or novel forms of misleading or coercive behavior that should constitute abusive conduct

We believe these proposed program integrity measures are necessary and appropriate to promote greater transparency in CMS' oversight of agents, brokers and web-brokers participating in the FFEs and SBE–FPs, as well as support more effective and efficient administration of the FFEs and SBE–FPs, for the reasons stated earlier in this section of this proposed rule. We seek comment on these proposals, as well as any other fact patterns that may be indicative of abusive conduct for which it would be appropriate for us to take enforcement under § 155.220(g)(5). We also seek comment on how CMS can improve transparency around the noncompliance and abusive conduct enforcement action processes.

b. Non-Exhaustive List of Examples of Abusive Conduct

We believe the following behaviors rise to the level of abusive conduct under proposed revisions to § 155.220(g)(5), subjecting an agent or broker to potential suspension and termination. We are providing these examples in the interest of transparency for agents, brokers, and web-brokers. This is a non-exhaustive list of behaviors, and CMS would retain the ability to take suspension and termination action based on any other misleading or coercive conduct it identifies through the course of an investigation, as proposed in new § 155.220(g)(5)(i)(D).

(1) Violation of Standards of Conduct

As noted above, we propose at § 155.220(g)(5)(i)(A) that abusive conduct includes a violation of the standards of conduct at 45 CFR 155.220(j)(2) Under current § 155.220(j)(2)(i) and (ii), agents, brokers, and web-brokers must provide consumers with correct information, without omission of material fact, regarding the FFEs and SBE–FPs, QHPs offered through the FFEs and SBE–FPs, and insurance affordability programs. Agents, brokers, and web-brokers must also refrain from conduct that is misleading or coercive and must provide the FFEs and SBE–FPs with correct information. We propose to amend § 155.220(j)(2)(i) and (ii) to specify types of behavior we consider to be misleading or coercive to make it easier for agents, brokers, and web-brokers to comply with the standards of conduct.

We propose to amend § 155.220(j)(2)(i) by moving the existing parenthetical that states ''including by having a direct enrollment website that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*'' to a new paragraph (A) and updating the list of websites to include other official websites such as Marketplace websites other than *HealthCare.gov* and other official website of the Federal or State government. We also propose to create a new paragraph (B) to specify that falsely claiming to represent the FFEs and SBE–FPs or suggesting Exchange coverage is free would constitute misleading or coercive behavior.

Specifically, we propose that agents, brokers, and web-brokers that fail to provide consumers with material facts or otherwise provide consumers with incorrect, misleading, or coercive information that impedes a consumer's ability to make an informed decision regarding their eligibility and enrollment in the FFEs SBE–FPs would be considered to engage in misleading or coercive conduct. This may include, but is not limited to (1) agents, brokers, and web-brokers misrepresenting themselves as agents of the FFEs and SBE–FPs (or similarly, the Marketplace, *HealthCare.gov*, Affordable Care Act, Exchanges), Medicaid, or Medicare; or (2) inaccurately suggesting to consumers that coverage on the Exchange is free.

As to the latter, even in situations where the consumer has a $0 net premium after the application of APTC, agents, brokers, and web-brokers must accurately communicate applicable deductibles, cost sharing, and other material costs to the consumer, and explain that APTC is an advanced payment based on projected income that may require repayment based on actual income, upon filing a Federal income tax return and reconciling APTC. We consider these examples to constitute abusive conduct because they are likely to cause harm to consumers or the Exchange. For example, when consumers wrongly believe that the agent, broker, or web-broker that is calling them represents an Exchange, they are unaware of the commission payment incentives that may steer them toward a specific plan or product. As another example, when consumers are misled into believing that coverage on the FFEs and SBE–FPs is free, they may be financially harmed when they are charged a deductible, copayment, and coinsurance, of if they are required to repay excess APTC. For consumers whose incomes are too low for APTC eligibility, the Exchanges are harmed by the outflow of millions of dollars in APTC subsidies that are not authorized by law nor capable of recoupment.

(2) Inaccurate Information on the Exchange Eligibility Application

Agents, brokers, and web-brokers that provide materially inaccurate information on the Exchange eligibility application, either knowingly or by failing to ask the consumer all questions on the eligibility application, may be subject to suspension and termination for abusive conduct consistent with these proposed revisions to § 155.220(j)(2)(ii). From investigations into agent, broker, and web-broker misconduct on the Exchanges, we have identified these behaviors as likely to cause harm to consumers or to the Exchanges. For example, enrollment of deceased individuals harms the Exchanges through the outflow of subsidy payments that are not authorized by law. In another example, entering incorrect address or contact information regularly causes consumer harm by creating insurance policies covering people who may already have coverage (introducing administrative burdens and access-to-care issues for consumers from processing coordination of benefits) or by keeping a consumer ignorant of a policy that has been created on their behalf and for which the consumer will be expected to pay back APTC payments in excess of their eligibility after filing for their income tax return. Similarly, entering incorrect information about household composition or residence is likely to cause an inaccurate APTC eligibility calculation that can result in unexpected financial losses for consumers when reconciling their APTC eligibility as part of the income tax filing process. We propose to amend the following regulations by adding examples to clarify types of behavior that are not permitted to make it easier for agents, brokers, and web-brokers to understand how to comply with the standards of conduct. We propose amending § 155.220(j)(2)(ii) as follows:

- Adding § 155.220(j)(2)(ii)(E)*(1)* that states: An agent, broker, or web-broker may not use or project, or ask a consumer to use or project, on the Exchange eligibility application the following:

++ An annual income that is not based on any actual or reasonably expected source of income.

++ Income the consumer is unlikely to earn.

++ Income that omits one or more tax household members.

++ Income based on inappropriate modified adjusted gross income calculations, such as projecting income based on income after income tax withholding.

++ A predetermined income amount that the consumer is coached, targeted, or steered towards by the agent, broker, or web-broker.

• Creating a new paragraph (F) that states: Submitting application and enrollment data only for consumers who are not deceased at the time of enrollment.

• Creating a new paragraph (G) that states: Accurately entering information provided and confirmed by the consumer pertaining to any existing minimum essential coverage as defined by 45 CFR part 156 Subpart G, that the consumer is eligible for or enrolled in.

• Creating a new paragraph (H) that states: Accurately entering information provided and confirmed by the consumer pertaining to all tax household members. Agents, brokers, and web-brokers must ask consumers about their household composition to the same extent consumers are asked about household composition on the Exchange eligibility application and accurately report each consumer response.

• Creating a new paragraph (I) that states: Accurately entering information provided and confirmed by the consumer regarding residence address in accordance with 45 CFR 155.305(a)(3).

• Creating a new paragraph (J) that states: Accurately entering information provided and confirmed by the consumer regarding household contact information including names, phone number and mailing address, and if the consumer chooses to provide them, accurate email address and mobile phone number for text messages. Consumer contact information must only be the consumer's personal contact information and cannot be contact information accessible or controlled by an agent, broker, web-broker or any other non-consumer persons or entities.

Each of these is described in more detail below.

(3) Enrollment in Other Health Coverage

We propose in 45 CFR 155.220(j)(2)(ii)(G) that agents, brokers, and web-brokers must enter information provided and confirmed by the consumer pertaining to any existing minimum essential coverage). From reviewing call recordings during investigations, we have identified many agents, brokers, or web-brokers that consistently failed to ask consumers whether they are eligible for, or already enrolled in, minimum essential coverage as defined by 45 CFR part 156 Subpart G (such as Medicaid, Medicare, employer-sponsored health coverage that meets the minimum value and affordability standards, or Veteran's Administration (VA) coverage). Additionally, we have identified many agents, brokers, and web-brokers that consistently only asked consumers whether they are eligible for, or enrolled in, a few types of minimum essential coverage, such as Medicaid or Medicare, and then inaccurately attested on the Exchange eligibility application that the consumers were neither eligible for, nor already enrolled in, any minimum essential coverage.

Under § 155.305(f)(1)(ii)(B), consumers are not eligible for APTC if they are eligible for minimum essential coverage for the full calendar month for which APTC will be paid, with the exception of coverage in the individual market, in accordance with 26 CFR 1.36B–2(a)(2) and (c). Under 45 CFR 155.220(j)(2)(ii) and (v), agents, brokers, and web-brokers must provide the Exchanges with correct information and comply with all applicable Federal and State laws and regulations. When agents, brokers, and web-brokers submit Exchange eligibility applications that include inaccurate attestations by consumers that they are not eligible for, or enrolled in, existing minimum essential coverage, consumers dually enrolled in Exchange coverage with APTC and other minimum essential coverage may be subject to significant medical or financial harm. For example, consumers dually enrolled in Exchange coverage with APTC and Medicaid may be confronted with unexpected administrative requirements and delays to using their benefits and determining which payer is appropriate for a service or drug that they require. Consumers can also be confronted with unexpected and confusing procedures for addressing coordination of benefits issues, which may ultimately lead to forgoing or delaying medical care. We have observed this pattern in consumer complaints received by the Marketplace. Thus, we propose in § 155.220(j)(ii)(G) that agents, brokers, and web-brokers must accurately enter information provided and confirmed by the consumer pertaining to any existing minimum essential coverage as defined by 45 CFR part 156 Subpart G, that the consumer is eligible for or enrolled in, and that failure to do so may result in suspension or termination for abusive conduct consistent with these proposed revisions to § 155.220(g)(5).

(4) Inaccurate or Implausible Income Projections

We propose in 45 CFR 55.220(j)(2)(ii)(E)(*1*) that an agent, broker, or web-broker may not use or project, or ask a consumer to use or project, on the Exchange eligibility application, the following: (a) An annual income that is not based on any actual or reasonably expected source of income; (b) Income the consumer is unlikely to earn; (c) Income that omits one or more tax household members; (d) Income based on inappropriate modified adjusted gross income calculations; or (e) A predetermined income amount that the consumer is coached, targeted, or steered towards by the agent, broker, or web-broker; and doing so may result in suspension and termination for abusive conduct consistent with these proposed revisions to § 155.220(j)(2)(ii)(E)(*1*).

The information included on the Exchange eligibility application is used to determine and assess eligibility for Medicaid and CHIP, as well as eligibility for QHP coverage and APTC, based, in part, on a consumer's income. Accurate income projection is therefore essential in establishing whether an individual is eligible for APTC in any given month, taking into account a variety of factors. For example, consumers are not eligible for APTC if they are eligible for Medicaid for the full calendar month for which APTC will be paid, in accordance with 26 CFR 1.36B–2(a)(2) and (c). In accordance with 42 CFR 435.603(h)(1), financial eligibility for Medicaid must be based on the current monthly household income and family size, while pursuant to 26 CFR 1.36B–1(e)(1), income for purposes of APTC determinations generally includes the sum of a taxpayer's modified adjusted gross income, plus the aggregate modified adjusted gross income of all other individuals who are included in the taxpayer's family and are required to file a return of tax for the taxable year. Under our regulations at 45 CFR 155.220(j)(2)(ii) and (v), agents, brokers, and web-brokers must provide the FFEs and SBE–FPs with correct information, only enter a consumer's household income projection that the consumer or the consumer's authorized representative designated in compliance with § 155.227 has knowingly authorized and confirmed as accurate,

and comply with all applicable Federal and State laws and regulations.

Our investigations have shown that some Exchange eligibility applications submitted by agents, brokers, and web-brokers include inaccurate or implausible income projections that appear designed to avoid Medicaid and CHIP eligibility and secure APTC eligibility, while increasing the amount of APTC for which a consumer is eligible.[180] Specifically, agents, brokers, and web-brokers are encouraging consumers to agree to inaccurate or implausible household income by projecting, or asking consumers to project (1) an annual income that is not based on any actual or reasonably expected source of income (for example, asking unemployed consumers who would have no income to report projected income they could earn if they potentially find a job by the end of the year, rather than indicating on the eligibility application that the consumer is currently unemployed with no income); (2) income the consumer is unlikely to earn (for example, annual income based on an unrealistic amount of overtime for a part-time employee); (3) income that omits one or more household members; (4) income based on inappropriate modified adjusted gross income calculations (for example, the consumer reports their income after taxes); or (5) reporting a predetermined income amount that is suggested or targeted by the agent, broker, or web-broker and does not reflect the consumer's actual or reasonably expected annual income (for example, reporting income much lower than actual income to increase APTC).

Our proposed § 155.220(j)(2)(ii)(E)(*1*) would not require agents, brokers, or web-brokers to independently determine the accuracy of the consumer's own income projection. This provision also would not prohibit income projections made by consumers on a reasonable factual basis. For example, a consumer who is unemployed at the time of application may reasonably anticipate income from a position where they have accepted employment and will begin later in the year. However, this provision is intended to prevent an agent, broker, or web-broker from using or projecting, or asking a consumer to use or project, an income that lacks a reasonable factual basis.

We believe these types of inaccurate or implausible income projections reflect abusive conduct by agents, brokers and web-brokers because they can result in significant financial or medical harm to consumers. Dual enrollment may also confront consumers with unexpected and confusing procedures for addressing coordination of benefits issues, which may ultimately lead to forgoing or delaying needed medical care.

Thus, we propose to consider situations where agents, brokers, and web-brokers use or project, or ask a consumer to use or project, on the Exchange eligibility application, inaccurate or implausible income projections, to constitute abusive conduct that can trigger the suspension and termination of the agent, broker or web-broker's Exchange Agreement(s) under these proposed revisions to 45 CFR 155.220(g)(5).

(5) Inaccurate Household Compositions

We propose in 45 CFR 155.220(j)(2)(ii)(H) that an agent, broker, or web-broker must accurately enter information provided and confirmed by the consumer pertaining to all tax household members. We also propose that agents, brokers, and web-brokers must ask consumers about their household composition to the same extent consumers are asked about household composition on the Exchange eligibility application and accurately report each consumer response, and that failure to do so may result in suspension and termination for abusive conduct consistent with these proposed revisions to § 155.220(j)(2)(G).

In accordance with § 155.305(f), a consumer may only be eligible for APTC if they are an applicable taxpayer, in accordance with 26 CFR 1.36B–2(b), which requires a taxpayer to have household income that is at least 100 percent but not more than 400 percent of the Federal Poverty Level for the taxpayer's family size for the taxable year. Further, in accordance 42 CFR 435.603(h), Medicaid financial eligibility for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

Our investigations have shown that some agents, brokers, or web-brokers are entering incorrect tax household compositions on Exchange eligibility applications. Agents, brokers, or web-brokers often fail to ask consumers about members of their household, as required in the eligibility application. For example, we have observed agents, brokers, and web-brokers who omit questions about marital status, spouse's name, spouse's health insurance coverage, and whether the applicant and their spouse are filing income tax returns jointly or separately. We have also seen instances where an agent, broker, or web-broker asks consumers about their household composition but does not include all household members on the Exchange eligibility application. Agents, brokers, and web-brokers are required to include all household members even if those household members are not applying for coverage. Our investigations have also uncovered situations where some Exchange eligibility applications that included an agent, broker, or web-broker's NPN included fictitious household members.

Omitting any part of the household composition information on the eligibility application is likely to cause harm to the affected consumer and therefore constitutes abusive conduct. For example, the consumer may be harmed financially, as APTC is an advanced payment based on projected tax household income and composition. If the consumer's actual household composition differs from the household composition on the eligibility application, the consumer may be required to repay any overpayment of APTC unexpectedly. Moreover, this practice causes harm to the Exchange as a result of the outflow of funds to pay APTC for ineligible consumers. The submission of inaccurate household composition information can also harm a consumer by resulting in denial of a consumer's eligibility for Medicaid, CHIP, APTC, or CSRs. Thus, we propose that agents, brokers, and web-brokers must accurately enter information provided and confirmed by the consumer pertaining to all tax household members, and that failing to do so may result in suspension and termination for abusive conduct consistent with these proposed revisions to § 155.220(g)(5).

(6) Inaccurate Addresses

We propose in 45 CFR 155.220(j)(2)(ii)(I) that an agent, broker, or web-broker must accurately enter information provided and confirmed by the consumer regarding residence address in accordance with 45 CFR 155.305(a)(3).

Under § 155.305(a)(3), for a consumer who is age 21 and over, the service area of the Exchange of the individual generally must be the service area of the Exchange in which the individual is living and intends to reside or otherwise

[180] *United States* v. *Cory Lloyd and Steven Strong,* No. 9:25–cr–80015 (S.D. Fl. Nov. 17, 2025). *CMS proposes regulations to lower health care costs, expand consumer choice, and protect taxpayers.* CMS. (n.d.). *https://www.cms.gov/newsroom/press-releases/cms-proposes-regulations-lower-health-care-costs-expand-consumer-choice-protect-taxpayers.*

has entered with a job commitment or is seeking employment. The Exchange uses the same standard for assessing or determining residency for purpose of Medicaid eligibility, consistent with 42 CFR 435.403(h)(1). Per 45 CFR 155.305(d), the Exchange also uses the same standards for assessing or determining residency for purpose of CHIP eligibility outlined in 42 CFR 457.320(e).

Our prior investigations have shown that some Exchange eligibility applications submitted by agents, brokers, or web-brokers include inaccurate residency information, particularly inaccurate addresses. For example, some agents, brokers, and web-brokers enrolling consumers at addresses where the consumer has never resided (for example, in a State in which they have never resided) or no longer resides. Inaccurate address information is likely to cause harm both to the consumer and the Exchange by interfering with the ability of the Exchange and its QHP issuers to communicate properly with the consumer about their health insurance coverage, upcoming Open Enrollment, or issues with their eligibility determinations. In our investigations, we have also observed the use of inaccurate residential addresses as a means of keeping individuals unaware that their personal information has been used to create a QHP enrollment for which an agent, broker, or web-broker is collecting commission payments. Thus, we propose that agents, brokers, and web-brokers must accurately enter information provided and confirmed by the consumer regarding residence address in accordance with 45 CFR 155.305(a)(3), and that failure to do so may result in suspension and termination for abusive conduct in accordance with these proposed revisions to § 155.220(g)(5).

(7) Deceased Consumers

We propose in 45 CFR 155.220(j)(2)(ii)(F) that an agent, broker, or web-broker must submit application and enrollment data only for consumers who are not deceased at the time of enrollment, and that failure to do so may result in suspension and termination for abusive conduct consistent with these proposed revisions to § 155.220(j)(2)(G).

Our prior investigative efforts and data analytics have also shown that some Exchange eligibility applications submitted by agents, brokers, or web-brokers are for consumers who were deceased at the time of enrollment. In accordance with § 155.220(j)(2)(ii), agents, brokers, and web-brokers must document that the eligibility application information has been reviewed and confirmed to be accurate by the consumer, or the consumer's authorized representative designated in compliance with § 155.227, prior to the submission of the eligibility application. A deceased consumer cannot review and confirm the accuracy of their eligibility application information. We believe existing § 155.220(j)(2)(ii) makes clear that an agent, broker, or web-broker does not have consent to enroll deceased consumers. However, to increase transparency, we are proposing to add § 155.220(j)(2)(ii)(F) that would explicitly prohibit the enrollment of deceased consumers.

The enrollment of deceased consumers causes harm to Exchange operations in multiple ways. First, enrollment of deceased consumers creates administrative burden for the Exchange to recoup APTC payments to QHP issuers made on these improperly created policies. Second, the recoupment of those APTC payments results in unexpected and unpredictable cash outflows for the QHP issuers who sell insurance on the Exchange. Third, the creation of these policies fundamentally undermines the integrity and reliability of the Exchange as a market, where transactions ought to be reliable and trustworthy when information is passed from consumer to Exchange to QHP issuer.

5. Extension of the Rebuttal Period

Under the existing framework in § 155.220(g)(5), in circumstances where we suspend an agent, broker, or web-broker's Exchange agreement(s), the agent, broker, or web-broker may submit evidence in a form and manner specified by CMS to rebut the allegation(s) during the 90-day period following the suspension. We propose in revised § 155.220(g)(5)(ii)(B) that if the agent, broker, or web-broker submits such evidence within 30 days of the suspension, CMS will review the evidence and make a determination on whether to lift the suspension within 90 calendar days of the suspension. This would provide CMS at least 60 calendar days for review of evidence submitted by an agent, broker, or web-broker as such evidence must be submitted within the first 30 days of the 90-day suspension period.

Based on our experience with prior Exchange oversight activities, we believe that extending CMS' review time from the current 45 calendar days to at least 60 calendar days is appropriate to allow CMS more time to review the submitted evidence and make an informed decision about whether such evidence persuades us to lift the suspension. These additional days are needed as the review process can involve parsing complex technical information and data, revisiting consumer complaints, and reaching out to consumers individually. While this proposal adds days to the review process, this minimal additional burden to agents, brokers, and web-brokers strikes the appropriate balance of protecting the FFEs, SBE–FPs, and their consumers from abusive conduct and quickly reviewing and making rebuttal determinations for agents, brokers, and web-brokers. This proposed review period also aligns with the 60-calendar day review period CMS has to review an agent, broker, or web-broker's reconsideration request under the revised 155.220(g)(5)(iii) and (h), which would make this process easier for CMS to administrate and regulated entities to follow.

We seek comment on these proposals.

E. Restriction on Access to the FFEs and SBE–FPs and Exchange Data From Outside the United States

We propose to add 45 CFR 155.220(j)(2)(ix) to codify existing requirements in the Exchange agreements described in § 155.220(d) that agents, brokers, and web-brokers enter into with the FFEs and SBE–FPs that prohibit agents, brokers, and web-brokers from remotely connecting, attempting to remotely connect, or transmitting data to the FFEs and SBE–FPs and systems that transmit data to the FFEs and SBE–FPs, from outside the United States or its territories, embassies, or military installations (referred to hereafter as the ''United States'' for brevity).[181] The prohibitions in the existing agreements include a prohibition against using a Virtual Private Network (VPN) or other similar technology that routes Exchange system traffic through a server, network, or other point located outside the United States, regardless of whether the agent, broker, or web-broker is physically located inside the United States.

Data, including consumer PII, once transmitted outside the United States, may not be recoverable because it

[181] *See* the PY 2027, ''Agent Broker General Agreement for Individual Market Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform,'' (Section IV, sub-section m), ''Privacy and Security Agreement Between Agent or Broker and the Centers for Medicare & Medicaid Services for Individual Market Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform,'' (Section V, sub-section l), and ''Agreement Between Web-Broker and The Centers for Medicare & Medicaid Services for the Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform,'' (Section X.m.).

becomes subject to a foreign jurisdiction or otherwise falls outside of CMS' enforcement authority. This means CMS loses the ability to ensure deletion, recovery, or continued protection of that data once it is transmitted outside the United States. Additionally, access from outside the United States may occur through networks, devices, or infrastructure that are not subject to the same cybersecurity standards and legal protections applicable to domestic systems, increasing the risk of data breaches and other cyberattacks. Foreign access also significantly complicates CMS' ability to monitor, audit, and enforce compliance with the data security requirements applicable to agents, brokers, and web-brokers assisting consumers with enrollments through the FFEs and SBE–FPs because the relevant systems, devices, records, personnel, or data may be located outside United States jurisdiction or otherwise beyond CMS' direct oversight and enforcement authority. For example, CMS has encountered situations in which an agent, broker, or web-broker routed outbound emails containing consumer PII through third-party email servers located outside the United States. In one such case, CMS determined that consumer PII was accessible to overseas technical teams through shared IT infrastructure, and that the entity's security posture was insufficient to prevent unauthorized foreign access to Exchange Systems. Data breaches and cyber-attacks of consumer PII transmitted outside the United States could result in consumer information getting into the hands of agents, brokers, or web-brokers that are looking to gain commissions through unauthorized enrollments or plan changes or to sell consumer information to other agents, brokers, or web-brokers looking to do so. Thus, these risks may result in significant consumer harm, including interruptions or loss of health coverage, and improper determinations or payments of APTCs or CSRs that may create financial consequences for consumers and taxpayers.

Existing Exchange agreements already prohibit remote connections to the FFEs and SBE–FPs, and systems connected to the FFEs and SBE–FPs from outside the United States, including through the use of technologies such as VPNs.[182] The prohibition on access routed through technologies such as VPNs also captures situations where an agent or broker may be located in the United States, when accessing Exchange Systems but Exchange system traffic is routed outside the United States, such that consumer PII becomes accessible to foreign actors or subject to foreign jurisdiction.

We are proposing to codify a standard that would require agents, brokers, and web-brokers to implement and maintain reasonable administrative, technical, and contractual safeguards. These safeguards would be designed to ensure that access and attempted access to the FFEs and SBE–FPs, systems that support the FFEs and SBE–FPs, and PII obtained through the FFEs and SBE–FPs by the agent, broker, or web-broker and all employees, contractors, subcontractors, and other downstream entities acting on their behalf occurs only from locations within the United States. For the purposes of this proposal, systems that support the FFEs and SBE–FPs, collectively referred to as ''Exchange Systems,'' would include, but not be limited to systems used for agent and broker training, registration, and certification; CMS identity and access management; and eligibility and enrollment functions.

Consistent with the existing prohibition in the Exchange Agreements, the proposal further provides that such reasonable safeguards must include safeguards to ensure that VPNs or other similar technologies do not route Exchange system traffic through a server, network, or other point located outside the United States regardless of whether the agent, broker, or web-broker is physically located inside the United States at the time of access, and regardless of whether the technology causes the access to appear to originate from a location inside the United States. Therefore, agents, brokers, and web-brokers would have to implement and maintain reasonable safeguards to ensure that their network architecture and any third-party services they use do not result in Exchange system traffic being routed, stored, or processed on foreign infrastructure.

In addition, we propose that CMS would not find an agent, broker, or web-broker noncompliant with the proposed requirements due to unauthorized activity resulting from compromised credentials or inadvertent network activity that the agent, broker, or web-broker could not reasonably have known about or prevented through reasonable safeguards. Agents, brokers, and web-brokers would be required to implement reasonable safeguards, such as network monitoring, access controls, and contractual restrictions on third-party service providers, to prevent prohibited access, including inadvertent routing. CMS would not find an agent, broker, or web-broker noncompliant with the proposed standard if they implemented such safeguards and a prohibited connection nonetheless occurs that the agent, broker, or web-broker could not reasonably have known about or prevented through reasonable safeguards.

We believe it is appropriate that agents, brokers, and web-brokers implement and maintain reasonable safeguards to prevent prohibited access by all employees, contractors, subcontractors, and other downstream entities acting on their behalf because it would help ensure that the proposed requirement cannot be circumvented by delegating Exchange-related functions to another individual or entity. When CMS determines through its existing monitoring, audit, or enforcement activities that an employee, contractor, subcontractor, or downstream entity accessed the FFEs and SBE–FPs, Exchange Systems, or PII obtained through the FFEs and SBE–FPs from outside the United States on behalf of an agent, broker, or web-broker, CMS would treat such conduct as noncompliance by the agent, broker, or web-broker and pursue appropriate enforcement against the agent, broker, or web-broker under the applicable regulations. However, CMS would not find an agent, broker, or web-broker noncompliant with the proposed prohibition if an agent, broker, or web-broker can demonstrate they had implemented reasonable safeguards related to their contractor, subcontractor, or downstream entity's access to the FFEs and SBE–FPs, Exchange Systems, or PII obtained through the FFEs and SBE–FPs and prohibited access or attempted access nonetheless occurs without their knowledge or authorization. Reasonable administrative, technical, contractual, and oversight measures may include but are not limited to the following:

- *Contractual measures:* Including express prohibitions on foreign access to Exchange Systems in contracts with employees, contractors, subcontractors, and downstream entities; requiring such individuals or entities to attest to compliance with the foreign access prohibition; and including audit rights allowing the agent, broker, or web-broker to verify compliance by such individuals or entities.
- *Technical measures:* Implementing network access controls that restrict connections to Exchange Systems to domestic IP addresses; deploying monitoring tools that detect and alert on access attempts from foreign locations or through foreign infrastructure; requiring multi-factor authentication for all Exchange System access; and

[182] *Id.*

configuring systems to block VPN or proxy connections that route Exchange traffic through foreign servers.

• *Oversight measures:* Conducting periodic reviews of access logs to identify unauthorized or suspicious connection attempts; requiring employees, contractors, subcontractors, and downstream entities to promptly report any known or suspected foreign access incidents; and maintaining documentation of compliance oversight activities sufficient to demonstrate that reasonable controls were in place.

CMS recognizes that what constitutes reasonable controls will depend on the facts and circumstances of each case, including the nature of the downstream relationship and the type of Exchange System access involved. CMS expects all regulated parties to take meaningful steps commensurate with their resources and the nature of their downstream relationships.

Codifying this requirement would protect the FFEs and SBE–FPs against the risk associated with access to Exchange Systems from outside of the United States and ensure agents, brokers, and web-brokers are notified that CMS may monitor, audit, and conduct enforcement activities related to access to Exchange Systems from outside of the United States in accordance 45 CFR 155.220(j)(2)(ix) and 155.220(c)(5), and consistent with applicable law. In addition, codification of these requirements would ensure that CMS is empowered to take appropriate enforcement actions available under 155.220(g)(1) through (5), (k)(1), and (k)(3) against agents, brokers, and web-brokers participating in the FFEs and SBE–FPs who violate this provision, protect consumer PII, and remove noncompliant agents, brokers, and web-brokers from the FFEs and SBE–FPs.

We seek comment on this proposal.

VII. Clarifying Existing Requirement and Adding a New Unsolicited Beneficiary Contact Prohibition

CMS proposes to add a new supplier standard under 42 CFR 424.57(c)(31) to prohibit unsolicited beneficiary contact by DMEPOS suppliers and their agents when supplying a Medicare-covered item (as that term is defined in 42 CFR 424.57(a)) using direct messages from social media platforms, email messages without opt-out features, and door-to-door in-person solicitation. As in 42 CFR 424.57(c)(11), if (1) the beneficiary has provided written permission to the supplier to contact the beneficiary by direct social media message, email message without opt-out features, or door-to-door in-person solicitation concerning the furnishing of a Medicare-covered item that is to be rented or purchased; (2) the supplier has furnished a Medicare-covered item to the beneficiary and is contacting the beneficiary to coordinate delivery; or (3) the supplier has previously furnished a covered item to the beneficiary in the 15-month period prior to the date of contact, then the communication would be permitted. This proposal is intended to prevent DMEPOS suppliers from targeting Medicare beneficiaries with unsolicited direct contact, including high-pressure marketing tactics or deceptive lead generation that allow DMEPOS suppliers to bill Medicare for medically unnecessary or unneeded items, or items that are never supplied.[183]

Additionally, CMS proposes to clarify the existing 42 CFR 424.57(c)(11) prohibition against unsolicited beneficiary contact by DMEPOS suppliers to make explicit the inclusion of third-party entities acting as the agents of DMEPOS suppliers (agents). CMS also proposes to clarify this provision by clarifying that contact by telephone refers to a telephone call or message, including text messages. If finalized, these clarifications to 42 CFR 424.57(c)(11) and the addition of 42 CFR 424.57(c)(31) would become effective 60 days after the publication of the final rule.

A. Current DMEPOS Supplier Standards

Section 1834(j)(1)(A) of the Act states that no payment may be made for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number. To obtain a supplier billing number, a supplier must comply with certain supplier standards as identified by the Secretary. Section 1834(j)(1)(B) of the Act gives the Secretary the authority to establish additional supplier standards. Consistent with the statutory authority described in sections 1834(j)(1)(A) and (B) of the Act, CMS established DMEPOS supplier standards set forth in 42 CFR 424.57(c), and may clarify and revise the DMEPOS supplier standards as needed to ensure the efficient administration of the Medicare program.[184]

Current 42 CFR 424.57(c)(11) requires that DMEPOS suppliers, when supplying a Medicare-covered item, agree not to contact a beneficiary by telephone unless the beneficiary has provided written permission to the supplier to contact the beneficiary by telephone concerning the furnishing of a Medicare-covered item that is to be rented or purchased, the supplier has furnished a Medicare-covered item to the beneficiary and is contacting the beneficiary to coordinate delivery, or the supplier has previously furnished a covered item to the beneficiary in the 15-month period prior to the date of contact. The existing requirement is one of the conditions that DMEPOS suppliers must meet to be eligible to receive payment for a Medicare-covered item and to participate in the program. Existing regulations at 42 CFR 424.57(e)(1) state that a DMEPOS supplier's failure to meet supplier standards may result in revocation of the supplier's Medicare billing privileges. If CMS or a DMEPOS supplier-accrediting body has evidence that a DMEPOS supplier has made prohibited contact with Medicare beneficiaries in violation of the provisions found in 42 CFR 424.57(c)(11), CMS may revoke that supplier's billing privileges. CMS also will determine whether submitted claims related to such contact are for unnecessary supplies, and may refer the supplier to law enforcement should it suspect potential fraud.

CMS briefly expanded the scope of the prohibition against unsolicited direct contact of Medicare beneficiaries by DMEPOS suppliers. In 2010, CMS published a final rule intended to strengthen the Medicare DMEPOS supplier standards specified in 42 CFR 424.57 to enhance the program integrity protections for Medicare FFS DMEPOS.[185] In the 2010 rule, CMS finalized a definition of ''direct solicitation'' that expanded the existing prohibition on unsolicited direct contact of Medicare beneficiaries via telephone, with certain exceptions.[186] During that rulemaking, several commenters expressed concerns that the expanded prohibition restricted commercial speech.[187] Following publication of the 2010 final rule, CMS subsequently determined that implementing the expanded prohibition was unfeasible

[183] Section 1834(a)(17) of the Act prohibits DMEPOS suppliers from soliciting Medicare beneficiaries by telephone, unless the beneficiary has given prior written consent or the supplier has an existing relationship with the beneficiary.

[184] Section 1871(a)(1) of the Act provides the Secretary the right to prescribe regulations as may be necessary to carry out the administration of the Medicare program.

[185] Ctrs. for Medicare & Medicaid Servs., Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards, 75 FR 52629 (August 27, 2010), *available at federalregister.gov.*

[186] 75 FR 52639.

[187] 75 FR 52638.

because the definition of ''direct solicitation'' it had finalized was overly broad, warranting further evaluation.

Accordingly, in a 2011 proposed rule, CMS proposed to remove the definition of ''direct solicitation'' and restore the supplier standard that existed prior to the 2010 rule.[188] CMS finalized that proposal in 2012, reverting to the prior standard and stating that the language in the 2010 final rule would have prohibited some types of marketing activity beyond what CMS intended to prohibit.[189]

B. Pervasiveness of Medicare DMEPOS Fraud, Waste, and Abuse

DMEPOS fraud, waste, and abuse in the Medicare program has been a serious problem for many years, placing billions of taxpayer dollars at risk and potentially resulting in patient harm when beneficiaries use medically unnecessary or substandard items.[190] [191] CMS' role in overseeing the Medicare program is to ensure that payments are made correctly and that fraud, waste, and abuse is stemmed because failure to do so endangers the Trust Funds and may result in beneficiary harm. Consequently, CMS rigorously scrutinizes DMEPOS suppliers upon enrolling, and to maintain enrollment, in Medicare.[192] Despite these safeguards, fraudulent billing for Medicare DMEPOS continues to be a major concern, and new schemes continue to emerge.[193]

In fact, in 2026, CMS announced a nationwide temporary enrollment moratorium on newly enrolling Medicare DMEPOS medical supply companies based on evidence that the supplier category presented significant program integrity concerns, including a history of fraudulent billing and other abusive practices. CMS determined that temporarily restricting new enrollments was necessary to protect Medicare while preserving beneficiary access through the substantial number of existing enrolled suppliers. A nationwide approach was taken because it was clear to us that DMEPOS fraud, waste, and abuse was not restricted to certain types of items or particular areas of the country. Rather, it was widespread across DMEPOS types and geographic areas.

Additionally, in March 2025, CMS launched the Fraud Defense Operations Center (FDOC), also referred to as the Fraud War Room, a cross-functional unit combining data analysts, investigators, health policy experts, legal advisors, and law enforcement personnel to identify and interdict fraudulent billing before payment is made. In its first year of operation (March 31, 2025 through March 31, 2026), the FDOC suspended payments to 138 suspect DMEPOS suppliers, and as of August 2026, was holding $1.9 billion through these payment suspensions.

In many fraud schemes, DMEPOS suppliers and their agents target Medicare beneficiaries with unsolicited direct contacts and use high-pressure marketing tactics or deceptive lead generation to obtain information and consent to enable the DMEPOS supplier to bill Medicare for medically unnecessary or unneeded items, or items that are never supplied at all. This unsolicited direct contact may include emails, text messages, direct messages on social media, and door-to-door in person solicitation. Increasingly, these schemes involve third-party organizations, such as telemarketers or independent marketing firms. In some cases, unsolicited outreach to beneficiaries is used to offer free services, medical equipment, or gift cards in exchange for their Medicare number, which is then used to fraudulently bill Medicare.[194]

Advances in technology also allow bad actors to spoof the number that appears on a beneficiary's caller ID so that an incoming call appears to be from a trusted health care provider or government agency.[195] Scammers also target Medicare enrollees through text messages with offers of free services, medical equipment, or gift cards upon confirming their personal information and eligibility for specific Medicare services. Often, the enticement for the individual is that they are ''qualified'' for items ''at no cost'' or ''free.'' Once the scammers obtain the enrollee's personal information, monthly billing to Medicare will begin for medically unnecessary supplies that may or may not actually be sent to the enrollee.[196] Accordingly, CMS has gone to great lengths to discourage beneficiaries from providing personal information such as Medicare or Social Security numbers, including a longstanding ''Guard Your Card'' campaign that offered such tips as ''Don't share your Medicare Number or other personal information with anyone who contacts you by phone, email, or approaches you in person, unless you've given them permission in advance.'' [197]

As previously described, CMS published a Request for Information (RFI Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH) on February 27, 2026.[198] This RFI requested stakeholder feedback on a number of potential regulatory and programmatic changes, including a possible change to the existing prohibition against unsolicited contact by telephone by DMEPOS suppliers.[199] CMS received multiple comments in response to the RFI that were generally supportive of efforts to curb abusive marketing and lead generation practices involving unsolicited beneficiary contact and specifically supported broadening the prohibition. Commenters described unsolicited telephone calls, texts, emails, and door-to-door solicitations, and noted concerns about third-party marketing firms and other entities acting on behalf of DMEPOS suppliers. Commenters also described agents approaching beneficiaries at their homes, unsolicited, and sometimes combined with emails using high

[188] 76 FR 18474.

[189] CMS, Medicare Program; Revisions to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Safeguards, 77 FR 14990 (March 14, 2012), *available at federalregister.gov.*

[190] *See* CMS, Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies, 90 FR 29108 (proposed July 2, 2025), *available at federalregister.gov*; CMS, Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Medical Supply Companies, 91 FR 9855 (February 27, 2026), *available at federalregister.gov.*

[191] The FY 2025 Medicare estimated improper payment amount for DMEPOS is $2.27 billion. Improper payments are payments that do not meet Medicare requirements or are made in incorrect amounts. *See https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/comprehensive-error-rate-testing-cert.*

[192] 90 FR 29108. *https://www.federalregister.gov/d/2025-12347/p-699.*

[193] *Id.*

[194] *https://oig.hhs.gov/fraud/consumer-alerts/consumer-alert-catheter-scam/; https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.*

[195] *https://www.fcc.gov/older-americans-and-medicare-scams.*

[196] *https://www.oig.hhs.gov/fraud/consumer-alerts/consumer-alert-catheter-scam/.*

[197] *https://www.medicare.gov/publications/10111-protecting-yourself-from-fraud.pdf.*

[198] Ctrs. for Medicare & Medicaid Servs.*https://www.federalregister.gov/documents/2026/02/27/2026-03968/request-for-information-rfi-related-to-comprehensive-regulations-to-uncover-suspicious-healthcare,* Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH), 91 FR 9803 (proposed February 27, 2026), *available at federalregister.gov.*

[199] 91 FR 9806. *https://www.federalregister.gov/d/2026-03968/p-78.*

pressure sales tactics to get approval for services, which the beneficiaries do not need or approve, yet claims were generated by the suppliers as though consent was provided. Several other commenters did express concern, however, about how further restrictions on solicitation may disrupt DMEPOS care coordination or patient education.

C. Proposed Revisions to Supplier Standards Pertaining to Beneficiary Solicitation

Despite the existing program integrity controls in place pertaining to beneficiary solicitation by DMEPOS suppliers, fraudulent billing for Medicare DMEPOS continues to be a major concern, and new schemes have emerged. A crucial element in many of these schemes is the targeted, unsolicited contact with beneficiaries by DMEPOS suppliers and their agents, who use manipulative tactics to obtain personal information and consent. Accordingly, CMS has determined that a clarification to make explicit the prohibition on unsolicited beneficiary contact by DMEPOS suppliers (and third-party entities acting as their agents) when supplying a Medicare-covered item is needed to address these schemes. We believe that making explicit the supplier standards specified in 42 CFR 424.57(c)(11) and the addition of new supplier standard at 42 CFR 424.57(c)(31) would help to ensure that legitimate DMEPOS suppliers furnish items of DMEPOS to Medicare beneficiaries consistent with Medicare requirements.

Specifically, we are proposing to revise the supplier standard at 42 CFR 424.57(c)(11) to clarify that suppliers must agree that they and their agents shall not contact a beneficiary when supplying a Medicare-covered item by telephone call or message, including text messages unless one of the following applies: (i) the beneficiary has provided written permission to the supplier to contact the beneficiary by telephone concerning the furnishing of a Medicare-covered item that is to be rented or purchased; (ii) the supplier has furnished a Medicare-covered item to the beneficiary and is contacting the beneficiary to coordinate delivery; or (iii) the supplier has previously furnished a covered item to the beneficiary in the 15-month period prior to the date of contact. This clarification would be consistent with the Telephone Consumer Protection Act's [200] long-standing definition of ''telephone solicitation'' as the initiation of a telephone call or message for the purpose of encouraging purchases or rentals of property, goods, or services, but excludes such a call or message when express permission for contact has been granted or there is an established business relationship.

In accordance with our authority in section 1834(j)(1)(B) of the Act to establish additional supplier standards, we are also proposing to add a supplier standard at 42 CFR 424.57(c)(31) that would require that a supplier must agree that they and their agents shall not contact a beneficiary when supplying a Medicare-covered item using direct messages from social media platforms, email messages without opt-out provisions, and door-to-door in-person solicitation unless one of the following applies: (i) the individual has given written permission to the supplier to contact them concerning the furnishing of a Medicare-covered item that is to be rented or purchased; (ii) the supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item; or (iii) if the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

We also propose to clarify that both 42 CFR 424.57(c)(11) and (31) apply to all DMEPOS suppliers, whether the DMEPOS supplier itself or another qualified party is furnishing the item. We believe such clarification is necessary in light of our observations that third-party organizations, such as telemarketers and independent marketing firms, are increasingly working with DMEPOS suppliers to engage in fraudulent schemes targeting Medicare. We note, however, that our proposed clarification that 42 CFR 424.57(c)(11) would apply to third-party agents and would not expand the existing prohibition. CMS and HHS–OIG have long interpreted the current version of 42 CFR 424.57(c)(11) as prohibiting DMEPOS suppliers from using agents or other third parties to make unsolicited telephone calls that improperly target consumers.[201]

CMS must take action to safeguard the Medicare program when bad actors exploit advances in technology and engage in coercive, high-pressure marketing tactics that result in the proliferation of fraudulent Medicare DMEPOS billing schemes. In doing so, however, CMS has continuously weighed the impact of additional contact limitations on both program integrity and DMEPOS suppliers' rights to engage in Constitutionally protected speech.

We believe that this proposed rule avoids the overly broad language of previous efforts and, if finalized as proposed, would not prohibit otherwise permissible marketing activity. This proposal is appropriately limited in scope and focuses on targeted communication that has significantly contributed to fraudulent Medicare DMEPOS billing. The proposed changes are designed not to prevent DMEPOS suppliers from engaging in legitimate marketing communications, but, instead, to strengthen CMS program integrity efforts to safeguard the Medicare program by preventing DMEPOS suppliers from utilizing third-party entities to indirectly engage in unsolicited beneficiary contact in which DMEPOS suppliers themselves may not engage when supplying a Medicare-covered item.[202] Further, the proposed changes would add methods of communication, such as electronic direct messages from social media platforms, that have provided new ways for bad actors to target Medicare beneficiaries with aggressive and deceptive tactics that can lead to fraudulent Medicare billing and other abusive practices.

The proposed revisions to the supplier standards aim to address critical program integrity concerns but would have a limited impact on a DMEPOS supplier's ability to advertise products and services to the general public or Medicare beneficiaries generally, or to otherwise engage in legitimate marketing activities. Television commercials, which broadcast ads for products or services with clear disclosures (for example, pharmaceutical ads listing side effects), radio advertisements, and print advertisements in newspapers, magazines, or brochures are examples of legitimate marketing activities that these proposals would not limit. Likewise, generalized advertising on digital platforms is another example of a legitimate marketing activity. In this proposed rule, CMS proposes to clarify

[200] 47 U.S.C. 227(a)(4) (1991).

[201] *https://oig.hhs.gov/newsroom/news-releases-articles/hhs-oig-alerts-medicare-suppliers-beneficiaries-about-prohibited-telemarketing-calls/;* HHS–OIG; Publication of OIG Updated Special Fraud Alert on Telemarketing by Durable Medical Equipment Suppliers, 75 FR 2105 (January 14, 2010); *available at federalregister.gov. https://www.federalregister.gov/d/2010-562/p-11.*

[202] *See* HHS–OIG, Publication of OIG Special Fraud Alert on Telemarketing by Durable Medical Equipment Suppliers, 68 FR 10254 (March 4, 2003); *available at federalregister.gov.*

the existing 42 CFR 424.57(c)(11) prohibition against unsolicited beneficiary contact by DMEPOS suppliers and add a new DMEPOS supplier standard under proposed 42 CFR 424.57(c)(31). We also propose to add specific severability clauses at 42 CFR 424.57(c)(11)(ii) and (31)(ii). To the extent a court may enjoin one provision of this rule as finalized, CMS proposes that the other provisions should remain in effect, ensuring the continuity of the regulations. We propose that any provision of the requirements of this rule that is held to be invalid or unenforceable by its terms or as applied to any person or circumstance would be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding is one of utter invalidity or unenforceability, in which event we propose that the provision would be severable from the other provisions of this rulemaking and would not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

We propose that if any section, subsection, sentence, clause, phrase, word, provision, or application of this proposed rule as finalized shall be found to be invalid, illegal, unconstitutional, or unenforceable, that finding shall not affect or undermine the validity of any other section, subsection, sentence, clause, phrase, word, provision, or application which can be enforced without the use of the offending provision. We request comments from the public on severability, particularly which policies could be severable, if finalized, and how the other policies in a final rule would operate absent those particular provisions.

We seek comments on this proposed clarification and addition to the prohibition on unsolicited beneficiary contact by DMEPOS suppliers wishing to receive payment from Medicare.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501–3520, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain confirmed or potential information collection requirements (ICRs). Comments, if received, will be responded to within the subsequent final rule (CMS–6098–F, RIN 0938–AV97).

A. Wage Estimates

To derive average costs and savings, we used data from the U.S. Bureau of Labor Statistics' (BLS') May 2025 National Occupational Employment and Wage Statistics for all wage estimates (*https://www.bls.gov/oes/tables.htm*). In this regard, Table C–A1 presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs [203] (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE C-A1: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation Title	Occupational Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialists	13-1000	43.76	43.76	87.52
Business Operations Specialists, All Other	13-1199	45.18	45.81	90.36
Claims Adjusters, Examiners, and Investigators	13-1031	38.69	38.69	77.38
Eligibility Interviewers, Government Programs	43-4061	26.97	26.97	53.94
Computer Systems Analysts	15-1211	55.10	55.10	110.20
General and Operations Managers	11-1021	64.87	64.87	129.74
Human Resources Managers	11-3121	78.96	78.96	157.92
Management Analysts	13-1111	54.71	54.71	109.42

For States and the private sector, the employee hourly wage estimates have been adjusted upwards by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

To estimate the financial burden on States, it was important to consider the Federal government's contribution to the cost of administering the Medicaid and CHIP programs. The Medicaid FMAP that is established for each State is based on the per capita income in the State as compared to the national average. Medicaid FMAPs range from a minimum of 50 percent in States with higher per capita incomes to a maximum of 83 percent in States with lower per capita incomes, but exceptions to the regular FMAP rate exist for certain States, situations, populations, providers, and services. For Medicaid, all States generally

[203] *https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework.*

receive a 50 percent FMAP for administration. States also receive higher Federal matching rates for certain systems improvements, redesign, or operations, including a 90 percent match rate for the design, development, and enhancement of Medicaid information technology (IT) systems. We have estimated that States would contribute 10 percent of applicable Medicaid IT costs. For CHIP, Congress created an ''enhanced'' Federal matching rate for CHIP that is generally about 15 percentage points higher than the Medicaid rate, averaging 71 percent nationally. To determine the Federal contribution to the costs of administering the Medicaid and CHIP programs for purposes of estimating State burden with respect to the collections of information, we elected to use the higher-end estimate that the States would contribute 50 percent of the costs. This assumption represents the upper bound of potential State burden, recognizing that the actual share is often lower once enhanced Federal match rates are applied.

B. Proposed Information Collection Requirements and Burden

This section details the information collection requirements (ICRs) and burden related to Enhancing Medicaid program integrity: deregulation of the MEQC program, Medicaid and CHIP beneficiary eligibility audits, Medicaid and CHIP beneficiary eligibility-related disallowances, PERM CAPs, Program Integrity CAPs, Medicaid fee-for-service overpayment reporting (60-day rule), Medicaid managed care oversight policies, enhanced electronic visit verification (EVV) requirements, and Medicaid and CHIP provider enrollment.

1. Medicaid and CHIP Program Integrity

a. ICRs Regarding Deregulation of the MEQC Program (§§ 431.800 Through 431.820)

The MEQC Program is currently approved under OMB control number: 0938–0147 (Expiration date: 08/31/2029). This rule proposes to deregulate the MEQC program. We do not believe that the proposed changes would impose any new or revised collection of information requirements or burden, including those associated with the creation or revision of State plan or other State-owned policy documents. The proposed change would have no impact on any collection of information requirements including that of collecting information, reporting information, disclosing information, and/or recordkeeping. As a result, the proposed deregulation of the MEQC program would not be subject to the requirements of the PRA. The collection of information will be formally discontinued once the 3-year phaseout is complete. If the proposed regulation becomes effective, once the 3-year phaseout is complete at the end of 2029, the current COI cost of $22,020,936 associated with information requirements including that of collecting information, reporting information, disclosing information, and recordkeeping, will be discontinued, producing an ongoing annual State cost savings of $11,010,468 ($22.020,936 ÷ 2) starting in the year 2030, which is the State share amount of $22,020,936.

This will generate then an ongoing annual Federal cost savings/transfer to the Federal government of $11,010,468 starting in 2030 ($22.020,936 ÷ 2), which represents the 50 percent Federal administrative match amount that the Federal government would have paid but for the deregulation of the MEQC program.

b. ICRs Regarding PERM CAPs (§§ 431.992(a), (b)(3)(ii)(E), (b)(3)(ii)(F), (c), and (e) and 431.1010(b)(2)(ii))

The following proposed changes will be submitted to OMB for review under control number 0938–1012 (Expiration date: November 30, 2027).

Ensuring that States are taking necessary steps as part of their PERM CAPs is vital to CMS and States being able to reduce improper payments in future years. While we provide guidance to States throughout the entire PERM CAP process, we currently have limited enforcement authority to ensure that States comply with all PERM CAP requirements and effectively attempt to reduce or prevent future PERM errors.

Under new § 431.992(c), this proposed rule would provide us with explicit authority to approve (with required revisions, as needed) or disapprove a State's PERM CAP. This would allow us to ensure that States submit high-quality, effective, and robust PERM CAPs that would reduce future errors, while also allowing us to make more effective ''good faith effort'' determinations.

Currently, as part of the PERM CAP development process, we review the CAP developed by the State to ensure that it includes all requirements outlined in § 431.992, including the identification of root causes of improper payments, how the State plans to avoid repeat errors, how the State will monitor CAP implementation, and evaluate the effectiveness of the corrective actions. In instances in which this information is missing or deemed insufficient by us, a request for additional information is issued to the State, and the State is expected to make the updates until the information in the PERM CAP is deemed by CMS to meet regulatory requirements. This process would largely be unchanged under these new regulations, as this proposal would simply provide CMS with the authority to approve or disapprove a State's PERM CAP. We do not believe that this proposal to provide CMS with explicit authority to approve or disapprove a State's PERM CAP would lead to an increased workload or costs on States. The request for additional information is exempt from the requirements of the PRA since each request would be non-standardized across the States.

We are also proposing to amend § 431.992(a) to require States to submit a combined PERM CAP that addresses both Medicaid and CHIP PERM errors and deficiencies, as applicable. This provision proposes combining the Medicaid and CHIP CAPs, which would eliminate the need for States to duplicate responses on both CAPs, as the errors and corrective actions are generally similar across programs. This would reduce the time needed for States to meet PERM CAP regulatory requirements, as two separate CAPs would no longer be required. It is estimated that this change would reduce the burden on States' staff processing time by approximately 30 hours (from 60 to 30 hr) at $77.38/hr, which is the approximate time it takes claims adjusters, appraisers, examiners, and investigators to generate responses on two separate reports. In aggregate, we estimate an annual burden reduction of minus 510 hours (17 States × 30 hr) and minus $39,464 ($-510$ hr × $77.38/hr). Accounting for the 50 percent Federal administrative match, the total State savings is adjusted to minus $19,732 ($-\$39{,}464 \times 0.50$).

We are also proposing to amend § 431.992(e) to require States with a Medicaid and/or CHIP eligibility improper payment rate exceeding the allowable threshold of 3 percent for consecutive Payment Error Rate Measurement (PERM) years to submit corrective action plan implementation updates to us every 6 months (twice per year) as applicable. This provision proposes to reduce the frequency of the required eligibility updates from every other month (6 times per year) to allow States' additional time to evaluate corrective actions and provide higher quality, more comprehensive status updates, providing us with clearer insights into the States' progress and challenges.

It is estimated that this change would reduce the burden on States' staff processing time by approximately 12 hours at $77.38/hr, which is the approximate time it takes claims adjusters, appraisers, examiners, and investigators to respond to eligibility updates 4 times per year. In aggregate, we estimate an annual burden reduction of minus 204 hours (17 States × 12 hr) and minus $15,786 (−204 hr × $77.38/hr). Accounting for the 50 percent Federal administrative match, the total State savings is adjusted to minus $7,893 (−$15,786 × 0.50). We summarize the proposed burden in Table C–A2 and compare the currently approved burden with the proposed burden in Table C–A3.

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TABLE C-A2: SUMMARY OF PROPOSED BURDEN ASSOCIATED WITH PERM CAP REQUIREMENTS

Requirement	No. of Respondents	Total Responses	Frequency	Time per Response (hr)	Total Time (hr)	Wage ($/hr)	Total Cost ($)	State Cost ($)	Federal Cost ($)
Submission of Combined Medicaid and CHIP PERM CAP (§ 431.992(a))	17 States	17	Annual	30	510	77.38	39,464	19,732	19,732
Submission of Eligibility Updates (§ 431.992(e))	17 States	34	Semiannual	3	102	77.38	7,893	3,946	3,946
TOTAL	17 States	51	Varies	42	612	77.38	47,357	23,678	23,678

TABLE C-A3: COMPARISON OF STATE ADMINISTRATIVE COSTS AND SAVINGS FROM AMENDING 431.992 ASSOCIATED WITH PERM CAP REQUIREMENTS

Requirement	Measure	Current Annual Cost	Proposed Annual Cost	Annual Savings
Submission of Combined Medicaid and CHIP PERM CAP (§ 431.992(a))	Annual Responses	34	17	-17
	Annual Burden (hr)	1,020	510	-510
	State Share Cost ($)	39,464	19,732	-19,732
	Federal Cost/Transfer ($)	39,464	19,732	-19,732
	Total Cost ($)	78,928	39,464	39,464
Submission of Eligibility Updates (§ 431.992(e))	Annual Responses	102	34	-68
	Annual Burden (hr)	306	102	-204
	State Share Cost ($)	11,839	3,946	-7,893
	Federal Cost/Transfer ($)	11,839	3,946	-7,893
	Total Cost ($)	23,678	7,893	-15,785
TOTAL	**Annual Responses**	**136**	**51**	**-85**
	Annual Burden (hr)	**1,326**	**612**	**-714**
	State Share Amount ($)	**51,303**	**23,678**	**-27,626**
	Federal Cost/Transfer ($)	**51,303**	**23,678**	**-27,626**
	Total Cost ($)	**102,606**	**47,357**	**-55,249**

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c. ICRs Regarding Medicaid and CHIP Managed Care Oversight Policies (§§ 438.3(c)(2) and 438.608(a)(3))

This rule proposes to clarify that managed care plans may not retain capitation payments for enrollees who have died or have moved out of State and also defines ''prompt'' reporting of beneficiary changes. We do not believe that the proposed changes would impose any new or revised collection of information requirements or burden including those associated with the creation or revision of State plans or other State-owned policy documents. As a result, the proposed Medicaid managed care oversight policies would not be subject to the requirements of the PRA. CHIP is incorporated via 42 CFR 457.1201(c) and 457.1285.

d. ICRs Regarding Revisions to § 455.17 Reporting Requirements

This section discusses the ICR burden associated with our proposed revisions to § 455.17, which would modernize Medicaid fraud and abuse reporting requirements for State Medicaid agencies. This section should be read together with section VIII.B.2. of this proposed rule, ''National Provider Identifier Requirements for Medicaid Providers,'' which addresses the separate burden associated with States collecting and maintaining NPIs generally; this section addresses only the burden of reporting the NPI as one of several data elements under § 455.17(b) once it is on file.

Table C–A4 lists the Bureau of Labor Statistics (BLS) hourly wage estimate(s) (see *https://data.bls.gov/oes/#/area/0000000/2025*) for the occupational category used in this section.

TABLE C-A4: MAY 2025 BLS NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
General and Operations Managers	11-1021	$64.87	64.87	$129.74

Under existing § 455.17(a), States are required to report to CMS the number of fraud and abuse complaints that warranted a full investigation. Under existing § 455.17(b), for cases of suspected provider fraud and abuse that warranted a full investigation, States are required to report six data elements, as described in section III. Medicaid and CHIP Program Integrity Proposals of this proposed rule.

We propose to amend § 455.17(b) to require States to report the following additional data elements for cases of suspected provider fraud and abuse that warranted a full investigation: (1) the provider's National Provider Identifier (NPI) or Medicaid provider identification number, if the provider is ineligible to receive an NPI; (2) the provider's Employer Identification Number or Taxpayer Identification Number (EIN/TIN); (3) the State in which the investigation is being conducted; (4) the investigation status; (5) the type of service involved; (6) the payor; (7) the relevant claim dates; (8) the estimated overpayment amount and, where available, the final overpayment amount; and (9) the approximate time period covered by the investigation. We also propose to replace the existing paragraphs (b)(1) through (6) with expanded requirements enumerated as paragraphs (b)(1) through (15). This will expand the reporting options for disposition of cases to include administrative actions taken by the State Medicaid agency, in addition to the existing requirement to report actions taken by law enforcement.

The ICR burden associated with this provision is limited to States collecting, compiling, and reporting these data elements for each qualifying case. There was a previously approved information collection for § 455.17, OMB Control No. 0938–0076 originally approved in 1978 and last approved by OMB in 1983. That control number expired in 1986. Following that expiration, CMS did not collect the information from States under § 455.17. Burden associated with this collection is associated with OMB control number 0938–0076; however, CMS is seeking to reinstate the collection. CMS will not begin collecting information related to these requirements until OMB approval is received.

We note that the provider's NPI (or Medicaid provider identification number, if the provider is ineligible to receive an NPI) is one of the nine additional data elements States would report under this proposal. Because this NPI/ID data element is reported as part of the same § 455.17(b) submission, for the same case, at the same time as the other eight additional data elements, we have not separately estimated its burden; the burden estimate in this section reflects the incremental time needed to compile and report all nine additional data elements together as a single reporting action. This approach is consistent with our general practice of estimating ICR burden based on the reporting event (that is, the submission), rather than by individual data field within that submission.

Under § 455.17(b), States are required to report the specified data elements for each case of suspected provider fraud and abuse that warranted a full investigation. We estimate that on average each State refers approximately 30 such cases to its State Medicaid Fraud Control Units (MFCUs) on an annual basis, based on MFCU annual reports.[204] MFCU reports cover a 3-year period and on average States report an estimated 89.6 cases over a review period.

All 50 States, the District of Columbia, and the applicable territories (hereafter collectively ''States'') are subject to this reporting requirement. We estimate a range of 30 to 100 cases requiring the additional data elements per State annually. Specifically, we estimate 65 cases per State.[205] We estimate that it will take a State Medicaid agency official approximately 2.00 hours] to compile and report the additional data elements for each qualifying case. This estimate reflects the fact that much of this information (for example, claim dates, payor, and estimated overpayment amount) is likely already maintained by the State as part of its existing investigation and case management processes and would primarily require compilation and formatting for submission to CMS rather than new data collection. (65 cases per State annually × 52 States = 3,380 cases) (3,380 cases × 2.00 hours = 6,760 hours) (6,760 hours × $129.74 = $877,042.40). The estimated annual cost is $877,042.40 with $438,521.20 as the State share, and $438,521.20 as the Federal transfer cost reflecting the 50 percent Federal administrative match.

To derive estimated cost, we used data from the U.S. Bureau of Labor Statistics' May 2025 Occupational Employment and Wages for the occupation, ''General and Operations Managers'' (Occupation Code 11–1021). This estimate includes the mean hourly wage ($64.87) with benefits calculated at 100 percent ($64.87) totaling $129.74 per hour. We calculated this using the mean average of 65 cases annually.

We estimate that the data would be compiled and submitted to CMS by a State Medicaid program integrity official with an hourly wage equivalent to that of a GS–12, Step 5 Federal employee, or $ 86,659. (See [DCB.pdf salary table citation/link].) The figure is $173,318 with FBO.

Table C–A5 summarizes the estimated annual ICR burden for this provision.

[204] *https://oig.hhs.gov/reports/all/?hhs-agency=MFCU&page=1.*

TABLE C-A5: PROPOSED § 455.17(B) ICR BURDEN ESTIMATE

Provision/Requirement	OMB Number	Number of Respondents (States)	Number of Responses (Cases)	Burden per Response (Hours)	Total Annual Burden (Hours)	Hourly Wage (Includes FBO) ($)	Total Cost
Additional Data Elements Reported Under § 455.17(b), Including Provider NPI/ID	0938-0076	52	3,380	2.00	6,760	$129.74	$877,042.40
TOTALS		52	3,380	2.00	6,760	$129.74	$877,042.40

Note: The provider NPI/ID data element is captured within the single line item rather than as a separate row, consistent with the discussion in section VIII.B.1. of this proposed rule.

Per Table C–A5, we project an average annual ICR burden of 6,760 hours and $877,042.40 associated with the proposed revisions to § 455.17(b).

We note that proposed § 455.17(a) is not being substantively revised and therefore imposes a *de minimis* ICR burden. Burden will be accounted for under the newly proposed collection of information previously approved under OMB control number 0938–0076.

e. ICRs Regarding Medicaid and CHIP Provider Enrollment (§§ 455.2, 455.101, 455.104, 455.106, 455.416, 455.436, 455.450, and 455.460)

As discussed in section V. of this proposed rule, we are proposing a number of changes to our Medicaid and CHIP provider enrollment regulations in subparts B and E of part 455. The changes include, but are not limited to, the following:

- Adding and revising definitions.
- Clarifying certain types of provider enrollment data that Medicaid and CHIP providers must submit to States.
- Adding and revising reasons for which the State must deny or terminate a provider's Medicaid enrollment.
- Revising provider enrollment application fee requirements.
- Making various technical revisions.

Under § 455.104, a disclosing entity must furnish to the State information regarding ''any person (individual or corporation) with an ownership or control interest'' in the disclosing entity. This information includes, for example:

- The aforementioned party's name, address, and tax identification number.
- Whether said party is related to another person with an ownership or control interest in the provider/disclosing entity.
- Identifying data about any managing employee of the disclosing entity.

We are proposing several revisions to these definitions and requirements. First, we propose to change the parenthetical ''(individual or corporation)'' in § 455.104 to ''individual or organization.'' Second, we propose to add a definition of ''managing organization'' to § 455.101. The proposed revisions, in effect, would require the following:

- Providers that are individual practitioners or groups thereof to disclose the information outlined in § 455.104.
- Providers to disclose § 455.104 data about: (1) entities other than corporations; and (2) managing organizations.

We do not have available data upon which we can reasonably estimate the burden on providers for disclosing such information. This is largely because: (1) each State has its own provider enrollment process and means of collecting information (the burden of which could differ by State); (2) some States may already collect this data, meaning no additional burden from our proposal; and (3) each State receives different volumes of applications each year. We accordingly solicit comments from interested parties, especially the States, on this potential burden, specifically:

- For States that do not presently collect this information, the burden that the State believes the provider would incur in reporting it.
- The burden that providers believe they would incur in collecting and reporting this data.

We also request data from the States regarding other potential information collection burdens that could arise from our proposed provider enrollment provisions. These could include, for instance, the State's: (1) revision of enrollment applications, internal procedures, and public guidance documents; and (2) processing of additional enrollment data.

For the foregoing requests for data concerning any enrollment information collection burden, we would appreciate statistics and burden calculations from interested parties that could help us prepare a reasonable burden assessment.

f. ICRs Regarding Medicaid Payment Suspensions Updates (§ 455.23)

The information collection activities associated with the proposed amendments to 42 CFR 455.23 are exempt from the PRA pursuant to 44 U.S.C. 3518(c)(1), which exempts from PRA coverage collections of information obtained as part of an agency's administrative enforcement activities, during the conduct of a Federal criminal investigation or prosecution, or during the disposition of a particular criminal or civil matter by or for a Federal agency. Specifically—

The proposed revisions at § 455.23(a)(1)(i), § 455.23(d)(4), § 455.23(e)(1)(i), and § 455.23(g)(3) involve the collection and exchange of information directly related to the investigation and adjudication of credible allegations of fraud (CAF) in the Medicaid program. The documentation, verification, and reporting activities contemplated under these provisions—including written determinations regarding active investigations, case-specific verification of good cause exceptions, and payment suspension status reporting—are conducted in connection with the investigation and potential prosecution of fraud against the Medicaid program and therefore fall within the scope of this exemption.

Although the following activities are not subject to PRA review, CMS provides the following summary for transparency and public awareness in Table C–A6.

TABLE C-A6: MEDICAID PAYMENT SUSPENSIONS

Regulatory Provision	Information Activity	Frequency	Respondents
§ 455.23(a)(1)(i)	Recordkeeping of accepted external CAF determinations	Per CAF referral accepted	SMAs
§ 455.23(d)(4)	Written determination and quarterly redetermination that CAF remains under active investigation	Per suspension; quarterly	SMAs
§ 455.23(e)(1)(i)	Case-specific good cause exception verification and documentation; reporting to CMS	Per good cause exception invoked	SMAs/MFCUs
§ 455.23(g)(3)	Quarterly payment suspension activity reporting to CMS	Quarterly	SMAs

Because the information collection activities described above are exempt from the PRA, no OMB control number is required for any of the proposed provisions. States are not required to display an OMB control number in connection with any documentation or reporting activities undertaken in accordance these regulations.

Because these provisions are exempt from the PRA, CMS is not required to estimate or publish a burden associated with the information activities described herein. Nevertheless, CMS notes that the administrative activities contemplated under these provisions are expected to impose minimal incremental burden on State Medicaid agencies (SMAs), as the underlying data and case tracking infrastructure necessary to support these activities are already maintained by States in connection with their existing Medicaid program integrity obligations. These are discussed in the Regulatory Impact Analysis section of this proposed rule. CMS remains committed to minimizing administrative burden on States consistent with the program integrity objectives of these proposed changes.

As stated in § 455.23(a), a SMA must suspend all Medicaid payments to a provider when there is pending an investigation of a credible allegation of fraud (CAF) under the Medicaid program against an individual or entity unless it has good cause to not suspend payments or to suspend payment only in part.

The burden associated with the proposed updates is the time and effort necessary for a SMA to report to CMS more frequently and coordinate with law enforcement agencies more frequently and with potentially more granular information. This collection of information requirement is PRA-exempt under 5 CFR 1320.4(a)(2).

g. ICRs Regarding National Provider Identifier (NPI) Requirements for Medicaid Providers (§ 455.440)

To derive average costs and savings, we used data from the U.S. Bureau of Labor Statistics' (BLS') May 2025 National Occupational Employment and Wage Statistics for all wage estimates (*https://www.bls.gov/oes/tables.htm*). In this regard, the following table presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs [206] (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE C-A7: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation Title	Occupational Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)	Number of Hours	Total
Office and Administrative Support Workers, All Other	43-9199	23.40	23.40	46.80	2.5	**$117**
Home Health and Personal Care Aides	31-1120	17.36	17.36	34.72	426,624	**$14,812,385**
IT Staff *	29-9021	$36.04	$36.04	$72.08	1,190	**$85,775**
Total					427,816.5	$14,897,224

** Note: The system update costs involve a wide range of professionals as detailed in the ICR analysis. For simplicity, the total cost for that activity is presented in aggregate in the summary table.*

For States and the private sector, the employee hourly wage estimates have been adjusted upwards by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

To estimate the financial burden on States, it was important to consider the Federal government's contribution to the cost of administering the Medicaid program. The Medicaid FMAP that is established for each State is based on the per capita income in the State as compared to the national average. Medicaid FMAPs range from a minimum of 50 percent in States with higher per capita incomes to a maximum of 83 percent in States with lower per capita incomes but exceptions to the regular FMAP rate exist for certain States, situations, populations, providers, and services. For Medicaid, all States generally receive a 50 percent FMAP for administration. States also receive higher Federal matching rates for certain systems improvements, redesign, or operations. To determine the Federal contribution to the costs of administering the Medicaid program for purposes of estimating State burden with respect to the collections of information, we elected to use the

[206] *https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework.*

higher end estimate that the States would contribute 50 percent of the costs. This assumption represents the upper bound of potential State burden, recognizing that the actual share is often lower once enhanced Federal match rates are applied.

2. National Provider Identifiers (NPIs) for Medicaid Providers

This section discusses the information collection requirements (ICRs) and burden associated with our proposed requirement that State Medicaid agencies collect, maintain, and use National Provider Identifiers (NPIs) for all Medicaid providers eligible to obtain an NPI as a covered health care provider under 45 CFR part 162.

This provision imposes ICR burden on two distinct populations: (1) State Medicaid agencies, which must identify providers lacking an NPI, conduct outreach, and update their systems; and (2) individual Medicaid providers who must apply for an NPI. The burden is primarily a one-time cost during the implementation period.

a. State Medicaid Agency Burden

We estimate a total one-time burden on State Medicaid agencies of 1,192.5 hours at a cost of $1,056,898, accounting for a 50 percent Federal administrative match for State costs. This burden consists of the following activities:

- *Identification of Providers Lacking an NPI:* States must review their provider files to identify enrolled providers who are eligible for an NPI but do not have one on file. Based on data from the 10 States that do not already require NPIs for PCAs, we estimate approximately 1.28 million providers nationwide (primarily personal care attendants and other non-traditional providers) lack an NPI. We estimate this review will take one staff member 0.25 hours per State, performed by an Administrative Support Worker.
- *Total Hours:* 10 Administrative Support Workers × 0.25 hr/provider = 2.5 hours.
- *Total Cost:* 2.5 hr × $46.80/hr = $117.
- *Provider Outreach:* States will need to conduct outreach to the identified providers to inform them of the new requirement. We assume a single, batched communication effort requiring 0.1 hours per staff member for 10 States, performed by an Administrative Support Worker.

++ *Total Hours:* 10 staff members × 0.1 hr × 1,280,000 providers = 128,000 hours.

++ *Total Cost:* (128,000 hr divided by 10 States) × $46.80/hr = $599,040.

- *System Updates for Consistent NPI Use:* States that currently do not require NPIs for PCAs will need to ensure their Medicaid Enterprise Systems (MES) and related processes are updated to consistently use the NPI as the authoritative identifier across all functions. We estimate this one-time effort will require 119 hours per State, involving a mix of IT, management, and compliance staff.

++ *Total Hours:* 119 hours per State × *10* States = *1,190* hours.

++ *Total Cost:* Based on the detailed occupational mix in the ICR, the aggregate cost is *$8,578* per State, for a total of *$85,775.*

b. Individual Provider Burden

We estimate that 1.28 million Medicaid providers will need to newly apply for an NPI through the National Plan and Provider Enumeration System (NPPES). This burden is accounted for under the existing NPPES collection (OMB Control No. 0938–0931; Expiration date: March 31, 2028) but is presented here for transparency. We estimate the application takes 20 minutes (0.3333 hours), performed by the provider (approximated as a Home Health/Personal Care Aide wage).

- *Total Hours:* 1,280,000 providers × 0.3333 hr/provider = 426,624 hours.
- *Total Cost:* 426,624 hr × *$34.72*/hr = $14,812,385.

TABLE C-A8: SUMMARY OF BURDEN ASSOCIATED WITH THE NPI REQUIREMENTS

Requirement	No. of Respondents (States)	Total Responses	Frequency	Time per Response (hr)	Total Time (hr)	Wage ($/hr)	Total Cost ($)	State Cost ($)	Federal Cost ($)
State Agency: Identification of Provider Gaps	10*	1,280,000	Once	0.25	320,000	46.80	117	58.5	58.5
State Agency: Provider Outreach	10*	1,280,000	Once	0.1	128,000	46.80	599,040	299,520	299,520
State Agency: Cross-System Updates	10*	10*	Once	119	1,190	72.08	85,775	8,578	77,197
State Subtotal	10*	2,560,010		119.35	449,190	165.68	385,985	328,746.30	356,712.20
Provider: NPI Application (Cross-Referenced)	1,280,000	1,280,000	Once	0.33	426,667	34.72	14,812,385		
TOTAL	**1,280,010**	**3,840,010**		**119.68**	**880,617**	**N/A**	**15,892,397**	**328,746.30**	**356,712**

*The same 10 States are performing these actions and are therefore only counted once.

c. ICRs Regarding Requirements for Program Integrity Corrective Action Plans (§ 455.600 et seq.)

The following proposed changes will be submitted to OMB for review under control number 0938–AV97 (CMS–6098).

As discussed in section III. of this proposed rule (Medicaid and CHIP Program Integrity Proposals), CMS conducts program integrity audits to assess State compliance with applicable Federal Medicaid program integrity requirements and identify programmatic vulnerabilities. Although CMS currently works with States to address findings identified through these audits, existing regulations do not establish standardized requirements governing when a State must develop a corrective action plan in response to findings identified through a CMS program integrity audit, the required contents of such a plan, or CMS review and oversight of its implementation.

Therefore, we propose at § 455.602 to establish requirements governing Program Integrity Corrective Action Plans (Program Integrity CAPs). Under the proposal, following a CMS program integrity audit, the final audit report would specify whether CMS requires the State to develop a Program Integrity CAP and would identify the findings of noncompliance that the State must address through the CAP. CMS would determine whether a CAP is required based on the circumstances identified through the audit.

If a Program Integrity CAP is required, the State would be required to develop and submit a single CAP addressing the findings identified by CMS for corrective action. The CAP would be required to include the elements specified in new § 455.602(b), including a root cause analysis; the corrective

actions the State would implement to address the identified findings and come into compliance; an implementation schedule and monitoring plan; and a plan for evaluating the effectiveness of the corrective actions. States would be required to submit a Program Integrity CAP to CMS no later than 30 calendar days after the date of the final audit report, and CMS would review the CAP to determine whether it satisfies the regulatory requirements and adequately addresses the applicable audit findings. If necessary, CMS could return the CAP to the State with feedback and require revision and resubmission. The State would also be required under § 455.602(c)(2) to provide updates on Program Integrity CAP implementation progress at each milestone timeframe identified in the implementation schedule for each corrective action and upon request by CMS. These updates would include the State's progress in implementing the corrective action in accordance with the approved implementation schedule and information regarding the effectiveness of the corrective action in rectifying the applicable finding or findings of noncompliance.

We believe these requirements would impose additional information collection burden on States that CMS requires to develop and implement a Program Integrity CAP. Based on our experience with existing [207] corrective action processes, we estimate that a State would require an average of 30 hours to develop and submit a Program Integrity CAP. We estimate that this work would be performed by a Claims Adjuster, Appraiser, Examiner, and Investigator at an adjusted hourly wage of $77.38. Actual burden could vary depending on the number and complexity of findings CMS requires the State to address and whether revisions to the CAP are necessary.

Because this is a new proposal, we do not yet have reliable data on the number of States that CMS would require to submit a program integrity CAP annually. For purposes of estimating the upper bound of potential annual burden, we estimate that CMS could conduct program integrity audits involving approximately 17 States annually. Because we cannot predict how many of those audits would result in CMS requiring a CAP, we conservatively assume for purposes of this burden estimate that CMS would require each of the 17 audited States to submit one Program Integrity CAP annually. This assumption is made solely for purposes of estimating potential burden and does not mean that CMS would require a CAP following every program integrity audit.

Under this assumption, we estimate an annual burden of 510 hours (17 States × 30 hr) and $39,463 (510 hr × $77.38/hr) associated with developing and submitting program integrity CAPs. Accounting for the 50 percent Federal administrative match, the total State cost is adjusted to $19,731 ($39,463 × 0.50). We summarize the total burden below in Table C–A9.

TABLE C-A9: SUMMARY OF BURDEN ASSOCIATED WITH PROGRAM INTEGRITY CAP REQUIREMENTS

Requirement	No. of Respondents	Total Responses	Frequency	Time per Response (hr)	Total Time (hr)	Wage ($/hr)	Total Cost ($)	State Cost ($)	Federal Cost ($)
Development of a Program Integrity CAP (§ 455.600 *et seq.*)	17 States	17	Annual	30	510	77.38	39,463	19,731	19,731
TOTAL	17 States	17	Annual	30	510	77.38	39,463	19,731	19,731

d. ICRs Regarding Medicaid and CHIP Beneficiary Eligibility Audits (§ 455.700, et seq.)

The following proposed changes will be submitted to OMB for review under control number 0938–TBD (CMS–10936).

This rule proposes to establish a new Medicaid and CHIP beneficiary eligibility audit program under part 455, subpart H (§ 455.700 *et seq*). The beneficiary eligibility audits offer Federal oversight of States' Medicaid and CHIP eligibility determination processes. By codifying the beneficiary eligibility audits, we intend to increase States' understanding of audit requirements and procedures as future audit findings could result in disallowances if this rule is finalized as proposed. Additionally, in conjunction with our proposal to deregulate the MEQC program, we expect that the additional burden from the eligibility audits will be minimal for States, since these audits are conducted by CMS and its Federal contractors.

As discussed in section III.G. of this proposed rule, we would conduct a risk-based analysis to select high-risk States for audits each year. However, at a minimum, all 50 States and the District of Columbia would undergo an eligibility audit at least once every 5 years. As this is a new proposal, we do not yet have reliable data on the number of Medicaid and CHIP eligibility audits we would conduct annually. We currently estimate that 15 States will be selected each year for an eligibility audit.[208] As outlined in proposed § 455.704(b), each audited State would be required to provide requested eligibility and enrollment data and documentation to CMS; assign at least two subject matter experts (SME) to navigate the necessary information contained in the State's eligibility and enrollment system(s) for the sampled cases in coordination with the auditors; provide requested copies of additional eligibility case records and any other necessary documentation to CMS and its Federal contractors; provide a written response to each eligibility error in our draft report; and develop and submit corrective action plans (CAPs) for approval to address identified eligibility errors, where applicable.

Sections 1902(a)(6) and (a)(75) of the Act allow CMS to require States to submit data and documentation for CMS to evaluate State eligibility determinations for compliance with Federal requirements. As discussed in section H of the preamble and proposed at §§ 455.704 and 455.710, States would be required to submit the following data and documentation to CMS within 10 business days of receiving the engagement letter unless granted an extension by CMS:

- Enrollment totals of individuals applying for and enrolled in Medicaid and CHIP
- Eligibility universe data
- State policy and operations manuals

[207] CMS is requesting approval of a revision to the information collection currently approved under OMB control number 0938–1012 (Expiration date: November 30, 2027) associated with the existing PERM CAP requirements. The revision reflects changes to State submission requirements and the associated burden estimates. CMS requests a three-year approval period for the revised collection.

[208] The number of audits conducted annually is subject to change based on available funding. 15 States is only an estimate. At a minimum, 10 States will be audited every year.

- Eligibility training and guidance materials
- State verification plans
- Any other data specified by CMS to review State eligibility processes

We estimate that it would take a Computer Systems Analyst 40 hours at $110.20/hr to collect and submit the initial data and documentation to CMS, including the enrollment data and eligibility case records. In addition, we estimate it will take a General and Operations Manager 4 hours at $129.74/hr to review the initial data and approve the submission of the requested data to CMS. In aggregate, we estimate an annual cost of $73,905 (15 × [(40 hr × $110.20/hr) + (4 hr × $129.74/hr)]). Accounting for a 50 percent Federal administrative match, the total State annual share is adjusted to $36,953 ($73,905 × 0.50).

We estimate that it would take two State eligibility interviewers a combined 375 hours at $53.94/hr to guide auditors through the State's eligibility and enrollment system(s).[209] The designated eligibility interviewers will navigate the State's system(s) at the request of CMS auditors and provide the relevant documentation for each of the 500 cases selected for the audit (specifically, 200 active Medicaid cases, 50 negative Medicaid cases, 200 active CHIP cases, and 50 negative CHIP cases). In aggregate, we estimate an annual burden of 5,625 hours (15 States × 375 hr) at a cost of $303,413 (5,625 hr × $53.94/hr) for the State SMEs to guide CMS auditors through the State's eligibility and enrollment system(s). Accounting for the 50 percent Federal administrative match, the total estimated State cost is adjusted to $151,707 ($303,413 × 0.50).

We estimate that it would take a Computer Systems Analyst 12 hours at $110.20/hr to provide any additional data and documentation pertaining to the sampled cases during the audit, including enrollment data and eligibility case records upon CMS' written request. We estimate it will take a General and Operations Manager 2 hours at $129.74/hr to review the additional data and documentation and approve the submission to CMS. In aggregate, we estimate an annual cost of $23,729 (15 × [(12 hr × $110.20/hr) + (2 hr × $129.74/hr)]). Accounting for a 50 percent Federal administrative match, the total State share is adjusted to $11,865 ($23,729 × 0.50).

We estimate that it would take a General and Operations Manager 8 hours at $129.74/hr to respond to the beneficiary eligibility audit draft report indicating agreement or disagreement with each of the identified eligibility errors. In aggregate, we estimate an annual burden of 120 hours (15 States × 8 hr) at a cost of $15,569 (120 hr × $129.74/hr). Accounting for the 50 percent Federal administrative match, the total State cost is adjusted to $7,785 ($15,569 × 0.50).

At § 455.712, we propose that each audited State develop a CAP to address identified eligibility errors and submit it to us for approval. We estimate that it would take a Business Operations Specialist, All Other 40 hours at $90.36/hr to develop and submit a CAP for approval. In aggregate, we estimate an annual burden of 600 hours (15 States × 40 hr) at a cost of $54,216 (600 hr × $90.36/hr). Accounting for the 50 percent Federal administrative match, the total State cost is adjusted to $27,108 ($54,216 × 0.50). We summarize the total burden in Table C–A10.

TABLE C-A10: SUMMARY OF BURDEN ASSOCIATED WITH THE MEDICAID AND CHIP BENEFICIARY ELIGIBILITY AUDIT REQUIREMENTS

Requirement	No. of Respondents	Total Responses	Frequency	Time per Response (hr)	Total Time (hr)	Wage ($/hr)	Total Cost ($)	State Cost ($)	Federal Cost ($)
Initial Data Collection and Submission (§ 455.700, *et seq.*)	15	15	Annual	44	660	Varies	73,905	36,953	36,953
Eligibility and Enrollment System(s) Navigation (§ 455.700, *et seq.*)	15	15	Annual	375	5,625	53.94	303,413	151,707	151,707
Additional Data Collection and Submission	15	15	Annual	14	210	Varies	23,729	11,865	11,865
State Response to Draft Report (§ 455.700, *et seq.*)	15	15	Annual	8	120	129.74	15,569	7,785	7,785
CAP Development and Submission (§ 455.700, *et seq.*)	15	15	Annual	40	600	90.36	54,216	27,108	27,108
TOTAL	15	15	Annual	481	7,215	N/A	470,832	235,418	235,418

e. ICRs Regarding Medicaid Beneficiary Eligibility-Related Disallowances (§ 455.800, et seq.)

This rule proposes to remove the current disallowance regulation at § 431.1010 and establish new disallowance regulations at part 455, subpart I (§ 455.800, *et seq.*) that would apply to the Medicaid beneficiary eligibility audit program proposed under part 455, Subpart H. Under the new disallowance framework, we are proposing that States undergoing Medicaid beneficiary eligibility audits would face full or partial eligibility-related disallowances if their calculated eligibility error rates exceed the 3-percent allowable threshold, unless they are determined to meet the new good faith waiver requirements in § 455.804. We do not believe that the proposed changes would impose any new or revised collection of information requirements or burden, including those associated with the creation or revision of State plans or other State-owned policy documents. Furthermore, we believe that the proposed disallowance regulations are exempt from PRA requirements because under 5 CFR 1320.3(c) a collection of information applies when imposed on ''10 or more persons,'' and fewer than 10 States would be subject to a potential disallowance under section 1903(u) of the Act each year. Thus, eligible to submit evidence for evaluation of good faith waiver eligibility under new § 455.804. We anticipate that fewer than 10 States will be affected by these new requirements, since we plan to conduct a maximum of 15 Medicaid beneficiary eligibility audits each year, and only audited States with eligibility error rates calculated using the lower limit of the 90 percent confidence interval above the 3-percent statutory threshold will be subject to potential disallowances. As a result, the proposed eligibility-related disallowance framework would not be subject to the requirements of the PRA.

[209] For the proposed eligibility audits, States do not need to establish new eligibility and enrollment systems or train auditors on current systems. Instead, States are required to assign SMEs to navigate the existing systems with the CMS auditors. Both SMEs don't need to present for each individual case review. Instead, we suggest that the assigned SMEs participate in different case reviews preferably even at the same time.

f. ICRs Regarding Medicaid Fee-For-Service Overpayment Reporting (60-Day Rule) (§ 455.900, et seq.)

Section 1128J(d) of the Act requires a person who has received an overpayment to report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate. The Act also requires that a notification be made to the payer, in writing, of the reason for the overpayment. Section 1128J(d)(2) of the Act requires persons receiving overpayments under Medicaid or Medicare to report and return the overpayment by the later of: (1) 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. Section 1128J(d)(3) of the Act specifies that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation subject to enforcement under the FCA (as defined in 31 U.S.C. 3729(b)(3)). The term ''person'' refers to any provider of services, supplier, Medicaid managed care organization, Medicare Advantage Organization, or Prescription Drug Plan sponsor. Section 1128J(d)(4)(C)(ii) of the Act excludes beneficiaries from the definition of person.

As discussed in section I.B.4.f. of this proposed rule, even without a final rule, all interested parties are already subject to the statutory requirements found in section 1128J(d) of the Act and could face potential FCA liability, CMPL liability, and exclusion from Federal health care programs for failure to report and return an overpayment. This proposed rule provides clarity and consistency in the reporting and returning of overpayments in Medicaid FFS by outlining these requirements in regulation. We believe that this change would spur persons to be more diligent in reporting and returning overpayments in the Medicaid FFS program. That would likely increase the overpayments that States collect and the associated FFP they return, as well as the reporting that States must perform related to these returned overpayments.

Despite the absence of a strong basis for estimating the magnitude of this clarification's effect on the reporting and returning of overpayments in the Medicaid FFS program, we believe that we can use existing data to approximate what the potential impact may be, both on persons eligible to receive Medicaid funds (who would be responsible for identifying and returning the overpayments to the State) and on States (which would need to return the Federal share of those overpayments to us through the standard CMS–64 reporting process that is currently approved by OMB under control number 0938–1265). As for the impact on persons eligible to receive Medicaid funds, we believe that the PERM improper payment rates provide us with national context on improper payment rates for the Medicaid FFS component of the PERM measurement, which was approximately 5 percent for FY 2024. Given that the total amount of projected improper payments reported was $31.10 billion, we can calculate the FFS component to be $11.23 billion. Although the actual improper payment rates for individual States can vary quite widely, we believe that it is reasonable for us to use the national numbers to approximate the impact on an average State. The CMS–64 does not track overpayments by providers; however, data exists related to PERM overpayment letters sent to States for reporting on the CMS–64. Under the PERM medical review and data processing recovery process, recovery amounts are based on payments identified in individual sampled claims. The total Federal share of Medicaid PERM overpayments identified for recovery for RY 2025 is $1,264,636. This amount is not extrapolated to the national payment universe. States report the Federal share through CMS–64 adjustments. Eligibility-related improper payments are addressed through the separate disallowance framework under section 1903(u) of the Act, including the 3 percent threshold and the good faith waiver provisions.

This proposed regulation may also have an impact on the States themselves, as they would be responsible for reporting and returning the Federal share through the standard CMS–64 reporting process, but we believe that the impact would be minimal because States already report and reconcile expenditures and recoveries through the CMS–64, which CMS reviews and finalizes quarterly. Given that States are already responsible for reporting and returning the Federal share of overpayments made in their FFS programs, we do not believe that there would be an appreciable increase in burden by clarifying these requirements in regulation, even if the regulation leads to increased reporting by providers. The steps to report this information in the CMS–64 are well established and would not require changes as a result of this regulation. We welcome public comments on our assumptions.

g. ICRs Regarding Enhanced Electronic Visit Verification (EVV) Requirements (42 CFR 447.45 and 455.14)

This rule proposes to amend §§ 455.14 and 447.45(f) to require SMAs to use EVV data for certain program integrity and improper payment oversight activities. We propose to amend § 455.14 to require that SMAs incorporate a review of EVV records as part of preliminary investigations into potential Medicaid fraud or abuse involving home-based service providers subject to Federal and State EVV requirements. We also propose to amend § 447.45 to require that SMAs verify that billed services are supported by EVV records during prepayment claims review, where applicable under Federal or State requirements. Specifically, we are proposing that for services subject to EVV, States verify during prepayment claims review that the following data elements are supported by an EVV record: (1) the type of service performed; (2) the individual receiving the service; (3) the date of service; (4) the location of service delivery; (5) the individual providing the service; and (6) the time the service begins and ends.

We do not believe that the proposed changes to §§ 447.45 and 455.14 would impose any new collection of information requirements. These regulatory changes do not require SMAs to report any new information to CMS or the public, just to update internal program integrity investigation and prepayment review processes. Additionally, the proposed requirement for SMAs to review available EVV data during preliminary investigations of applicable in-home service providers would be exempt from PRA requirements in accordance with § 1320.4(a)(2), which grants an exception to collection of information requirements during an investigation involving an agency against specific individuals or entities. As a result, the proposed EVV requirements are not subject to the requirements of the PRA.

3. Medicare Advantage and Medicare Part D Program Integrity

a. ICRs Relating to Risk Adjustment Data Validation (RADV) (42 CFR 422.300, 422.310, and 422.311)

Section 1853(a)(1)(C) of the Act requires that CMS risk-adjust payments made to MA organizations. Risk adjustment strengthens the MA program by ensuring that accurate payments are made to MA organizations based on the health status and demographic characteristics of their enrolled beneficiaries, and that MA organizations

are paid appropriately for their plan enrollees (that is, less for healthier enrollees who are expected to incur lower health care costs, and more for less healthy enrollees who are expected to incur higher health care costs). Making accurate payments to MA organizations also ensures we are safeguarding Federal taxpayer dollars.

The diagnosis data that MA organizations submit to CMS does not undergo a validation review by CMS before being relied on by CMS to calculate each enrollee's risk score and make payments. CMS conducts post-payment audits of diagnosis data submitted by MA organizations from a selection of MA organizations for specific payment years to ensure that the diagnoses they submitted are supported by their enrollees' medical records. These audits are called contract-specific MA Risk Adjustment Data Validation (RADV) program audits. CMS conducts RADV audits, which require MA organizations to submit a sample of medical records to CMS for validation of risk adjustment data pursuant to 42 CFR 422.310(e).

In the event MA organizations experience extraordinary circumstances beyond their control that may make it difficult to meet medical record submission or other audit requirements, they may request a hardship exception. MA organizations requesting a hardship exception are required to submit supporting documentation that clearly demonstrates extraordinary circumstances exists and includes all relevant details required for CMS to comprehensively assess the incident or issue. Supporting documentation includes, but is not limited to, any communications associated with the incident and all available evidence substantiating that the incident occurred.

Collection of information to conduct contract-specific RADV audits was previously included in CMS–10191, which expired on June 30, 2023. CMS–10191 has since been replaced by a more streamlined collection of information under OMB control number: 0938–1395 (Expiration date: January 31, 2027).[210] The information collection request is specific to CMS' compliance audits designed to ensure MA organizations comply with all Medicare Parts C and D program requirements. This is accomplished by conducting audits that focus on high-risk areas with the greatest potential for beneficiary harm, thereby strengthening CMS' oversight and accountability framework for MA organizations. Therefore, CMS is proposing a new collection that includes RADV audits, as CMS has determined that the collection of information pursuant to contract-specific RADV audits should be included in its own dedicated PRA package.

The discussion in this section informs the public of the information collected in connection with and to comply with contract-specific RADV audit requirements.

b. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2025 National Occupational Employment and Wage Estimates for all salary estimates (*https://data.bls.gov/oes/#/area/0000000/2025*). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage. We selected the following personnel for our burden estimate based on our previous experiences conducting similar Part C program audits.

TABLE C-A11 NATIONAL OCCUPATIONAL MEAN HOURLY WAGE AND ADJUSTED HOURLY WAGE

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr.)	Fringe Benefit ($/hr.)	Adjusted Hourly Wage ($/hr.)
Medical and Health Services Managers	11-9111	67.77	67.77	135.54
Legal Support Workers, All Other	23-2099	43.10	43.10	86.20
Medical Records Specialists	29-2072	27.30	27.30	54.60
Medical Secretaries and Administrative Assistants	43-6013	22.50	22.50	45.00

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

The following table shows the burden (hours) and total cost by occupation, and total cost for an average audited contract. The average hourly wage for the RADV audit information collection is $52.05, which is derived by dividing Total Cost ($37,946.48) by the Burden (729) (see Table C–A12).

[210] *https://www.federalregister.gov/documents/2026/07/06/2026-13603/agency-information-collection-activities-submission-for-omb-review-comment-request.*

TABLE C-A12 NATIONAL OCCUPATIONAL MEAN HOURLY WAGE AND ADJUSTED HOURLY WAGE

Occupation	Adj Hourly Wage	Burden (Hours)	Total Cost
Medical and Health Service Managers	$135.54	21.4	$2,900.56
Legal Support Workers, All Other	$86.20	21.4	$1,844.68
Medical Records Specialists	$54.60	241.9	$13,207.74
Medical Secretaries and Administrative Assistants	$45.00	444.3	$19,993.50
Total		**729**	**$37,946.48**

Table C–A13 shows the burden (hours) and total cost by occupation, and total cost for an average audited contract. The average hourly wage for the Hardship Exception information collection is $59.55, which is derived by dividing Total Cost ($595.47) by the Burden (10).

TABLE C-A13 NATIONAL OCCUPATIONAL MEAN HOURLY WAGE AND ADJUSTED HOURLY WAGE

Occupation	Adj Hourly Wage	Burden (Hours)	Total Cost
Medical and Health Service Managers	$135.54	0.5	$67.77
Legal Support Workers, All Other	$86.20	1.5	$129.30
Medical Records Specialists	$54.60	4	$218.40
Medical Secretaries and Administrative Assistants	$45.00	4	$180.00
Total		**10**	**$595.47**

c. Burden Summary

Based on our audit strategy, contract-specific audits are conducted for each payment year. For each MA organization, we estimate an average of 729 hours for administrative and systemic work to assemble the requested information, review the information for completeness, and submit the information to CMS.

CMS announced an aggressive strategy to enhance and accelerate MA audits in May 2025.[211] This strategy included increasing the number of eligible MA contracts selected for audits. CMS identified enrollees that it believes are at most risk for being associated with payment error in MA and focused audits on these enrollees. However, some contracts that did not have enrollees that met the top 25 percent threshold were subject to random selection for audits. CMS estimates it will include approximately 492 contracts for payment years 2022 and 2023 RADV audits and approximately 590 MA contracts in payment year 2025 and later payment years using this methodology.

Based on prior contract-specific RADV audits, approximately 50 percent of MA organizations' contracts submit hardship exception requests. On average, it takes an MA organization 10 hours to review the requirements and complete and submit a hardship exception request with all required supporting documentation. Information collected by MA organizations during an audit will also be used to compile the information as part of a hardship exception request, reducing duplicative effort.

MA organizations that want to submit hardship exception requests must submit required information and upload relevant supporting documents in the RADV secure system, the Centralized Data Abstraction Tool (CDAT). Each hardship exception request must include hardship justification and supporting documentation. Additionally, MA organizations must designate the type of hardship exception request they are submitting: contract, enrollee, or HCC.

TABLE C-A14: TOTAL COST OF PROPOSED POLICIES BY YEAR (in Millions)

ICR	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
RADV Audit	$59.73	$22.39	$22.39	$22.39	$22.39	$22.39	$22.39	$22.39	$22.39	$22.39	$261.24
Hardship Exceptions	$0.47	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$2.09
Total	$60.20	$22.57	$22.57	$22.57	$22.57	$22.57	$22.57	$22.57	$22.57	$22.57	$263.33

[211] *https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-accelerate-medicare-advantage-audits.*

Proposed Information Collection Requirements and Burden

b. ICRs RADV Data Validation (§ 422.300)

The proposed changes will be submitted to OMB for review under control number 0938–NEW (CMS–10980).

CMS conducts contract-specific RADV audits each payment year on MA contracts meeting its audit criteria, covering approximately 590 MA contracts per payment year. Each audited HCC requires one submitted medical record, totaling approximately 336 medical records per contract. CMS estimates 729 hours per contract to respond to the audit (see Table C–A15).

TABLE C-A15: RADV AUDIT ICRs

Information Collection	No. of Respondents	Responses (per Respondent)	Total Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($/hr)	Total Cost
RADV audits	590	336	198,240	729	430,110	$52.05	$22,388,421

c. ICRs Extrapolation (§ 422.310(e))

The proposed provision would not impose any new or revised information collection requirements (that is, reporting, recordkeeping, or third-party disclosure requirements) or burden since the utilization of extrapolation will not affect the existing process for MA organizations submitting medical record documentation pursuant to RADV audits. Consequently, the provisions are not subject to the PRA.

d. ICRs Hardship Exception Request (§ 422.310(e)(1))

The proposed changes will be submitted to OMB for review under control number 0938–NEW (CMS–10980).

Based on prior contract-specific RADV audits, approximately 50 percent of MA organizations' contracts submit a hardship exception request. On average, an MA organization takes 10 hours to review the requirements, complete, and submit a hardship exception request with all required supporting documentation. Information MA organizations collect during an audit will also be used to compile the hardship exception request, reducing duplicate effort.

TABLE C-A16: HARDSHIP REQUEST ICRs

Information Collection	No. of Respondents	Responses per Respondent	Total Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($/hr)	Total Cost ($)
Hardship exception request	295	1	295	10	2,950	59.55	175,664

e. ICRs RADV Audit Dispute and Appeal Procedures (§ 422.311)

Upon conclusion of a RADV audit, MA organizations are afforded an opportunity to appeal their audit findings pursuant to 42 CFR 422.311(c). In accordance with the implementing regulations at 5 CFR 1320.4(a)(2), the burden associated with information collected during the conduct of an administrative action is not subject to the PRA. Additional information collected by CMS from MA organizations in connection with RADV appeals is exempt from the PRA because the data collection is a result of an administrative action. Therefore, we have not provided burden estimates for this task.

f. ICRs Relating to Mandatory Reporting of Fraud, Waste, and Abuse (42 CFR 422.500, 422.503 and 423.504)

The following changes will be submitted to OMB for approval under control numbers 0938–1383 (CMS–10724) for MA organizations and 0938–1262 (CMS–10517) for Part D plans.

The modified sections at 42 CFR 422.503(b)(4)(vi)(G)(*3*)(*i*) and 423.504(b)(4)(vi)(G)(*3*)(*i*) and 42 CFR 422.503(b)(4)(vi)(G)(*3*)(*iii*) and 423.504(b)(4)(vi)(G)(*3*)(*iii*) will require MA organizations and Part D plan sponsors, respectively, to have procedures to identify and report to CMS or its designee: (1) any payment suspension implemented by an MA organization or Part D plan sponsor, pending investigation of credible allegations of fraud, which must be implemented in the same manner as the Secretary's requirement under section 1862(o)(1) of the Act; and (2) any substantiated or suspicious activities of a provider of services (including a prescriber) or a supplier related to fraud, waste or abuse for initiating or assisting investigations conducted by CMS, or its designee, a Medicare program integrity contractor, or law enforcement partners.

Beginning January 1, 2022, CMS implemented requirements of sections 2008 and 6063 of the SUPPORT Act, which included the establishment of the HPMS FWA Reporting Module. Since that time, Medicare Part C and Part D plan sponsors have submitted referrals of payment suspensions for other provider types and substantiated or suspicious FWA at their discretion. As such, CMS is able to use the submission data as a method of estimating the number of referrals of substantiated or suspicious FWA to the HPMS FWA Reporting Module annually, through a frequency report.[212]

For calendar year 2025, individual MA organization and Part D plan sponsor contracts submitted 1,788 referrals for payment suspensions for credible allegations of fraud that were for all provider and supplier types, based on an HPMS frequency report. CMS then utilized the 2025 Quarterly

[212] A frequency report is an internal report CMS is able to pull within the HPMS FWA Reporting Module. It allows CMS to see, for a specified timeframe, the frequency a contract has made referrals for each reporting period.

FWA Reports to estimate that approximately 782 of those referrals were for payment suspensions of entities other than pharmacies. For the 2025 calendar year, based on an HPMS frequency report, individual MA organization and Part D plan sponsor contracts submitted 8,062 referrals of substantiated or suspicious FWA submissions to the HPMS FWA Reporting Module. These payment suspensions and substantiated or suspicious FWA submissions were made by 19 percent and 46 percent of the 2025 contracts, respectively. CMS believes it is reasonable to make a few assumptions:

- Not all contracts currently report referrals for payment suspensions based on credible allegations of fraud for providers and suppliers outside of pharmacies, as such reporting is not currently required.
- Not all contracts currently report referrals of substantiated or suspicious FWA to CMS, even when the referral meets the definition at 42 CFR 422.500 and 423.4, as such reporting is not currently required.
- Not all contracts will have a referral each year that meets the definition at 42 CFR 405.370, 455.2 and 423.4 for credible allegation of fraud.
- Not all contracts will have a referral each year that meets the definition at 42 CFR 422.500 and 423.4 for substantiated or suspicious FWA.
- The plan sponsors are already familiar with the HPMS FWA Reporting Module; therefore, the estimated burden is reasonably expected to be the same across all years. CMS expects no increased burden in the first year as there is no need to establish new processes for reporting.

Given these assumptions, CMS believes that multiplying the number of payment suspensions by a factor of 5 and doubling the number of referrals received for substantiated or suspicious FWA in calendar year 2025 would be reasonable to estimate the number of submissions per calendar year and determine annual burden. We estimate that there would be 20,034 ($782 \times 5 + 8{,}062 \times 2$) referrals each calendar year. The burden consists of the time and effort needed to prepare and report the information for payment suspensions based on credible allegations of fraud and referrals of substantiated or suspicious FWA to CMS. The reporting across plan sponsors and contracts will not be consistent based on many varying factors such as size of beneficiary enrollment and internal policies and procedures. As such, CMS cannot reasonably estimate which plan sponsors may have higher or lower reporting. We propose to create an estimate based on average reporting across all plan sponsors. For the 2027 plan year, there are 769 MA organization and PDP contracts in total or 722 MAO contracts and 47 PDP contracts when separated. We estimate there will be approximately 26 annual referrals on average per plan sponsor (20,034 referrals/769 MA organizations and PDP plans). We estimate each referral would take approximately 30 minutes to complete, resulting in approximately 13 hours (26 annual referrals/0.5 hr) spent on referrals for each plan sponsor.

Therefore, we estimate it would take 722 MA organizations 9,386 hours (722 plans $\times$ 13 hrs/plan) at a cost of $1,027,016.12 (9,386 hrs $\times$ $109.42/hr for a management analyst using 2025 BLS wage estimates) to fulfill the reporting requirements annually as shown in Table C–A18.

We estimate it would take 47 Part D plan sponsors 611 hours (47 plans $\times$ 13 hrs/plan) at a cost of $66,855.62 (611 hrs $\times$ $109.42/hr) to fulfill the reporting requirements annually as shown in Table C–A18.

TABLE C-A18: MA ORGANIZATION AND PART D PLAN SPONSOR BURDEN ESTIMATES

Regulatory Citation	OMB Control Number	Response Summary	Total Number of Respondents	Time per Respondent (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Cost Annually ($)
§ 422.503(b)(4)(vi)(G)(*3*)	0938-1383	MA organizations report payment suspensions and FWA	722	13	9,386	109.42	1,027,016.12
§ 423.504(b)(4)(vi)(G)(*3*)	0938-1262	Part D plan sponsors report payment suspensions and FWA	47	13	611	109.42	66,855.62
TOTAL*			769	13	9,997	109.42	1,093,871.74

We solicit comments on our proposed provisions, burden estimates, and assumptions.

4. ICRs Related to Medicare Provider Enrollment Provisions

This section discusses the ICR burdens associated with our proposed Medicare provider enrollment provisions. Two sets of provisions are addressed: (1) those that impose an ICR burden; and (2) those that do not but which require further explanation. Provisions that are not mentioned have no ICR impact. For purposes of obtaining approval from the Office of Management and Budget (OMB) for the following information collection requirements, all burden estimates are based on a standard 3-year approval.

Table C–A19 lists the Bureau of Labor Statistics (BLS) hourly wage estimates (see *https://data.bls.gov/oes/#/area/0000000/2025*) for the occupational categories used in this section.

TABLE C-A19: MAY 2025 BLS NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Office and Administrative Support Workers, All Other	43-9199	23.40	23.40	46.80
Business and Financial Operations Occupations	13-0000	45.78	45.78	91.56
General and Operations Managers	11-1021	64.87	64.87	129.74
Physicians	29-1210	133.30	133.30	266.60
Healthcare Diagnosing or Treating Practitioners	29-1000	63.46	63.46	126.92

a. Surety Bonds (§ 424.57(d)(16))

Under proposed new § 424.57(d)(16), CMS could decline to accept DMEPOS surety bonds from an authorized surety when the surety has not paid or satisfied an administratively final bond obligation that is owed to CMS. CMS notifies the surety in writing of its intention to do so and gives the surety 15 days to submit a rebuttal.

In accordance with the implementing regulations of the PRA at 5 CFR 1320.4(a)(2), information collected as part of or subsequent to an administrative action is not subject to the PRA. We believe CMS' declining to accept DMEPOS surety bonds from an authorized surety when the surety has not paid or satisfied an administratively final bond obligation that is owed to CMS is an administrative action. Therefore, we are not assigning burden to the rebuttal process.

b. Reporting of Additional Information on the Form CMS–855S

We are proposing in new § 424.57(i) to require all DMEPOS suppliers to report on the Form CMS–855S application (or its successor form) all domestic and foreign entities and individuals that:

- Perform any marketing service of any type for the supplier.
- Furnish DMEPOS items or services to beneficiaries on the supplier's behalf, such as fulfillment companies.
- Are wholesalers from which the supplier purchases DMEPOS items for provision to the supplier's beneficiaries.

c. Initial Enrollments, Revalidations, Reactivations, and CIMOs

There are presently about 70,616 enrolled DMEPOS suppliers, with approximately 5,167 suppliers submitting initial enrollment applications each year. (This includes suppliers that are undergoing a § 424.551 CIMO.) Approximately 5,176 DMEPOS suppliers each year submit reactivation applications and 17,413 submit revalidation applications; reactivation and revalidation applications require completion of the entire Form CMS–855S.

Based on projections we have made regarding previous additions of data elements to the Form CMS–855S, we estimate that it would take the supplier 0.67 hours to prepare and provide this information. Consistent with prior Form CMS–855S burden estimates, we believe that office and administrative staff would gather and submit said data; hence, we will use Table C20's $46.80 figure (with FBO) for such personnel. The resulting ICR burdens by application type can be found in Table C–A20.

TABLE C-A20: PROPOSED § 424.57() ICR BURDEN ESTIMATES FOR CERTAIN FORM CMS-855S CATEGORIES

Form CMS-855S Application Type	Annual Number of Submissions	Total Hour Burden (Annual Submissions x 0.67)	Total Cost Burden (Total Hour Burden x $46.80)
Initial (Including CIMOs)	5,167	3,462	$162,022
Reactivations	5,176	3,468	$162,302
Revalidations	17,413	11,667	$546,016
Total	**27,747**	**18,597**	**$870,340**

d. Changes of Information (COIs)

Among our proposals is that providers and suppliers must report any change in their enrollment information within 30 days of the change. This would include changes in § 424.57(i) data. As this is new data on the Form CMS–855S, we have no history we can use to reliably project the number of § 424.57(i) COIs that would be submitted. Solely to solicit comment to help us prepare an estimate, we tentatively project that 2,500 DMEPOS suppliers per year would submit such COIs and—in line with our current COI time estimates—that it would take each supplier 1 hour to do so.

We believe the supplier's office staff (with the $46.80 hourly wage) would prepare and submit these COIs. Consistent with current Form CMS–855S burden estimates: prepare and submit these COIs. Consistent with current Form CMS–855S burden estimates:

- The COI would be signed by either an authorized or delegated official of the supplier (if the latter is an entity) or the physician if the supplier is an individual.
- The applicable BLS wage categories for these signatories are: (1) General and Operations Managers (GOM) (for authorized officials and delegated officials as those terms are defined in § 424.502); and (2) Physicians. The mean GOM wage with FBO is $129.74; it is $266.60 for physicians.

• About 80 percent of the 1-hour COI burden would be incurred by the office employee in preparing and sending the COI. The manager or physician would incur the remaining 0.2 hours in reviewing and signing the COI.

• Approximately 75 percent of Form CMS–855S applications (including COIs) are submitted by DMEPOS supplier organizations and the remaining 25 percent by DMEPOS supplier physicians.

Applying an annual time burden of 2,500 hours (2,500 suppliers × 1 hour), the foregoing results in the following burden estimates.

TABLE C-A21: Proposed § 424.57(i) ICR Burden Estimates for Form CMS-855S COIs

Submitter	Total Hour Breakdown	Total Cost Breakdown
DMEPOS Supplier Entity	1,500 Hours for Office Staff (2,500 x 0.8 x 0.75) 375 Hours for Managers (2,500 x 0.2 x 0.75)	$70,200 (1,500 x $46.80) for Office Staff $48,653 (375 x $129.74) for Managers
DMEPOS Supplier Physician	500 Hours for Office Staff (2,500 x 0.8 x 0.25) 125 Hours for Physicians (2,500 x 0.2 x 0.25)	$23,400 (500 x $46.80) for Office Staff $33,325 (125 x $266.60) for Physicians
Totals	2,500	$175,578

e. Documentation Verifying Identity and Other Information (§ 424.510(d)(2))

Under existing § 424.510(d)(2)(ii), providers and suppliers (hereafter occasionally ''providers'') must submit all documentation required by CMS to uniquely identify the provider. Proposed revised § 424.510(d)(2)(ii) would: (1) list types of documentation that could fall within said paragraph's purview; and (2) clarify that § 424.510(d)(2)(ii) includes documentation pertaining to the provider's owners and managing employees. Current § 424.510(d)(2)(iii)(C), meanwhile, requires the provider to submit any other documentation needed to verify and confirm the information on the enrollment application, including documentation regarding ownership or management. Proposed revised § 424.510(d)(2)(iii)(C) would make clear that this includes domestic and foreign owners and managers.

We believe the documentation categories in existing § 424.510(d)(2)(ii) and (d)(2)(iii)(C) already effectively capture the documents we are proposing to reference in these paragraphs. While this might indicate no additional ICR burden, it is possible that revised § 424.510(d)(2)(ii) and (d)(2)(iii)(C) would trigger additional documentation requests. We cannot predict the number of such requests or the types of documentation that would be involved. Yet we believe a general estimate, solely for purposes of this ICR section, is feasible.

Since the provider's office personnel would likely compile and provide this documentation, we will use the aforementioned $46.80 wage rate. We estimate that: (1) roughly 1,000 additional requests would be made annually; and (2) it would take the provider 15 minutes (0.25 hr.) to furnish the data. The annual burden would thus be 250 hours (1,000 × 0.25 hrs.) and $11,700 ($46.80 × 250).

f. ICRs Regarding the Enrollment of MA Providers, Suppliers, and First-Tier, Downstream, and Related Entities (FDRs) (§ 422.223)

We are proposing in new § 422.223 to require providers and suppliers that bill MA for services and items furnished to MA beneficiaries to be enrolled in Medicare fee-for-service (FFS) in order to receive payment. There are over 2 million providers and suppliers nationwide that are enrolled in Medicare FFS. Through our analysis of currently available MA encounter data, roughly 149,751 providers and suppliers that currently bill MA are not FFS-enrolled and would thus have to enroll under our proposed requirement. These providers and suppliers are of the types that would, per our internal data, complete the following applications according to the following estimates:

- Form CMS–855A (Medicare Enrollment Application: Institutional Providers (OMB Control No. 0938–0685))—6,409 providers and suppliers
- Form CMS–855B (Medicare Enrollment Application: Clinics/Group Practices and Other Suppliers (OMB Control No. 0938–1377))—28,693 suppliers
- Form CMS–855I (Medicare Enrollment Application: Physicians and Non-Physician Practitioners (OMB Control No. 0938–1355) — 111,960 physicians and practitioners
- Form CMS–855S—2,689 DMEPOS suppliers

Consistent with prior ICR estimates we have made, the hour burdens for completing these applications are 4 hours for the Form CMS–855A, 3 hours for the Form CMS–855B, 3 hours for the Form CMS–855I, and 3 hours for the Form CMS–855S. These forms are typically completed by office and administrative staff (Occupation Code 43–9199). The Forms CMS–855A, B, and S are signed by general and operations managers (Occupation Code 11–1021). About 75 percent of Form CMS–855I applications are signed by physicians and the remaining 25 percent by healthcare practitioners (Occupational Code 29–1000). Using the hourly wage figures in Table C–A22, this results in the following burden estimate over the first 3 years of the requirements.

TABLE C-A22: HOUR AND COST ESTIMATES IN FIRST 3 YEARS OF MA ENROLLMENT REQUIREMENT

Form Type	Hour Burden and Associated Wage	Total Number of Application Submissions	Total Hour Burden	Cost Per Application	Total Cost
CMS-855A	3.5 hrs (Office Staff ($46.80)) + 0.5 hours (Manager ($129.74))	6,409	25,636	$228.67 ((3.5 x $46.80) + (0.5 x 129.74))	$1,465,546
CMS-855B	2.5 hrs (Office Staff ($46.80)) + 0.5 hours (Manager ($129.74))	28,693	86,079	$181.87 ((2.5 x $46.80) + (0.5 x 129.74))	$5,218,396
CMS-855I	2.5 hrs (Office Staff ($46.80)) + 0.5 hours (Physician/$266.60 or Practitioner/$126.92)	111,960 (Physicians – 83,970 applications; Practitioners – 27,990)	335,880	Physicians - $250.30 ((2.5 x $46.80) + (0.5 x $266.60)) Practitioners - $180.46 ((2.5 x $46.80) + (0.5 x $126.92))	$26,068,766 (Physicians: $21,017,691 + Practitioners: $5,051,075)
CMS-855S	2.5 hrs (Office Staff ($46.80)) + 0.5 hours ((Manager ($129.74))	2,689	8,067	$181.87 ((2.5 x $46.80) + (0.5 x 129.74))	$489,048
Total	**N/A**	**149,751**	**455,662**	**N/A**	**$33,241,756**

The foregoing results in an average annual burden in the first 3 years of this requirement of 151,887 hours and $11,080,585. We request feedback from stakeholders as to the number of CMS–855 changes of information these newly enrolling providers and suppliers might submit during this 3-year period.

g. Medicaid or CHIP Denial and Termination Data (New § 455.418)

Per proposed new § 455.418, each State would have to submit to CMS on a monthly basis—and in a format required by CMS—the legal business and doing business names, address, tax identification number, and National Provider Identifier of each Medicaid or CHIP provider that, within the applicable monthly period, the State: (1) denied or terminated under § 455.416; or (2) was required to deny or terminate under § 455.416 but declined to do so because the State determined that a denial or termination was not in Medicaid's best interests. As part of this, the State must cite the regulatory basis involved, the facts of the case, and an explanation (with, as applicable, supporting rationale) for its decision.

Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States. The time it would take for each State to submit its report would vary by State and month (for example, larger States may have more denials and terminations to disclose). Strictly to establish an estimate, we project that the average hour burden for each report would be 1.5 hours. Concerning costs, we estimate that the data would be prepared and submitted to CMS by one State Medicaid official with an hourly wage equivalent to that of a GS–9, Step 5 Federal employee in the Washington, DC/Baltimore/Arlington payment locality, or $38.35.[213] The figure is $76.70 with FBO. The consequent annual ICR burden would be 1,008 hours (56 programs × 12 reports/program × 1.5 hours/program) with a $77,314 cost (1,008 hours × $76.70/hour).

h. Reporting COIs Within 30 Days

Under our existing regulations, certain changes in Medicare enrollment information must be reported within 30 calendar days of the change while others must be disclosed within 90 days. As earlier indicated, we are proposing a standard 30-day timeframe for all such changes. As with past Medicare provider enrollment rulemaking where we have reduced submission timeframes to 30 days for certain changed data, we do not believe this regulatory revision would increase the currently approved ICR burden of COI submissions. This is because COIs must still be submitted irrespective of whether a 30-day or 90-day deadline applies.

i. Total Projected Burden

Table C–A23 outlines the estimated annual hour and cost ICR burdens of our provider enrollment proposals.

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[213] *https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2026/DCB_h.pdf.*

TABLE C-A23: ANNUAL ICR BURDEN OF PROPOSED PROVIDER ENROLLMENT PROVISIONS OVER 3-YEAR PERIOD

Provision/Requirement	OMB Number	Number of Respondents	Number of Responses	Burden per Response (Hours)	Total Annual Burden (Hours)	Hourly Wage (Includes Fringe Benefits and Overhead) ($)	Total Cost
Form CMS-855S Initial Enrollments (Including Changes in Majority Ownership that Require a New Enrollment) – Disclosing Additional Parties (§ 424.57(i))	0938-1056	5,167	5,167	0.67	3,462	46.80	$162,022
Form CMS-855S Reactivations - Disclosing Additional Parties (§ 424.57(i))	0938-1056	5,176	5,176	0.67	3,468	46.80	$162,302
Form CMS-855S Revalidations - Disclosing Additional Parties (§ 424.57(i))	0938-1056	17,413	17,413	0.67	11,667	46.80	$546,016
Form CMS-855S Changes of Information - Disclosing Additional Parties (§ 424.57(i))	0938-1056	2,500	2,500	1	2,500	Varies	$175,578
Documentation Verifying Identity and Other Information (§ 424.510(d))	0938-New	1,000	1,000	0.25	250	46.80	$11,700
State Reports on Medicaid & CHIP Denials and Terminations (§ 455.418)	0938-New	56	672	1.5	1,008	76.70	$77,314
MA Enrollment Requirements (Forms CMS-855A, CMS-855B, CMS-855I, and CMS-855S)*		Varies	Varies	Varies	151,887	Varies	$11,080,585
TOTALS	**N/A**	**31,312**	**31,928**	**Varies**	**174,242**	**Varies**	**$12,215,517**

* See Table C-A23 – Hour and Cost Estimates in First 3 Years of MA Enrollment Requirement for more information.

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Per Table C–A23, we project in each of the first 3 years of our proposed provider enrollment requirements an average annual ICR burden of 174,242 hours and $12,215,517.

5. Marketplace Program Integrity

a. Strengthening Oversight of Agents, Brokers, and Web-Brokers in the Marketplace

This rule proposes a number of additions and amendments to 45 CFR 155.20 and § 155.220 to improve the integrity of the Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE–FPs), reduce abusive conduct by agents, brokers, and web-brokers, and better protect consumers within the FFEs and SBE–FPs. We are proposing to amend § 155.20 to add definitions of ''convicted'' and ''credible allegation of abusive conduct.'' We are also proposing to add participation standards for agents and brokers to § 155.220(g)(3), which would prevent agents and brokers that pose an undue risk from participating in the FFE. Additionally, we are proposing to amend § 155.220(g)(5) to increase transparency around program integrity oversight of the FFEs and SBE–FPs and further strengthen our administrative actions against suspected bad actors and amend § 155.220(j)(2)(i) and (ii) by adding specific examples of behavior that CMS considers abusive conduct.

To further strengthen oversight and improve the fairness of enforcement proceedings following findings of agent, broker, and web-broker noncompliance as defined in § 155.220(g)(2), we are proposing additional revisions to § 155.220. Specifically, to increase transparency and to help ensure accuracy and efficiency in CMS noncompliance determinations and resulting enforcement actions, we propose to amend § 155.220(g)(3)(i) to replace the existing opportunity for agents, brokers, and web-brokers to ''resolve'' noncompliance determinations before CMS terminates their Exchange Agreements(s) Exchange agreement(s) and imposes other penalties with an opportunity to

''refute.'' We also propose to codify factors that CMS would consider when determining whether to terminate an agent, broker, or web-broker's Exchange agreement(s) for cause and to impose other penalties under § 155.220(k)(1) after making a noncompliance determination. In addition, we propose to amend § 155.220(h) to clarify that agents, brokers, or web-brokers may request reconsideration when HHS denies them the right to enter into Exchange agreement(s) in addition to when CMS terminates their Exchange agreement(s) for cause.

We also propose to add a new standard in § 155.220(j) to codify a term in the existing Exchange Agreements, requiring agents, brokers, and web-brokers to implement and maintain reasonable safeguards to ensure that access and attempted access to the FFEs and SBE–FPs, systems that support the FFEs and SBE–FPs, and personally identifiable information obtained through the FFEs and SBE–FPs occur only from locations within the United States.

We do not believe that the proposed changes to § 155.20 and § 155.220 would impose any new collection of information requirements. Agents, brokers, and web-brokers may be asked to submit documentation over the course of a noncompliance or abusive conduct investigation and enforcement action, as well as for potential referral for nonprocurement suspension and debarment. However, CMS believes these changes would be exempt from the PRA requirements as stated in 5 CFR 1320.4(a)(2), because the collection would occur during the conduct of an investigation and/or administrative action. The proposed changes to §§ 155.20 and 155.220 are not subject to the requirements of the PRA.

6. ICRs Relating to Clarification of Existing Unsolicited Beneficiary Contact Requirement and Adding a New Unsolicited Beneficiary Contact Prohibition (42 CFR 424.57(c)(11) and (c)(31))

In section VIII. of this proposed rule, we propose to clarify the existing prohibition against unsolicited beneficiary contact by DMEPOS suppliers at 42 CFR 424.57(c)(11) to make explicit the inclusion of third-party entities acting as the agents of DMEPOS suppliers; and to clarify that the prohibition against unsolicited beneficiary contact by telephone refers to a telephone call or message, including text messages. In addition, we propose to add a new supplier standard under 42 CFR 424.57(c)(31) to prohibit unsolicited beneficiary contact by DMEPOS suppliers and their agents when supplying a Medicare-covered item by direct messages from social media platforms, email message without opt-out features, and door-to-door in-person solicitation, unless a specified exception applies.

While there is burden associated with complying with this standard, we believe it is exempt from the PRA as stated in 5 CFR 1320.3(b)(2), to the extent that the time, effort, and financial resources necessary to comply with the information collection requirements would be incurred by DMEPOS suppliers in the normal course of their activities.

DMEPOS suppliers have been prohibited from engaging in unsolicited beneficiary contact by telephone when supplying a Medicare-covered item for decades. The current regulation (42 CFR 424.57(c)(11)) requires the DMEPOS supplier to obtain written permission from the beneficiary to allow telephone contact, or, in the alternative, that the DMEPOS supplier has furnished a Medicare-covered item to a beneficiary and is coordinating delivery or has furnished a covered item to the beneficiary during the 15-month period preceding the date of contact. Further, CMS' and HHS–OIG's interpretation of the current provisions already prohibits a DMEPOS supplier's agents from engaging in unsolicited telephone calls to beneficiaries. Given the existing requirements, DMEPOS suppliers typically maintain such policies and records as a usual and customary business practice.

We solicit comments on our proposed provisions, burden estimates, and assumptions.

C. Summary of Collection of Information Burden and Savings Estimates for Proposed Requirements

TABLE C-A24: SUMMARY OF PROPOSED COLLECTION OF INFORMATION BURDEN ESTIMATES (IN MILLIONS)

Policy Area	Associated Burden Estimates
Medicaid and CHIP Program Integrity ICR Cost Savings to States	($69.75)
Medicare Advantage and Medicare Part D Program Integrity ICR Costs	$274.23
Provider Enrollment Program Integrity ICR Costs	$122.20
Marketplace Program Integrity ICR Costs	N/A
Clarifying Existing Requirement and Adding a New Unsolicited Beneficiary Contact Provision ICR Costs	N/A
Total Associated Burden Estimate	**$326.68**

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed previously, please visit the CMS website at *https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing,* or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** sections of this proposed rule and identify the rule (CMS–6098–F, RIN 0938–AV97), the ICR's CFR citation, and the OMB control number.

IX. Regulatory Impact Analysis

A. Statement of Need

CMS' current Original Medicare, Medicaid and CHIP, Medicare Advantage, Medicare Part D, and Marketplace program integrity frameworks contain outdated, inconsistent, or incomplete requirements across several regulatory areas. These gaps limit CMS' ability to

detect fraud, hold States accountable, and recover improper payments. The proposals below address these gaps by modernizing reporting, clarifying enforcement authority, and closing structural vulnerabilities in oversight tools. CMS seeks public comments on all assumptions and estimates related to stakeholders impacted, benefits, costs, and transfers as part of these provisions.

1. Medicaid and CHIP Program Integrity

a. PERM CAPs (§§ 431.992(a), (b)(3)(ii)(E), (b)(3)(ii)(F), (c), and (e) and 431.1010(b)(2)(ii))

Section 431.992 currently requires each State selected for a Payment Error Rate Measurement (PERM) review to develop separate Medicaid and Children's Health Insurance Program (CHIP) corrective action plans (CAPs) for each improper payment rate measurement. Each CAP must address the State's PERM errors and deficiencies and include an error analysis, corrective actions, an implementation schedule and monitoring plan, and an evaluation of the CAP from the previous measurement. States must submit and begin implementing the CAP no later than 90 calendar days after their improper payment rates are posted and must provide implementation updates annually and upon request. A State with an eligibility improper payment rate above 3 percent for consecutive PERM years must also submit implementation updates every other month.

Although the existing requirements provide an important framework for addressing PERM errors and deficiencies, the current process requires each State to prepare and submit two CAPs—one for Medicaid and one for CHIP—even when the two submissions include similar information. The every-other-month update requirement also results in six responses each year for affected States. In addition, CMS currently reviews State CAPs and requests revisions when a submission does not sufficiently address the applicable requirements, but § 431.992 does not expressly set out an approval, revision, and disapproval process.

To reduce duplicative administrative work and clarify the CAP process, we propose to revise § 431.992(a) to require one combined Medicaid and CHIP PERM CAP while preserving the separate program requirements through program-specific identification of each error, deficiency, and CAP element. We also propose to revise § 431.992(b)(3)(ii)(E) and add § 431.992(b)(3)(ii)(F) to clarify the monitoring and effectiveness-evaluation information included in the CAP; establish at § 431.992(c) a CMS approval, revision, and disapproval process with a defined 90-calendar-day correction period; and revise § 431.992(e) to reduce eligibility corrective action implementation updates from every other month to every 6 months. Under proposed § 455.804, implementation of a CMS-approved Medicaid PERM CAP would be a condition for approval of a good faith waiver of an eligibility-related disallowance, but would not require a separate submission.

b. Medicaid and CHIP Managed Care Oversight Policies

States generally pay Medicaid managed care plans a per member per month capitation payment to provide a specified benefit package. These payments are made for Medicaid-eligible enrollees regardless of whether an enrollee uses services in a given month. Under § 438.3(c)(2), managed care plans may retain capitation payments only for Medicaid-eligible enrollees. States also must ensure that capitation rates are actuarially sound and reflect the reasonable, appropriate, and attainable costs of providing services under the contract, as required by § 438.4(a).

Existing requirements provide a foundation for preventing payments on behalf of individuals who are no longer eligible, but they do not fully address how changes in an enrollee's circumstances are reported and how resulting capitation overpayments are recovered. Section 438.608(a)(3) requires managed care plans to promptly notify the State when they receive information about changes in an enrollee's circumstances that may affect an enrollee's eligibility, including a change of address or death. The regulation does not define ''prompt'' or require states to specify procedures for receiving these reports. As a result, states and plans may learn of or act on changes at different times. An out-of-state move or death may go unreported while capitation payments continue, and an in-state move may leave an enrollee assigned to a plan whose service area no longer includes the enrollee's residence.

Federal oversight has demonstrated the financial significance of these gaps. A Department of Health and Human Services Office of Inspector General (HHS–OIG) review found that Medicaid incurred approximately $117.1 million in capitation costs in August 2020 associated with beneficiaries concurrently enrolled in managed care programs in two states. Separate HHS–OIG audits of 14 states identified more than $249 million in unallowable capitation payments made on behalf of deceased enrollees, including $172 million in Federal funds. CMS has also identified practical barriers to recovery, including uncertainty about the date of an out-of-state relocation and managed care contracts that do not clearly address recovery of the associated payments.

Limited State access to data and the current regulatory ambiguity create a need for clearer, more consistent requirements that allow states to identify these changes, determine their effect on eligibility and plan enrollment, and recover inappropriate capitation payments. To address this need, we propose to amend § 438.608(a)(3) to require managed care plans and PCCMs to report an enrollee's death and verified address changes within 30 calendar days of receiving the information, and to require states to establish procedures for those reports. We also propose to amend § 438.3(c)(2) to clarify the recovery of capitation payments for periods following an enrollee's death or out-of-state relocation and the return of the applicable Federal share to CMS. These recovery actions would occur between states and managed care plans and would not create liability for beneficiaries. Applicable eligibility redetermination, notice, and fair hearing requirements would continue to govern state action affecting an enrollee's coverage.

Finally, we propose to clarify § 438.608(d)(1)(iv) so that the overpayment return flexibilities in § 438.608(d) do not result in duplicative treatment of recoveries retained under the False Claims Act or through other Federal or State investigations. Together, these revisions would strengthen Medicaid and CHIP managed care program integrity, improve the accuracy of capitation payments, and give states and plans clearer procedures for reporting and addressing changes in enrollee circumstances.

c. Revisions to 455.17 Reporting Requirements

States are currently required to report certain provider fraud and abuse information to CMS pursuant to 42 CFR 455.17. These reporting requirements were established in 1983 and designed primarily to capture basic information regarding provider fraud and abuse investigations. The authority to collect this information expired in 1986. While these reporting requirements may have provided useful information to CMS and its oversight partners, they have not

been updated to reflect significant changes in law and regulatory landscape. They were, for example, developed decades before the 2006 enactment of the Medicaid Integrity Program at section 1936 of the Act which significantly bolstered our development of nationwide Medicaid program integrity efforts and before the widespread use of modern data analytics, cross-State information sharing, managed care program integrity activities, and many current fraud detection techniques.

Under the expired requirements at § 455.17(a), States were required to report to CMS the number of fraud and abuse complaints that warranted a full investigation. Under § 455.17(b), for cases of suspected provider fraud and abuse that warranted a full investigation, States are required to report: (1) the provider's name and number; (2) the source of the complaint; (3) the type of provider; (4) the nature of the complaint; (5) the approximate range of dollars involved; and (6) the legal and administrative disposition of the case, including actions taken by law enforcement. Consistent with the 1983 final rule (48 FR 3756), these reporting requirements applied only to suspected provider fraud and abuse cases and did not extend to suspected beneficiary fraud cases.

These requirements were meant to provide a foundation for Medicaid program integrity reporting for over 40 years, but CMS has determined that they no longer provide the level of detail necessary to support effective national oversight or provide CMS with sufficient information to hold States accountable for lacking program integrity operations. Specifically, the expired existing reporting requirements do not consistently provide information necessary to support national trend analysis, identify emerging fraud schemes, evaluate investigative outcomes, or coordinate oversight activities among Federal and State partners. CMS, State Medicaid Agencies (SMAs), Medicaid Fraud Control Units (MFCUs), Unified Program Integrity Contractors (UPICs), managed care plans, and law enforcement entities routinely coordinate activities involving provider investigations and administrative actions, and more detailed and standardized reporting would meaningfully strengthen those efforts.

We have also identified specific data gaps in the prior reporting requirement that limited its usefulness for program integrity purposes. The prior reporting requirement did not consistently capture provider identifiers in a standardized format, limiting CMS' ability to cross-reference reported cases against other data sources or match investigation records across States and programs. It also did not capture the estimated or final overpayment amounts associated with investigated cases, limiting CMS' ability to evaluate the financial impact of fraud and abuse activity or assess the effectiveness of State investigative efforts. Finally, the prior reporting requirement did not capture administrative actions taken by SMAs (such as provider terminations, payment suspensions, and overpayment recovery actions) separately from law enforcement dispositions, limiting CMS' visibility into the full range of program integrity actions States are taking in response to identified fraud and abuse.

To address these issues, we propose to revise § 455.17 to modernize Medicaid fraud and abuse reporting requirements and improve the usefulness of information reported to CMS. Consistent with the prior scope of § 455.17, these proposed revisions would apply only to suspected provider fraud and abuse cases and would not extend reporting requirements to beneficiary cases. Specifically, we propose to amend § 455.17(b) to require States to report the following additional data elements for cases of suspected provider fraud and abuse that warranted a full investigation: (1) the provider's NPI, or Medicaid ID if the provider is ineligible to receive a NPI; (2) the provider's Employer Identification Number or Taxpayer Identification Number (EIN/TIN); (3) the State in which the investigation is being conducted; (4) the investigation status; (5) the type of service involved; (6) the payor (for example, Fee-For-Service, managed care); (7) the relevant claim dates; (8) the estimated overpayment amount; and (9) where available, the final overpayment amount and the approximate time period covered by the investigation. We also propose to renumber the existing § 455.17 (and expand is scope to include additional reporting options to include the disposition of the case to include administrative actions taken by the SMA, including provider termination, payment suspension (including good cause exceptions identified under § 455.23), and overpayment recovery status, in addition to the existing requirement to report actions taken by law enforcement.

We seek comments on these proposals, including on the operational feasibility of the proposed data elements, whether additional data elements should be included, and the timeframe States would need to come into compliance with the revised reporting requirements.

d. Medicaid Payment Suspensions Updates (§ 455.23)

This set of proposed provisions would impact all 50 States, the District of Columbia, and the applicable territories. Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States.

Consistent with sections 1902(a)(68) of the Act (which requires States to require certain entities to maintain policies and procedures for detecting fraud, waste, and abuse) and 1903(i)(2)(C) of the Act (which prohibits payment of Federal Financial Participation (FFP) with respect to services furnished by a provider to which the state has failed to suspend payment pending investigation of a credible allegation of fraud (CAF)), we are proposing a number of Medicaid payment suspension provisions to strengthen and clarify certain aspects of the payment suspension process.

Medicaid is one of the largest Federal-state partnership programs in the United States. Fraud, waste, and abuse represent a persistent threat to the program's financial integrity. Payment suspensions based on CAFs are among the most powerful tools available to State Medicaid Agencies (SMAs) to halt potentially fraudulent payments before they become unrecoverable, while the CAF is investigated. The proposed regulatory changes are designed to ensure that this tool is used consistently, effectively, and in a timely manner across all States. Medicaid and CHIP fraud undermine the programs' integrity and harm the public. Fraudulent providers exploit gaps in oversight to extract payments from a public insurance program funded by Federal and State taxpayers. The costs are borne broadly by the public, while the benefits accrue to bad actors. The payment suspension provisions described address this failure in distinct and complementary ways.

TABLE C-B1: SUMMARY OF PROPOSED MEDICAID PAYMENT SUSPENSION REGULATORY CHANGES

Provision	Current Requirement	Proposed Change
§ 455.23(a)(1)(i)	SMAs must independently determine CAF credibility	SMAs may rely on CAF determinations by CMS or other Federal/State agencies
§ 455.23(d)(4)	Suspension must end if law enforcement declines referral	Suspension may continue if CAF remains under active investigation, regardless of whether law enforcement declines; quarterly redetermination required
§ 455.23(e)(1)(i)	Good cause exception invocable without case-specific verification	SMAs must verify good cause exception on a case-by-case basis and report basis to CMS
§ 455.23(g)(3)	Annual reporting of payment suspension activity	Quarterly reporting; removal of "summary" qualifier

(1) Inconsistent State Implementation of CAF Determinations

Under the current regulatory framework, the absence of explicit guidance on whether SMAs must independently redetermine the credibility of a CAF received from an outside agency has produced significant variation in State practice. Some States immediately initiate payment suspensions upon receipt of an externally determined CAF, while others conduct full independent credibility reviews before acting. This inconsistency creates exploitable gaps: bad actors operating in States with more deliberate review processes may continue receiving Medicaid payments for extended periods, increasing the total overpayment amount and reducing the likelihood of full recoupment.

The financial consequences of delayed payment suspensions are compounded by the behavior of fraudulent providers once detected. Upon discovery, such providers frequently cease operations, dissolve business entities, or file for bankruptcy protection, leaving States with limited or no viable pathway to recover funds already disbursed.

(2) Payment Suspension Lapses Due to Law Enforcement Declinations

CMS has observed that payment suspensions may be terminated because MFCUs or other law enforcement agencies have declined fraud referrals due to resource constraints or competing priorities. Under current § 455.23(d)(4), States without alternative Federal or State authority to maintain the suspension are required to terminate it upon law enforcement declination, even when the CAF remains credible and unresolved. This creates a structural vulnerability in the payment suspension framework that is unrelated to the merits of the underlying allegation.

(3) Overutilization of Good Cause Exceptions

CMS data (reported by states) from CY 2025 indicates that approximately 75 percent of CAF cases reported under § 455.23(g)(3) did not proceed to a payment suspension because an SMA invoked a good cause exception. Several States reported good cause exception rates exceeding 90 percent, with some States recording hundreds of good cause exceptions against only a handful of actual payment suspensions. While good cause exceptions serve a legitimate purpose—particularly when a payment suspension could compromise an active law enforcement investigation—the data suggests that some States may be invoking the exception as a blanket policy to avoid provider abrasion, administrative burden, or litigation risk, rather than on a case-by-case basis as required.

(4) Limitations of Annual Reporting

The current annual reporting cadence under § 455.23(g)(3) limits CMS' ability to identify emerging trends, provide timely technical assistance to States, and conduct effective program integrity oversight. Given that much of the relevant data is already exchanged between SMAs and MFCUs on a quarterly basis through existing case tracking systems, the annual reporting requirement represents a missed opportunity for more proactive and responsive oversight.

e. National Provider Identifier (NPI) Requirements for Medicaid Providers (§ 455.440)

Accurate provider identification is fundamental to the effective administration of the Medicaid program and to CMS' ability to oversee program integrity activities. Provider identifiers support virtually every operational component of Medicaid administration, including provider enrollment, claims processing, payment administration, managed care oversight, fraud detection, audit activities, and coordination with Federal and State oversight partners. As Medicaid programs have become increasingly dependent upon electronic data exchange and sophisticated analytical tools, consistent provider identification has become an essential component of effective program administration.

The Department adopted the National Provider Identifier (NPI) as the standard unique health care provider identifier under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification provisions. Since its implementation, the NPI has become the nationally recognized provider identifier used throughout Medicare and much of the commercial health care sector. The NPI was specifically designed to improve administrative efficiency by providing a single identifier that could be used consistently across multiple health care transactions and operational systems.

Within Medicaid, however, provider identification practices have evolved incrementally over time rather than through the implementation of a comprehensive enterprise-wide provider identification strategy. Although States generally collect NPIs

where required for HIPAA standard transactions or specific Medicaid operational functions, current Medicaid regulations do not require States to consistently collect, maintain, and use NPIs throughout all systems for every Medicaid provider eligible to obtain an NPI.

As a result, States have developed differing approaches to provider identification. In many States, multiple provider identifiers continue to exist across separate business functions, with internal provider numbers serving as the primary identifier for some operational activities while NPIs are used only where specifically required. Consequently, the same provider may be represented by different identifiers within provider enrollment systems, claims processing systems, managed care oversight activities, program integrity databases, and reporting systems.

CMS has determined that inconsistent provider identification practices have become an increasingly significant limitation on effective Medicaid program integrity oversight. Over the past decade, CMS has substantially expanded the use of advanced data analytics, predictive modeling, and coordinated Federal and State oversight activities. The effectiveness of these activities depends upon accurate and consistent provider identification.

When provider identifiers differ across operational systems or jurisdictions, CMS' ability to accurately associate provider activity across multiple datasets is diminished. These inconsistencies reduce the effectiveness of automated data matching, increase administrative complexity, and require additional manual review before investigative resources can be effectively deployed.

CMS has also identified specific operational limitations associated with inconsistent provider identifiers that affect several complementary proposals contained elsewhere in this proposed rule. For example, elsewhere in this proposed rule CMS proposes to strengthen State reporting requirements under § 455.17 by requiring additional standardized information regarding provider fraud and abuse investigations. The usefulness of those additional reporting elements depends in significant part upon the availability of a standardized provider identifier.

CMS believes that these considerations collectively demonstrate that existing Medicaid regulations no longer provide sufficient consistency to support modern Medicaid program integrity operations.

f. Requirements for Program Integrity Corrective Action Plans (§ 455.600, *et seq.*)

Effective oversight of Medicaid and CHIP requires that CMS have mechanisms to ensure States address identified vulnerabilities. Despite ongoing efforts to provide effective oversight, we continue to find errors and deficiencies in State program integrity operations that result in repeat findings and recommendations. Currently, our authority to take action for instances of sustained non-compliance with Federal requirements is limited to a small subset of CMS program integrity initiatives. Our ability to require a State to develop and implement a Corrective Action Plan (CAP) in response to our program integrity-related activities is significantly limited.

As a result of these limitations, our existing authorities do not sufficiently allow us to take administrative actions should a State fail to effectuate their CAPs or comply with program integrity requirements. This significantly limits the effectiveness of our oversight efforts and allows known vulnerabilities to persist.

To address these gaps, we propose to amend part 455 by adding a new subpart G (§ 455.600, *et seq.*) titled ''Requirements for Program Integrity Corrective Action Plans'' that codifies the administrative actions we may pursue when States fail to comply with program integrity requirements. Specifically, we propose adding a new § 455.602 that would require a State to respond to a final audit report by developing and implementing a Program Integrity CAP for each area of non-compliance. The necessary elements of the Program Integrity CAP would be codified in new § 455.602(b) and serve as a basis for CMS to evaluate whether the Program Integrity CAP mitigates program integrity risks in a meaningful and effective way.

g. Medicaid and CHIP Beneficiary Eligibility Audits (§ 455.700, *et seq.*)

This rule proposes to establish a Medicaid and CHIP beneficiary eligibility audit program under new part 455, subpart H (§ 455.700, et seq). The Medicaid and CHIP beneficiary eligibility audits provide us with enhanced oversight of States' eligibility determination processes, enable us to focus additional resources on high-risk States, and strengthen our ability to identify and recover erroneous excess payments. By establishing a regulatory framework for our beneficiary eligibility audits, we intend to increase transparency of audit requirements and procedures. If this rule is finalized as proposed, future audit findings could result in disallowances under section 1903(u) of the Act, establishing a new mechanism for overpayment recovery. In addition, beneficiary eligibility audits will be conducted more frequently, with each State undergoing an audit at least once in a five-year period and some States audited multiple times within that period based on their risk score.

h. Enhanced Electronic Visit Verification (EVV) Requirements

Section 1903(l) of the Act requires the use of EVV systems for certain services provided by an in-home provider. However, there are no existing Federal regulations establishing how EVV data must be used by SMAs. This rule proposes to amend §§ 455.14 and 447.45(f) to require SMAs to use collected EVV data for specific program integrity and improper payment oversight activities. We propose to amend § 455.14 to require that SMAs incorporate a review of EVV records as part of preliminary investigations into potential Medicaid fraud or abuse involving in-home service providers subject to Federal and State EVV requirements. We also propose to amend § 447.45 to require that SMAs verify that billed services are supported by EVV records during prepayment claims review, where applicable under Federal or State requirements.

2. Medicare Advantage and Medicare Part D Program Integrity

a. Mandatory Reporting of Fraud, Waste, and Abuse (42 CFR 422.500, 422.503 and 423.504)

All Medicare Advantage (MA) organizations and Part D plan sponsors are required to adopt and implement effective compliance programs to oversee provider networks, benefits, and payments. Compliance programs must include measures that prevent, detect, and correct non-compliance with CMS' program requirements, including fraud, waste, and abuse.[214] As part of these requirements, plan sponsors must establish and implement procedures and systems for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.

[214] *See* section 1860D–4(c)(1)(D) of the Act and 42 CFR 422.503(b)(4)(vi) and 423.504(b)(4)(vi).

An important part of plan sponsors' fraud, waste, and abuse initiatives involves sharing data with CMS. In accordance with the requirements of Sections 2008 and 6063 of the SUPPORT Act, CMS established a secure web-based program integrity portal for plan sponsor reporting in the HPMS FWA Reporting Module in the Contract Year 2022 Medicare Advantage and Part D Final Rule (CMS–4190–F2) (86 FR 5864). Since January 1, 2022, under §§ 422.503(b)(4)(vi)(G)(*4*)–(*5*) and 423.504(b)(4)(vi)(G)(*4*)–(*5*) and the associated timelines for reporting found at §§ 422.503(b)(4)(vi)(G)(*6*) and 423.504(b)(4)(vi)(G)(*6*), plan sponsors must report to CMS: (1) payment suspensions pending investigations of credible allegations of fraud by pharmacies; and (2) information concerning investigations, credible evidence of suspicious activities of a provider (including a prescriber) or supplier related to the inappropriate prescribing of opioids, and other actions taken by the plan sponsor related to the inappropriate prescribing of opioids. In addition, when plan sponsors choose to report a referral of substantiated or suspicious activities of a provider or supplier related to fraud, waste, or abuse, they must also use the HPMS FWA Reporting Module to do so in accordance with §§ 422.503(b)(4)(vi)(G)(*5*) and 423.504(b)(4)(vi)(G)(*5*).

In this proposed rule, CMS proposes to expand on its implementation of the requirements in Sections 2008 and 6063 of the SUPPORT Act. Specifically, CMS is proposing to require the reporting of a referral of substantiated or suspicious activities of a provider of services (including a prescriber) or a supplier related to fraud, waste and abuse to initiate or assist with investigations conducted by CMS, or its designee, a Medicare program integrity contractor, or law enforcement partners as well as require the reporting of all payment suspensions based on credible allegations of fraud for all providers and suppliers, rather than only those by pharmacies.

CMS believes that increased reporting is essential to the oversight of the Medicare Part C and Part D programs, as this information is valuable to CMS and assists with investigations, referrals to law enforcement, and trend monitoring. In addition, more stringent reporting requirements allow CMS to anonymously share more robust data on referred providers or suppliers with other MA organizations and Part D contracts on a quarterly basis to assist in their own internal fraud, waste, and abuse efforts. Data transparency and information sharing with our partners are at the core of CMS' strategy to crush fraud. Changes proposed in this rule will affect the Medicare Part C and Part D plan sponsors contracted with CMS to provide Medicare beneficiaries coverage under the Medicare Part C and Part D programs.

b. Risk Adjustment Data Validation (RADV)

This rule proposes certain program integrity policies in the MA program, specifically, the recovery of improper payments identified during RADV audits, and aligns with the Administration's focus on the fiscal sustainability of the MA program and the interests of Medicare beneficiaries, providers, and MA organizations. Additionally, this rule proposes a hardship exception request process for MA organizations facing extraordinary circumstances and unable to comply with contract-specific RADV audit requirements.

The improper payment measurements conducted each year by CMS, which are included in the HHS Agency Financial Report, as well as audits conducted by the HHS–OIG, have demonstrated that the MA program is at high risk of improper payments. In FY 2025 (based on CY 2023 payments), we calculated that CMS made over $21 billion in Part C overpayments.[215] The HHS–OIG has also released several reports over the past few years that also demonstrate a high risk of improper risk adjustment payments in the MA program,[216] and has identified the MA program as one of the top management and performance challenges facing HHS for several years due to the high rate of improper payments.[217] The Medicare program, including MA, has also been identified by the GAO as a high-risk program due to the risk of substantial improper payments.[218]

RADV audits are CMS's main corrective action for improper overpayments in the MA program made to MA organizations when there is a lack of documentation in the medical record to support the diagnoses reported for risk adjustment. The RADV audits confirm the presence of the diagnoses

[215] HHS, FY 2025 HHS Agency Financial Report, pg. 154, *https://www.hhs.gov/sites/default/files/fy-2025-hhs-agency-financial-report.pdf.* CMS made over $23 billion in total Part C improper payments. The improper payment measurement for the MA program in FY 2025 included both overpayments ($21 billion) and underpayments ($2 billion).

[216] *https://oig.hhs.gov/reports/all/2026/cms-potentially-overpaid-medicare-advantage-organizations-462-million-based-on-certain-unsupported-acute-stroke-diagnosis-codes/https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-priority-health-contract-h2320-submitted-to-cms/https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-gateway-health-plan-inc-contract-h5932-submitted-to-cms/https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-blue-cross-and-blue-shield-of-alabama-contract-h0104-submitted-to-cms/https://oig.hhs.gov/reports/all/2025/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-humana-health-benefit-of-louisiana-contract-h1951-submitted-to-cms/https://oig.hhs.gov/reports/all/2025/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-coventry-health-and-life-insurance-company-contract-h1608-submitted-to-cms/https://oig.hhs.gov/oas/reports/region7/71901187.asphttps://oig.hhs.gov/oas/reports/region2/21801028.asphttps://oig.hhs.gov/oas/reports/region3/31900001.asphttps://oig.hhs.gov/oas/reports/region2/22001009.asphttps://oig.hhs.gov/oas/reports/region7/71701169.asphttps://oig.hhs.gov/oas/reports/region7/71601165.asp* For example, see reports: CMS Potentially Overpaid Medicare Advantage Organizations $462 Million Based on Certain Unsupported Acute Stroke Diagnosis Codes, Issued on May 28, 2026, *https://oig.hhs.gov/reports/all/2026/cms-potentially-overpaid-medicare-advantage-organizations-462-million-based-on-certain-unsupported-acute-stroke-diagnosis-codes/;*

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Priority Health (Contract H2320) Submitted to CMS, Issued March 31, 2026, *https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-priority-health-contract-h2320-submitted-to-cms/;* Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Gateway Health Plan, Inc., (Contract H5932) Submitted to CMS, Issued March 12, 2026, *https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-gateway-health-plan-inc-contract-h5932-submitted-to-cms/;* Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross and Blue Shield of Alabama (Contract H0104) Submitted to CMS, Issued March 10, 2026, *https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-blue-cross-and-blue-shield-of-alabama-contract-h0104-submitted-to-cms/;* Medicare Advantage Compliance Audit of Specific Diagnosis Codes Humana Health Benefit of Louisiana (Contract H1951) Submitted to CMS, Issued December 18, 2025, *https://oig.hhs.gov/reports/all/2025/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-humana-health-benefit-of-louisiana-contract-h1951-submitted-to-cms/;* Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health and Life Insurance Company (Contract H1608) Submitted to CMS, Issued June 3, 2025, *https://oig.hhs.gov/reports/all/2025/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-coventry-health-and-life-insurance-company-contract-h1608-submitted-to-cms/.*

[217] *https://oig.hhs.gov/reports-and-publications/top-challenges/2021/2021-tmc.pdf* For example, see OIG, 2024 Top Management and Performance Challenges Facing HHS, *https://oig.hhs.gov/reports-and-publications/top-challenges/2021/2021-tmc.pdf https://oig.hhs.gov/documents/tmc/10057/2024%20Top%20Management%20and%20Performance%20Challenges%20Facing%20HHS.pdf.*

[218] *https://www.gao.gov/highrisk/medicare-program-improper-payments* For example, see reports: GAO, *Medicare Program & Improper Payments, https://www.gao.gov/highrisk/medicare-program-improper-payments;*

Actions Needed to Reduce Improper Payment and Fraud Risks in VA Community Care and Medicare Advantage, GAO–26–107946 (2026), *https://www.gao.gov/products/gao-26-107946.*

related to the enrollee's HCC profile through the review of certain categories of medical records submitted by the MA organizations for the purpose of a RADV audit. Risk adjustment discrepancies are identified when an enrollee's HCCs used for payment (which is, again, based on MA organization self-reported data) differ from the HCCs assigned based on the medical record review performed by CMS through the RADV audit process. Risk adjustment discrepancies can be aggregated to determine an overall amount of payment error for sampled enrollees. In turn, this payment error for the sample of contract enrollees can be extrapolated to calculate a payment error estimate for the universe of enrollees from which the sample is selected.

The provisions in this proposed rule are essential to having an effective RADV program that protects taxpayer dollars and ensures oversight of the MA program.

3. Medicare Provider Enrollment Provisions

Consistent with section 1866(j) of the Act, we are proposing several Medicare provider enrollment provisions to strengthen and clarify certain aspects of the provider enrollment process. These include, but are not limited to, adding and modifying grounds for denying or revoking a provider's or supplier's Medicare enrollment. We are also proposing to enhance our DMEPOS supplier surety bond process under § 424.57(d), to collect additional information from DMEPOS suppliers regarding certain relationships they may have, and to require DMEPOS suppliers to have a process for obtaining prior DMEPOS beneficiary consent for items the supplier sends to the beneficiary at their home or residence. We are further proposing to revise subparts B and E of 42 CFR part 455, which address Medicaid and CHIP provider enrollment, to: (1) add more reasons for which the State must deny or terminate a provider's enrollment; and (2) require Medicaid and CHIP providers to submit certain data regarding their ownership, management, and associated adverse legal history. Too, we are proposing that providers that bill MA for services and items furnished to MA beneficiaries be enrolled in Original Medicare in order to receive payment. All the foregoing changes are necessary to help ensure that payments are made only to qualified Medicare, Medicaid, CHIP, and MA providers and suppliers, that the Medicare program can recoup monies it is owed, and that the financial integrity and beneficiaries of Medicare, Medicaid, CHIP, and MA are protected.

4. Marketplace Program Integrity

In recent years, there has been a substantial increase in consumer complaints from individuals who reported they were unaware they had been enrolled by an agent, broker, or web-broker in Exchange coverage. From 2023 through 2025, CMS received over 624,000 consumer complaints attesting to unauthorized Exchange enrollments or unauthorized plan switching by agents, brokers, or web-brokers and confirmed by issuer and CMS review; 300,000 of the 624,000 were received in 2025 alone. These improper enrollments may constitute abusive conduct, costing Federal taxpayers billions of dollars and can cause significant medical or financial harm to consumers.

Consistent with sections 1312(e), 1313, and 1321 of the Affordable Care Act (ACA), we are proposing a number of additions and amendments to 45 CFR 155.220 to improve the integrity of the FFEs, reduce abusive conduct by agents, brokers, and web-brokers, and better protect consumers within the FFEs. These proposals include but are not limited to: (1) amending 45 CFR 155.20 to add a definition of ''convicted'' and ''credible allegation of abusive conduct,''(2) adding participation standards for agents and brokers to 45 CFR 155.220(g)(3), which would prevent agents and brokers that pose unacceptable risk from participating in the FFE, (3) amending 155.220(g) to replace the existing 30-calendar day opportunity to resolve noncompliance before CMS may terminate an agent, broker, or web-broker's Exchange agreement(s) for cause with an opportunity to refute identified noncompliance and to codify factors that CMS would consider in determining whether to terminate an agent, broker, or web-broker's Exchange agreement(s) for cause and to impose other penalties, (4) amending 45 CFR 155.220(g)(5) to increase transparency around program integrity oversight of the FFE and further strengthen our administrative actions against suspected bad actors, (5) amending 45 CFR 155.220(j)(2)(i) and (ii) by adding specific examples of behavior that CMS considers abusive conduct, and (6) codifying a term in the existing Exchange Agreements with the FFEs and SBE–FPs which would prohibit agents, brokers, and web-brokers from accessing and attempting to access, the FFEs and SBE–FPs, Exchange systems, and personally identifiable information obtained through the FFEs and SBE–FPs from outside the United States. The impacted stakeholders for the provisions described in this section are agents, brokers, and web-brokers participating in the FFEs and SBE–FPs, and their downstream entities such as employees of agents, brokers, and web-brokers, contractors engaged by agents, brokers, and web-brokers, and subcontractors engaged by those contractors.

5. Clarifying Existing Requirement and Adding a New Unsolicited Beneficiary Contact Prohibition

This rule includes a provision to clarify the existing prohibition against unsolicited beneficiary contact by DMEPOS suppliers to make explicit the inclusion of third-party entities acting as the agents of DMEPOS suppliers; and to clarify that the prohibition against unsolicited beneficiary contact by telephone refers to a telephone call or message, including text messages. This rule also includes a provision to add a new supplier standard under 42 CFR 424.57(c)(31) to prohibit unsolicited beneficiary contact by DMEPOS suppliers and their agents when supplying a Medicare covered item by direct messages from social media platforms, email messages without opt-out features, and door-to-door in-person solicitation, unless a specified exception applies.

Fraudulent billing for Medicare DMEPOS continues to be a major concern. Despite an existing prohibition on unsolicited beneficiary contact by telephone, DMEPOS suppliers and third parties acting as their agents are targeting Medicare beneficiaries with unsolicited text messages and other direct messages, door-to-door in person solicitation, unwanted telephone calls, and other means to engage in high-pressure marketing tactics and deceptive lead generation that allow DMEPOS suppliers to bill Medicare for medically unnecessary or unneeded items, or items that are never supplied at all. These changes are necessary to help ensure that legitimate DMEPOS suppliers are furnishing medically necessary items of DMEPOS to Medicare beneficiaries consistent with Medicare requirements, which we believe would assist in protecting the Trust Funds and Medicare beneficiaries.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354);

section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts.). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f) of E.O. 12866. The Office of Information and Regulatory Affairs has determined that this is a significant regulatory action per section 3(f).

We believe these proposed changes would meaningfully improve CMS' nationwide visibility into program integrity activities, facilitate trend analysis, improve coordination among Federal and State oversight entities, and support evaluation of program integrity outcomes. We also believe these enhanced reporting requirements would strengthen States' ability to meet their responsibilities relating to fraud and abuse reporting, oversight, and data analysis under section 1902(a)(64) of the Act. We also considered whether to expand the scope of § 455.17 reporting to include waste, in addition to fraud and abuse. We are not proposing to make that change at this time, as doing so would likely require corresponding revisions to the preliminary and full investigation requirements at §§ 455.14 and 455.15, and we want to carefully evaluate the State burden implications of such an expansion before proposing such a policy. However, we seek comments on whether and how waste should be incorporated into § 455.17 reporting requirements in future rulemaking, including what types of activities States would consider waste for reporting purposes and what burden such a requirement would impose on SMAs.

C. Detailed Economic Analysis

As was mentioned in the COI section of this rule, ''To estimate the financial burden on States, it was important to consider the Federal Government's contribution to the cost of administering the Medicaid and CHIP programs. The Medicaid FMAP that is established for each State is based on the per capita income in the State as compared to the national average. Medicaid FMAPs range from a minimum of 50 percent in States with higher per capita incomes to a maximum of 83 percent in States with lower per capita incomes, but exceptions to the regular FMAP rate exist for certain States, situations, populations, providers, and services. For Medicaid, all States generally receive a 50 percent FMAP for administration. States also receive higher Federal matching rates for certain systems improvements, redesign, or operations, including a 90 percent match rate for the design, development, and enhancement of Medicaid information technology (IT) systems. We have estimated that States would contribute 10 percent of applicable Medicaid IT costs. For CHIP, Congress created an ''enhanced'' Federal matching rate for CHIP that is generally about 15 percentage points higher than the Medicaid rate, averaging 71 percent nationally.

To determine the Federal contribution to the costs of administering the Medicaid and CHIP programs for purposes of estimating State burden with respect to the collections of information and reviewing the regulation and training staff, we elected to use the higher end estimate that the States would contribute 50 percent of the costs. This assumption represents the upper bound of potential State burden, recognizing that the actual share is often lower once enhanced Federal match rates are applied.''

1. Medicaid and CHIP Program Integrity

a. PERM CAPs (§§ 431.992(a), (b)(3)(ii)(E), (b)(3)(ii)(F), (c), and (e) and 431.1010(b)(2)(ii))

(1) Stakeholders Impacted

All 50 States, the District of Columbia, and the applicable territories are subject to these reporting requirements. Including all States and Puerto Rico (hereafter collectively ''States''), there are 52 Medicaid programs in the United States applicable to PERM CAPs.

(2) Benefits

In addition to the quantified cost savings mentioned below, we expect the proposal to require submission of combined Medicaid and CHIP PERM CAPs to produce difficult-to-quantify benefits for States and CMS. A single submission would reduce duplication and fragmentation, improve the organization and usefulness of PERM CAP information, and allow related Medicaid and CHIP findings and corrective actions to be presented in a coordinated manner. The combined format would also provide a clearer basis for reviewing implementation schedules, monitoring activities, and evaluations of corrective action effectiveness. For States, the streamlined process would reduce the staff needed to prepare and process CAP submissions while preserving existing corrective action implementation, monitoring, and evaluating responsibilities. For CMS, the combined CAP would streamline receipt, tracking, review, feedback, and follow-up and provide a more complete view of the State's corrective action efforts. The combined format would preserve program-specific accountability because each Medicaid and CHIP error, deficiency, corrective action, and required CAP element would continue to be separately identified, as applicable. Accordingly, the proposal would improve coordination and administrative efficiency without merging or reducing the distinct requirements applicable to Medicaid and CHIP. Under the current baseline, the 17 States in an annual PERM cycle submit 34 CAPs and incur an estimated 1,020 burden hours annually. Requiring one combined Medicaid and CHIP PERM CAP would reduce annual State responses to 17 and annual burden to 510 hours, eliminating 17 responses and 510 burden hours each year. Using the wage information from the Bureau of Labor Statistics (BLS) for claims adjusters, examiners, and investigators (Code 13–1031) (*https://data.bls.gov/oes/#/area/0000000/2025*), we estimate a mean hourly rate of $38.69 with an adjusted labor rate of $77.38 per hour including fringe benefits and overhead costs. Therefore the estimated annual labor-cost savings would be $39,464. After application of the 50-percent Federal administrative match, we estimate annual savings of $19,732 to States and $19,732 as transfers to the Federal Government. These savings would result from eliminating one duplicative CAP submission for each State while continuing to require program-specific identification of

Medicaid and CHIP errors, deficiencies, corrective actions, and other required CAP elements.

Clarifying the monitoring and effectiveness-evaluation elements would provide a more structured basis for assessing implementation progress and whether corrective actions are reducing or preventing repeat errors. Formalizing the existing CMS review and revision process would also provide clearer expectations for States without creating a separate response.

(3) Costs

Under current § 431.992, States already incur costs to analyze PERM errors and deficiencies, develop and document corrective actions, establish implementation schedules and monitoring plans, evaluate the CAP from the previous measurement, and prepare any necessary revisions. For the 17 States in an annual PERM cycle, the current requirement to prepare separate Medicaid and CHIP CAPs is estimated to require 1,020 hours annually, or 60 hours per State. Using the wage information from the BLS for claims adjusters, examiners, and investigators (Code 13–1031) (*https://data.bls.gov/oes/#/area/0000000/2025*) we estimate an adjusted labor rate of $77.38 per hour including fringe benefits and overhead costs, the estimated annual labor cost is $78,928, or $4,643 per State. After adjusting for the 50-percent Federal administrative match, the estimated annual cost is $39,464 to States and $39,464 transfer cost to the Federal Government.

Under this proposal, States would include the same program-specific CAP elements in one combined submission estimated to require 510 hours annually or 30 hours per State. The annual labor cost would be $39,464, or $2,321 per State. After adjusting for the 50-percent Federal administrative match, the estimated annual cost would be $19,732 to States and $19,732 transfer cost to the Federal Government. The 30-hour estimate includes the time needed to develop and document the required CAP elements, provide monitoring and evaluating for effectiveness information, review CMS feedback, and make ordinary revisions and resubmissions. These estimates quantify the administrative labor associated with developing, documenting, reviewing, revising, and submitting the CAP. The specific actions a State selects to correct its errors and deficiencies may differ based on the nature and complexity of the State's findings. States would continue to undertake corrective action implementation, monitoring, and evaluation under the existing PERM CAP framework. We do not anticipate that these proposed amendments would cause those activities to occur more extensively than they would in the absence of the amendments.

Accordingly, the costs of the underlying corrective action activities remain in the baseline, and we estimate no additional operational costs attributable to these amendments. The existing regulation already requires the identified CAP elements and implementation activities.

Reducing eligibility corrective action implementation updates to every 6 months would decrease reporting frequency from six to two responses per year for affected States. The longer interval would reduce reporting burden and allow additional time for States to implement corrective actions and evaluate progress before submitting an update.

The proposed change to § 431.992(e) would reduce annual responses from 102 to 34 and annual burden from 306 hours to 102 hours, a reduction of 68 responses and 204 hours. As was determined in the COI section of this proposed rule, using the wage information from the BLS for claims adjusters, examiners, and investigators (Code 13–1031) (*https://data.bls.gov/oes/#/area/0000000/2025*) we estimate an adjusted labor rate of $77.38 per hour including fringe benefits and overhead costs. Therefore, the estimated total annual labor-cost reduction would be $15,785. After application of the 50-percent Federal administrative match, we estimate annual State costs of $7,893 after the application of 50 percent FMAP, which will represent an equal transfer cost of $7,893 to the Federal Government. The proposal would not amend § 431.992(d); accordingly, the currently approved burden associated with annual and CMS-requested updates under paragraph (d) would remain unchanged.

In total, we estimate that the affected requirements would reduce annual responses from 136 to 51 and annual burden from 1,326 hours to 612 hours at a total annual cost of $47,357. This represents a net annual reduction of 85 responses and 714 hours, annual cost savings of $55,249. Using the wage information from the BLS for claims adjusters, examiners, and investigators (Code 13–1031) (*https://data.bls.gov/oes/#/area/0000000/2025*), the total annual labor-cost reduction would be $55,249, shown in the COI section, Table C–A3. For ease of reference and projection purposes, Table C–B2 presents the State share of those costs and administrative cost savings from 2027 through 2036 in 2026 dollars. Because the costs and administrative cost savings are projected over 10 years, the total estimated costs exceed the annual amount shown in the collection of information section.

TABLE C-B2: 10 YEAR PROJECTED COSTS TO STATES OF AMENDING § 431.992 (IN 2026 DOLLARS)

State Impact	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Costs under Current Requirements	$51,303	$51,303	$51,303	S51,303	$51,303	$51,303	$51,303	$51,303	$51,303	$51,303	S513,030
State Share of Costs under Proposed Requirements	$23,678	$23,678	$23,678	S23,678	$23,678	$23,678	$23,678	$23,678	$23,678	$23,678	S236,780
State Share of Admin. Cost Savings	$27,626	$27,626	$27,626	$27,626	$27,626	$27,626	$27,626	$27,626	$27,626	S27,626	$276,260

(4) Transfers

As was mentioned above, the Medicaid and CHIP Program Integrity annual transfer costs to the Federal Government are $23,678.

b. Medicaid and CHIP Managed Care Oversight Policies

(1) Stakeholders Impacted

All 50 States, the District of Columbia, and the applicable territories are subject to this reporting requirement. Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States.

Managed care plans. The burden estimate covers approximately 828 plan entries: 629 Medicaid and 199 CHIP managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans.

(2) Revisions to Standard Contract Requirements Relating to Capitation Payments Retention (§§ 438.3(c)(2), 438.608(a)(3), and 438.608(d)(1)(iv))

We propose to amend § 438.608(a)(3) to require Medicaid and CHIP managed care plans and PCCMs to report an enrollee's death and verified address changes to the State within 30 calendar days of receiving the information. We also propose to require States to establish procedures for receiving these reports. To estimate labor costs, we use May 2025 national mean hourly wages from the Bureau of Labor Statistics and add 100 percent of wages for fringe benefits and overhead. The resulting hourly costs are $90.36 for a business operations specialist, $101.12 for a computer programmer, $129.74 for a general and operations manager, $91.12 for an accountant, and $44.80 for a customer service representative. The adjustment for benefits and overhead is an estimating assumption; it is not part of the BLS wage data.

For this illustrative projection, we assume that 629 Medicaid and 199 CHIP managed care contracts would be affected. CMS historical burden estimates, section IV.B. of this proposed rule: Supports the historical counts of 629 Medicaid and 199 CHIP contracts and 44 Medicaid and 32 CHIP State programs. These counts require confirmation for this proposal; the source uses 654 Medicaid contracts for certain program integrity requirements. We estimate that each contract would require a one-time expenditure of 8 hours of business operations work to revise reporting and recovery procedures, 8 hours of programming to establish or modify reporting processes, and 2 hours of management review. BLS May 2025 national occupational wage data: Supports the base hourly wages used in the calculations; it does not establish the overhead adjustment or workload hours. At $1,791.32 per contract, the estimated one-time plan cost would be approximately $1.48 million across 828 contracts.

- *Plan reporting and recovery process setup:* We estimate a one-time burden for 828 Medicaid and CHIP managed care contracts. For each contract, we assume 8 hours of business operations work, 8 hours of programming, and 2 hours of management review.

++ *Total hours:* 828 contracts × (8 business operations + 8 computer programing + 2 management review) hours = 14,904 hours.

++ *Total cost:* 828 × [(8 × $90.36) + (8 × $101.12) + (2 × $129.74)] = $1,483,212.96.

++ *Federal and State shares:** Assuming a 50 percent FMAP match applies to all estimated costs, the Federal share is $1,483,212.96 × 50% = $741,606.48, and the remaining State share is $741,606.48.

States would incur costs to revise contracts and reporting instructions and establish procedures for receiving information from plans. Assuming 44 Medicaid and 32 CHIP State programs, we estimate a one-time expenditure of 8 hours of business operations work, 8 hours of programming, 4 hours of management review, and 4 hours of accounting work per program. This yields an estimated one-time State administrative cost of $183,561 across 76 program estimates. The Medicaid and CHIP figures are program counts and do not represent 76 distinct States. For this analysis, we assume States bear 50 percent of State administrative costs and the Federal Government bears the remaining 50 percent.

- *State contract and reporting process setup:* We estimate a one-time burden across 76 Medicaid and CHIP State program estimates. For each program, we assume 8 hours of business operations work, 8 hours of programming, 4 hours of management review, and 4 hours of accounting work. The 76 program estimates do not represent 76 distinct States.

++ *Total hours:* 76 programs × (8 + 8 + 4 + 4) hours = 1,824 hours.

++ *Total cost:* 76 × [(8 × $90.36) + (8 × $101.12) + (4 × $129.74) + (4 × $91.12)] = $183,561.28.

++ *State and Federal shares:* Assuming each pays 50 percent of State administrative costs, $183,561.28 × 0.50 = $91,780.64 each.

- *Plan processing of reported changes:* For an illustrative annual volume of 100,000 reports, we assume a plan customer service representative spends 5 minutes, or 1/12 hour, processing each report.

++ *Total hours:* 100,000 reports × 1/12 hour = approximately 8,333 hours.

++ *Total cost:* 100,000 × 1/12 hour × $44.80 = $373,333.33 annually.

- *State processing of reported changes:* We assume a State business operations specialist spends 10 minutes, or 1/6 hour, processing each of the same 100,000 reports.

++ *Total hours:* 100,000 reports × 1/6 hour = approximately 16,667 hours.

++ *Total cost:* 100,000 × 1/6 hour × $90.36 = $1,506,000 annually.

++ *State and Federal shares:* Assuming each pays 50 percent of State administrative costs, $1,506,000 × 0.50 = $753,000 each annually.

Combined burden: One-time setup totals 16,728 hours and $1,666,774.24 across plans and State programs. In the illustrative 100,000-report annual scenario, processing totals 25,000 hours and $1,879,333.33, or approximately $18.79 per report across the plan and State activities. The annual figure excludes process maintenance. Actual annual costs depend on the number of additional reports attributable to the proposal.

TABLE C-B3: SUMMARY OF PROPOSED BURDEN ASSOCIATED WITH MANAGED CARE REPORTING AND CAPITATION RECOVERY REQUIREMENTS

Requirement	No. of respondents	Total responses	Frequency	Time per response (hr)	Total time (hr)	Wage ($/hr)	Total cost ($)	State cost ($)	Federal cost ($)
Plan reporting and recovery process setup	28 contracts	828	One-time	18	14,904	99.52*	1,483,212.96	—	—
State contract and reporting process setup	76 State program estimates	76	One-time	24	1,824	100.64*	183,561.28	91,780.64	91,780.64
One-time subtotal	**828 contracts; 76 program estimates**	**904**	**One-time**	**Varies**	**16,728**	**Varies**	**1,666,774.24**	**91,780.64**	**91,780.64**
Plan processing of reported changes	828 contracts	100,000 assumed reports	Annual scenario	0.0833	8,333	44.80	373,333.33	—	—
State processing of reported changes	76 State program estimates	100,000 assumed reports	Annual scenario	0.1667	16,667	90.36	1,506,000.00	753,000.00	753,000.00
Annual total with 100,000 reports	**828 contracts; 76 program estimates**	**100,000 reports processed by plans and States**	**Annual scenario**	**Varies**	**25,000**	**Varies**	**1,879,333.33**	**753,000.00**	**753,000.00**

* Note: The blended hourly rate reflects the occupational mix specified above. Costs were calculated using the individual occupational rates before rounding the blended rate shown in the table. The State and Federal columns divide State administrative costs equally under the assumed 50 percent sharing rate; they do not allocate managed care plans' labor costs. Displayed hours per report and total hours are rounded.

The table estimates $1.67 million in one-time setup costs. Of the State portion of those costs, States and the Federal Government would each bear approximately $91,781 under the assumed sharing rate. After setup, the table includes costs only when a plan and State process a report. At the assumed processing times, each reported change adds approximately $18.79 in combined labor costs. An illustrative 100,000 reports annually would cost approximately $1.88 million, including $1.51 million in State processing costs shared equally by States and the Federal Government. We do not have a reliable estimate of how many reports would be attributable to this proposal beyond those already submitted under existing requirements. More complex eligibility reviews, disputed relocation dates, payment recoveries, and appeals could add costs beyond the amounts shown.

More timely reporting and clearer recovery provisions could prevent improper capitation payments and increase recoveries from managed care plans to States, with the applicable Federal share returned to CMS. HHS–OIG found approximately $117.1 million in Medicaid capitation costs associated with concurrent enrollment in two States in August 2020. Separate audits of 14 States identified more than $249 million in unallowable capitation payments on behalf of deceased enrollees, including $172 million in Federal funds. These historical findings indicate the potential scale of improper payments but are not projected savings from the proposals: some payments may already be identified or recovered, and the proposals would not prevent every payment identified in the audits.

We also propose to clarify § 438.608(d)(1)(iv) concerning recoveries retained under the False Claims Act or through other Federal or State investigations. We do not anticipate a separately measurable transfer from this clarification. We seek comment and supporting data on current contract and reporting practices, the number of changes plans would report each year, the staff time needed to review them, the frequency and cost of disputed recoveries, and the value of capitation payments States already recover.

(3) Transfers

Federal Government would bear approximately a one-time transfer cost of $ 91,781 and, based on the illustrative 100,000 reports annually would cost approximately $753,000 in transfers. See Table C–B3 in section VIII. Collection of Information Requirements of this proposed rule for a detailed accounting of these provisions, copied from the COI section.

c. Revisions to 455.17 State Reporting Requirements

(1) Stakeholders Impacted

All 50 States, the District of Columbia, and the applicable territories are subject to this reporting requirement. Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States.

(2) Overview

The States would be responsible for complying with the revised reporting requirements. CMS would benefit from more complete information concerning State program integrity activities, including provider terminations, payment suspensions, and overpayment

recovery. This regulatory requirement would allow CMS to make better financial impact assessments related to fraud reporting and clearer visibility into administrative actions.

Existing requirements do not capture administrative actions in addition to law enforcement dispositions. The proposed revisions would require States to report the following:

- Provider terminations.
- Payment suspensions (including good cause exceptions under § 455.23).
- Overpayment recovery status.

This would give CMS full visibility into the complete range of program integrity actions taken by States. The requirement could also foster stronger coordination among partners.

The updates would meaningfully strengthen coordination among—

- CMS.
- SMAs.
- MFCUs.
- UPICs.
- Managed Care Plans.
- Law enforcement entities.

Finally, this will allow CMS alignment with modern tools and law. The original requirements predate—

- The 2006 Medicaid Integrity Program (§ 1936 of the Act).
- Modern data analytics.
- Cross-State information sharing.
- Managed care program integrity activities.
- Current fraud detection techniques.

The updates would bring reporting requirements in line with today's program integrity landscape.

(3) Benefits

(a) Enhanced National Oversight

The existing requirements—established in 1983—no longer provide sufficient detail for effective national oversight. The proposed updates would:

- Enable national trend analysis of fraud and abuse patterns.
- Help identify emerging fraud schemes more quickly.
- Allow CMS to better hold States accountable for their program integrity operations.

(b) Improved Data Standardization

Current reporting lacks standardized provider identifiers. The proposed additions would require:

- NPI (National Provider Identifier) or Medicaid ID.
- EIN/TIN (Employer Identification Number/Taxpayer Identification Number).

This would allow CMS to:

- Cross-reference reported cases against other data sources.
- Match investigation records across States and programs.

(4) Costs

Current reporting does not capture overpayment amounts. The proposed updates would require:

- Estimated overpayment amounts.
- Final overpayment amounts (where available).
- Approximate time period covered by the investigation.

This enables CMS to evaluate the financial impact of fraud and abuse and assess the effectiveness of State investigative efforts.

We estimate that it will take a State Medicaid agency official approximately 2.00 hours to compile and report the additional data elements for each qualifying case. This estimate reflects the fact that much of this information (for example, claim dates, payor, and estimated overpayment amount) is likely already maintained by the State as part of its existing investigation and case management processes and would primarily require compilation and formatting for submission to CMS rather than new data collection. (65 cases annually × 52 States = 3,380 cases) (3,380 cases × 2.00 hours = 6,760 hours) (6,760 hours × $129.74 = $877,042.40). The estimated annual cost is $877,042.40 with $438,521.20 as the state share to account for the 50 percent Federal match.

To derive estimated cost, we used data from the U.S. Bureau of Labor Statistics' May 2025 Occupational Employment and Wages for the occupation, ''General and Operations managers'' (Occupation Code 11–1021). This estimate includes the hourly wage ($64.87) with fringe benefits and overhead costs calculated at 100 percent ($64.87) totaling $129.74 per hour. We calculated this using the mean average of 65 cases per annually.

(5) Transfers

The estimated annual cost to the Federal Government is ($877,042.40 * 2 = $438,521,20).

d. Medicaid Payment Suspensions Updates (§ 455.23)

(1) Stakeholders Impacted

All 50 States, the District of Columbia, and the applicable territories are subject to this reporting requirement. Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States. Medicaid providers whose payments are subject to suspension would also be impacted by this provision.

(2) Benefits

- § *455.23(a)(1)(i)—Authorization to Rely on External CAF Determinations*

++ *Reduction in Duplicative Administrative Review.* By permitting SMAs to rely on CAF determinations made by CMS or other Federal agencies, this provision would eliminate the need for independent credibility determinations in cases where a Federal agency has already established the existence of a CAF. The permissive standard is intended to provide a clear, affirmative authorization for States to rely on external CAF determinations—removing any regulatory ambiguity that currently causes some States to question whether such reliance is permissible—while preserving the flexibility for States to exercise independent judgment where warranted. This is expected to reduce the administrative burden on SMAs and accelerate the initiation of payment suspensions. Since the number of payment suspension varies by State and by year, there is not a reliable way to estimate amount of administrative burden this proposed provision would remove from States. We also would not want to prescribe a floor or ceiling to the number of payment suspensions that a state should do in any given timeframe. Additionally, fraud schemes shift and may require administrative actions (*e.g.,* payment suspensions) and at other times large-scale enforcement actions. We therefore do not have the data to make assumptions or estimates.

++ *Faster Payment Suspensions and Reduced Overpayments.* Reducing the time between a CAF referral and the implementation of a payment suspension would directly limit the number of potential overpayments disbursed during the intervening period. The magnitude of this benefit is a function of the volume of CAF referrals received from external agencies and the average payment amounts involved. Even modest reductions in the delay between CAF determination and payment suspension initiation could yield significant savings at the program level. Similarly to what was discussed above, the amount of potential savings is based on expected overpayments resulting from unknown future fraud schemes and the difference between each States' investigative times including the difference between the current and future reliance on CAF determinations made by CMS or other agencies. Since CMS does not dictate State policy and we see the large variability, we cannot estimate the potential savings from decreased overpayments.

++ *Uniform National Standards.* Establishing a clear, uniform standard for how SMAs may treat externally determined CAFs would reduce the exploitable variation in State practice

and create a more consistent national framework for Medicaid program integrity. This benefit is not expected to have measurable outcomes.

++ *Deterrence.* A more consistent and rapid payment suspension response to CAF determinations may deter fraudulent providers from targeting Medicaid programs in States that previously had more deliberate review processes. This benefit is not expected to have measurable outcomes.

- *§ 455.23(d)(4)—Maintaining Payment Suspensions*

++ *Prevention of Suspension Lapses Due to Law Enforcement Resource Constraints.* By permitting SMAs to maintain payment suspensions when a CAF remains under active investigation—regardless of whether law enforcement has accepted the referral—this provision would close a structural gap that currently allows fraudulent payments to resume solely because of law enforcement capacity limitations unrelated to the merits of the underlying allegation. This would provide policy norms across States.

++ *Protection of Medicaid Funds During Ongoing Investigations.* Maintaining payment suspensions throughout the duration of an active investigation would preserve the financial integrity of the Medicaid program and maximize the potential for recoupment of improperly paid funds. Since the number of payment suspension and resources available to law enforcement agencies varies by State, we cannot estimate how much may be saved by this proposal. We also would not want to prescribe a floor or ceiling to the number of payment suspensions that a state should do in any given timeframe, as discussed above.

++ *Preservation of State Flexibility.* The proposed provision would preserve State flexibility by allowing—rather than requiring—SMAs to maintain suspensions, while establishing clear procedural guardrails (written documentation and quarterly redetermination) to ensure that suspensions remain tethered to actual, ongoing investigations. This benefit is not expected to have measurable outcomes.

++ *Safeguard Against Indefinite Suspensions.* The quarterly redetermination requirement would ensure that payment suspensions maintained under this provision remain time-limited and subject to meaningful review, consistent with the statutory authority under section 1903(i)(2)(C) of the Act. This would protect providers from open-ended suspensions in cases where the underlying investigation has effectively concluded. This is a benefit to providers that is not expected to have measurable outcomes.

- *§ 455.23(e)(1)(i)—Verifying Good Cause Exceptions*

++ *Reduction in Improper Good Cause Exception Invocations.* We expect that requiring SMAs to affirmatively verify, on a case-by-case basis, that a good cause exception is warranted for each individual CAF case would reduce the rate of improper or unsupported good cause exception invocations. Based on CY 2025 data showing a 75 percent good cause exception rate, even a modest reduction in improper invocations could result in a meaningful increase in the number of appropriate payment suspensions implemented, with corresponding reductions in fraudulent payments. Since the number of payment suspensions and how States have used the law enforcement good cause exception varies by State, we cannot estimate how much may be saved by this proposal. Similarly, we would not want to direct States to implement a certain number of payment suspensions, as discussed above.

++ *Improved Accountability and Transparency.* Requiring SMAs to document the basis for each good cause exception and transmit documentation to CMS would create an auditable record of good cause exception decisions, enabling CMS to identify patterns of potential overutilization and provide targeted technical assistance. This benefit is not expected to have measurable outcomes.

++ *Alignment with Existing MFCU Obligations.* This proposed verification requirement would be consistent with existing obligations under § 1007.9(h), which already contemplates MFCUs providing quarterly updates to SMAs regarding payment suspensions for each case. This policy alignment is a benefit that is not expected to have a measurable outcome. The marginal burden of providing case-specific good cause confirmations is therefore expected to be limited.

- *§ 455.23(g)(3)—Quarterly Reporting*

++ *Enhanced CMS Oversight Capabilities.* Quarterly reporting would enable CMS to compile and analyze program-wide data on payment suspension activity on a more timely basis, identify systemic trends earlier, and potentially provide technical assistance to States before problematic patterns become entrenched. More granular and timely data on payment suspension activity would enhance CMS' ability to conduct risk-based State Program Integrity reviews and target oversight resources toward States with potential systemic deficiencies. Similarly, quarterly data would support more robust and timely aggregate reporting on Medicaid program integrity outcomes, consistent with CMS' broader commitment to transparency and accountability. More frequent reporting would also enable CMS to identify States that may benefit from technical assistance and provide guidance in a more timely manner, reducing the risk that problematic patterns persist unaddressed for extended periods. Since fraud schemes are variable and how States choose to utilize technical assistance is anticipated to vary, we cannot estimate how much may be saved by this proposal.

We request comments from States on our benefits assumptions for the Medicaid payment suspension provisions.

(3) Costs

- *§ 455.23(a)(1)(i)—Authorization to Rely on External CAF Determinations.* The primary cost associated with this provision is the one-time administrative cost of updating internal policies and procedures to reflect the new standard. We estimate that it will take a State Medicaid agency official approximately 10 hours to update the internal policies and procedures. This estimate assumes that a standard operating procedure will need to be updated and that two drafts of the section on how to verify a credible allegation of fraud will be completed and then reviewed and verified by a second-line manager. For this estimate, we assume that all 56 States and territories will need to update their procedures in some way. To calculate an estimated cost, we used data from the U.S. Bureau of Labor Statistics' May 2025 Occupational Employment and Wages for the occupation, ''General and Operations managers'' (Occupation Code 11–1021). This estimate includes the mean hourly wage ($64.87) with benefits and overhead costs calculated at 100 percent ($64.87) totaling $129.74 per hour.[219] (56 States × 10 hours = 560 hours) (560 hours × 129.74 = $72,654.40). The estimated one-time cost is $72,654.40, with $36,327.20 as the state share to account for the 50 percent Federal match. We request comments from States on our assumptions.

- *§ 455.23(d)(4)—Maintaining Payment Suspensions.* The primary new cost associated with this provision is the

[219] *https://data.bls.gov/oesprofile/?major_group=110000&occupation=111021&measure=01&areas=INDUSTRY,STATE,MSA.*

administrative burden of preparing and maintaining written documentation of:

++ The initial determination that a CAF remains under active investigation; and

++ Subsequent redeterminations conducted quarterly.

Using the U.S. Bureau of Labor Statistics' May 2025 Occupational Employment and Wages for the occupation, we assume that quarterly reporting would be completed by ''Office and Administrative Support Workers, All Other'' (Occupation Code 43–9199). The mean hourly wage for this position is $23.40 with benefits and overhead costs calculated at 100 percent ($23.40) totaling $46.80 per hour.[220] We estimate an average of 1.5 hours of work quarterly for a State to maintain one payment suspension (1.5 hours × 4 quarters = 6 hours) (6 hours × $46.80 = $280.80). We therefore estimate that the annual additional cost of a State to maintain one payment suspensions for 1 year with this provision is $280.80, with $140.40 as the state share to account for the 50 percent Federal match. Since we expect variation on how many payment suspensions are maintained within each State, we do not provide an annual estimate of cost to each State or as a whole. We request comments from States on our assumptions.

• *§ 455.23(e)(1)(i)—Verifying Good Cause Exceptions.* The primary new cost associated with this provision is the administrative burden of:

++ Documenting the basis for the good cause exception; and

++ Transmitting the documentation to CMS.

Using the U.S. Bureau of Labor Statistics' May 2025 Occupational Employment and Wages for the occupation, we assume that quarterly reporting would be completed by ''Office and Administrative Support Workers, All Other'' (Occupation Code 43–9199). Using the U.S. Bureau of Labor Statistics' May 2025 Occupational Employment and Wages for the occupation, we assume that this work would be completed by ''Office and Administrative Support Workers, All Other'' (Occupation Code 43–9199). The mean hourly wage for this position is $23.40 with benefits and overhead costs calculated at 100 percent ($23.40) totaling $46.80 per hour.[221] We estimate 2 hours of work quarterly for a State to verify each good cause exception (2 hours × 4 quarters = 8 hours) (8 hours × $46.80 = $374.40). We therefore estimate that the annual additional cost of verifying each good cause exceptions with this provision is $374.40, with $187.20 as the state share to account for the 50 percent Federal match. To the extent that this provision reduces the number of improper good cause exception invocations, however, the above estimated burden may be partially offset by a reduction in the number of cases requiring good cause documentation. Since we expect variation on how many good cause exceptions are maintained within each State, we do not provide an annual estimate of costs to each State or as a whole.

MFCUs and other law enforcement agencies may also incur a marginal burden associated with providing case-specific good cause confirmations if they are not currently held to comply with § 1007.9(h). This burden is expected to be limited, given that MFCUs are already required under § 1007.9(h) to provide quarterly updates to SMAs regarding payment suspensions. We therefore only acknowledge this potential as opposed to adding the burden to this estimate. We request comments from States on our assumptions.

• *§ 455.23(g)(3)—Quarterly Reporting.* The primary new cost associated with this provision is the incremental administrative burden of compiling and submitting payment suspension data to CMS on a quarterly rather than annual basis. We estimate that the quarterly reporting requirement would require approximately 3 hours per quarter per State, depending on the volume of payment suspension activity. This cost is expected to be modest, given that much of the relevant data is already exchanged between SMAs and MFCUs on a quarterly basis through existing case tracking systems, and § 1007.9 already contemplates MFCUs transmitting payment suspension information to SMAs on a quarterly basis upon request.

Using the U.S. Bureau of Labor Statistics' May 2025 Occupational Employment and Wages for the occupation, we assume that quarterly reporting would be completed by ''Office and Administrative Support Workers, All Other'' (Occupation Code 43–9199). The mean hourly wage for this position is $23.40 with benefits and overhead costs calculated at 100 percent ($23.40) totaling $46.80 per hour.[222] We estimate 3 hours of work quarterly (56 States × 3 hours × 4 quarters = 672 hours) (672 hours × $46.80 = $31,449.60). We therefore estimate that the annual additional cost of quarterly reporting on payment suspension data with this provision is $31,449.60, with $15,724.80 as the state share to account for the 50 percent Federal match. We request comments from States on our assumptions.

See Table C–B3 for a summary of costs of proposed Medicaid payment suspension provisions. We request comments from States on our assumption.

[220] *https://data.bls.gov/oesprofile/?major_group=430000&occupation=439199&measure=01&areas=INDUSTRY,STATE,MSA.*

[221] *https://data.bls.gov/oesprofile/?major_group=430000&occupation=439199&measure=01&areas=INDUSTRY,STATE,MSA.*

[222] *https://data.bls.gov/oesprofile/?major_group=430000&occupation=439199&measure=01&areas=INDUSTRY,STATE,MSA.*

TABLE C-B3: ANNUAL COSTS OF PROPOSED MEDICAID PAYMENT SUSPENSION PROVISIONS TO STATES

BURDEN TO STATE							
Provision	**Hour Burden Per Provision**	**Total Hours**	**Wage ($)**	**Total Cost**	**Total Average Annual Cost**	**Average Cost After 50% Federal Matching**	**Notes**
§ 455.23(a)(1)(i) — Authorization to Rely on External CAF Determinations - Update Policies	10	10	$129.74 per hour	$1,297.40	$72,654.40	$36,327.20	One time cost (2027 only)
§ 455.23(d)(4) — Maintaining Payment Suspensions	1.5	6 (1.5 x 4 quarters)	$46.80 per hour	$280.80	Variable	Variable	Total Cost is per payment suspension. Average Annual Cost will depend on the number of payment suspension per year
§ 455.23(e)(1)(i) — Verifying Good Cause Exceptions	2	6 (2 x 4 quarters)	$46.80 per hour	$374.40	Variable	Variable	Total Cost is per good cause exception. Average Annual Cost will depend on the number of good cause exception per year
§ 455.23(g)(3) — Quarterly Reporting	3	12 (3 x 4 quarters)	$46.80 per hour	$561.60	$31,449.60	$15,724.80	Annual recurring cost (2027 to 2036)

(4) Transfers

There are Federal transfer costs related to these proposed Medicaid payment suspension provisions due to the 50 percent administrative match that the Federal Government provides to States. For year 2027, there is a total Federal transfer cost paid to states of $52,052 (the $36,327.20 one-time cost for year 2027 only plus the $15,724.80 annual recurring cost, as shown in Table C–B3), and for each year from 2028 to 2036 the recurring annual Federal transfer cost paid to states is $15,724.80, as shown in Table C–B3. We also acknowledge that half of the total variable costs for maintaining payment suspensions and verifying good cost will be borne by the Federal Government as opposed to the States.

e. National Provider Identifier (NPI) Requirements for Medicaid Providers (§ 455.440)

(1) Stakeholders Impacted

The States and territories, and individual providers that act as Personal Care Attendants will be impacted by this provision. In the absence of comprehensive national data identifying the number and characteristics of all health care providers that would be newly affected by these requirements, this analysis uses personal care attendants (PCAs) as a proxy for estimating the potential burden on affected providers. PCAs provide a reasonable proxy because they represent a large population of individual providers participating in Medicaid-funded services for whom provider identification, enrollment, and screening requirements vary across states. As a result, the PCA population provides an observable basis for estimating the administrative and financial burden associated with obtaining an NPI and completing related provider enrollment activities.

All 50 States, the District of Columbia, and the applicable territories are subject to this reporting requirement. Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States.

(2) Benefits

To address the limitations described above, this rule proposes to require State Medicaid agencies to collect, maintain, and use NPIs for all Medicaid providers eligible to obtain one. Under this proposal, the NPI would serve as the standardized provider identifier used consistently across Medicaid provider enrollment, claims processing, managed care oversight, program integrity, and reporting systems.

The proposed changes would improve the consistency and reliability of provider information available to States and CMS and strengthen the infrastructure supporting Medicaid program integrity activities. Although the proposed revisions would not directly prevent fraud or improper payments, the consistent use of NPIs would improve the ability of States and CMS to match provider information across Medicaid systems, identify potentially suspicious billing patterns, evaluate provider activity across jurisdictions, and coordinate program integrity and oversight activities.

The proposed benefits associated with this provision are primarily assessed qualitatively and include:

- *Improved Data Quality and Interoperability:* The proposed revisions would establish a standardized provider identifier across Medicaid systems, improving the consistency and reliability of provider information and facilitating more effective data matching. The use of a standardized identifier would also reduce administrative complexity associated with managing multiple maintaining and reconciling multiple provider identifiers.
- *Enhanced Program Integrity Analytics:* The proposed revisions would improve the ability of States and CMS to analyze provider information, identify potentially suspicious billing patterns, evaluate provider activity across jurisdictions, and support coordination of program integrity and investigative activities with other oversight entities.

• *Strengthened Foundation for Other Program Integrity Initiatives:* The standardized use of NPIs would provide infrastructure that supports other program integrity proposals in this rule, including enhanced fraud reporting under § 455.17 and EVV utilization requirements. More consistent provider identification would also provide a stronger foundation for existing and future Medicaid program integrity and oversight activities.

(3) Costs

As noted previously, this proposed rule would require State Medicaid agencies to collect, maintain, and use the NPI for all Medicaid providers eligible to obtain one. The proposed costs associated with this provision fall on the 10 State Medicaid agencies that do not currently require NPIs for PCAs. These 10 SMAs must update their systems and conduct provider outreach, and on certain individual providers who must newly obtain an NPI. The following cost estimates are derived from the approved Information Collection Request (OMB Control No. 0938–XXXX) associated with this provision.

• *State Medicaid Agency Burden:* We estimate a one-time implementation burden on the 10 State Medicaid agencies who do not currently require NPIs for PCAs, of 1,192.5 hours with an equivalent cost of $1,056,898. This is broken down into three activities:

• *Identification of Providers Lacking an NPI:* States will need to review their files to identify an estimated 1.28 million providers (primarily personal care attendants) who lack an NPI. We estimate this review will take one staff member 0.25 hours per State, performed by an Administrative Support Worker.

++ *Total Hours:* 10 Administrative Support Workers × 0.25 hr/provider = 2.5 hours.

++ *Total Cost:* 2.5 hr × $46.80/hr = $117.

• *System Updates for NPI Consistency:* States must update their Medicaid Enterprise Systems to ensure the NPI is used consistently across all modules. We estimate a one-time burden to be approximately 119 hours per State, for a total of 1,190 hours and a total cost of approximately $85,775 across 10 States.

• *Provider Outreach:* States will need to conduct outreach to providers who must obtain an NPI. We estimate a single, batched communication effort requiring 0.1 hours per staff member for 10 States, performed by an Administrative Support Worker.

++ *Total Hours:* 10 staff members × 0.1 hr/ × 1,280,000 providers = 128,000 hours.

++ *Total Cost:* (128,000 hr divided by 10 States) × $46.80/hr = $599,040.

• *Individual Provider Burden:* An estimated 1.28 million Medicaid providers will need to apply for an NPI through the National Plan and Provider Enumeration System (NPPES). The application is estimated to take 20 minutes (0.3333 hours) per provider.

++ This results in a total burden of 426,624 hours with an associated cost of $14,812,385. This burden is accounted for under the existing Paperwork Reduction Act approval for the NPI application (OMB Control No. 0938–0931) and is not a new cost attributable to this rule, but we present it here for a complete accounting of the rule's impact.

(4) Transfers

This provision does involve the direct transfers of funds because of the 50 percent Federal administrative match. This one-time transfer costs estimate is $1,056,898.

f. Requirements for Program Integrity Corrective Action Plans (§ 455.600, et seq.)

(1) Stakeholders Impacted

All 50 States, the District of Columbia, and the applicable territories would be subject to this reporting requirement. Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States. States would be responsible for complying with the correct action requirements, and CMS would oversee the resolution of audit findings.

(2) Benefits

We expect this proposal to generate meaningful benefits by systematizing the resolution of audit findings. By mandating a structured CAP process, CMS would be able to ensure that States take concrete, measurable steps to mitigate identified program integrity risks. This would reduce the incidence of repeat findings, strengthen overall program compliance, and safeguard Medicaid and CHIP funds more effectively.

(3) Costs

The costs associated with this provision would fall on State Medicaid agencies that are selected for a program integrity audit and subsequently required to submit a CAP. Based on our experience with existing PERM CAP requirements, we estimate that a State would require an average of 30 hours to develop a CAP for any given program integrity review or audit conducted by CMS that includes areas of Federal non-compliance.

We estimate 17 States would be selected no more than once each year for a program integrity audit. Assuming each of these 17 States would need to submit a program integrity CAP, we estimate an aggregate annual burden of 510 hours (17 States × 30 hours). Using an adjusted hourly wage of $77.38 for a claims adjuster, appraiser, examiner, and investigator, the total annual cost is estimated at $39,463.

(4) Transfers

This provision does involve the direct transfers of funds because of the 50 percent Federal administrative match. This annual transfer costs estimate is $19,732.

g. Medicaid and CHIP Beneficiary Eligibility Audits (§ 455.700, et seq.)

(1) Stakeholders Impacted

All 50 States and the District of Columbia would be subject to these requirements. States and CMS would be impacted by this provision. Sampled Medicaid and CHIP applicants and beneficiaries would potentially be impacted by this provision if an audit identifies that their most recent eligibility determination was incorrect.

(2) Benefits

The proposed changes to part 455 would codify the Medicaid and CHIP beneficiary eligibility audit program. The proposed eligibility audits would evaluate whether SMAs are determining Medicaid and CHIP eligibility in accordance with Federal requirements and claiming the appropriate Federal reimbursement. During these audits we would provide States with technical assistance to prospectively improve the accuracy of eligibility determinations. Should this rule be finalized as proposed, the eligibility audits would allow us to identify improper Medicaid and CHIP denials and terminations, as each beneficiary eligibility audit would include four statistically valid samples: one sample of active Medicaid cases, one of active CHIP cases, one of negative Medicaid cases, and one of negative CHIP cases.[223] In addition, the proposed eligibility audit program should better enable us to hold States accountable for improper Medicaid and CHIP eligibility determinations by establishing a new recovery mechanism for identified eligibility overpayments.

[223] Negative cases are defined as individuals who have been denied enrollment in or disenrolled from Medicaid.

(3) Costs

This proposed rule would establish new requirements for States undergoing a Medicaid and CHIP beneficiary eligibility audit. The estimated quantified costs for States are associated with information collection requirements, and those impacts are reflected in the COI section of this rule. We estimate the annual burden to be 481 hours for each audited State, or 7,215 hours annually across all 15 States. Factoring in a 50 percent Federal administrative match, the State share of the burden across all 15 States is estimated to be $235,418 annually. For additional details on the calculated State burden, see the COI section of this proposed rule. Since we currently plan to audit the same number of States annually, we expect the estimated State expenditures for the eligibility audits to remain consistent. The projected annual State expenditures, Federal expenditures, and total expenditures for the next 10 years are shown in Table C–B4. However, we note that the actual costs to States and the Federal Government may differ from these estimates.

TABLE C-B4: PROJECTED STATE AND FEDERAL EXPENDITURES FOR THE MEDICAID AND CHIP BENEFICIARY ELIGIBILITY AUDITS, FY 2027-2036 (EXPENDITURES IN 2026 DOLLARS)

Fiscal Year	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036
State Expenditures ($ millions)	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24
Federal Expenditures ($ millions)	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24
Total Expenditures ($ millions)	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48

(4) Transfers

We expect the proposed beneficiary eligibility audits to result in transfers from both the Federal Government to the States, and the States to the Federal Government. States generally receive a 50 percent Federal administrative match for administering the Medicaid program and CHIP. We estimate that the Federal Government is covering the Federal share of States' audit-related activity expenditures (refer to the COI section of this rule for additional information). We would expect transfer from State governments to the Federal Government if audits identify eligibility-related overpayments that result in a program-wide error rate that exceeds the 3 percent allowable threshold, and the State does not qualify for a good faith waiver. We cannot accurately estimate the amount of potential transfers from the State government at this time, since we have not performed any beneficiary audits using the proposed audit methodology.

h. Electronic Visit Verification

(1) Stakeholders Impacted

All 50 States, the District of Columbia, and the applicable territories would be subject to the requirements to utilize EVV data for certain program integrity and improper payment oversight activities. Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States.

(2) Benefits

The proposed changes to §§ 455.14 and 447.45(f) would establish requirements for the use of EVV data for certain State program integrity and improper payment oversight activities. The proposed changes are intended to benefit States by enhancing preliminary investigations of suspect providers and prepayment review processes. Specifically, our proposal seeks to enhance State identification and oversight of fraudulent and abusive activities by in-home service providers.

(3) Costs

At this time, we lack available data on the potential financial impact our proposed EVV requirements will have on SMAs. We seek comments on the potential costs required for State to integrate EVV record review into preliminary investigation and prepayment claims review processes. We are particularly interested in comments regarding whether system upgrades would be necessary to implement these requirements and if applicable, the associated cost of upgrades.

(4) Transfers

If there are any costs to the States, we anticipate that the proposed EVV requirements would result in direct transfer of funds from the Federal Government because of the 50 percent Federal administrative match. However, at this time, we lack available data on the potential financial impact our proposed EVV requirements will have on SMAs.

2. Medicare Advantage and Medicare Part D Program Integrity

a. Stakeholders Impacted

Medicare Advantage (MA) organizations and Medicare Part D Plan Sponsors will be impacted by these provisions.

We were unable to determine the overall impact of requiring MA organizations and Part D plan sponsors to report payment suspensions based on credible allegations of fraud and substantiated or suspicious fraud, waste, and abuse for all provider and supplier types to CMS because we do not have adequate data to support an estimate of the potential costs and savings due to the variability in plan sponsors' own internal processes, organization structures, and sizes. CMS requests public comments and suggestions on the potential costs and savings associated with this proposal. As plan sponsors currently are required to maintain compliance programs that meet CMS requirements, including measures to prevent, detect, and correct fraud, waste, and abuse, CMS believes that the impact of this proposal will be on the staff entering referrals within the HPMS FWA Reporting Module. CMS believes this impact to be minimal as the staff implementing these proposed requirements are already familiar with the HPMS FWA Reporting Module and the expectations CMS has for these referrals. CMS believes there may be savings generated through actions taken by MA organizations and Part D plan sponsors that conduct their own due diligence based on the reporting and sharing of administrative actions, as well as through the use of leads generated in the FWA quarterly report. These activities include information sharing between CMS, MA organizations and Medicare Part D plan sponsors (including MA organizations offering MA–PD plans), as well as

additional law enforcement actions. However, we cannot estimate the impact at this time given the variability in plan sponsors' internal processes, organization structure, and sizes. We welcome comments and suggestions for data that could be relied upon for this purpose.

MA organizations with contracts subject to Risk Adjustment Data Validation (RADV) audits and the Federal Government, through CMS, would be impacted by these provisions. MA organizations would be subject to recovery of improper payments based on extrapolated audit findings, with recovered funds transferred to the Federal Government. CMS would be responsible for the costs of administering the RADV audit program. The extrapolation provision would not increase MA organizations' audit compliance costs. The hardship exception provision would clarify existing policies for MA organizations experiencing extraordinary circumstances that prevent timely submission of medical record documentation.

b. Regulatory Review Costs for MA Organizations and PDPs

There are approximately 968 MA contracts (of which, 48 MA contracts include PDPs). We assume each entity will have one designated staff member who will review the entire rule, clarify uncertainties, and disseminate the information to all the relevant decision makers within the organizations. Other assumptions are possible and will be reviewed after the calculations. Using the May 2025 wage information from the BLS for medical and health services managers (code 11–9111), we estimate that the cost of reviewing this rule is $135.54 per hour, including fringe benefits and overhead costs (*https://data.bls.gov/oes/#/area/0000000/2025*). Assuming an average reading speed for technical materials of 250 words per minute, we estimate that it will take approximately 1.5 hours for each person to review this final rule. For each entity that reviews the rule, the estimated cost is therefore $203.31 (1.5 hours * $135.54). Therefore, we estimate that the total cost of reviewing this regulation is $196,804.08 ($203.31 * 968 reviewers). Note that this analysis assumes one reader per contract.

c. Risk Adjustment Data Validation (RADV)

This proposed rule creates regulations to govern the collection of extrapolated audit findings in MA. As we develop our approach to statistical sampling and extrapolation, we are taking account of the recommendations of the 2016 GAO report [224] entitled, ''Fundamental Improvements Needed in CMS' Effort to Recover Substantial Amounts of Improper Payments.'' The GAO recommended that CMS select plans based on the risk for improper payments. Prior to the GAO report, CMS selected stratified random samples of enrollees during RADV audits, including our 2011 to 2013 audits. However, beginning with audits of MA contracts for payment year 2014, CMS began incorporating the potential risk of improper payments to MA organizations, based on past audit findings and other factors, into selecting enrollee samples for audits. Accordingly, CMS expects to be more effective in identifying improper payments in future audit years.

To clarify in more detail how this proposed rule impacts the recovery audit process, we note the following:

- The Part C Improper Payment Measurement program (not RADV audits) measures and reports improper payments in accordance with the Payment Integrity Information Act of 2019 (PIIA) Public Law (116–117) in the Medicare Part C program.[225] After defining the eligible population, a representative sample of beneficiaries from risk adjustment eligible contracts are selected for medical record review. MA organizations submit medical record documentation to substantiate the CMS–HCC payments sampled by CMS for each year's Part C Improper Payment Measurement. Certified coders code the medical records, and the findings are used to recalculate risk scores for each sampled beneficiary. The difference between the payment risk scores and the recalculated risk scores is termed Risk Adjustment Error. Validation results from the sample are extrapolated to the broader Part C population to produce payment error estimates that meet the PIIA requirements for the payment year. No recoveries are made through these audits.
- Findings from the Part C Improper Payment Measurement audits and contract-specific RADV audits are used to help identify cohorts of beneficiaries for which CMS may be most at risk for making improper payments to MA organizations. While CMS has flexibility to decide how to focus audits, starting with the PY 2014 audits, CMS took a more focused approach on areas of high risk of improper payments and CMS intends to focus audits on such MA organizations in the future and continue taking a more focused approach on areas of high risk of improper payments.
- By better targeting contract-specific RADV audits based on MA organizations' risk of receiving improper payments, CMS expects to have a sentinel effect and reduce the historical Part C improper payment rate over time.
- Lastly, CMS understands that there may be extraordinary circumstances beyond MA organizations' control that may make it difficult to meet medical record submission or other audit requirements. In this proposed rule, CMS is adding a provision to allow MA organizations to request a hardship exception, as prescribed by CMS, if they cannot submit medical records timely as required. If CMS approves an MA organization's hardship exception request, the MA organization is not required to submit medical record documentation for the audited CMS–HCC and the audited CMS–HCC will not negatively impact error calculation.

d. Expected Impact of These Provisions

(1) Extrapolation

While we cannot fully estimate (quantitatively) the impact of this provision, we can clearly identify certain components of impact. We use the following facts and assumptions:

- Findings from audits of MA organization contracts for PYs 2011, 2012, 2013, 2014, and 2015 identified a total of approximately $37.6 million in improper payments (not extrapolated) for 29,900 sampled enrollees, and an average overpayment of $1,258 per sampled enrollee ($37.6 million divided by 29,900 sampled enrollees) transferred from the Federal Government to MA organizations. These improper payments resulted from human coding errors, which caused CMS to pay improper risk adjusted payments to MA organizations. We use the $37.6 million in improper payments and average overpayment per sampled enrollee from these audits to estimate future extrapolated recoveries (or transfers) for this proposed rule.
- As we are adopting GAO recommendations to focus on contracts at higher risk for improper payments, if we assume over the next ten-year period from 2027–2036 that the average overpayment per sampling frame enrollee in each RADV audit holds constant at $1,258, the total number of audited MA contracts is 8,260, and the total estimated number of sampling frame enrollees to be included in RADV

[224] GAO, at 26, *https://www.gao.gov/assets/gao-16-76.pdf* (April 2016).

[225] See: *https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/medicare-part-c-ipm* for more information on the Medicare Part C Improper Payment Measurement.

audits is approximately 71.7 million, then the total estimated overpayments (with extrapolation) over the time period will be $90.2 billion (see Table C–B8).

We also assume the average number of MA contract audits concluded per calendar year and the average number of sampling frame enrollees associated with these audits per calendar year will be 826 and 7.2 million, respectively.

- Extrapolating audit findings does not increase the cost burden on an MA organization with an audited MA contract. The cost to the MA organization of complying with a RADV audit is neither the subject of nor affected by this provision.
- We estimate the total cost of the RADV audit program for the time period of 2027–2036 is approximately $478.7 million. This includes planned resources needed for support contracts, technology, and analytical tools/software needed to operate the program.
- We estimate that the annualized monetized cost of the contract-level RADV audit program for the time period of 2027–2036 is approximately $48 million.

In conclusion, with extrapolation applied to audit findings for payment years 2018 and later during calendar years 2027–2036, we estimate that the annualized monetized transfers from MA organizations to CMS would be approximately $9.2 billion and the annualized monetized cost would be $48 million for the contract-specific-RADV audit program.

In total, the estimated recovery amount from 2027 through 2036 is $90.2 billion; see Table C–B5. This money is a reduction in spending of the Medicare Trust Fund resulting mostly from recoveries, and this money is considered a transfer from MA organizations to the Federal Government; there will be no money transferred to enrollees.

The intent of this rule is to protect taxpayer dollars and ensure oversight of the MA program, in part, by reducing Part C improper payments.

TABLE C-B5: RADV TOTAL TRANSFER FROM MA ORGANIZATIONS TO THE FEDERAL GOVERNMENT WITH EXTRAPOLATION ($ IN MILLIONS)

	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
RADV Audit ICR	$59.73	$22.39	$22.39	$22.39	$22.39	$22.39	$22.39	$22.39	$22.39	$22.39	$261.24
RADV Hardship Exception ICR	$0.47	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$2.09
RADV Transfer	$2,201.80	$16,804.20	$16,813.60	$13,586.70	$6,793.30	$6,793.30	$6,793.30	$6,793.30	$6,793.30	$6,793.30	$90,166.30

(2) Hardship Exception Request

We believe the proposed hardship request provision has no additional impact on MA organizations and is intended to clarify existing policies and processes. Submitting hardship exception requests for contract-specific RADV audits was previously in sub-regulatory guidance and benefits MA organizations to the extent they are able to demonstrate extraordinary circumstances that prevent them from submitting medical record documentation and complying with RADV audit requirements. We are seeking comments on documentation and process requirements.

TABLE C-B6: IMPACT ON ESTIMATED COLLECTIONS OF IMPROPER PAYMENTS PER YEAR FROM RADV PROVISIONS ($ IN MILLIONS)

	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Estimated Non-Extrapolated Collections Assumed Without RADV Proposed Rule Changes	$18.0	$83.9	$85.3	$63.0	$31.5	$31.5	$31.5	$31.5	$31.5	$31.5	$439.1
Estimated Collections from Audits Completed with RADV Proposed Rule Changes	$2,201.8	$16,804.2	$16,813.6	$13,586.7	$6,793.3	$6,793.3	$6,793.3	$6,793.3	$6,793.3	$6,793.3	$90,166.3
Additional Estimated Collections as a Result of RADV Proposed Rule	$2,183.8	$16,720.4	$16,728.3	$13,523.7	$6,761.9	$6,761.9	$6,761.9	$6,761.9	$6,761.9	$6,761.9	$89,727.3

3. Provider Enrollment Program Integrity

a. Stakeholders Impacted

Medicare-enrolled providers and suppliers, including hospices, durable-medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, and physicians, and other practitioners who order DMEPOS items or services, would be impacted by the proposed revocation provisions. Affected stakeholders also include hospice medical directors and administrators, as well as owners, managing employees, managing organizations, partners, officers, directors, and other individuals or entities whose relationships with providers or suppliers are addressed by these provisions. Additional affected parties include but are not limited to: (1) DMEPOS suppliers that would be required to report certain relationships; (2) providers that bill MA but are not enrolled in Medicare fee-for-service, who would now have to enroll in order to receive MA payment; and (3) Medicaid and CHIP providers that would be required to report additional information under 42 CFR part 424, subpart B, and be subject to denial and termination of their Medicaid and CHIP enrollment under § 455.416. The Federal Government (through CMS) and the States (for the Medicaid and CHIP provisions) would be responsible for administering and enforcing the proposed requirements.

b. Provider Enrollment

As previously noted, we are proposing a number of Medicare, Medicaid, CHIP, and MA provider enrollment provisions to strengthen and

clarify certain aspects of the provider enrollment process. This RIA addresses provisions that: (1) we believe would have a financial impact; and (2) would not, in our view, have such an impact but which require explanation. For those that are not mentioned, we have determined that there would be no such impact—though we note that certain provisions addressed in the ICR section of the proposed would have an ICR burden, which we have calculated in that section and will be included in the total cost estimate in this RIA.

(1) Medicare Provider Enrollment

(a) New Revocation Reasons

We are proposing the following new or expanded grounds for revoking Medicare enrollment:

- *Expanded § 424.535(a)(7)*—The provider or supplier engages in improper activity related to its Medicare enrollment, any billing number or identifier, or EFT arrangement.
- *New § 424.535(a)(26)*—The provider's or supplier's practice location is in the same suite or office as another provider or supplier whose Medicare enrollment has been revoked or denied under § 424.535 or § 424.530.
- *New § 424.535(a)(27)*—A hospice's enrollment may be revoked if any of the following apply:

++ The hospice's medical director is either of the following:

++ The medical director of multiple other hospices.

++ Practices at such a distance (for example, in a different State) from the enrolling hospice that the medical director cannot realistically perform all medical director functions required under 42 CFR part 418.

++ The hospice's administrator is either of the following:

++ The administrator of multiple other hospices.

++ Located at such a distance from the hospice that the administrator cannot realistically perform all administrator functions required under 42 CFR part 418.

+ The hospice's medical director does not have an active physician medical license in the State in which they are practicing.

- *New § 424.535(a)(28)*—A hospice's enrollment may be revoked if the hospice changes its administrator within 36 months of its initial enrollment or its most recent change in administrator.
- *New § 424.535(a)(29)*—A physician's or practitioner's enrollment may be revoked if the individual ordered a DMEPOS item or service that was not reasonable or necessary.
- *New § 424.535(a)(30)*—The provider or supplier has a domestic or foreign owner, managing employee, managing organization, partner (general or limited), officer, or director:

++ Whose identity, location, or adverse action history cannot be confirmed; or

++ That CMS determines poses an undue risk of fraud, waste, or abuse to the Medicare program.

- *New § 424.535(a)(31)*—A DMEPOS supplier's enrollment may be revoked if CMS determines that any entity or individual reported pursuant to § 424.57(i)—or the relationship or business arrangement the entity or individual has with the supplier—poses an undue risk or fraud, waste, or abuse to the Medicare program or of beneficiary harm.
- *New § 424.535(a)(32)*—CMS determines that a revocation under § 424.536 (which would address certain provider changes in majority ownership) is warranted.

(i) Stakeholders Impacted

All Medicare providers and suppliers may be impacted by these provisions, though certain provisions only apply to certain provider and supplier types (such as hospices).

(ii) Benefits

As with all our prior provider enrollment revocation grounds, we believe our proposed revocation reasons would assist in protecting the Medicare program from non-compliant providers and suppliers, including those engaging in fraud, waste, or abuse.

(iii) Savings, Costs, and Transfers

As these are new or expanded revocation grounds, we have no historical data upon which we can base an estimate of savings, costs, or transfers. We thus request comments from stakeholders as to the potential impact.

(b) Potential Surety Bond Recoupment Amounts

We are proposing in new § 424.57(d)(16) that CMS may decline to accept from an authorized surety DMEPOS supplier surety bonds required under § 424.57(d) if the requirements of § 424.57(d)(16) (for example, providing the surety an opportunity to rebut CMS' intended declination) are met. We would also maintain a list of sureties from which CMS may decline to accept DMEPOS surety bonds under paragraph (d)(16).

(i) Stakeholders Impacted

Sureties and DMEPOS suppliers would be the principal parties impacted by this proposal.

(ii) Benefits

In section V. of this proposed rule, we cited data showing many millions of dollars in unpaid debts to CMS due to sureties' failures to make required payments under the bonds. We believe that proposed § 424.57(d)(16) would help spur sureties to fulfill their financial obligations to CMS.

(iii) Savings, Costs, and Transfers

Because this is a new provision, we have no historical information to assist us in projecting the amount of additional debts we would collect. In this same vein, we lack sufficient data to assess the impact to sureties under § 424.57(d)(16). We therefore seek comments from stakeholders, including sureties, as to (1) the potential additional recoupment from our surety bond proposal and (2) any other impacts associated with § 424.57(d)(16).

c. DMEPOS Accreditation Surveys

Under § 424.58, DMEPOS suppliers must be surveyed and accredited by a CMS-approved accrediting organization (AO): (1) to initially enroll in Medicare; and (2) on an annual basis to remain enrolled in Medicare; this includes, but is not limited to, accreditations for a new item type the supplier has not previously furnished or as required under the DMEPOS supplier CIMO provisions under § 424.551. We are proposing that an accreditation survey must also be performed if the supplier undergoes:

- A CIMO regardless of whether the change requires a new, initial enrollment under § 424.551.
- A change in practice location.

We made significant revisions to § 424.58's DMEPOS accreditation requirements in the CY 2026 HH PPS final rule (90 FR 55342). The aforementioned proposal expands upon these changes.

(1) Stakeholder Impact

The principal impacted stakeholders would be DMEPOS suppliers and DMEPOS AOs.

(2) Benefits

As explained in section V. of the proposed rule, we believe that our proposals would help ensure that the supplier under its new ownership or in its new location is compliant with the DMEPOS quality standards.

(3) Savings, Costs, and Transfers

Our proposal would involve two types of costs. One would be the cost to the supplier of the survey. While survey costs can vary widely by AO, we project a cost of roughly $3,000 per survey, which generally aligns with certain other survey cost estimates we made in the CY 2026 HH PPS final rule. The supplier would pay the survey fee to the AO. The second cost would involve the time and effort burden on the supplier and the AO in receiving and performing the survey. Consistent with various survey hour burden estimates we used in the CY 2026 HH PPS final rule, we will base our projections for our proposal on the following assumptions:

- It would take the AO 8 hours to perform the survey and 6 hours to review the results and make its determination.
- The supplier would incur a burden of 6 hours during the survey.
- The survey would be performed by AO personnel falling within the BLS wage category of ''Other Healthcare Practitioners and Technical Occupations'' (OHPTO) (Occupation Code 29–9000). The hourly mean wage is $35.55; the wage is $71.10 with fringe benefits and overhead.[226] *https://data.bls.gov/oes/.*
- Individuals in the BLS wage categories of ''Registered Nurses'' (Occupation Code 29–1141) and ''Medical and Health Services Managers'' (MHSM) (Occupation Code 11–9111) would review the survey results. The mean wage for registered nurses is $48.76 ($97.52 with fringe benefits and overhead costs) and $67.77 for MHSMs ($135.54 with fringe benefits and overhead costs). As we did in the CY 2026 HH PPS final rule, we will combine these two hourly wages and then divide the total in half to derive an average fringe benefit and overhead wage for this activity, which would be $116.53 ($233.06/2).
- The BLS wage category for the supplier survey burden would be ''Office and Administrative Support Workers, All Other'' (Occupation Code 43–9199). The mean wage would be $23.40, or $46.80 with fringe benefits and overhead costs.

Based on internal CMS data, we further project that approximately: (1) 500 suppliers per year would undergo a CIMO that would not require an initial enrollment; and (2) 851 suppliers per year would change their practice location.

With 1,351 (500 + 851) surveys being performed annually, the foregoing results in the following annual burden:

TABLE C-B7: ANNUAL COSTS AND TRANSFERS OF PROPOSED DMEPOS SUPPLIER SURVEY REQUIREMENTS

BURDEN TO AO				
Task	**Hour Burden Per Task**	**Total Hours**	**Wage ($)**	**Total Cost**
AO Burden Survey	8	10,808 (8 x 1,351)	71.10	$768,449
AO Burden – Application/Post-Survey Review/Decision	6	8,106 (6 x 1,351)	116.53	$944,592
Accreditation Fee Collections	N/A	N/A	N/A	($4,053,000) (or $3,000 fee x 1,351 surveys)
TOTAL	14	18,914	Varies	($2,339.959)
BURDEN TO SUPPLIER				
Burden to Supplier During Survey	6	8,106 (6 x 1,351)	46.80	$379,361
Accreditation Fee	N/A	N/A	N/A	$4,053,000
TOTAL	6	8,106	N/A	$4,432,361
COMBINED NET BURDEN	**N./A**	**27,020**	**N/A**	**$2,092,402**

Note that the $4,053,000 in fee payments represents a transfer from DMEPOS suppliers to DMEPOS suppliers. The annual cost burden to the AOs would be $1,763,041 ($768,449 + $994,592) and that to DMEPOS suppliers would be $379,361. We have no historical data upon which we can estimate the amount of savings to Medicare based on the supplier's failure to meet the quality standards under these surveys, though we indeed expect savings.

d. Other DMEPOS Enrollment Proposals

As already mentioned in the ICR section of this proposed rule, two additional DMEPOS enrollment proposals are to—

- Collect additional information from DMEPOS suppliers on the Form CMS–855S regarding certain relationships they may have; and
- Require DMEPOS suppliers to have a process for obtaining prior DMEPOS beneficiary consent for items the supplier sends to the beneficiary at their home or residence.

(1) Stakeholders Impacted

DMEPOS suppliers and beneficiaries would be the parties most impacted by these proposals.

(2) Benefits

We explained at length in section V of this proposed rule that the aforementioned Form CMS–855S data collection would afford us valuable insight into the DMEPOS chain of operations—a particularly important consideration in light of the DMEPOS fraud schemes we have seen. As for beneficiary consent, we also stated in section V. that this proposal could reduce the practice of beneficiaries receiving unwarranted or unnecessary items.

(3) Savings, Costs, and Transfers

For the former, we calculated in the ICR section of this proposed rule an annual reporting cost burden of $1,045,918 ($870,340 for initial, revalidation, and reactivation Form CMS–855S submissions + $175,578 for Form CMS–855S changes of information). Regarding the latter proposal, this requirement would involve the supplier emailing or telephoning the beneficiary or their representative for consent and recording the contact in a written log. We believe that some suppliers may already conduct this activity, in which case there would be no addition burden. However, to assist us in preparing a burden estimate, we request comments from stakeholders about: (1) the current prevalence of this activity among DMEPOS suppliers; (2) the typical time it would take a supplier to make and document the inquiry; and (3) how frequently within a certain time period (for example, one month) the supplier would have to undertake this task.

[226] *https://data.bls.gov/oes/#/area/0000000/2025.*

We believe there could be savings or transfers to the Medicare program from the revocation of DMEPOS suppliers that fail to comply with the beneficiary consent requirement or stemming from the Form CMS–855S reporting proposal. However, we have no historical enrollment data to help us assess a potential amount as these are new enrollment provisions.

e. Medicaid, CHIP, and MA Provider Enrollment and Other Considerations

(1) Additional Medicaid and CHIP Denial and Termination Reasons (§ 455.416)

We are proposing several new and expanded grounds for which the States must deny or terminate a provider's Medicaid or CHIP enrollment under § 455.416. These include, but are not limited to, the following:

- *Non-compliance:* Deny or terminate if the provider is non-compliant with any requirement described in subpart B or E of Part 455.
- *Felony convictions:* Deny or terminate if the provider, any person or organization with an ownership or control interest in the provider, or any managing employee or managing organization of the provider was, within the preceding 10 years, convicted of a Federal or State felony offense that the State determines is detrimental to the best interests of its Medicaid program or CHIP and its beneficiaries.
- *Prescribing Authority:* Deny or terminate if: (1) a physician's or practitioner's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked or is surrendered in response to an order to show cause.
- *Misuse of enrollment:* Terminate if the provider knowingly sells to or allows another individual or entity to use its enrollment to bill Medicaid or CHIP.
- *Improper prescribing practices:* Terminate the physician or practitioner has a pattern or practice of prescribing Medicaid or CHIP drugs that is abusive, represents a threat to the health and safety of Medicaid or CHIP beneficiaries, or fails to meet Medicaid or CHIP requirements.
- *Abusive ordering, certifying or referring of Medicaid or CHIP services or item:* The physician or practitioner has a pattern or practice of ordering, certifying or referring Medicaid or CHIP services or items that is abusive, represents a threat to the health and safety of Medicaid or CHIP beneficiaries, or otherwise fails to meet Medicaid or CHIP requirements.

(a) Stakeholders Impacted

The principal impacted parties would be the States and Medicaid and CHIP providers.

(b) Benefits

We believe that our proposed denial and revocation grounds would: (1) facilitate greater consistency between Medicare and Medicaid as well as between State Medicaid agencies and CHIPs; and (2) protect Medicaid and CHIP from non-compliant providers.

(c) Savings, Costs, and Transfers

We are unable to assess the cost impact of these provisions or calculate potential transfers for two main reasons. First, as these are new or expanded grounds, we have no precedent in Medicaid or CHIP upon which we can establish an estimated impact. Second, although most of these bases are duplicated in § 424.535(a) with respect to Medicare, we do not believe that using the annual number of Medicare revocations on these grounds as a basis for calculating the likely number of Medicaid and CHIP terminations is appropriate. This is because the number of situations in which these Medicaid and CHIP termination situations will arise may be very different from that for Medicare. This is particularly true because these grounds are discretionary in Medicare but would be mandatory in Medicaid and CHIP (absent a State finding that the termination would not be in the best of the Medicare program or CHIP). States may therefore have considerably more terminations than Medicare. Too, some States, for instance, may already have several of these denials and termination reasons (or variations of them) under State law, meaning there would be no material increase or decrease in denials or terminations for such provider activity.

Due to this uncertainty, we request comments from interested parties (in particular, the States) on the potential impact of these proposed bases. We are particularly interested in comments regarding whether the States currently use termination reasons similar to those we are proposing and, if so, how frequently.

As with our proposed Medicare revocation reasons, we believe there could be savings or transfers from terminations of Medicaid or CHIP enrollment, though we are unable to estimate a potential amount.

(2) Medicaid and CHIP Application Fee (§ 455.460)

Consistent with § 455.460, States must collect the applicable provider enrollment application fee from a prospective or revalidating provider. There are exceptions, though. These include, but are not limited to, providers identified in § 455.460(a)(2) that—

- Are enrolled in either Medicare or another State's Medicaid program or CHIP.
- Have paid the applicable application fee to a Medicare contractor or another State.

In general, application fees are intended to cover the State's cost of screening the provider and the application. States screen a provider's application at the same level (limited, moderate, or high) that CMS uses for that same provider type under § 424.518. However, States under § 455.452 may screen an application at a higher level (using more stringent methods) than that required by part 424, subpart E.

Some States have expressed reluctance to screen at higher levels under § 455.452 because of the inability to collect an application fee under § 455.460 to cover the additional costs. States therefore have occasionally been unable for financial reasons to use enhanced screening methods when the State believed they were necessary. We are concerned that this has resulted in certain Medicaid providers having been insufficiently screened. To remedy this, we are proposing that § 455.460(a)(2)(A)(*1*) and (*2*) would not apply if the State is screening the provider at a higher level under subpart E than the Medicare contractor or other State to which the provider paid the fee; in this situation, the State would be permitted to collect an application fee from the provider consistent with § 455.460.

(a) Stakeholders Impacted

The States and Medicaid/CHIP providers would be principally affected.

(b) Benefits

We believe our proposal could make States more willing to engage in enhanced screening when they believe it is warranted. This, in turn, could lead to greater scrutiny of potentially problematic providers.

(c) Savings, Costs, and Transfers

As this would be a new provision, we have no historical data to help us ascertain its impact. We thus request comments from interested parties, especially States, regarding the frequency with which States might request a fee under our proposal, the expected number of impacted providers with that State, and what the fee amount might be. We believe this would help us

assess the cost of our proposal in terms of the total fee payments (which would qualify as a transfer from providers to the States).

We are unable to assess the dollar amount that might be saved from providers that were terminated due to this stricter screening, though we do anticipate some savings.

(d) General Solicitation of Comments From States Regarding Our Enrollment Provisions

For all of our proposed Medicaid and CHIP provider enrollment provisions, we also ask States to identify any impact they may experience in implementing and executing our proposed provisions, including potential costs.

(e) MA Enrollment

We are proposing to require providers that bill MA to be enrolled in Medicare in an approved status in order to receive payment for furnished MA services and items.

(i) Stakeholders Impacted

MA organizations, and providers that bill MA would be the main parties affected.

(ii) Benefits

As explained in much greater detail in section V. of this proposed rule, we believe that the principal benefit of our MA enrollment proposal would be the strengthening of the ability to ensure that providers are adequately screened for program integrity issues before billing MA.

(iii) Savings, Costs, and Transfers

As explained in the ICR section of this proposed rule, we estimate an average annual ICR cost over the first 3 years of this requirement of $11,080,585.

We request comments from stakeholders as to additional costs this requirement might involve, especially the costs to MA organizations of implementation.

We expect that savings would accrue from this greater scrutiny, since providers that do not meet enrollment requirements would be unable to bill MA. Since this is a new requirement, however, we are unable to calculate a savings estimate, though we welcome comments from stakeholders on this topic.

4. Marketplace Program Integrity

a. Stakeholders Impacted

The Marketplace provisions would impact insurance agents, insurance brokers, and insurance web-brokers. Some entities within these categories may qualify as small businesses.

b. Expand Authority To Terminate Agents, Brokers, and Web-Brokers' Exchange Participation

We propose to revise 45 CFR 155.220(g)(3) to add participation standards that would prevent agents, brokers, and web brokers that pose unacceptable risk from participating in the FFEs and SBE–FPs. Specifically, agents, brokers, and web-brokers that pose unacceptable risk would not be permitted to register, complete training, or enter into Exchange agreement(s) with CMS.

Additionally, this proposed rule would update § 155.220(g)(3) to allow CMS to immediately terminate agents, brokers, and web-brokers who pose unacceptable risk from participating in the FFEs and SBE–FPs, without waiting 30 calendar days from the date of notice. This proposed rule would also add a definition of ''convicted'' to § 155.20 in alignment with the Medicare program.

We do not expect the proposed changes to § 155.20 or § 155.220(g)(3) to have a financial impact on agents, brokers, or web-brokers because the changes do not impose any new requirements on them. We also expect these changes to only have minimal impact on CMS' oversight responsibilities because CMS already has systematic access to the data required for implementation. We anticipate that these changes would have benefits, including reducing the amount of taxpayer dollars being inappropriately disbursed, increasing transparency around program integrity oversight of the FFE, and improving public trust with the FFE and the agent, broker, and web-broker community.

We believe disruptions in the broker market will be limited to brokers that pose an undue risk of fraud in FFEs and SBE–FPs. That is, any disruptions in the broker market will be related to fraudulent brokers or dollars that should not have been paid out in the first place. We will analyze feedback submitted in response to the agent-broker moratoria announcement. In addition, we will analyze the comments received from stakeholders to enrich the newly proposed provision when this rule is finalized.

c. Strengthen CMS' Authority To Terminate and Agent, Broker, or Web-Broker for Cause

(1) Opportunity To Refute Determinations of Noncompliance (45 CFR 155.220(g)(3)(i)) and Factors CMS May Consider in Enforcement Determinations (45 CFR 155.220(g)(1)(i))

We propose to revise § 155.220(g)(3)(i) to provide agents, brokers, and web-brokers with an opportunity to refute determinations of noncompliance, with the exception of determinations make under § 155.220(g)(3)(ii) and proposed §§ 155.220(g)(3)(iii)–(iv), prior to the termination of their Exchange Agreement(s) for cause and imposition of other penalties under § 155.220(k)(1), which would replace the existing opportunity to ''resolve'' identified noncompliance. We also propose to revise § 155.220(g)(1) and add a new paragraph at § 155.220(g)(1)(i) to clarify how CMS would determine whether to terminate an agent, broker, or web-broker's Exchange Agreement(s) and impose a penalty under § 155.220(k)(1) when CMS has made a determination of noncompliance under § 155.220(g)(1).

These proposals are expected to result inminimal compliance costs for agents, brokers, and web-brokers associated with responding to noncompliance determinations. We anticipate this burden would be roughly equivalent to burden associated with providing CMS with information to ''resolve'' identified noncompliance as operationalized under the current regulations. Similarly, we expect any administrative costs for HHS to implement this change to be done at minimal additional costs and burden. These proposals continue to support the existing benefits of the existing policies that are clarified by these proposed revisions, transparency, accuracy, and efficiency in CMS noncompliance determinations and resulting enforcement actions against agents, brokers, and web-brokers.

(2) Policies To Address Abusive Conduct

We propose to revise 45 CFR 155.220(g)(5) to move from a fraud-based standard to an abusive conduct-based framework. Additionally, we propose to adjust the standard of proof for suspensions and terminations for cause of an agent, broker, or web-broker's Exchange Agreement(s) by CMS under § 155.220(g)(5). We propose to amend § 155.220(j)(2)(i) and § 155.220(j)(2)(ii) by adding illustrative, but not exhaustive examples of behavior that CMS considers abusive conduct and amend § 155.220(j)(4) to exclude these provisions from the good faith exception.

We do not anticipate the proposed changes to § 155.220(g)(5) and § 155.220(j)(2) will result in costs for agents, brokers, and web-brokers because the changes are focused on updating and clarifying internal processes. We anticipate that these changes would support the goals of the existing policies that are clarified by these proposed revisions, including

reducing the amount of taxpayer dollars being inappropriately disbursed, increasing transparency around program integrity oversight of the FFE, and improving public trust with the FFE and the agent, broker, and web-broker community.

(3) Extension of the Rebuttal Period

In circumstances where we suspend an agent, broker, or web-broker's Exchange agreement(s) under proposed § 155.220(g)(5), the agent, broker, or web-broker may submit evidence in a form and manner specified by CMS to rebut the allegation(s) within 30 days of the suspension. We propose in revised § 155.220(g)(5)(ii)(B) that if the agent, broker, or web-broker submits such evidence within 30 days of the suspension, CMS will review the evidence and make a determination on whether to lift the suspension within 90 calendar days of the suspension.

We do not anticipate the proposed changes will result in costs for agents, brokers, and web-brokers because these changes do not impose any additional operational requirements or compliance burdens. We anticipate that these changes would have benefits for agents, brokers, and web-brokers seeking to gather information required to demonstrate their compliance during an administrative adjudication. Similarly, we expect this will have benefits to the overall program integrity of the FFE by allowing greater time for the development of the administrative record.

d. Restriction on Access to the FFEs and Exchange Data From Outside the United States (45 CFR 155.220(j)(2)(ix))

We propose to add 45 CFR 155.220(j)(2)(ix) to codify existing requirements in the agreements described in § 155.220(d) requiring agents, brokers, and web-brokers to implement and maintain reasonable safeguards to ensure that access and attempted access to the FFEs and SBE–FPs, systems that support the FFEs and SBE–FPs, and personally identifiable information obtained through the FFEs and SBE–FPs occurs only from locations within the United States.

We do not anticipate that agents, brokers, and web-brokers will incur costs associated with maintaining compliance with the codified standard as agents, brokers, and web-brokers are already prohibited from accessing such systems and information from outside the United States as a term of the Exchange Agreement(s) they enter into with CMS.

(1) Regulatory Review Costs for Agents, Brokers, and Web-Brokers

We do anticipate there may be regulatory review and training costs for agents, brokers, and web-brokers participating in the Exchanges. In calculating these cost, we assumed approximately 8,046 medical and health service managers (Code 11–9111) would review this proposed rule. This assumption was informed by the 2027 HHS Notice of Benefit and Payment Parameters (NBPP) Final Rule, which uses the same estimate of reviewers when estimating regulatory review costs.[227] The NBPP is CMS' primary annual regulation governing the agency's marketplace programs and is therefore sufficient precedent and an adequate proxy for estimating the number of reviewers. Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimated that the cost of reviewing the proposed rule is $135.54 per hour, including overhead and fringe benefits (*https://data.bls.gov/oes/#/area/0000000/2025*). It would take 5.05 hours for one person to review half of the rule, clarify uncertainties, and disseminate the information to all the relevant decision makers within the organizations, assuming an average word read per minute of 250. Thus, we anticipate that the regulatory review cost for the agent, broker, and web-broker community will be approximately $5,507,301.94. We seek comments on these estimates and assumptions.

5. Clarifying Existing Requirement and Adding a New Unsolicited Beneficiary Contact Prohibition

a. Stakeholders Impacted

The proposed unsolicited beneficiary contact provisions would affect Medicare-enrolled DMEPOS suppliers, Medicare beneficiaries, and CMS. DMEPOS suppliers would be responsible for complying with the applicable beneficiary contact requirements. The provisions are intended to protect Medicare beneficiaries from prohibited unsolicited contact, with CMS responsible for oversight and enforcement of the supplier standards.

b. Regulatory Review Costs for Reading, Clarifying, and Disseminating the Rule, and the Costs of Clarifying the Existing Requirement and Adding a New Unsolicited Beneficiary Contact Prohibition (42 CFR 424.57(c)(11); 42 CFR 424.57(c)(31))

The provision contained in this proposed rule will impact DMEPOS suppliers. In 2025 there were 79,360 approved DMEPOS supplier Medicare enrollments. Using the mean hourly wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing the proposed rule is $67.77 per hour ($135.54 including overhead and fringe benefits).[228] Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 12.688 minutes for the staff to review this provision of the proposed rule (review includes clarification and dissemination). For each entity that reviews this provision of the proposed rule, the estimated cost is $28.66 (12.688 minutes × $135.54 per hour). We are estimating that only half of the approved DMEPOS suppliers Medicare enrollments will review this provision of the proposed rule. Therefore, we estimate that the total cost of reviewing this provision of the proposed rule is $1,137,229 ($28.66 × 39,680 reviewers) (where 79,360 approved DMEPOS supplier Medicare enrollments divided by 2 equals 39,680 reviewers). We do not believe that DMEPOS suppliers will incur additional costs beyond the one-time regulatory review cost to review, clarify, and disseminate the proposed rule. The provisions contained in this proposed rule are primarily procedural and do not require DMEPOS suppliers to incur additional operating costs, as DMEPOS suppliers typically maintain such policies and records regarding contact with beneficiaries and furnishing of DMEPOS items to beneficiaries as a usual and customary business practice. We solicit comments on our proposed burden estimates and assumptions.

D. Regulatory Review Costs

Although we request comments from stakeholders on the potential number of reviewers of the Medicare, Medicaid, CHIP, and MA provider enrollment portions of this proposed rule, we will tentatively project—solely for purposes of soliciting comment and only for purposes of this particular proposed rule—we will estimate that 8,250

[227] *https://www.federalregister.gov/documents/2026/05/20/2026-10050/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2027-and.*

[228] *https://data.bls.gov/oesprofile/?year=2025&major_group=110000&occupation=119111&measure=01&areas=INDUSTRY,STATE,MSA.*

persons will read these enrollment provisions. Using the May 2025 wage information from the BLS for medical and health services managers (code 11–9111), we estimate that the cost of reviewing this rule is $135.54 per hour, including fringe benefits and overhead costs (*https://data.bls.gov/oes/#/area/0000000/2025*). Assuming an average reading speed for technical materials of 250 words per minute, we project that it will take approximately 1.5 hours for each person to review these sections. For each person that reviews the rule, the estimated cost is $203.31 (1.5 hours × $135.54). Therefore, we estimate that the total cost of reviewing the provider enrollment sections of this proposed rule is $1,677,308 ($203.31 × 8,250 reviewers).

E. State Medicaid Agency Regulatory Review and Training Costs

We anticipated one medical and health service manager (Code 11–9111) from each of the 50 States, the District of Columbia, and the applicable territories to read, clarify, and disseminate this proposed rule. Including all States and territories (hereafter collectively ''States''), there are 56 Medicaid programs in the United States.

It is possible that some of these reviewers will choose not to comment on the proposed rule. Therefore, we assumed that approximately 56 Medicaid programs may review the proposed rule. For these reasons, we think that the number of Medicaid programs in the United States would be a fair estimate of the number of reviewers who are directly impacted by the proposed rule. We are requesting comments on this assumption.

We also recognize that different Medicaid health service managers are in many cases affected by mutually exclusive sections of the proposed rule. However, for the purposes of our estimate, we assume that each Medicaid Health Service Manager reads 50 percent of the proposed rule.

Using the May 2025 mean (average) wage information from the BLS for medical and health services managers (Code 11–9111), we estimated that the cost of reviewing the proposed rule is $135.54 per hour, including fringe benefits and other indirect costs (*https://data.bls.gov/oes/#/area/0000000/2025*). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 303.03 minutes (5.05 hours) for the staff to read the proposed rule, which is approximately 75,759 words. For each medical and health services manager (Code 11–9111) that reviews the proposed rule, the estimated cost is (5.05 × $135.54) or $684.48. In part, we estimate that the cost of reviewing this proposed rule by medical and health service managers is $38,330.72 ($684.48 × 56 reviewers).

We also assume that it would take approximately two hours for State Medicaid agencies, medical and health service managers to train their staff on the provisions in this rule. Therefore, the total cost for training is $15,180.48 (2 hours × 56 States × $135.54).

The regulatory review and training costs that would be incurred by States do involve direct transfer of funds because of the 50-percent Federal administrative match.

We acknowledge that these assumptions may understate or overstate the costs of reviewing the proposed rule.

F. Summary of Cost and Benefits From the CRUSH Rule

Table C–B8 is a comprehensive summary of the costs and benefits/savings related to the CRUSH rule over a 10-year period, broken out by provision.

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TABLE C-B8: TOTAL COST/COST SAVINGS OF PROPOSED POLICIES BY YEAR (in Millions)

Category of Provisions	Year(s)										
TRANSFERS	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**10-year Total**
MA RADV	(2,201.80)	(16,804.20)	(16,813.60)	(13,586.70)	(6,793.30)	(6,793.30)	(6,793.30)	(6,793.30)	(6,793.30)	(6,793.30)	(90,166.10)
Medicaid PERM CAPs	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.30)
Medicaid NPI Requirements for States	0.36	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.36
Medicaid/CHIP Beneficiary Eligibility Audits	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	2.35
Medicaid/CHIP Managed Care Oversight Policies	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	7.40
Medicaid Payment Suspensions Updates	0.05	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.20
Medicaid State Reporting Requirements	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	4.40
Medicaid MEQC Deregulation	N/A	N/A	N/A	(11.01)	(11.01)	(11.01)	(11.01)	(11.01)	(11.01)	(11.01)	(77.07)
TOTAL TRANSFER COSTS	**(2,200.00)**	**(16,802.80)**	**(16,812.20)**	**(13,596.31)**	**(6,802.91)**	**(6,802.91)**	**(6,802.91)**	**(6,802.91)**	**(6,802.91)**	**(6,802.91)**	**(90,228.76)**
COSTS	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**10-year Total**
ICR Costs to States											
Medicaid PERM CAPs (42 CFR 431.992(a))	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.20
Medicaid PERM CAPs (42 CFR 431.992(c))	0.00395	0.00395	0.00395	0.00395	0.00395	0.00395	0.00395	0.00395	0.00395	0.00395	0.04
Medicaid NPI Requirements for States	0.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.33
Medicaid/CHIP Beneficiary Eligibility Audits	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	2.35
Medicaid State Reporting Requirements	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	4.40
Medicaid MEQC Deregulation	0.00	0.00	0.00	-11.01	-11.01	-11.01	-11.01	-11.01	-11.01	-11.01	-77.07
TOTAL ICR COSTS TO STATES	**1.03**	**0.70**	**0.70**	**-10.31**	**-10.31**	**-10.31**	**-10.31**	**-10.31**	**-10.31**	**-10.31**	**-69.75**
Other Costs to States	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**10-year Total**
Medicaid/CHIP Managed Care Oversight Policies	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	7.40
Medicaid Payment Suspensions Updates	0.05	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.20
Other Costs to States	**0.79**	**0.76**	**0.76**	**0.76**	**0.76**	**0.76**	**0.76**	**0.76**	**0.76**	**0.76**	**7.60**
TOTAL COSTS TO STATES	**1.82**	**1.46**	**1.46**	**(9.55)**	**(9.55)**	**(9.55)**	**(9.55)**	**(9.55)**	**(9.55)**	**(9.55)**	**(62.11)**
Private Costs	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**10-year Total**
Medicaid NPI Requirements for Providers (PCAs/HHAs)	14.81	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	14.81
MA RADV ICR	60.20	22.57	22.57	22.57	22.57	22.57	22.57	22.57	22.57	22.57	263.33
MA & Part D Mandatory Reporting ICR	1.09	1.09	1.09	1.09	1.09	1.09	1.09	1.09	1.09	1.09	10.90
MA & Part D RADV & Mandatory Reporting Regulatory Review Costs	0.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.20
Provider Enrollment ICR	12.22	12.22	12.22	12.22	12.22	12.22	12.22	12.22	12.22	12.22	122.20
DMEPOS Supplier Survey Requirements	2.09	2.09	2.09	2.09	2.09	2.09	2.09	2.09	2.09	2.09	20.90
Provider Enrollment Regulatory Review Costs	1.68	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.68
Marketplace Regulatory Review Costs	5.51	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.51
Clarifying Existing Requirement and Adding a New Unsolicited Beneficiary Contact Prohibition Regulatory Review Costs	1.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.14
TOTAL PRIVATE COSTS	**98.94**	**37.97**	**37.97**	**37.97**	**37.97**	**37.97**	**37.97**	**37.97**	**37.97**	**37.97**	**440.67**
TOTAL COSTS	**100.76**	**39.42**	**39.42**	**28.41**	**28.41**	**28.41**	**28.41**	**28.41**	**28.41**	**28.41**	**378.51**

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G. Alternatives Considered

1. Medicaid and CHIP Program Integrity

a. PERM CAPs (§§ 431.992(a), (b)(3)(ii)(E), (b)(3)(ii)(F), (c), and (e) and 431.1010(b)(2)(ii))

We considered maintaining the current requirements in § 431.992. Under this alternative, each of the 17 States in an annual PERM cycle would continue to submit separate Medicaid and CHIP CAPs, and affected States would continue to submit eligibility corrective action implementation updates every other month. This alternative would avoid regulatory changes, but it would preserve duplicative submissions, require 85 additional responses and 714 additional burden hours each year compared with the proposed approach, and leave the current CMS review and revision process unstated in the regulation. We determined that requiring one combined CAP, reducing the update frequency to every 6 months, and formalizing the review and revision process would reduce administrative burden while preserving program-specific requirements and CMS oversight.

b. Medicaid Managed Care Capitation Payments and Reporting of Enrollee Changes in Circumstances (§§ 438.3(c)(2), 438.608(a)(3), and 438.608(d)(1)(iv))

We considered maintaining the current requirements. Managed care plans would continue to notify States promptly when they receive information about an enrollee's death or change of residence, without a specified 30-calendar-day deadline, and States would continue to administer capitation payments and recoveries under existing requirements. This alternative would avoid implementation costs attributable to the proposed changes, but it would leave States and managed care plans without the proposed reporting deadline and recovery clarifications. The burden analysis estimates $1.67 million in one-time setup costs and, for an illustrative 100,000 reports, $1.88 million in annual processing costs under the proposed approach. These amounts should not be treated as the savings from maintaining current requirements because managed care plans and States already perform some reporting and processing, and the number of additional reports is unknown. We determined that a defined reporting deadline and clearer recovery procedures would help States address changes in enrollee circumstances and improper capitation payments more consistently. We cannot quantify the additional recoveries attributable to the proposal.

c. Revisions to 455.17 Reporting Requirements

CMS does not currently collect this information from states. The alternative to updating and adding the updated requirements is to continue not collecting the information or to collect the information without the enhanced reporting requirements.

d. Medicaid Payment Suspensions Updates (§ 455.23)

- *No Action (Status Quo).* Under the status quo, the inconsistencies, gaps, and inefficiencies identified above would persist. States would continue to apply divergent standards for CAF determinations, payment suspensions would continue to lapse due to law enforcement declinations, good cause exceptions would continue to be overutilized, and CMS would continue to receive only annual reporting data. This alternative was rejected because it fails to address the documented program integrity vulnerabilities and does not reflect 15 years of implementation experience.
- *Mandatory (Rather Than Permissive) Reliance on External CAF Determinations.* CMS considered but did not propose requiring SMAs to accept all externally determined CAFs without any independent review. This alternative was rejected because it would eliminate State flexibility and could result in payment suspensions being initiated based on CAF determinations that may not be fully applicable to the Medicaid context. Moreover, it would not comply with current statutory language referencing CAF determinations by the State. The proposed permissive standard appropriately preserves State discretion while reducing unnecessary duplication.
- *Mandatory Payment Suspension Maintenance.* CMS considered but did not propose requiring SMAs to maintain payment suspensions in all cases where a CAF remains unresolved, regardless of law enforcement declination. This alternative was rejected because it would eliminate State flexibility and could result in open-ended suspensions in cases where the underlying investigation has effectively concluded. Moreover, it would not comply with current statutory language requiring a pending investigation. The proposed permissive standard with quarterly redetermination requirements appropriately balances these considerations.
- *Monthly Reporting.* CMS considered but did not propose increasing the reporting cadence to monthly rather than quarterly. This alternative was rejected because the incremental oversight benefit of monthly reporting was not considered sufficient to justify the additional administrative burden on SMAs, particularly given that the primary data sources (case tracking systems) may not be updated this frequently.

e. National Provider Identifier (NPI) Requirements for Medicaid Providers (§ 455.440)

We considered an alternative in which we would encourage, but not require, States to maintain another unique identifier for providers who are not eligible to obtain an NPI. While we encourage this as a best practice, we are not currently proposing it as a requirement, but we may adopt it, or other approaches in the final rule based on comments and evidence received.

Instead, we are focusing potentially mandating NPIs, which are a national standard and covers the vast majority of providers in the majority of states, and we believe the most effective approach to achieving our program integrity goals without imposing unnecessary burden for non-traditional or atypical provider types. We believe the current proposal strikes the right balance by establishing a consistent enterprise-wide identifier where it is most impactful. However, we invite comments on alternative approaches for reliable provider identification, in particular for providers where direct oversight is limited and fraud risk is elevated, for example those providers furnishing services in home- and community-based settings. Please submit supporting data and explain how each approach would address the issues at hand. Depending on the comments and evidence received, the final rule may adopt the proposed approach, the alternative described here, or a variation within the range described in this notice.

f. Requirements for Program Integrity Corrective Action Plans (§ 455.600, *et seq.*)

We considered maintaining the status quo, relying on our existing, limited authorities to encourage State compliance. However, we determined that this alternative would allow repeat audit findings and program vulnerabilities to persist without a formalized enforcement mechanism, undermining the overarching goals of Medicaid program integrity modernization.

g. Medicaid Beneficiary Eligibility Audits (§ 455.700, *et seq.*)

We considered, but did not propose, a targeted methodology for the Medicaid and CHIP beneficiary eligibility audits. Targeted beneficiary eligibility audits would only focus on a subset of Medicaid and CHIP beneficiaries, such as only those from a specific eligibility category. It was determined that a targeted audit methodology would not be compliant with section 1903(u) of the Act and therefore, could not lead to potential eligibility-related disallowances. We also considered, but ultimately did not propose, selecting States for eligibility audits exclusively using a risk-based analysis. To ensure more equitable treatment, we propose auditing every State on a minimum 5-year audit cadence, while also selecting a few additional States each year based on their risk score.

h. Enhanced Electronic Visit Verification (EVV) Requirements

We considered, but ultimately did not propose, requiring States to implement claims processing edits for services subject to Federal or State EVV requirements, which would mean that applicable claims without a matching EVV record would be rejected automatically. This regulatory requirement would likely require significant investments from States and the Federal Government to upgrade Medicaid systems. We did not propose this alternative because of unresolved operational issues associated with implementing automatic claims edits, including potential variations in State EVV and claims processing systems.

2. Medicare Advantage and Medicare Part D Program Integrity

a. Risk Adjustment Data Validation (RADV)

This rule includes transfers from MA organizations to the Federal Government. The aggregate impact of each of these over 10 years is approximately $90.2 billion (see Table C–B8). Various alternatives to this rulemaking were considered, including the use and timing of extrapolation. These alternatives are described in this section of this rule.

b. Alternatives Related to the Extrapolation of RADV Findings

As an alternative to our decision to extrapolate our RADV audits beginning in PY 2018, we considered policies whereby we would not extrapolate and would only collect improper payments associated with sampled enrollees as a result of RADV audits. While such a policy would likely be favorably received by MA organizations, it would result in a drastic reduction in potential recoveries and dilute the sentinel impact that the RADV program has on reducing the Part C improper payment rate. More specifically, we estimate that total non-extrapolated overpayment recoveries would be approximately $89.7 billion less than total extrapolated overpayment recoveries for the time period of 2027–2036. Further, the RADV audit program would have a negative return on investment of approximately $3.2 million per calendar year. This assumes the annualized monetized cost of the contract-level RADV audit program is approximately $48 million and annualized monetized non-extrapolated recoveries of $44.8 million. CMS has a fiduciary responsibility to reduce and recover improper payments for the Medicare Trust Funds. Not extrapolating and incurring a negative return on investment for the audit program would be in direct conflict with our responsibilities under the PIIA to reduce improper payments and fiduciary responsibility to recover improper payment from the Medicare Trust Funds, and therefore, this alternative was not an acceptable alternative to CMS.

c. Alternatives Related to the Application of an FFS Adjuster to RADV Improper Payment Determinations

As an alternative to our proposal to not apply an FFS Adjuster to our RADV overpayment determinations, we considered a policy whereby we would apply an FFS Adjuster to RADV overpayment determinations. We believe such an approach through regulatory or other means would be an unsupportable and unreasonable interpretation of the Act.

As previously described, we have determined that the ''actuarial equivalence'' and ''same methodology'' provisions do not apply to the obligation of an MA organization to report and return overpayments that they have identified, including overpayments due to lack of medical record support for diagnoses, or their obligation to return overpayments identified based on a RADV audit. In *UnitedHealthcare,* the D.C. Circuit held that actuarial equivalence and same methodology do not apply to the MA organizations' obligation to report and return overpayments that they have identified, including overpayments arising from the MA organizations' submission of and payments based on diagnoses unsupported by their beneficiaries' medical records. Although *UnitedHealthcare* addressed the enforceability of the Part C overpayment regulation, its reasoning applies just as strongly in the RADV context and supports our proposed conclusion that the use of an FFS Adjuster is neither required nor appropriate for a RADV audit.

We also believe that it would be unreasonable to interpret the Act as requiring a minimum reduction in payments in one provision (the coding pattern provision), while at the same time prohibiting CMS in an adjacent provision (the actuarial equivalence provision) from enforcing those longstanding documentation requirements (by requiring an offset to the recovery amount calculated for CMS audits). To the contrary, because the Act requires CMS to reduce payments to MA organizations by at least a specific minimum percentage, the only reasonable interpretation of the Act is that CMS would pay MA organizations at those reduced rates, under the existing payment model,[229] and enforce the longstanding documentation requirements through CMS' audits.

d. Alternatives Related to Mandatory Reporting of Fraud, Waste, and Abuse

An alternative to this proposal would be to keep the existing policy requirements at §§ 422.503(b)(4)(vi)(G)(4) through (7) and 423.504(b)(4)(vi)(G)(4) through (7), that state MA organizations and Part D plan sponsors are required, in accordance with §§ 422.503(b)(4)(vi)(G)(5) and 423.504(b)(4)(vi)(G)(5), to report information concerning: (1) any payment suspensions implemented by a plan sponsor, pending the investigation of credible allegations of fraud by a pharmacy, which must be implemented in the same manner as the Secretary's implementation under section 1862(o)(1) of the Act; and (2) investigations, credible evidence of suspicious activities of a provider of services (including a prescriber) or supplier, and other actions taken by the plan sponsor related to the inappropriate prescribing of opioids to the Health Plan Management System (HPMS) Fraud, Waste, and Abuse (FWA) Reporting Module. While CMS currently encourages plan sponsors to report referrals of substantiated or suspicious fraud, waste, or abuse to CMS, it is not mandatory. However, as described in section IV. of this proposed rule, CMS believes that requiring the

[229] Any changes to the CMS–HCC risk adjustment model are published in the annual Rate Announcement.

reporting of referrals of substantiated or suspicious FWA mandatory for MA organizations and Part D plan sponsors, as well as expanding the required reporting of credible allegation of fraud payment suspensions by pharmacies to all provider and supplier types will strengthen oversight of the Medicare Part C and Part D programs, as this information is valuable in assisting with investigations, referrals to law enforcement, and trend monitoring. In addition, more stringent reporting requirements would allow CMS to appropriately share the more robust data on referred providers or suppliers with other MA organizations and Part D contracts on a quarterly basis to assist in their own internal fraud, waste, and abuse efforts. Data transparency and information sharing with our partners are at the core of CMS' strategy to crush fraud.

An alternative for estimating regulatory review cost includes assuming one reader per parent organization. Using parent organizations instead of contracts would reduce the number of reviewers to approximately 300, and this would reduce the total cost of reviewing by 69 percent. However, we believe it is likely that reviewing will be performed at the contract level. The argument for this is that a parent organization might have local reviewers; even if that parent organization has several contracts that might have a reader for each distinct geographic region, to identify effects of provisions specific to that region.

3. Provider Enrollment Program Integrity

There are number of alternatives we considered.

First, we considered reproposing with only slight modifications our proposal in our March 1, 2016, provider enrollment proposed rule (81 FR 10720) to give CMS the authority to reject surety bonds from a surety that failed to make a required payment to CMS. However, we believe that adhering to the general principles of 31 CFR 223 regarding (1) surety bond declination and (2) rebuttal rights for sureties was the better approach, for it would facilitate a more robust process for all parties.

Second, we contemplated indefinitely continuing with the existing preclusion list for MA providers. As we explained in section V. of the proposed rule (81 FR 10720), though, we are very concerned about providers potentially billing MA without the strict screening that the fee-for-service provider enrollment process affords.

Third, and with respect to our Medicaid and CHIP provider enrollment proposals, we considered (1) making our proposed new denial and termination grounds in § 455.416 discretionary and (2) requesting more information from providers under §§ 455.104 and 455.106 (such as additional adverse actions) than we proposed to collect. With the former, we decided to make the grounds mandatory to remain consistent with the mandatory nature of most of § 455.416's existing reasons and to help facilitate consistency between States; discretionary grounds, we believe, would lead to inconsistent determinations across States. Regarding the data collection, we did not go beyond what we proposed in order to limit the burden on providers.

We wish to emphasize that the goal of our enrollment provisions is not to burden providers and suppliers, particularly small businesses. We recognize the concerns that some stakeholders expressed in their comments on the CY 2027 HH PPS proposed rule regarding the enrollment provisions in that proposed rule. We also stress that we will only take denial and revocation action under our proposals only when genuinely warranted after a thorough and careful review of the facts and circumstances of the case; we are well aware of the impact that a revocation can have on a provider or supplier. Nonetheless, we have an obligation to protect the Medicare, Medicaid, CHIP, and MA programs, their beneficiaries, and the taxpayers (which includes providers and suppliers themselves) from improper payments and fraud, waste, and abuse. This is the overriding reason for our enrollment proposals, all of which we feel are necessary to target significant program vulnerabilities we have seen.

4. Marketplace Program Integrity

Regarding the opportunity to refute determinations of noncompliance, CMS considered retaining the existing ''resolved to the satisfaction of HHS'' standard in § 155.220(g)(3)(i) without modification but determined providing agents, brokers, and web-brokers with an opportunity to refute determinations of noncompliance or submit information for CMS' consideration before enforcement action is taken improves procedural clarity and fairness as discussed in more detail above in this proposed rule. CMS also considered retaining the existing ''sufficiently severe'' standard in § 155.220(g)(1) as the sole basis for determining whether to terminate an agreement for cause and impose other penalties after making a finding of noncompliance, with the exception of determinations made in accordance with § 155.220(g)(3)(ii) through (iv) as proposed in this proposed rule. CMS determined that relying solely on that standard may not adequately account for the full range of circumstances relevant to enforcement determinations, including repeated or escalating noncompliance that may collectively result in significant consumer harm or risks to Exchange operations. CMS further considered adopting a more prescriptive framework establishing fixed numerical thresholds or specific categories of violations that would automatically result in termination or other penalties. CMS declined to adopt such an approach because it would reduce flexibility and may not appropriately account for the varying factual circumstances presented in individual cases.

We considered leveraging the existing regulatory standards for abusive conduct cases, which allow enforcement action against an agent, broker, or web-broker engaging in noncompliance under § 155.220(g)(1) through (3). However, the current noncompliance standards do not allow for an immediate suspension of an agent, broker, or web-broker's Exchange Agreement(s), which is critical for abusive conduct cases that often involve high-risk behavior and imminent consumer harm. We determined that updating § 155.220(g)(5) to an abusive-conduct standard from a fraud-based standard would better reflect the types of cases identified during our investigations, improve transparency on CMS' enforcement action processes, allow CMS to address abusive conduct quickly, and reduce consumer harm.

Finally, CMS considered continuing to address restrictions on foreign access solely through agreement terms entered into under § 155.220(d) rather than codifying these requirements in regulation. HHS determined that codifying these standards in regulation would provide greater clarity, transparency, and enforceability regarding the obligations of agents, brokers, and web-brokers and would ensure that violations are subject to the full range of remedial actions available under § 155.220. CMS also considered adopting more technology-specific requirements, such as mandating particular technical controls or security measures, but declined to do so because technical specifications may become outdated over time and may be more appropriately addressed through operational guidance or Exchange agreement(s) requirements.

5. Clarifying Existing Requirement and Adding a New Unsolicited Beneficiary Contact Prohibition

An alternative to this proposal would be to keep the existing policy prohibiting unsolicited beneficiary contact by DMEPOS suppliers and their agents when supplying a Medicare covered item by telephone. However, as described in section VII. of this proposed rule, DMEPOS fraud, waste, and abuse in the Medicare program remains a serious problem that has placed billions of taxpayer dollars at risk and may result in beneficiary harm. We believe that the proposed clarification and addition will strengthen program integrity safeguards for the Medicare program and reduce fraudulent billing for Medicare DMEPOS.

H. Accounting Statement and Table

As required by OMB Circular A–4, we have prepared an accounting statement in Table C–B9 showing the classification of the impact associated with the provisions of this rule. Monetary annualized benefits and non-budgetary costs are presented using 3 percent and 7 percent discount rates. The annualized costs of $46.08 million reflect the costs accruing to Providers (PCAs/HHAs), MA RADV ICR, MA & Part D Mandatory Reporting ICR MA & Part D RADV & Mandatory Reporting Regulatory Review Costs, and Provider Enrollment ICR. Meanwhile, the saving accruing to states results from the annual burden from 1,326 hours to 612 hours, and these savings to States do not come at the expense of high-risk recipients. However, most of the annualized transfers of $9,335.20 derive from businesses or high-risk recipients back to the federal government. These transfers derive from the GAO recommendations to focus on contracts at higher risk for improper payments, over the next ten-year period from 2027–2036, with the total estimated overpayments (with extrapolation) over the time period of $90.2 billion (see Table C–B8). The impact on these high-risk recipients cannot be determined at this time. Thus, we seek comments from the public to aid in understanding the impact these transfers will have on these high-risk recipients.

TABLE C-B9: ACCOUNTING STATEMENT (MILLIONS $)

Category	Estimate	Year	Source
Annualized monetized costs *:			
7% Discount	46.08	2027-2036	RIA
3% Discount	44.91	2027-2036	RIA
Annualized monetized costs to States:			
7% Discount	(5.39)	2027-2036	RIA
3% Discount	(5.86)	2027-2036	RIA
Annualized monetized transfers:			
7% Discount	(9,335.20)	2027	RIA
3% Discount	(9,165.43)	2027	RIA

I. Initial Regulatory Flexibility Act (IRFA)

The IRFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the IRFA, HHS estimates that many impacted entities are small entities, as that term is used in the IRFA, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business. Small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Individuals and states are not included in the definition of a small entity. Executive Order 13272 requires that HHS thoroughly review rules to assess and take account of their potential impact on small businesses, small governmental jurisdictions, and small organizations (as mandated by the IRFA).

If a proposed rule has a significant economic impact on a substantial number of small entities, then the proposed rule must discuss steps taken, including alternatives considered, to minimize the burden on small entities. The IRFA does not define the terms ''significant economic impact'' or ''substantial number''. The SBA advises that this absence of statutory specificity allows what is ''significant'' or ''substantial'' to vary, depending on the problem that is to be addressed in rulemaking, the rule's requirements, and the preliminary assessment of the rule's impact. Nevertheless, HHS typically considers a ''significant'' impact to be 3 to 5 percent or more of the affected entities' costs or revenues and a ''substantial number'' to be greater than 5 percent of entities.

The IRFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the IRFA, we estimate that there are some entities that can be considered small entities as that term is used in the IRFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $9.0 million to $47.0 million in any 1 year) as of 2023). The SBA has recently updated this threshold in 2025, which has resulted in more hospitals and health care providers.[230] Given that there will be more hospitals and health care providers, the costs estimated because of this rule could be distributed more widely, and therefore each entity would end up paying a smaller share.

1. Objectives and Legal Basis

CMS' current Medicare, Medicaid and CHIP, and marketplace program integrity frameworks contain outdated, inconsistent, or incomplete requirements across several regulatory areas. These gaps limit CMS' ability to detect fraud, hold States accountable, and recover improper payments. The provisions in this rule discuss these gaps by modernizing reporting, clarifying enforcement authority, and closing structural vulnerabilities in oversight tools. Small businesses,

[230] **Federal Register**:: *Small Business Size Standards.*.

including DMEPOS suppliers, insurance agents, brokers, and web-brokers would face minimal costs for implementing the provisions discussed in this rule. At this time, we cannot determine the cost for each impacted industry, but as can be seen in Table C–B13, if we assume the annualized costs of $46.08 million are distributed evenly over each impact entity, then that cost would be a minimal cost of $127.65. We are seeking comments from the public regarding this assumption.

Thus, we are proposing enhancements to our DMEPOS supplier surety bond process under § 424.57(d). This rule includes a proposal to clarify the existing prohibition against unsolicited beneficiary contact by DMEPOS suppliers to make explicit the inclusion of third-party entities acting as the agents of DMEPOS suppliers; and to clarify that the prohibition against unsolicited beneficiary contact by telephone refers to a telephone call or message, including text messages. This rule also includes a proposal to add a new supplier standard under 42 CFR 424.57(c)(31) to prohibit unsolicited beneficiary contact by DMEPOS suppliers and their agents when supplying a Medicare-covered item by direct messages from social media platforms, email messages without opt-out features, and door-to-door in-person solicitation, unless a specified exception applies. At this time, we cannot determine how much revenue is currently being generated by these practices that are being banned.

Fraudulent billing for Medicare DMEPOS continues to be a major concern. Despite an existing prohibition on unsolicited beneficiary contact by telephone, DMEPOS suppliers and third parties acting as their agents are targeting Medicare beneficiaries with unsolicited text messages and other direct messages, door-to-door in person solicitation, unwanted telephone calls, and other means to engage in high-pressure marketing tactics and deceptive lead generation that allow DMEPOS suppliers to bill Medicare for medically unnecessary or unneeded items, or items that are never supplied at all. These changes are necessary to help ensure that legitimate DMEPOS suppliers are furnishing medically necessary items of DMEPOS to Medicare beneficiaries consistent with Medicare requirements, which we believe would assist in protecting the Trust Funds and Medicare beneficiaries. There could be a large reduction in revenue for these businesses, but at this time we are unable to estimate such reductions.

Additionally, this rule proposes a number of additions and amendments to 45 CFR 155.20 and § 155.220 to improve the integrity of the FFE, reduce abusive conduct by agents, brokers, and web-brokers, and better protect consumers within the FFE. We are proposing to amend § 155.20 to add a definition of ''convicted'' and ''credible allegation of abusive conduct''. We are also proposing to add participation standards for agents and brokers to § 155.220(g)(3), which would prevent agents and brokers that pose unacceptable risk from participating in the FFE. Moreover, we are proposing to amend § 155.220(g)(5) to increase transparency around program integrity oversight of the FFE and further strengthen our administrative actions against suspected bad actors and amend § 155.220(j)(2)(i) and (ii) by adding specific examples of behavior that CMS considers abusive conduct. At this time, we are unable to determine how much revenue will be lost to how many businesses because of this provision.

To further strengthen oversight, improve the fairness of enforcement proceedings following findings of agent, broker, and web-broker noncompliance as defined in § 155.220(g)(2), we are proposing additional revisions to § 155.220. Specifically, to increase transparency and to help ensure accuracy and efficiency in CMS noncompliance determinations and resulting enforcement actions, we propose to amend § 155.220(g)(3)(i) to replace the existing opportunity for agents, brokers, and web-brokers to ''resolve'' noncompliance determinations before CMS terminates their Exchange Agreements(s) and imposes other penalties with an opportunity to ''refute.'' At this time, we are unable to determine if these penalties will be cost to small entities.

We also propose codifying factors that CMS would consider when determining whether to terminate an agent, broker, or web-broker's Exchange agreement(s) with the FFE for cause and to impose penalties other than termination under 155.220(k)(1) after making a noncompliance determination. In addition, we propose to amend § 155.220(h) to clarify that agents, brokers, or web-brokers may request reconsideration when HHS denies them the right to enter into Exchange Agreement(s) in addition to when HHS terminates their Exchange Agreement(s).'' We are seeking comments from the public to aid us in determining how complicated, time-consuming, or costly such requests will be for these small businesses.

We also propose to add a new standard in § 155.220(j) to codify a term in the Exchange Agreement(s), which would prohibit agents, brokers, and web-brokers from accessing and attempting to access FFE and SBE–FPs systems that support the Exchanges, and personally identifiable information obtained through those Exchanges from outside the United States. At this time, we cannot determine the cost for the imposition of this standard nor how time-consuming and costly this will be for these small businesses. We are seeking comments from the public on these issues.

Agents, brokers, and web-brokers may be asked to submit documentation over the course of a noncompliance or abusive conduct investigation and enforcement action.

2. Impacted Entities

Excluding Medicaid and CHIP, MA Organizations, Part D Plan Sponsors, and Part D Plans, discussed in the section IX.C. of this proposed rule (Detailed Economic Analysis), small businesses that would be impacted by this rule include:

- Home Health Agencies and Personal Care Assistants.
- DMEPOS suppliers.
- Physicians.
- Hospices.
- Agents/Brokers, Web-brokers.

Data does not permit us to determine the costs or burdens will be within each industry.

3. Medicaid and CHIP

Title XIX of the Act established the Medicaid program as a federal-state partnership to provide and finance medical assistance to specified groups of eligible low-income individuals and their families. States claim federal matching funds quarterly based on their program expenditures. Medicaid managed care plans and CHIP managed care plans reflect a somewhat consolidated market with a mix of for-profit, non-profit, and government plans. Government plans often mean county run plans, but there are examples of state agencies acting as a plan. Many county plans are PIHP that provide mental health services, with the main exception of HIOs in CA (often called COHS) that provide comprehensive benefits. 2022 survey data suggest that 16 managed care firms (including Aetna, Centene, United Health Care and others) were responsible for approximately 63 percent of the market. The remaining 36 percent of managed care enrollment reflects local/regional managed care companies,[231] which are more likely to

[231] Centers for Medicare & Medicaid Services. (2026). Medicaid Managed Care Enrollment and

Continued

be considered small, though data on their size distribution by annual receipt size is limited. This kind of uncertainty makes it very difficult to certify this rule. However, since Medicaid managed care plans and CHIP managed care entities receive 100 percent capitation from the state, we expect that the projected costs associated with the provisions of this proposed rule, if finalized, will be included in their capitation rates. Currently, we cannot quantify the magnitude of these costs that small entities may or may not be able to pass through via capitation rates.

4. Medicare Advantage

Each year, MA organizations estimate costs for the upcoming plan year and then submit bids and proposed PBPs to CMS. These bids project payments to hospitals, providers, and staff for covered benefits, as well as the cost of plan administration and profits. Because the provisions proposed in this rule would apply to every MA plan and each MA plan must furnish at least the Medicare Part A and Part B benefits, we assume that the cost of implementing the stated provisions would be built into the administrative component of the basic benefit bid. At this point in time, we are unable to quantify these costs. These bids in turn determine one component of the payments of the Medicare Trust Fund to the MA organizations who reimburse providers and subcontractors for their services. A second component of the Trust Fund payment to MA organizations are the rebates, which are a portion of the difference between the basic benefit bid compared to an administratively set benchmark for the MA plan's service area (currently, based on our past and projected experience, rebates vary by plan and are approximately 66 percent). If the bid is below the benchmark, CMS pays an amount equal to the standard bid of the MA organization. However, if the bid is above the benchmark, CMS pays the portion of the cost up to the benchmark and the MA organization bears the extra cost and must charge enrollees a premium for the remaining amount, as set forth in section 1854 of the Act. As the cost of providing services by these entities is covered by a combination of government funding and in some cases by enrollee premiums, MA and Part D plans are not expected to incur burdens or losses because the private companies' costs are being supported by the government and enrolled beneficiaries. This lack of expected burden applies to both large and small MA health plans. Any MA health plans that are considered ''small'' would be expected to include the costs of compliance with the proposed regulations in their bids, thus avoiding additional burden, since the cost of complying with any regulation is funded by payments from the government and, if applicable, enrollee premiums. Historically, at most two percent of plans bid above the benchmark, and they contain roughly one percent of all plan enrollees. In the present circumstances, we are unable to quantify this burden and costs estimate.

Table C–B10 reports the percentage of MA organizations bidding above the benchmark and the percentage of affected enrollees in recent years. This table reports aggregates of proprietary bid data collected by the CMS Office of the Actuary (OACT). Unfortunately, this table does not present the direct, compliance burden since data are not available at this time. As shown in Table C–B29, the percentage of plans incurring additional costs by bidding above the benchmark is 0.11 percent in 2024 and 0.07 percent in 2025, while the CMS threshold for what constitutes a significant impact for purposes of the IRFA is 3 to 5 percent. Since at least 99 percent of MA organizations bid below the benchmark in recent years, we estimate that the federal government fully pays these MA organizations their projected costs for providing services to enrollees for the coming year. Unfortunately, we cannot determine at this time if this across-the-board increase in costs would increase the share of bids that bid above the benchmark. The preceding analysis shows that MA plans, whether small or large entities, are not significantly affected by this proposed rule since the vast majority (all but at most 1 percent) will have their costs subsidized by the federal government and would not be materially impacted. Quantifying all such (potentially passed through) costs to small entities is not possible at this time.

TABLE C-B10: PERCENTAGE OF MA ORGANIZATIONS BIDDING ABOVE THE BENCHMARK BY YEAR

Year	Number of Unique Bid IDs that Bid Above the Benchmark	Projected Enrollment in Plans that Bid Above the Benchmark (Member Months)	Number of Unique Bid IDs	Projected Enrollment (Member Months)	Bid ID Percentage	Enrollment Percentage
2024	6	15,635	5,699	328,703,043	0.11%	0.00%
2025	4	99,807	5,600	314,624,972	0.07%	0.03%

a. Direct Health and Medical Insurance Carriers and Government Health Plans (Part D Plan Sponsors)

For the purposes of this IRFA, CMS evaluates Part D Plan Sponsors or health insurance issuers categorized under the North American Industrial Classification (NAICS) code 524114 (Direct Health and Medical Insurance Carriers). Based on the latest available 2022 Statistics of U.S. Business Statistics (SUSB) from the Census Bureau, 803 total firms fall under code 524114. According to SBA size standards, entities with average annual receipts of $47 million or less would be considered small entities in this category.[232] CMS examined the premium revenue data from the MLR annual report submissions for the 2023

Program Characteristics 2024. Retrieved from *https://www.medicaid.gov/medicaid/managed-care/downloads/2024-medicaid-managed-care-enrollment-report.pdf.*

[232] U.S. Small Business Administration. (2024, October 15). Size Standards Tool. Retrieved from *https://www.sba.gov/federal-contracting/contracting-guide/size-standards/size-standards-tool.*

MLR reporting year and approximately 84 out of 479 issuers of health insurance coverage nationwide have a total premium revenue of $47 million or less.[233] Furthermore, approximately 80 percent of these small issuers belong to non-small holding groups based on the total premium revenue of all associated subsidiaries available in the MLR data. Many, if not all, of these holding group companies are likely to have other non-health lines of business in addition to health plan premium revenue that likely result in their total revenues exceeding $47 million.[234] Therefore, CMS intends to concludes that the Qualified Health Plan or Part D Plan Sponsor on the FFEs population impacted by these proposed policies may unlikely to include small entities and possibly could be excluded from this IRFA. Currently, we are unable to estimate the impact on half of these small Part D Plan Sponsors.

b. Home Health Agencies, DMEPOS Suppliers, Physicians, and Hospices

For the provisions proposed by the Provider Enrollment Program Integrity Policy, Medicare-enrolled providers and suppliers, including hospices (NAICS 623110) durable-medical equipment, prosthetics, orthotics supplies (DMEPOS) suppliers, and physicians (NAICS 6211), and other practitioners who order DMEPOS items or services, would be impacted by the proposed provisions.

According to the SBA's website at *http://www.sba.gov/content/small-business-size-standards,* DMEPOS suppliers may fall into either (NAICS code 456199) All Other Health and Personal Care Retailers, (NAICS code 532283) Home Health Equipment Rental, and (NAICS code 423450) Medical, Dental, and Hospital Equipment and Supply Merchant Wholesale. Table C–B11 shows the SBA size standards according to revenue or number of employees, and the total number of DMEPOS businesses identified as small.

TABLE C-B11: DMEPOS SUPPLIERS SIZE STANDARDS (In Millions)

NAICS (6-digit)	Industry Subsector Description	SBA Size Standard/Small Entity Threshold	Total Small Businesses
423450	Medical, Dental, and Hospital Equipment and Supply Merchant Wholesale	Fewer than 200 employees	8,031
532283	Home Health Rental	$41	450
456199	All Other Health and Personal Care Retailers	$9.5	5,421

Source: 2022 Economic Census

Since we are uncertain of the DMEPOS suppliers' composition, we seek comments from the public to aid in understanding the various industries that supply DMEPOS products. So far, we have identified only the three industries in Table C–B30. We note that Non-Employer Statistics (NES) data show an additional 738 nonemployee firms.

c. Agents/Brokers, Web-brokers

We propose to revise 45 CFR 155.220(g)(3) to add participation standards that would prevent agents, brokers, and web-brokers (NAICS 524210) posing undue risk from participating in the FFE and SBE–FPs. Note, NES data only provide data at the 5-digit level but include an additional 128,893 non-employers within the 456190 NAICS code. Nevertheless, we are unable at this time to use the SUSB data to approximate the share of these non-employers that belong to the 456199 NAICS. Agents, brokers, and web-brokers that pose undue risk would not be permitted to register, complete training, or enter into Exchange Agreement(s) with CMS. We are unsure how many are expected to fall under each category. Additionally, this proposed rule would update § 155.220(g)(3) to allow CMS to immediately terminate agents, brokers, and web-brokers who pose undue risk from participating in the FFE and SBE–FPs, without waiting 30 calendar days from the date of notice.

We do not expect the proposed changes to § 155.20 or § 155.220(g)(3) to have a financial impact on agents, brokers, or web-brokers because the changes do not impose any new requirements on them. Currently, we are unable to determine an estimate of how many agents, brokers, or web-brokers would be impacted. However, we assume that these entities would incur implementation; that is, the costs that would be incurred for their staff to read and implement the provisions proposed in this rule.

We also propose to revise § 155.220(g)(3)(i) to provide agents, brokers, and web-brokers with an opportunity to refute determinations of noncompliance, with the exception of determinations make under § 155.220(g)(3)(ii) and proposed §§ 155.220(g)(3)(iii)–(iv), prior to the termination of their Exchange Agreement(s) for cause and imposition of other penalties under § 155.220(k)(1), which would replace the existing opportunity to ''resolve'' identified noncompliance. This is explained in detail in the summary of the proposal above. We also propose to revise § 155.220(g)(1) and add a new paragraph at § 155.220(g)(1)(i) to clarify how CMS would determine whether to terminate an agent, broker, or web-broker's Exchange Agreement(s) and impose a penalty under § 155.220(k)(1) when CMS has made a determination of noncompliance under § 155.220(g)(1). The existing standard is that CMS can terminate if an agent or broker's noncompliance is ''sufficiently severe.'' We're clarifying that we'd assess severity based on several enumerated factors. We do not believe that this clarification will impact on the number of terminations.

[233] Centers for Medicare & Medicaid Services. (n.d.). Medical Loss Ratio Data and System Resources. Retrieved from *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

[234] Based on internal CMS MLR calculations. Source: Centers for Medicare & Medicaid Services. (2025, November 21). Medical Loss Ratio Data and System Resources. Retrieved from *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

TABLE C-B12: SBA SIZE STANDARDS FOR APPLICABLE NAICS INDUSTRY CODES*

NAICS Code	Description	SBA Size Standard/Entity Threshold (Millions $)	Total Small Business Count
524114	Direct Health and Medical Insurance Carriers and Government Health Plans	$47	803
621610	Home Health Services	$19	27,140
532283	DMEPOS		
456199	Home Health Rental	$41	450
	All Other Health and Personal Care Retailers[235]	$9.5	5,421
423450	Medical, Dental, and Hospital Equipment and Supply Merchant	Fewer than 200 employees	8,031
6211	Physicians	$16	141,446
623110	Hospice (Skilled Nursing Facility)	$34	9,709
524210	Insurance Agents/Brokers, Web-brokers	$15	119,114
Total			**312,114**

*Note: The SBA has recently proposed (A Proposed Rule by the Small Business Administration on 08/22/2025) to update the size standards of industries, which will (when finalized) include far more hospitals and health care providers: Federal Register :: Small Business Size Standards. https://www.federalregister.gov/documents/2025/08/22/2025-16142/small-business-size-standards-monetary-based-industry-size-standards.

At this time,we are unable to identify what share of the $90 billion in transfers will come from each industry. Nevertheless, based on the SBA size threshold described in Table C–B12, HHS analyzed the revenue for direct health and medical insurance carriers and government health plans, home health services, DMEPOS, physicians, hospice, and insurance agents/brokers, and web-brokers small businesses, which met the SBA criteria for small entities and their anticipated change in revenue, illustrated in Table C–B13. Even though the rule only impacts participants within CMS programs and the count of impacted small firms would be far smaller than the count below would suggest, we do not have that data. That said, the counts below can serve as useful proxies to determine the share of participants within each industry that qualify as small entities. Therefore, to conduct this revenue test, HHS used the total count of firms considered small based on the latest 2022 SUSB data (306,693). Given the lack of granular or disaggregated data at micro-level, it is difficult to determine the impact of only those small firms who are participants in CMS's. Therefore, at this time we assume that the impacts are spread across all the 306,693 firms. Then, HHS calculated the percentage of these small firms that fall into size ranges by receipt (''% of Small Firms'' column in Table C–B13). These percentages are applied to the average revenue *for all small entities,* which yields the average revenue for each firm's size. We do not have data for each category. The average revenue for each firm size is then divided by the annualized cost for the identified small businesses (excluding the States costs) of the proposed rule per firm and reflected as a percentage. When the annualized net primary cost estimates were determined, there were $46.08million net annualized costs for the identified industries overall. The net annualized costs for this proposed rule are $46.08 million, meaning each of the 306,963 small businesses incur a net annualized cost of $150.25, regardless of their size by receipts. Currently, we are unable to net out the $90 billion transfer costs from businesses to the federal government. Furthermore, since we do not have the data for only those small firms who participate in the relevant CMS programs, we used SUSB 306,963 small businesses as an approximate. While the compliance costs would be spread evenly across impact firms in the way we suggest, this is not the case for the $90 billion in transfers from private industry. As was stated, we are unable to determine the impact of these $90 billion transfers at this time.

This resulting percentage (''Revenue Test'' column in Table C–B13) is the anticipated revenue test for small firms due to the proposed rule. As a measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 percent and presents this analysis in Table C–B13.

5. Does the Impact on Small Businesses Meet the Two-Part Threshold

As a measure of its significant economic impact on small entities, HHS uses a change in revenue of more than 3 to 5 percent. The agency considers the rule to have a significant impact on a substantial number of small businesses when more than 5 percent of impacted small entities meet the significant economic impact threshold defined above.

According to Table C–A13, the provisions in this proposed rule would have almost no impact (<0.019 percent) on small the small businesses identified.

Moreover, given that the annual revenue for the 5th percentile firm is over $29 billion and 3 percent of this revenue gives a significant impact threshold of a significantly large estimate (>$888 million), then any cost estimates smaller than this estimate will not have a significant impact on a substantial number of small businesses. Assuming the firm size distribution provided in Table C–B13, we expect the annualized costs estimated as a result of this proposed rule to fall below this significant impact threshold. We believe that the threshold for significant economic impact on a substantial number of small businesses will not be reached by the requirements in this proposed rule. At this moment, we are unable to determine the impact of the $90 billion transfers from businesses to the federal government. Even though including the nonemployers from NES data is important, and shows that very small firms make up a much larger share of the size distribution, we are unable to determine the impact on revenue.

[235] Data by revenue buckets are not available on Census's SUSB database.

TABLE C-B13: REVENUE TEST FOR THE ECONOMIC IMPACT ON SMALL ENTITIES

Firm Size (by Receipts)	Firm Count	Percent of Small Firms	Average Revenue	Annualized Cost per Firm	Revenue Test
SMALL FIRMS	**306,693[236]**	**100.00%**	**$657,691.93**	$150.25	0.023%
<100,000	40,829	13.31	$32,036.04	$150.25	0.469%
100,000-499,999	123,181	40.16	$157,199.01	$150.25	0.096%
500,000-999,999	59,554	19.42	$320,245.14	$150.25	0.047%
1,000,000-2,499,999	45,024	14.68	$658,073.69	$150.25	0.023%
2,500,000-4,999,999	18,774	6.12	$1,496,155.55	$150.25	0.010%
5,000,000-7,499,999	7,585	2.47	$2,906,440.15	$150.25	0.005%
7,500,000-9,999,999	4,281	1.40	$3,612,879.70	$150.25	0.023%
10,000,000-14,999,999	4,621	1.51	$6,402,942.10	$150.25	0.004%
15,000,000-19,999,999	1,970	0.64	$7,983,371.24	$150.25	0.002%
20,000,000-24,999,999	377	0.12	$20,504,822.28	$150.25	0.001%
25,000,000-29,999,999	211	0.07	$23,949,739.34	$150.25	0.001%
30,000,000-34,999,999	165	0.05	$25,559,327.27	$150.25	0.001%
35,000,000-39,999,999	39	0.01	$33,442,666.67	$150.25	0.000%
40,000,000-49,999,999	82	0.03	$39,102,621.95	$150.25	0.000%
LARGE FIRMS					
Receipts > 49 million	NA	NA	NA	NA	NA

J. Alternatives for Small Entities

As was mentioned previously, this proposed rule would update § 155.220(g)(3) to allow CMS to immediately terminate agents, brokers, and web-brokers who pose undue risk from participating in the FFE and SBE–FPs, without waiting 30 calendar days from the date of notice. As an alternative, CMS would terminate agents, brokers, and web-brokers who pose undue risk from participating in the FFE and SBE–FPs, after 30 calendar days from the date of notice.

Additionally, as was also mentioned previously, we are proposing enhancements to our DMEPOS supplier surety bond process under § 424.57(d). This rule includes a proposal to clarify the existing prohibition against unsolicited beneficiary contact by DMEPOS suppliers to make explicit the inclusion of third-party entities acting as the agents of DMEPOS suppliers; and to clarify that the prohibition against unsolicited beneficiary contact by telephone refers to a telephone call or message, including text messages. This rule also includes a proposal to add a new supplier standard under 42 CFR 424.57(c)(31) to prohibit unsolicited beneficiary contact by DMEPOS suppliers and their agents when supplying a Medicare-covered item by direct messages from social media platforms, email messages without opt-out features, and door-to-door in-person solicitation, unless a specified exception applies.

1. Identifying Duplication

CMS confirms that the proposed provisions in this rule do not duplicate efforts of previous rulemaking, but rather, they build upon and refine them to ensure that CMS' current Medicaid and CHIP program integrity framework contains updated, consistent or complete or requirements across several regulatory areas. These requirements will greatly enhance CMS' ability to prevent and detect fraud, hold States accountable, and recover improper payments.

2. Conclusion and Request for Public Comments

CMS concludes that the provisions relevant to impacted entities do not produce a significant economic impact on a substantial number of impacted small businesses. CMS seeks public comments on their assumptions related to the number of direct health and medical insurance carriers and government health plans, home health agencies, personal care assistants, DMEPOS suppliers, physicians, hospices, and agents/brokers, and web-brokers, that could be considered small businesses, small governmental jurisdictions, or small organizations. We request public comments specifically on how the provisions increase or decrease administrative burden for small entities.

For the purposes of the IRFA analysis, CMS concludes that there is not a significant impact on small entities. As a measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 percent. As illustrated by the revenue test in Table C–B13, none of the small firm sizes approached the 3 percent threshold.

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 603 of the IRFA. For the 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. Therefore, the Secretary has certified that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals, and as a result we are not preparing an analysis for section 1102(b) of the Act.

K. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. This proposed rule would not impose a mandate that will result in the expenditure by State, local, and Tribal

[236] Data does not include 5,421 firms revenue estimates for NAICS 456199–All Other Health and Personal Care Retail.

Governments, in the aggregate, or by the private sector, of more than $193 million in any 1 year.

L. Federalism

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.

M. E.O. 14192, ''Unleashing Prosperity Through Deregulation''

Executive Order 14192, entitled ''Unleashing Prosperity Through Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.'' [237] This proposed rule, if finalized as proposed, is expected to be exempt from otherwise-applicable requirements under E.O. 14192, per footnote 1 of the OMB's Accounting Methods.[238]

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document.

List of Subjects

42 CFR Part 410

Diseases, Health facilities, Health professions, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 417

Administrative practice and procedure, Grant programs—health, Health care, Health insurance, Health maintenance organizations (HMO), Loan programs—health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 422

Administrative practice and procedure, health facilities, health maintenance organizations (HMO), Medicare, penalties, privacy, and reporting and recordkeeping requirements.

42 CFR Part 423

Administrative practice and procedure, emergency medical services, health facilities, health maintenance organizations (HMO), health professionals, Medicare, penalties, privacy, reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 431

Grant programs—health, Health facilities, Medicare, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 438

Citizenship and naturalization, Civil rights, Grant programs—health, Individuals with disabilities, Medicaid, Reporting and recordkeeping requirements, Sex discrimination.

42 CFR Part 447

Accounting, Administrative practice and procedure, Health professions, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 455

Fraud, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Health insurance, and Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, and Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interests, Consumer protection, Grants administration, Grant programs—health, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Technical assistance, Women and youth.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV and the Department of Health and Human Services proposes to ament 45 CFR part 155 as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

Authority: 42 U.S.C. 1302, 1395m, 1395hh, 1395rr, and 1395ddd.

■ 1. Section 410.33 is amended by revising paragraph (g)(2) to read as follows:

§ 410.33 Independent diagnostic testing facility.

* * * * *

(g) * * *

(2) Provides complete and accurate information on its enrollment application. All changes in enrollment information must be reported to the Medicare fee-for-service contractor within 30 calendar days of the change.

* * * * *

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

■ 2. The authority citation for part 417 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh and 300e, 300e-5, and 300e–9, and 31 U.S.C. 9701.

■ 3. Section 417.478 is amended by—

■ a. In the introductory text, removing the phrase ''to comply with—'' and adding in its place the phrase ''to comply with all of the following:'';

■ b. In paragraphs (a) and (b), removing ''; '' and adding in its place ''.'';

■ c. In paragraph (c), removing ''; and'' and adding in its place ''.''; and

■ d. Redesignating paragraphs (e)(1) and (2) as paragraphs (e)(1)(i) and (ii).

■ e. In paragraph (e)(1) introductory text, adding the phrase ''Before January 1, 2030.''—

■ f. Revising newly redesignated paragraph (e)(2).

The revisions and additions read as follows:

§ 417.478 Requirements of other laws and regulations.

* * * * *

(e) * * *

(2) Beginning January 1, 2030, —t

(i) The prohibitions, procedures, and requirements of §§ 422.223 and 422.224 of this chapter, which require all providers or suppliers that are types of individuals or entities that can enroll in Medicare in accordance with section 1861 of the Act, to be enrolled in Medicare in an approved status and prohibit payment to providers and suppliers that are not enrolled in Medicare in an approved status, are excluded by the OIG, are revoked from Medicare under § 424.535, or are on the

[238] Accounting Methods under Executive Order 14192. *https://www.reginfo.gov/public/pdf/eo14192/Accounting_Methods_under_EO_14192.pdf.*

preclusion list as described in § 423.120(c)(6) and defined in § 423.100, apply to- HMOs and CMPs that contract with *CMS* under section 1876 of the *Act.*

(ii) In applying the provisions of §§ 422.223 and *422.224* of this chapter under paragraph (e)(2) of this section, references to part 422 of this chapter must be read as references to this part, and references to MA organizations as references to HMOs and CMPs.

* * * * *

■ 4. Section 417.484 is amended by—

■ a. Redesignating paragraph (b)(3) as new paragraph (b)(3)(i).

■ b. In new redesignated paragraph (b)(3)(i), removing the phrase ''That payments'' and adding in its place the phrase ''Before January 1, 2030, that payments''.

■ c. Adding paragraph (b)(3)(ii).

The addition reads as follows:

§ 417.484 Requirement applicable to related entities.

* * * * *

(b) * * *

(3) * * *

(ii) Beginning January 1, 2030, that payments must not be made to providers and suppliers that are eligible to enroll in Medicare in accordance with section 1861 of the Act but are not enrolled in Medicare in an approved status.

PART 422—MEDICARE ADVANTAGE PROGRAM

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

Authority: 42 U.S.C. 1302 and 1395hh.

■ 6. Section 422.2 is amended by revising the introductory text of the definition for ''Preclusion list'' to read as follows:

§ 422.2 Definitions.

* * * * *

Preclusion list means, before January 1, 2030, and with respect to this part, a CMS compiled list of individuals and entities that—

X. Section 422.204 is amended by revising paragraph (c) to read as follows:

§ 422.204 Provider selection and credentialing.

* * * * *

(c)(1) Before January 1, 2030, an MA organization must follow a documented process that ensures compliance with the preclusion list provisions in § 422.222.

(2) Beginning January 1, 2030, an MA organization must follow a documented process that ensures compliance with the provisions of § 422.223.

■ 7. Section 422.222 is amended by adding the following opening paragraph before paragraph (a): ''The provisions of this section apply before January 1, 2030.''

■ 8. Adding § 422.223 to read as follows:

§ 422.223 Enrollment for contracted and non-contracted individuals and entities.

(a) *General enrollment requirement.* Beginning January 1, 2030, providers that are types of individuals or entities that are eligible to enroll in Medicare (in accordance with section 1861 of the Act) must be Medicare-enrolled in an approved status to receive payment from an MA organization for health care items or services provided to a Medicare enrollee who receives their Medicare benefit through the MA organization. (For purposes of this requirement, ''approved status'' means the provider is neither revoked from Medicare under § 424.535 nor deactivated under § 424.540.) This includes all of the following providers:

(1) In-network and out-of-network MA providers.

(2) First-tier, downstream, and related entities (FDR) as defined at § 422.2.

(3) Providers in Health Maintenance Organizations (HMOs) or Competitive Medical Plans that contract with CMS under section 1876 of the Act.

(4) Providers participating in demonstration programs or in pilot programs.

(5) Locum tenens providers.

(6) Incident-to providers.

(b) An MA organization that does not comply with *paragraph (a)* of this section may be subject to sanctions under § 422.750 and termination under § 422.510.

■ 9. Section 422.224 is amended by—

■ a. Revising the section heading.

■ b. Redesignating paragraphs (a) and (b) as new paragraphs (a)(1) and (a)(2).

■ c. In revised paragraph (a), adding ''Before January 1, 2030-'' -

■ d. Revising paragraph (b).

■ e. Adding new paragraphs (b)(1) and (b)(2).

The revisions and additions read as follows:

§ 422.224 Payment to individuals and entities excluded by the OIG, revoked from Medicare, or on the preclusion list.

* * * * *

(b) Beginning January 1, 2030—

(1) An MA organization may not pay, directly or indirectly, on any basis, for items or services furnished to a Medicare enrollee by any individual or entity that is excluded by the Office of the Inspector General (OIG), revoked from Medicare under § 424.535, or on the preclusion list as described in § 423.120(c)(6) and as defined in § 423.100.

(2) If an MA organization receives a request for payment by, or on behalf of, an individual or entity that is excluded by the OIG, revoked from Medicare under § 424.535, or on the preclusion list as described in § 423.120(c)(6) and as defined in § 423.100, the MA organization must notify the enrollee and the excluded, revoked, or precluded individual or entity, as directed by contract or other direction provided by CMS, that payments will not be made. Payment may not be made to, or on behalf of, an individual or entity that is excluded by the OIG, revoked from Medicare under § 424.535, or on the preclusion list as described in § 423.120(c)(6) and as defined in § 423.100.

■ 10. Section 422.300 is revised to read as follows:

§ 422.300 Basis and scope.

This subpart is based on sections 1106, 1128J(d), 1852, 1853, 1854, and 1858 of the Act. It sets forth the requirements for making payments to MA organizations offering local and regional MA policies, including calculation of MA capitation rates and benchmarks, conditions under which payment is based on plan bids, adjustments to capitation rates (including risk adjustment), collection of risk adjustment data, conditions for use and disclosure of risk adjustment data, collection of improper payments and other payment rules. Section 422.458 specifies the requirements for risk sharing payments to MA regional organizations.

■ 11. Section 422.310 is amended by revising paragraph (e) to read as follows:

§ 422.310 Risk adjustment data.

* * * * *

(e) *Validation of risk adjustment data.* MA organizations and their providers and practitioners are required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data. MA organizations must remit improper payments based on RADV audits, in a manner specified by CMS in accordance with applicable HHS and CMS overpayment collection regulations. For RADV audits, CMS may extrapolate RADV Contract-Specific audit findings for payment year 2018 and subsequent payment years and may apply published payment error calculation methodologies.

(1) *RADV hardship exception requests.* An MA organization selected for a RADV audit may submit a hardship exception request if it can demonstrate that an extraordinary

circumstance that prevents it from submitting required medical record documentation for the entire MA contract, a sampled enrollee's audited hierarchical condition categories (CMS–HCCs), or a subset of audited CMS–HCCs for a given sampled enrollee. The request must be submitted in a manner, by a deadline as outlined in subregulatory guidance in advance of each payment year audit, and with supporting documentation, as prescribed by the Secretary.

(i) An MA organization is required to withdraw a specific hardship exception request before submitting it with modifications.

(ii) If an MA organization submits a valid medical record for an audited CMS–HCC(s) for which it has submitted a hardship exception request, then the hardship exception request and any decision made by CMS for the request is rendered moot.

(2) *RADV hardship exception requests documentation criteria.* An MA organization is required to submit supporting documentation with a hardship exception request that clearly demonstrates an extraordinary circumstance(s) exists and includes all relevant details required for CMS to comprehensively assess the incident or issue.

(i) Supporting documentation includes, but is not limited to, communications associated with the extraordinary circumstance and available evidence proving that the circumstance occurred.

(ii) MA organizations must pursue all potential sources of medical record documentation before submitting a hardship exception request and should review relevant record retention requirements.

(ii) MA organizations must actively pursue and submit an alternative medical record that supports an audited CMS–HCC(s) when the initial medical record sought is unavailable or insufficient to support the audited CMS–HCC(s).

(iii) An MA organization is required to submit documentation demonstrating that it sought medical record documentation from all providers associated with encounter records or other diagnosis data that the MA organization is required to submit to CMS for the purposes of receiving risk adjusted payments for sampled enrollee(s).

(3) *State requirements.* MA organizations must be aware of State requirements for medical records to be placed in the care of a custodian for a period of time when a health care provider's office closes.

(i) If a health care provider has closed, retired, passed away, changed ownership, or otherwise undergo a change that, according to State law, should have led their medical records to be placed in the care of a custodian, MA organizations must contact the custodian to request the relevant medical records.

(ii) CMS denies a hardship request if the MA organization fails to submit sufficient supporting documentation, including documentation of the MA organization's pursuit of all possible medical record sources.

(4) *RADV hardship exception requests appeals.* A decision about whether to grant a RADV hardship exception request is final and not subject to appeal.

* * * * *

■ 12. Section 422.311 is amended by revising paragraph (a) to read as follows:

§ 422.311 RADV audit dispute and appeal processes.

(a) *Risk adjustment data validation (RADV) audits.* In accordance with §§ 422.2 and 422.310(e), the Secretary annually conducts RADV audits to ensure risk-adjusted payment integrity and accuracy.

(1) Recovery of improper payments from MA organizations will be conducted in accordance with the Secretary's payment error calculation methodologies and recovery methodologies in accordance with applicable HHS and CMS overpayment collection regulations.

(2) CMS may apply extrapolation to audits for payment year 2018 and subsequent payment years.

* * * * *

■ 13. Section 422.500 is amended in paragraph (b) by adding the definition for ''Credible allegation of fraud'' in alphabetical order to read as follows:

§ 422.500 Scope and definitions.

* * * * *

(b) * * *

Credible allegation of fraud means an allegation from any source, including but not limited to the following:

(1) Fraud hotline tips verified by further evidence.

(2) Claims data mining.

(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability.

* * * * *

■ 14. Section 422.501 is amended by—

■ a. Redesignating paragraphs (c)(1)(iv) and (2) as new paragraphs (c)(1)(iv)(A) and (c)(2)(i).

■ b. In new paragraphs (c)(1)(iv)(A) and (c)(2)(i), inserting the following language at the beginning of the paragraph: ''Before January 1, 2030''.

■ c. Adding new paragraphs (c)(1)(iv)(B) and (2)(ii).

The additions read as follows:

§ 422.501 Application requirements.

* * * * *

(c) * * *

(1) * * *

(iv) * * *

(B) Beginning January 1, 2030, documentation demonstrating and verifying that payment for health care services and items is not being and will not be made to providers that are eligible to enroll in Medicare in accordance with section 1861 of the Act but that are not enrolled in Medicare in an approved status.

(2) * * *

(ii) Beginning January 1, 2030, the authorized individual must thoroughly describe how the entity and MA plan meet, or will meet, all the requirements described in this part, including providing documentation demonstrating and verifying that payment for health care services and items is not being and will not be made to providers that are eligible to enroll in Medicare in accordance with section 1861 of the Act but that are not enrolled in Medicare in an approved status.

* * * * *

■ 15. Section 422.503 is amended by—

■ a. Removing paragraph (b)(4)(vi)(G)(*3*);

■ b. Redesignating paragraphs (b)(4)(vi)(G)(*4*) through (b)(4)(vi)(G)(*7*) as paragraphs (b)(4)(vi)(G)(*3*) through (b)(4)(vi)(G)(*6*), respectively; and

■ c. Revising newly redesignated paragraphs (b)(4)(vi)(G)(*3*) through (b)(4)(vi)(G)(*5*).

The revisions read as follows:

§ 422.503 General provisions.

* * * * *

(b) * * *

(4) * * *

(vi) * * *

(G) * * *

(*3*) The MA organization must have procedures to identify, and must report to CMS or its designee, any of the following in the manner described in paragraphs (b)(4)(vi)(G)(*3*) and (*4*) of this section:

(*i*) Any payment suspension implemented by an MA organization, pending investigation of credible allegations of fraud, which must be implemented in the same manner as the Secretary's requirement under section 1862(o)(1) of the Act.

(*ii*) Any information concerning investigations, credible evidence of

suspicious activities of a provider of services (including a prescriber) or supplier, and other actions taken by the MA organization related to the inappropriate prescribing of opioids.

(*iii*) Any substantiated or suspicious activities of a provider of services (including a prescriber) or a supplier related to fraud, waste, or abuse for initiating or assisting investigations conducted by CMS, or its designee, a Medicare program integrity contractor, or law enforcement partners.

(*4*) The MA organization must submit data, as specified in this section, in the program integrity portal when reporting the referrals described in paragraph (b)(4)(vi)(G)(*3*) of this section. The data categories, as applicable, include referral information and actions taken by the MA organization on the referral.

(*i*) The MA organization is required to notify the Secretary, or the Secretary's designee, of a payment suspension described in paragraph (b)(4)(vi)(G)(*3*)(*i*) of this section 7 days prior to implementation of the payment suspension. The MA organization may request an exception to the 7-day prior notification to the Secretary, or the Secretary's designee, if circumstances warrant a reduced reporting time frame, such as potential beneficiary harm.

(*ii*) The MA organization is required to submit the information described in paragraphs (b)(4)(vi)(G)(*3*)(*ii*) and (*iii*) of this section, or the absence of any information, no later than January 30, April 30, July 30, and October 30 of each year for the preceding periods, respectively, of October 1 through December 31, January 1 through March 31, April 1 through June 30, and July 1 through September 30.

(*5*) CMS provides MA organizations with data report(s) or links to the information described in paragraphs (b)(4)(vi)(G)(*3*)(*i*) through (*iii*) of this section no later than April 15, July 15, October 15, and January 15 of each year based on the information in the portal, respectively, as of the preceding October 1 through December 31, January 1 through March 31, April 1 through June 30, and July 1 through September 30. These reports do the following:

(*i*) Include administrative actions, pertinent information related to opioid overprescribing, and other data determined appropriate by the Secretary in consultation with stakeholders.

(*ii*) Are anonymized information submitted by MA organizations without identifying the source of such information.

* * * * *

■ 16. Section 422.504 is amended by—

■ a. In paragraph (a)—

■ i. In paragraph (a)(6), removing the phrase ''and the preclusion list'' and adding in its place the phrase ''and, before January 1, 2030, the preclusion list''.

■ ii. Adding new paragraph (a)(22).

■ b. In paragraph (g)—

■ i. Redesignating paragraph (g)(1)(iv) as new (g)(1)(iv)(A).

■ ii. Adding the following language at the beginning of new paragraph (g)(1)(iv)(A): ''Before January 1, 2030,''.

■ iii. Adding new paragraph (g)(1)(iv)(B).

■ iv. Adding ''Before January 1, 2030'' at the beginning of paragraph (g)(1)(v).

■ c. In paragraph (i):

■ i. Redesignating paragraph (i)(2)(v) as new paragraph (i)(2)(v)(A).

■ ii. Adding the following language at the beginning of new paragraph (i)(2)(v)(A): ''Before January 1, 2030,''.

■ iii. Adding new paragraph (i)(2)(v)(B).

The additions read as follows:

§ 422.504 Contract provisions.

* * * * *

(a) * * *

(22) Beginning January 1, 2030, to comply with the requirements of §§ 422.223 and 422.224(b).

* * * * *

(g) * * *

(1) * * *

(iv) * * *

(B) Beginning January 1, 2030, ensure that the enrollee does not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to the enrollee by an MA contracted provider that is eligible to enroll in Medicare under section 1861 of the Act but that is not enrolled in Medicare in an approved status.

* * * * *

(i) * * *

(2) * * *

(v) * * *

(B) Beginning January 1, 2030, they will ensure that payments are not made to providers that are eligible to enroll in Medicare under section 1861 of the Act but are not enrolled in Medicare in an approved status.

* * * * *

■ 17. Section 422.510 is amended by—

■ a. Redesignating paragraph (a)(4)(xiii) as new paragraph (a)(4)(xiii)(A).

■ b. Adding at the beginning of new paragraph (a)(4)(xiii)(A) the following: ''Before January 1, 2030,''.

■ c. Adding new paragraph (a)(4)(xiii)(B).

The addition reads as follows:

§ 422.510. Termination of contract by CMS.

(a) * * *

(4) * * *

(xiii) * * *

(B) Beginning January 1, 2030, fails to meet the requirements of §§ 422.223 or 422.224(b).

* * * * *

■ 18. Section 422.752 is amended by—

■ a. Redesignating paragraph (a)(13) as new paragraph (a)(13)(i).

■ b. Adding at the beginning of new paragraph (a)(13)(i) the following: ''Before January 1, 2030,''.

■ c. Adding new paragraph (a)(13)(ii).

The addition reads as follows:

§ 422.752 Basis for imposing intermediate sanctions and civil money penalties.

(a) * * *

(13) * * *

(ii) Beginning January 1, 2030, fails to comply with §§ 422.223 and 422.224(b), which require the MA organization not to make payment to providers that are excluded by the OIG, revoked from Medicare under 424.535, on the preclusion list as described in § 423.120(c)(6) and as defined in § 423.100, or are eligible to enroll in Medicare under section 1861 of the Act but are not enrolled in Medicare in an approved status.

* * * * *

■ 19. Section 422.2267 is amended by—

■ a. Revising the title of paragraph (e)(15).

■ b. Redesignating paragraph (e)(15) as new paragraph (e)(15)(i).

■ c. Adding the language ''Before January 1, 2030'' at the beginning of new paragraph (e)(15)(i).

■ d. Adding new paragraph (e)(15)(ii).

The additions read as follows:

§ 422.2267 Required materials and content.

* * * * *

(e) * * *

(15) *Excluded, revoked, or precluded provider notice.*

* * * * *

(ii) Beginning January 1, 2030, this is a model communications material through which plans must notify enrollees when a provider they visit or consult is excluded by the OIG, revoked from Medicare under § 424.535, on the preclusion list as described in § 423.120 and as defined in § 423.100, or is eligible to enroll in Medicare under section 1861 of the Act but is not enrolled in Medicare in an approved status.

* * * * *

PART 423—VOLUNTARY MEDICARE PRESCRIPTION DRUG BENEFIT

■ 20. The authority citation for part 423 continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395w-101 through 1395w-152, and 1395hh.

■ 21. Section 423.504 is amended by—
■ a. Removing paragraph (b)(4)(vi)(G)(*3*);
■ b. Redesignating paragraphs (b)(4)(vi)(G)(*4*) through (b)(4)(vi)(G)(*7*) as paragraphs (b)(4)(vi)(G)(*3*) through (b)(4)(vi)(G)(*5*), respectively; and
■ c. Revising newly redesignated paragraphs (b)(4)(vi)(G)(*3*) through (b)(4)(vi)(G)(*5*).

The revisions read as follows:

§ 423.504 General provisions.

* * * * *

(b) * * *
(4) * * *
(vi) * * *
(G) * * *

(*3*) The Part D plan sponsor must have procedures to identify, and must report to CMS or its designee, any of the following in the manner described in paragraphs (b)(4)(vi)(G)(*3*) and (*4*) of this section:

(*i*) Any payment suspension implemented by a Part D plan sponsor, pending investigation of credible allegations of fraud, which must be implemented in the same manner as the Secretary's requirement under section 1862(o)(1) of the Act.

(*ii*) Any information concerning investigations, credible evidence of suspicious activities of a provider of services (including a prescriber) or supplier, and other actions taken by the Part D plan sponsor related to the inappropriate prescribing of opioids.

(*iii*) Any substantiated or suspicious activities of a provider of services (including a prescriber) or a supplier related to fraud, waste, or abuse for initiating or assisting investigations conducted by CMS, or its designee, a Medicare program integrity contractor, or law enforcement partners.

(*4*) The Part D plan sponsor must submit data, as specified in this section, in the program integrity portal when reporting the referrals described in paragraph (b)(4)(vi)(G)(*3*) of this section. The data categories, as applicable, include referral information and actions taken by the Part D plan sponsor on the referral.

(*i*) The Part D plan sponsor is required to notify the Secretary, or the Secretary's designee, of a payment suspension described in paragraph (b)(4)(vi)(G)(*3*)(*i*) of this section 7 days prior to implementation of the payment suspension. The Part D plan sponsor may request an exception to the 7-day prior notification to the Secretary, or the Secretary's designee, if circumstances warrant a reduced reporting time frame, such as potential beneficiary harm.

(*ii*) The Part D plan sponsor is required to submit the information described in paragraph (b)(4)(vi)(G)(*3*)(*ii*) and (*iii*) of this section, or the absence of any information, no later than January 30, April 30, July 30, and October 30 of each year for the preceding periods, respectively, of October 1 through December 31, January 1 through March 31, April 1 through June 30, and July 1 through September 30.

(*5*) CMS provides Part D plan sponsors with data report(s) or links to the information described in paragraphs (b)(4)(vi)(G)(*3*)(*i*) through (*iii*) of this section no later than April 15, July 15, October 15, and January 15 of each year based on the information in the portal, respectively, as of the preceding October 1 through December 31, January 1 through March 31, April 1 through June 30, and July 1 through September 30. These reports do all of the following:

(*i*) Include administrative actions, pertinent information related to opioid overprescribing, and other data determined appropriate by the Secretary in consultation with stakeholders.

(*ii*) Are anonymized information submitted by Part D plan sponsors without identifying the source of such information.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

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

Authority: 42 U.S.C. 1302 and 1395hh.

■ 23. Section 424.57 is amended by—
■ a. In paragraph (a), revising the definition of ''sufficient evidence'';
■ b. Revising paragraph (c)(11);
■ c. Adding paragraphs (c)(31) and (32);
■ d. Revising paragraph (d)(5); and
■ e. Adding paragraphs (d)(16) and (i).

The revisions and additions read as follows:

§ 424.57 Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.

* * * * *

(a) * * *

Sufficient evidence means that CMS has furnished documentation to the surety that establishes all of the following:

(1) The amount and basis of the overpayment, CMP, or assessment that the DMEPOS supplier owes.

(2) It is an unpaid claim.

(3) A valid surety bond exists.

(4) The request to the surety for payment satisfies the surety bond requirements, specifically—

(i) When a bond is in effect, that the unpaid claim, CMP, or assessment occurred during the term of the bond; or

(ii) When the DMEPOS supplier fails to furnish a bond, submit a rider when required, or if the DMEPOS supplier's billing privileges are revoked, that the unpaid claims, CMPs, or assessments are asserted or imposed against the DMEPOS supplier during the 2 years following, and they are based on overpayments or other events that took place during the term of the bond or rider.

* * * * *

(c) * * *

(11)(i) Must agree that neither the supplier nor third-party entities acting as agents for the DMEPOS supplier (agent) shall contact a beneficiary when supplying a Medicare-covered item by telephone call or message, including text messages, unless one of the following applies:

(A) The individual has given written permission to the supplier to contact them concerning the furnishing of a Medicare-covered item that is to be rented or purchased.

(B) The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item.

(C) If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier or agent makes such contact.

(ii) *Severability.* Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to other, dissimilar circumstances.

* * * * *

(31)(i) Must agree that neither the supplier nor third-party entities acting as agents for the DMEPOS supplier (agent) shall contact a beneficiary when supplying a Medicare-covered item using direct messages from social media platforms, email messages without opt-out features, or door-to-door in-person solicitation unless one of the following applies:

(A) The individual has given written permission to the supplier to contact them concerning the furnishing of a Medicare-covered item that is to be rented or purchased.

(B) The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item.

(C) If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier or agent makes such contact.

(ii) *Severability.* Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to other, dissimilar circumstances.

(32) DMEPOS suppliers must have a process for obtaining prior beneficiary consent for items the supplier sends to the beneficiary at their home or residence. For purposes of this standard—

(i) The standard only applies to the initial order the supplier receives, not to refills; and.

(ii) The process must, at a minimum, include the following:

(A) After receiving a valid order for the item from the ordering or prescribing provider or supplier, the DMEPOS supplier must telephone or email the beneficiary (or, if applicable, their representative (such as a caretaker or guardian)) and ask whether the beneficiary or representative is aware of the order or prescription, whether the beneficiary needs the item, and consents to receiving the item. The item cannot be delivered until these three conditions are met, even if the beneficiary or representative cannot be reached. If only the representative can satisfy the three conditions, the supplier's process must include a means of confirming that this individual is authorized to act on the beneficiary's behalf.

(B) For each such item, the supplier must document all of the following in a written log:

(*1*) The beneficiary's or representative's name and either their phone number or email address (whichever means of communication was used).

(*2*) Time(s) and date(s) of the contact(s).

(*3*) A statement that all the conditions in paragraph (c)(32)(ii)(A) were met.

* * * * *

(d) * * *

(5) * * * *

(ii) The bond must provide the following:

(A) The surety is liable for unpaid claims, CMPs, or assessments that occur during the term of the bond.

(B) The surety agrees not to challenge or dispute the amount CMS determines is owed from the obligor, the underlying calculations, or the basis for overpayment.

(C) The surety must make payment to CMS as required under the bond and this paragraph (d) regardless of whether the obligor has available options to appeal, or pending appeals of, the overpayment, CMP, or assessment.

* * * * *

(16)(i) CMS may decline to accept DMEPOS supplier surety bonds from an authorized surety (as defined in paragraph (a) of this section) under paragraph (d) of this section if the ''for cause'' standard in paragraph (d)(16)(ii) and the written notice and opportunity for rebuttal requirements of paragraph (d)(16)(iii) are met.

(ii) CMS' declination to accept DMEPOS supplier surety bonds from an authorized surety must be ''for cause.'' For purposes of paragraph (d)(16)—

(A) ''For cause'' is when a surety under paragraph (d) has not paid or satisfied an administratively final DMEPOS supplier surety bond obligation that is owed to CMS.

(B) A DMEPOS supplier surety bond obligation becomes administratively final under paragraph (d) when—

(1) CMS has furnished sufficient evidence (as defined in paragraph (a) of this section) to the surety of its obligation to make payment under the surety bond; and

(2) The surety fails to make the required payment within 30 calendar days of receiving notice from CMS or its contractor to do so.

(iii) CMS sends written notice to the surety via certified mail of its intention to decline to accept DMEPOS supplier surety bonds from the surety. The notice must do all of the following:

(A) State the intention of CMS to decline bonds underwritten by the surety.

(B) List the reason(s) or cause for CMS' intention, including identifying the instance(s) in which the surety failed to make required payment(s).

(C) Explain the surety's rebuttal rights.

(D) Provide the surety with a 30-day opportunity to cure the stated reasons or cause.

(iv)(A)*(1)* After receiving the notice described in paragraph (d)(16)(iii) of this section, the surety has 30 calendar days from the date of the notice to submit a rebuttal to CMS' intention to decline to accept DMEPOS supplier surety bonds from the surety.

(2) CMS may, at its discretion, extend the 30-day time-periods referenced in paragraph (d)(16)(iv)(A)*(1)* of this section.

(B) A rebuttal submitted in accordance with paragraph (d)(16)(iv) of this section must meet all of the following:

(1) Be in writing.

(2) Specify all facts or issues with which the surety disagrees with CMS' intention to decline to accept surety bonds.

(3) Submit all documentation the surety wants CMS to consider in its review of the rebuttal.

(4) Be submitted in the form of a letter that is signed and dated by one of the following:

(i) The surety's chief executive officer, chief operating officer, general partner, or equivalent official who is a W–2 employee of the surety with the authority to legally and financially bind the surety to Federal and State laws.

(ii) A representative (as defined in 42 CFR 498.10). If the legal representative is an attorney, the attorney must include a statement that he or she has the authority to represent the surety; this statement is sufficient to constitute notice of such authority. If the legal representative is not an attorney, the surety must file with CMS written notice of the appointment of a representative; this notice of appointment must be signed and dated by, as applicable, the official in paragraph (d)(16)(iv)(B)*(4)(i)* of this section or a legal representative.

(C)(*1*) The surety's failure to submit a rebuttal that is both timely under paragraph (d)(16)(iv)(A) of this section and fully compliant with all the requirements of paragraph (d)(16)(iv)(B) of this section constitutes a waiver of all rebuttal rights under this section.

(*2*) If the surety fails to submit a timely, compliant rebuttal, CMS issues a subsequent written determination that it will not accept bonds underwritten by the surety and states the declination's effective date, which would not be before the date of this written determination.

(D) Upon receipt of a timely and compliant rebuttal, CMS reviews the rebuttal to determine whether to proceed with its intended declination of surety bonds from the surety.

(E) After its receipt of any submitted rebuttal, CMS notifies the surety in writing of all of the following:

(1) Its review of the rebuttal.

(2) Its decision as to whether to proceed with its intended declination to accept DMEPOS surety bonds from the surety and the basis for that decision.

(3) If applicable, the effective date of the declination, which must not be before the date of the written notice described in this paragraph (d)(16)(iv)(E) of this section.

(F) A determination made under paragraph (d)(16)(iv)(E) of this section is not an initial determination under § 498.3(b), and, therefore, is not appealable under 42 CFR 498.5.

(v)(A) The surety has 30 days to cure the stated reasons or cause for CMS' intention to decline to accept the surety's bonds. CMS may, at its discretion, extend this 30-day period.

(B)(*1*) The surety, within the required timeframe, must submit written proof that it has cured all the deficiencies in question. This proof could include, for example, documentation that it has fully paid or satisfied all outstanding financial obligations forming the bases of CMS' intended declination.

(*2*) CMS decides whether the submitted written proof is adequate and whether all deficiencies have been corrected. If the surety submitted a timely and compliant rebuttal, CMS includes this decision in the rebuttal decision letter described in paragraph (d)(16)(iv). If the surety does not submit a timely and complete rebuttal, CMS includes its decision in a final letter to the surety confirming whether CMS will decline to accept surety bonds issued by the surety.

(vi)(A) CMS maintains on its website a publicly available list of sureties from which CMS does not accept DMEPOS supplier surety bonds under paragraph (d) of this section. This list is updated as needed.

(B)(*1*) CMS, at its discretion, may at any time remove a surety from the list described in paragraph (d)(16)(vi)(A) of this section.

(*2*) CMS notifies the surety in writing of the removal from the list and the effective date of the removal as established by CMS.

* * * * *

(i) All DMEPOS suppliers must report on the Form CMS–855S application (or its successor form), in a complete and accurate manner (including any documentation requested by CMS under § 424.510(d)(2)(iii)(C) to verify or explain the furnished information), all domestic and foreign entities and individuals that meet any of the following:

(1) Perform any marketing service of any type for the supplier.

(2) Furnish DMEPOS items or services to beneficiaries on the supplier's behalf, such as fulfillment companies.

(3) Are wholesalers from which the supplier purchases DMEPOS items for provision to the supplier's beneficiaries.

■ 24. Section 424.58 is amended in paragraph (e) by revising paragraph (8)(i)(A) to read as follows:

§ 424.58 Accreditation.

* * * * *

(e) * * *

(8) * * *

(i) * * *

(A)*(1)* Perform a survey of all DMEPOS supplier locations for which the supplier seeks accreditation or reaccreditation with the DMEPOS accrediting organization. This includes, but is not limited to, accreditations for a new item type the supplier has not previously furnished or as required under § 424.551.

(2) Regardless of whether the accredited DMEPOS supplier is seeking accreditation or reaccreditation with the DMEPOS accrediting organization, perform a survey of the supplier location if the supplier:

(*i*) Undergoes a change in majority ownership. For purposes of this section only, a *change in majority ownership* occurs when an individual or organization acquires more than a 50 percent direct ownership interest in a DMEPOS supplier (including through the cumulative effect of asset sales, stock transfers, consolidations, or mergers), irrespective of whether the ownership change occurred more than 36 months after the supplier's initial enrollment or its most recent change in majority ownership or the supplier qualifies for an exception under § 424.551(c); or

(*ii*) Changes its practice location.

* * * * *

■ 25. Section 424.205 is amended by revising paragraph (c)(5) to read as follows:

§ 424.205 Requirements for Medicare Diabetes Prevention Program suppliers.

* * * * *

(c) * * *

(5) The MDPP supplier must report to its Medicare fee-for-service contractor via the enrollment application any change in its enrollment information within 30 calendar days of the change.

* * * * *

■ 26. Section 424.510 is amended by revising paragraphs (d)(2)(ii)(C) to read as follows:

§ 424.510 Requirements for enrolling in the Medicare program

* * * * *

(d) * * *

(2) * * *

(ii) Submission of all documentation required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to uniquely identify the provider or supplier.

(A) This documentation may include, but is not limited to, proof of the legal business name, practice location, social security number (SSN), tax identification number (TIN), National Provider Identifier (NPI) (if issued), and owners and managing employees of the business.

(B) Specific identification verifying documents that CMS may require include, but are not limited to, copies of the provider's, supplier's, owner's, or managing employee's driver's license, passport, social security card, birth certificate, or similar documentation.

(C) Any other documentation needed to verify and confirm the information furnished on the enrollment application. This includes, but is not limited to, documentation regarding the provider's or supplier's domestic or foreign ownership or management.

* * * * *

■ 27. Section 424.516 is amended by revising paragraphs (d) and (e).

The revisions read as follows:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

* * * * *

(d) *Reporting requirements for all other provider and supplier types.* All changes in enrollment information must be reported to the Medicare-fee-for-service contractor within 30 calendar days of the change.

(e) *Special air ambulance supplier reporting requirements.* Within 30 days of any revocation or suspension of a Federal or State license or certification including Federal Aviation Administration certifications, an air ambulance supplier must report a revocation or suspension of its license or certification to the applicable Medicare contractor. The following FAA certifications must be reported:

(1) Specific pilot certifications including but not limited to instrument and medical certifications.

(2) Airworthiness certification.

* * * * *

■ 28. Section 424.530 is amended by–

■ a. Revising paragraph (a)(6)(ii)(C)

■ b. Removing paragraph (a)(7)(iii);

■ c. Revising paragraphs (a)(12), (14)(i), (15)(i), and (17);

■ d. Adding paragraphs (a)(23) through (27);

The revisions and additions read as follows:

§ 424.530 Denial of enrollment in the Medicare program.

(a) * * *

(6) * * *

(ii) * * *

(C) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse.

* * * * *

(12) *Revoked under different name, numerical identifier or business identity.* The provider or supplier is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired.

* * * * *

(14) * * *

(i) The provider or supplier—or any owner, managing employee, or managing organization thereof—is currently terminated or suspended (or otherwise barred) from participation in a State Medicaid program or any other Federal health care program, or the provider's or supplier's license is currently revoked or suspended (or voluntarily surrendered in lieu of further action) in a State other than that in which the provider or supplier is enrolling.

* * * * *

(15) * * *

(i) The physician or other eligible professional (as that term is defined in 1848(k)(3)(B) of the Act) has been subject to prior action from a State oversight board, Federal or State health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm.

* * * * *

(17) *False Claims Act (FCA).* The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the FCA (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

* * * * *

(23) *High-Risk based on excess providers in area.* CMS determines that the provider's or supplier's enrollment presents a high risk of fraud, waste, or abuse due to the provider's or supplier's location within a limited geographic area that has an excessive number of providers and suppliers.

(24) *Change in hospice administrator.* CMS may deny a hospice's enrollment if the hospice changes its administrator within 36 months after its initial enrollment or its most recent change in administrator.

(25) *Owning or managing party.* The provider or supplier has a domestic or foreign owner, managing employee, managing organization, partner (general or limited), officer, or director—

(i) Whose identity or location cannot be confirmed; or

(ii) That CMS determines poses a risk of fraud, waste, or abuse to Medicare.

(26) *DMEPOS supplier undue risk relationship.* CMS determines that any entity or individual reported in accordance with § 424.57(i)—or the relationship or business arrangement the entity or individual has with the supplier—poses an undue risk of fraud, waste, or abuse, or of beneficiary harm.

(27) *Denial under § 424.536*—CMS determines that a denial is warranted under § 424.536.

* * * * *

■ 29. Section 424.535 is amended by—

■ a. Revising paragraphs (a)(7), (9), (12)(i), (14), (15), (17)(i), (18), (20), (21), (22)(i);

■ b. Adding paragraphs (a)(26) through (a)(32).

■ c. Revising paragraph (c)(3);

■ d. Adding paragraphs (g)(1)(xxvii) through (xxxiii); and

■ e. Revising paragraphs (i) and (j)(1).

The revisions and additions read as follows:

§ 424.535 Revocation of enrollment in the Medicare program.

* * * * *

(a) * * *

(7) *Improper activity.* The provider or supplier engages in improper activity related to its Medicare enrollment, any billing number or identifier, or EFT arrangement.

* * * * *

(9) *Failure to report.* The provider or supplier did not comply with the reporting requirements specified in § 424.516(d) or (e), § 410.33(g)(2) of this chapter, or § 424.57(c)(2).

* * * * *

(12) * * *

(i) The provider or supplier is terminated, revoked or otherwise barred from participation in a State Medicaid program or any other Federal health care program.

* * * * *

(14) *Improper prescribing practices.* CMS determines that the physician or eligible professional has a pattern or practice of prescribing Medicare-covered drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries or both, or fails to meet Medicare requirements.

* * * * *

(15) *False Claims Act (FCA).* The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the FCA (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

* * * * *

(17) * * *

(i) The provider or supplier failed to repay a debt that CMS appropriately referred to the United States Department of Treasury.

* * * * *

* * * * *

(18) *Revoked under different name, numerical identifier or business identity.* The provider or supplier is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired.

* * * * *

(20) *Billing from non-compliant location.* CMS may revoke a provider's or supplier's Medicare enrollment or enrollments, even if all of the practice locations associated with a particular enrollment comply with Medicare enrollment requirements, if the provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements.

* * * * *

(21) *Abusive ordering, certifying, referring, or prescribing of Part A or B services, items or drugs.* The physician or eligible professional has a pattern or practice of ordering, certifying, referring, or prescribing Medicare Part A or B services, items, or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements.

(22) * * *

(i) The physician or other eligible professional (as that term is defined in 1848(k)(3)(B) of the Act) has been subject to prior action from a State oversight board, Federal or State health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm.

* * * * *

(26) *Same suite.* The provider's or supplier's practice location is in the same suite or office as another provider or supplier whose Medicare enrollment has been revoked or denied under § 424.535 or § 424.530.

(27) *Hospice medical director or administrator.* A hospice's enrollment may be revoked if any of the following apply:

(i) The hospice's medical director is either of the following:

(A) The medical director of multiple other hospices.

(B) Practices at such a distance (for example, in a different State) from the enrolling hospice that the medical director cannot realistically perform all medical director functions required under 42 CFR part 418.

(ii) The hospice's administrator is either of the following:

(A) The administrator of multiple other hospices.

(B) Located at such a distance from the enrolling hospice that the administrator cannot realistically perform all administrator functions required under 42 CFR part 418.

(iii) The hospice's medical director does not have an active physician medical license in the State in which they are practicing.

(28) *Change in hospice administrator.* CMS may revoke a hospice's enrollment if the hospice changes its administrator within 36 months after its initial enrollment or its most recent change in administrator.

(29) *DMEPOS item or service.* CMS may revoke a physician's or practitioner's enrollment if the individual ordered a DMEPOS item or service that was not reasonable or necessary.

(30) *Owning or managing party.* The provider or supplier has a domestic or foreign owner, managing employee, managing organization, partner (general or limited), officer, or director:

(i) Whose identity or location cannot be confirmed; or

(ii) That CMS determines poses an undue risk of fraud, waste, or abuse to Medicare.

(31) *Supplier undue risk relationship.* CMS determines that any entity or individual reported in accordance with § 424.57(i)—or the relationship or business arrangement the entity or individual has with the supplier—poses an undue risk of fraud, waste, or abuse, or of beneficiary harm.

(32) *Revocation under § 424.536*—CMS determines that a revocation is warranted under § 424.536.

* * * * *

(c) * * *

(3) CMS may impose a reenrollment bar of up to 20 years on a provider or supplier if the provider or supplier is being revoked from Medicare for the second time.

* * * * *

(g) * * *

(1) * * *

(xxvii) For revocations under paragraph (a)(27), the date on which CMS determines that the hospice should be revoked under this paragraph.

(xxviii) For revocations under paragraph (a)(28), the date on which CMS determines that the hospice should be revoked under this paragraph.

(xxix) For revocations under paragraph (a)(29), the date on which CMS determines that the supplier should be revoked under this paragraph.

(xxx) For revocations under paragraph (a)(30), the date on which CMS determines that the provider or supplier should be revoked under this paragraph.

(xxxi) For revocations under paragraph (a)(31), the date on which CMS determines that the supplier should be revoked under this paragraph.

(xxxii) For revocations under paragraph (a)(32), the date on which CMS determines that the provider or supplier should be revoked under this paragraph.

(xxxiii) For revocations under paragraph (a)(26), the date of which CMS determines that the provider or supplier should be revoked under this paragraph.

* * * * *

(i) If a provider's or supplier's Medicare enrollment is revoked under paragraph (a) of this section, CMS may revoke any and all of the provider's or supplier's Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types.

(j) * * *

(1) CMS may revoke a provider's or supplier's Medicare enrollment if CMS determines that the provider or supplier voluntarily terminated its Medicare enrollment in order to avoid a revocation under paragraph (a) of this section that CMS would have imposed had the provider or supplier remained enrolled in Medicare.

* * * * *

■ 30. Adding § 424.536 to read as follows:

§ 424.536 Parties in a change in majority ownership.

(a) Denial or revocation. CMS may, as applicable to the situation, deny or revoke the enrollment of any provider or supplier involved in a change in majority ownership if CMS determines—

(1) The seller, the buyer, or any provider or supplier involved in the change in majority ownership failed to comply with Medicare enrollment requirements; or

(2) The change in majority ownership, the seller, the buyer, or any provider or supplier involved in the change of majority ownership poses an undue risk of fraud, waste, and abuse to the Medicare program.

(b) *Applicability.* CMS may deny or revoke enrollment under paragraph (a) of this section regardless of whether the provider's or supplier's name, identity, or location changes due to the change in majority ownership.

(c) *Change in majority ownership defined.* For purposes of this section only, a change in majority ownership—

(1) Occurs when an individual or organization acquires more than a 50 percent direct ownership interest in a provider or supplier. This includes acquiring majority ownership through the cumulative effect of asset sales, stock transfers, consolidations, or mergers.

(2) Applies regardless of—

(A) The provider or supplier type involved;

(B) Whether the change in majority ownership occurred within 36 months of either initial enrollment or the provider's or supplier's most recent change in majority ownership; or

(C) Whether the change in majority ownership requires a new, initial enrollment.

(d) *Relation to other change in majority ownership provisions.* Nothing in this section affects the requirement that an HHA, hospice, or DMEPOS supplier enroll as a new provider or supplier and be surveyed/accredited if § 424.550(b) or § 424.551 applies.

* * * * *

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 31. The authority citation for part 431 is revised to read as follows:

Authority: 42 U.S.C. 1302.

§§ 431.800 through 431.820 will be phased out

■ 32. Sections 431.800 through 431.820 will be phased out over a 3-year period.

■ 33. Section 431.992 is amended by—

■ a. Revising paragraphs (a) and (b)(3)(ii)(E);

■ b. Adding paragraphs (b)(3)(ii)(F); and

■ c. Revising paragraphs (c) and (e) introductory text.

The revisions and additions read as follows:

§ 431.992 Corrective action plan.

(a) The State must develop a combined corrective action plan for Medicaid and CHIP for each improper payment rate measurement, designed to reduce improper payments in each

program based on its analysis of the improper payment causes in the FFS, managed care, and eligibility components.

(1) The corrective action plan must address all errors that are included in the State improper payment rate defined at § 431.960(f) and all deficiencies.

(2) * * *

(3) The State must identify whether each error, deficiency and corrective action plan element required under paragraph (a) and (b) of this section applies to Medicaid, CHIP, or both programs.

(b) * * *

(3) * * *

(ii) * * *

(E) A monitoring plan to monitor the progress of implementation of the corrective action.

(F) A plan for evaluating the effectiveness of each corrective action that includes at a minimum the—

(1) Number of samples used for each evaluation; and

(2) Frequency of each evaluation.

(c) Submission, CMS approval, revision, deemed disapproval, and implementation.

(1) Initial submission and CMS approval.

(i) No later than 90 calendar days after the date on which the State's Medicaid and CHIP improper payment rates are posted to the CMS contractor's website, the State must submit to CMS for approval the corrective action plan developed under this section and begin implementing each corrective action in accordance with the implementation schedule required under paragraph (b)(3) of this section.

(ii) The State must obtain CMS approval of each applicable portion of the combined corrective action plan. CMS separately reviews the Medicaid and CHIP portions and, within each program, the eligibility and non-eligibility (FFS and managed care portions). CMS approves each portion of the corrective action plan that meets the requirements of paragraphs (a) and (b) of this section and will approve or disapprove each portion separately.

(2) CMS review, revision, and disapproval.

(i) *Initial notice.* If CMS determines that a corrective action plan or any portion does not meet the criteria in paragraphs (a) and (b) of this section, CMS notifies the State in writing of the affected portion, the unmet requirements, the information or revisions needed, and the revision deadline. CMS limits requests for additional information or revisions to those necessary to address the identified issues and determine whether the affected portion meets the applicable requirements of paragraphs (a) and (b) of this section. The notice describes the approval and disapproval procedures applicable to that portion, including, for an eligibility portion, the deemed-disapproval rule and pending-review exception in paragraph (c)(2)(iii) of this section.

(ii) *Revision period.* The State must submit revisions that address the identified issues and meet the applicable requirements of paragraphs (a) and (b) of this section within 90 calendar days after the date of CMS' initial written notice under paragraph (c)(2)(i) of this section for the affected portion. A revised submission does not restart that period. CMS works with the State during the revision period and communicates in writing any remaining issues identified through its review. A timely revised eligibility portion remaining under review at the revision deadline is subject to paragraph (c)(2)(iii)(B) of this section.

(iii) *Eligibility portions.*

(A) *Deemed disapproval.* Except as provided in paragraph (c)(2)(iii)(B) of this section, each affected eligibility portion not approved by the end of the revision period will be deemed disapproved for the applicable PERM-review year, without a separate written disapproval determination. Following a deemed disapproval, the State must continue to address the identified issues and seek CMS approval of a revised eligibility portion that meets the applicable requirements of paragraphs (a) and (b) of this section. CMS' subsequent written approval supersedes the earlier deemed disapproval of that portion for the applicable PERM review year, as provided in paragraph (c)(2)(v) of this section.

(B) *Pending review.* An eligibility portion is not deemed disapproved while CMS review of the most recent revision submitted within the revision period remains pending. CMS provides written status communication when that review remains pending at the revision deadline. This exception applies whether or not CMS has issued the status communication by that deadline. The notice neither approves nor disapproves the portion.

(C) *Determination after pending review.* Upon completion of the review that remained pending under paragraph (c)(2)(iii)(B) of this section after the revision deadline, CMS approves the eligibility portion if it meets the applicable requirements of paragraphs (a) and (b) of this section. Otherwise, CMS issues a written disapproval identifying the unmet requirements. The disapproval takes effect when CMS issues the notice and is not effective retroactively at the revision deadline.

(iv) *Non-eligibility portions.* The provisions in paragraph (c)(2)(iii) of this section does not apply to non-eligibility portions. After the revision period and completion of its review, CMS issues a written disapproval identifying the unmet requirements for a non-eligibility portion that does not meet the applicable requirements of paragraphs (a) and (b) of this section. The disapproval takes effect when CMS issues the notice. The approval status of a non-eligibility portion does not determine satisfaction of the condition in § 455.804(b)(1).

(v) *Continuing obligation and later approval.* The State must continue to revise and resubmit each unapproved eligibility and non-eligibility portion until CMS approves it, including after the correction period or a deemed or written disapproval. CMS reviews subsequent submissions and approves each portion that meets the applicable requirements of paragraphs (a) and (b) of this section. CMS' written approval supersedes the prior disapproval of that portion for the applicable PERM review year. The effect of an eligibility portion's approval status, including later approval, on the PERM corrective action plan condition for a good faith waiver is governed by § 455.804(b)(1). Disapproval under this section does not, by itself, impose a Medicaid or CHIP disallowance or constitute a final good faith waiver determination.

(3) *Implementation before and after CMS review.*

(i) The State must begin implementing corrective actions within the period specified in paragraph (c)(1)(i) of this section and follow the implementation schedule in its most recently submitted, unapproved portion while CMS review is pending, including during the revision period and after a disapproval, unless CMS directs the State in writing to defer, modify, or discontinue a specific corrective action. An approved portion remains operative unless CMS approves a revision or directs a change in writing.

(ii) Upon CMS approval of a corrective action plan or a program specific portion, the State must implement the approved plan or portion and must promptly revise its implementation schedule and ongoing activities, as necessary, to conform to the approved corrective action plan or portion.

(iii) Corrective actions implemented before CMS approval count toward implementation to the extent that the actions are consistent with the approved plan or portion. Revision or disapproval

of one portion does not, by itself, require the State to restart work on another portion or repeat work consistent with the approved portion.

* * * * *

(e) Semiannual eligibility updates. In addition to paragraphs (a) through (d) of this section, each State that has an eligibility improper payment rate over the allowable threshold of 3 percent for consecutive PERM years must submit updates on the status of corrective action implementation to CMS every 6 months, beginning 2 months after CMS formally approves the State's corrective action plan, and ending before CMS posts the State's eligibility improper payment rate for the next subsequent PERM cycle. Where a State's eligibility improper payment rate remains over the allowable threshold for a subsequent PERM cycle, requiring approval of a new or updated corrective action plan, the reporting window described in this paragraph (e) begins anew, two months after CMS' approval of that subsequent corrective action plan, independent of any prior reporting window. Where only the Medicaid eligibility improper payment rate or only the CHIP eligibility improper payment rate exceeds the 3 percent threshold, the State's status updates required under this paragraph (e) need only address the program that exceeds the threshold. Status updates must include, but are not limited to the following:

* * * * *

§ 431.1010 [Removed]

■ 34. Section 431.1010 is removed effective DATE TO BE DETERMINED.

PART 438—MANAGED CARE

■ 35. The authority citation for part 438 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 36. Section 438.3 is amended by revising paragraph (c)(2) to read as follows:

§ 438.3 Standard contract requirements.

* * * * *

(c) * * *

(2) Capitation payments may only be made by the State and retained by the MCO, PIHP, or PAHP for Medicaid eligible enrollees, provided that—

(i) Following the provision of notice of action and fair hearing rights in accordance with 42 CFR 435.917 and 435.918, and part 431 subpart E, States must recover capitation payments for any payment periods following the enrollee's date of death, and may recover capitation payments for any payment periods following the date of relocation out-of-State.

(ii) The State must reimburse CMS for an amount equal to the Federal share of all capitation payments subject to recovery under paragraph (c)(2)(i) of this section, taking into account applicable differences in the Federal matching rate.

* * * * *

■ 7. Section 438.608 is amended by revising paragraphs (a)(3) and (d)(1)(iv), redesignating paragraph (f) as paragraph (g); and adding new paragraph (f) to read as follows:

§ 438.608 Program integrity requirements under the contract.

(a) * * *

(3) Provision for notification to the State, using the State's defined procedure, within 30 calendar days of when it receives information about a change in an enrollee's circumstances that may affect their eligibility, including the following:

(i) Any change in the enrollee's address information if provided by the enrollee or verified directly with the enrollee, including both out-of-State and in-State address changes.

(ii) The death of an enrollee.

* * * * *

(d) * * *

(1) * * *

(iv) This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other audits or investigations, which include those performed by, but not limited to, any of the following:

(A) The Federal Government, including Federal agencies, or its contractors.

(B) A State or its contractors.

* * * * *

(f) Paragraph (a)(3) of this section applies to PCCMs and PCCM entities.

* * * * *

PART 447—PAYMENTS FOR SERVICES

■ 37. Section 447.45 is amended by adding paragraph (f)(1)(vi) to read as follows:

§ 447.45 Timely claims payment.

(f) * * *

(1) * * *

(vi) Verification that the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends, for services subject to the requirements of section 1903(l) of the Act and additional Medicaid services the State independently subjects to EVV, are supported by an EVV record.

PART 455—PROGRAM INTEGRITY: MEDICAID

■ 38. The authority citation for part 455 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 39. Section 455.2 is amended by revising the definitions of ''Credible Allegation of Fraud'' and ''Conviction or Convicted'' to read as follows:

§ 455.2 Definitions.

* * * * *

Credible allegation of fraud. A credible allegation of fraud is an allegation that has indicia of reliability, which may come from any source.

(1) Sources include the following:

(i) Fraud hotline tips verified by further evidence.

(ii) Claims data mining.

(iii) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

(iv) Other sources not specified in paragraphs (1)(i) through (iii) of this definition.

(v) A determination by CMS, or by another Federal agency, that an allegation of fraud against a provider is credible.

(2) Allegations are considered to be credible when they have indicia of reliability. This means that:

The State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. For CMS or other Federal agency determinations, a State may rely on such other agency's determination without re-verifying the underlying allegation, unless the State has specific, documented information indicating that reliance on the CMS or other Federal agency determination would be unreasonable under the circumstances.

Conviction or Convicted has the same meaning as the definition of ''Convicted'' in 42 CFR 1001.2.

* * * * *

■ 40. Section 455.14 is amended by revising the paragraph to read as follows:

§ 455.14 Preliminary investigation.

(a) If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

(1) For preliminary investigations of allegations of Medicaid fraud or abuse by providers involving services subject to the requirements of section 1903(l) of the Act and additional Medicaid

services the State independently subjects to electronic visit verification (EVV) requirements, the State Medicaid agency must review and analyze the associated EVV records to attempt to verify the validity of the allegation or questionable practice, including whether billed services were rendered for the appropriate duration and at the appropriate location.

(2) [Reserved].

(b) {Reserved].

■ 41. Section 455.17 is amended by revising paragraph (b) to read as follows:

§ 455.17 Reporting of fraud and abuse to the State Medicaid agency and to CMS.

* * * * *

(b) For cases of suspected provider fraud and abuse that the State Medicaid agency has determined warrant a full investigation, the State must report to CMS the following information:

(1) The provider's name;

(2) The provider's National Provider Identifier (NPI), or Medicaid provider identification number if the provider is ineligible to receive an NPI under applicable Federal law;

(3) The provider's Employer Identification Number or Taxpayer Identification Number (EIN/TIN), if available;

(4) The State in which the investigation is being conducted;

(5) The source of the complaint;

(6) The type of provider;

(7) The type of service involved;

(8) The nature of the complaint;

(9) The payor (for example, Medicaid Fee-For-Service or managed care);

(10) The relevant claim dates;

(11) The approximate time period covered by the investigation;

(12) The estimated overpayment amount;

(13) Where a final determination has been made, the final overpayment amount;

(14) The investigation status; and

(15) The legal and administrative disposition of the case, including the following:

(i) Actions taken by law enforcement.

(ii) Administrative actions taken by the State Medicaid agency, including provider termination, payment suspension (including good cause exceptions identified under § 455.23), and overpayment recovery status.

■ 42. Section 455.23 is amended by—

■ a. Creating subparagraph (a)(1)(i) in paragraph (a)(1);

■ b. Updating paragraph (d)(4) and creating subparagraphs (i), (ii), and (iii);

■ c. Creating subparagraph (1)(i) in paragraph (e); and

■ d. Updating the title of paragraph (g) and subparagraph (g)(3).

The changes read as follows:

§ 455.23 Suspension of payments in cases of fraud.

(a) * * *

(1) * * *

(i) A credible allegation of fraud may be identified by CMS or any other Federal agency. States are permitted to rely on the determination by CMS or another Federal agency that an allegation is credible.

(d) * * *

(4) If the Medicaid Fraud Control Unit (MFCU) or other law enforcement agency declines to accept the fraud referral for investigation or notifies the State agency that it has closed such an investigation without resolution of the allegation, the State agency must discontinue the payment suspension unless the State agency—.

(i) Has alternative Federal or State authority by which it may impose a suspension or makes a fraud referral to another law enforcement agency. In that situation, the provisions of paragraph (d)(3) of this section apply equally to that referral as well; or

(ii) Determines and documents in writing that the credible allegation of fraud remains under active investigation by the State Medicaid agency or by another State or Federal agency.

(iii) A suspension maintained under paragraph (d)(4)(ii) of this section is subject to the following limitations:

(A) The State Medicaid agency must, at least quarterly, redetermine and document in writing whether the credible allegation of fraud continues to be under active investigation warranting the continuation of the payment suspension. If at any redetermination the State agency cannot make this finding, the State agency must immediately discontinue the suspension.

* * * * *

(e) *Good cause not to suspend payments.* A State may find good cause not to suspend payments—or not to continue a payment suspension already in place—to an individual or entity under investigation for a credible allegation of fraud, if any of the conditions below apply. Before forgoing or discontinuing a payment suspension based on a good cause exception under this paragraph (e) or paragraph (f), the State must evaluate and document in writing that the specific criteria for the invoked exception have been met in that individual case.

(1) * * *

(i) If the good cause exception invoked is the exception described in this paragraph (e) (1), the State must also request a certification from the MFCU or other law enforcement agency for justifications and updates pertaining to the good cause exceptions and verification that the good cause still exists.

(g) *Documentation, record retention, and reporting requirements.* State Medicaid agencies must meet the following requirements:

* * *

(3) Quarterly report to the Secretary information on each of the following:

■ 43. Section 455.101 is amended by—

■ a. Adding a definition of ''Managing organization'' in alphabetical order;

■ b. Revising the title and opening paragraph of the current definition of ''Person with an ownership or control interest''.

The addition and revision read as follows:

§ 455.101 Definitions.

* * * * *

Managing organization means an entity that exercises operational or managerial control over, or that directly or indirectly conducts the day-to-day operations of, a provider, either under contract or through some other arrangement.

* * * * *

Person or organization with an ownership or control interest is one that meets any of the following:

* * * * *

■ 44. Section 455.104 is amended by—

■ a. In paragraph (b)(1)(i),

■ i. Removing the phrase ''(individual or corporation)'' and adding in its place the phrase ''or organization''; and

■ ii. Removing the phrase ''for corporate entities'' and adding in its place the phrase ''for entities'';

■ b. Revising paragraph (b)(1)(iii);

■ c. In paragraph (b)(2), removing the phrase ''(individual or corporation)'' and adding in its place the phrase ''or organization'' each time it appears;

■ d. Revising paragraph (b)(4); and

The revisions read as follows:

§ 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

* * * * *

(b) * * *

(1) * * *

(iii) The tax identification number of both of the following:

(A) Any organization with an ownership or control interest in, or that serves as a managing organization of, the disclosing entity (or fiscal agent or managed care entity).

(B) Any subcontractor in which the disclosing entity has an ownership or control interest.

* * * * *

(4)(i) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(ii) The name, address, and tax identification number of any managing organization of the disclosing entity (or fiscal agent or managed care entity).

* * * * *

■ 45. Section 455.106 is amended by revising paragraph (a) and removing paragraph (c) to read as follows:

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) *Information that must be disclosed.* Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency whether the provider, any person or organization with an ownership or control interest in the provider, or an agent, managing employee or managing organization of the provider, under any current or former name, numerical identifier, or business identity meets any of the following:

(1) Was, within the preceding 10 years, convicted of a Federal or State felony offense (regardless of type).

(2) Has been convicted of a misdemeanor under Federal or State law related to—

(i) The person's or organization's involvement with any Federal or State health care program in the previous 10 years; or

(ii) Sexual assault or financial misconduct.

(3) Has been revoked or terminated, or is currently suspended, from participation in any State Medicaid program, CHIP, Medicare or any Federal health care program.

(4) Is currently subject to a payment suspension under Medicaid, CHIP, or Medicare.

(5) Has had its health care license revoked, or whose license is currently suspended, in any State. (This includes situations where the individual or entity voluntarily surrendered the license in lieu of disciplinary action.)

* * * * *

§ 455.107 [Amended]

■ 46. Section 455.107 is amended by removing paragraph (g) and redesignating paragraph (h) as paragraph (g).

■ 47. Section 455.416 is amended to read as follows:

§ 455.416 Reasons for denial or termination of enrollment.

(a) *Exclusion or debarment.* The State must deny or terminate a provider's enrollment if the provider, any person or organization with an ownership or control interest in the provider, or any managing employee or managing organization or agent of the provider, or other health care or administrative or management services personnel furnishing services payable by a Federal health care program of the provider is either of the following:

(1)(i) Excluded from the Medicare, Medicaid, and any other Federal health care programs, as defined in 42 CFR 1001.2 of this chapter, in accordance with sections 1128, 1156, 1842, 1862, 1867, or 1892 of the Act; or

(ii) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement activity in accordance with section 2455 of the Federal Acquisition Streamlining Act (FASA).

(2) The individuals and organizations identified in paragraph (a)(1) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider.

(b) *Undue risk.* The State must deny or terminate a provider's enrollment if the State, in consultation with CMS, determines under § 455.107 that a particular affiliation poses an undue risk of fraud, waste or abuse.

(c) *Program termination.* The State must deny or terminate a provider's enrollment if the provider is terminated under title XVIII of the Act or under the Medicaid program or CHIP of any other State and is currently included in the termination database under § 455.417.

(d) *Certain misdemeanor convictions.*

(1) The State must deny or terminate a provider's enrollment if the provider, any person or organization with an ownership or control interest in the provider, or any managing employee or managing organization of the provider, under any current or former name or numerical identifier or business identity, has been convicted in the previous 10 years of a misdemeanor under Federal or State law is related to:

(i) The person or organization's involvement with the Medicare, *Medicaid,* or title XXI program; or

(ii) Sexual assault or financial misconduct, and the State determines that the misdemeanor conviction is detrimental to the best interests of the Medicaid program or CHIP and its beneficiaries.

(2) The State may forgo denial or termination under paragraph (d) of this section if it determines that denial or termination of enrollment is not in the best interests of the Medicaid program or CHIP and its beneficiaries and the State documents that determination in writing.

(e) *Non-compliance.*

(1) The State must deny or terminate a provider's enrollment if the-provider is non-compliant with any requirement described in subpart B or E of this part 455. Examples of non-compliance include, but are not limited to, the following:

(i) The provider or a person with an ownership or control interest or who is an agent or managing employee or managing organization of the provider fails to submit timely or accurate information or fails to cooperate with any screening requirement required under subpart B or E.

(ii) The provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or State Medicaid agency request.

(iii) The provider fails to permit access to provider locations for any site visits under § 455.432.

(iv) The State cannot verify the provider's identity.

(2) The State may forgo denial or termination under paragraph (e) of this section if it determines that denial or termination of enrollment is not in the best interests of the Medicaid program or CHIP and its beneficiaries and the State documents that determination in writing.

(f) *Felony convictions.*

(1) The State must deny or terminate a provider's enrollment if the provider, any person or organization with an ownership or control interest in the provider, or any managing employee or managing organization of the provider was, within the preceding 10 years, convicted of a Federal or State felony offense that the State determines is detrimental to the best interests of its Medicaid program or CHIP and its beneficiaries. Offenses would include, but not be limited in scope or severity to, any of the following:

(i) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted.

(ii) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted.

(iii) Any felony that placed the Medicaid program or CHIP or its beneficiaries at immediate risk, such as a malpractice suit that results in a

conviction of criminal neglect or misconduct.

(iv) Any felony that would result in mandatory exclusion under section 1128(a) of the Act.

(2) The State may forgo denial or termination under paragraph (f) of this section if it determines that denial or termination of enrollment is not in the best interests of the Medicaid program or CHIP and its beneficiaries and the State documents that determination in writing.

(g) *False or misleading information.*

(1) The State must deny or terminate a provider's enrollment if the provider submitted false or misleading information to (or omitted information from) the Medicaid or CHIP program in order to gain or maintain enrollment.

(2) The State may forgo denial or termination under paragraph (g) of this section if it determines that denial or termination of enrollment is not in the best interests of the Medicaid program or CHIP and its beneficiaries and the State documents that determination in writing.

(h) *Drug Enforcement Administration Certificates.*

(1) The State must deny or terminate a physician's or practitioner's enrollment if the physician's or practitioner's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked or is surrendered in response to an order to show cause.

(2) The State may forgo denial or termination under paragraph (h) of this section if it determines that denial or termination of enrollment is not in the best interests of the Medicaid program or CHIP and its beneficiaries and the State documents that determination in writing.

(i) *Misuse of enrollment.* (1) The State must terminate a provider's enrollment if the provider knowingly sells to or allows another individual or entity to use its enrollment to bill Medicaid or CHIP. This does not include either of the following:

(i) Providers who enter into a valid Medicaid or CHIP assignment of payment under § 447.10(g).

(ii) When State law permits another individual or entity to bill Medicaid or CHIP under the provider's enrollment in a change of ownership situation.

(2) The State may forgo termination under paragraph (i) of this section if it determines that termination of enrollment is not in the best interests of the Medicaid program or CHIP and its beneficiaries and the State documents that determination in writing.

(j) *Improper prescribing practices.*

(1) The State must terminate enrollment if a physician or practitioner has a pattern or practice of prescribing Medicaid or CHIP drugs that meets either of the following:

(i) Is abusive or represents a threat to the health and safety of Medicaid or CHIP beneficiaries.

(ii) Fails to meet Medicaid or CHIP requirements.

(2) The State may forgo termination under paragraph (j) of this section if it determines that termination of enrollment is not in the best interests of the Medicaid program or CHIP and its beneficiaries, and the State documents that determination in writing.

(k) *Abusive ordering, certifying, or referring of Medicaid or CHIP services or items.*

(1) The State must terminate a physician's or practitioner's enrollment if the physician or practitioner has a pattern or practice of ordering, certifying, or referring Medicaid or CHIP services or items that is abusive, represents a threat to the health and safety of Medicaid or CHIP beneficiaries or otherwise fails to meet Medicaid or CHIP requirements.

(2) The State may forgo termination under paragraph (k) of this section if it determines that termination of enrollment is not in the best interests of the Medicaid program or CHIP and its beneficiaries and the State documents that determination in writing.

■ 48. Section 455.418 is added to read as follows:

§ 455.418 State reporting of denials and terminations.

(a) *Reporting.* Each State must submit to CMS on a monthly basis—and in a format required by CMS—the legal business and doing business names, address, tax identification number, and National Provider Identifier of each Medicaid or CHIP provider whose enrollment, within the applicable monthly period, the State:

(1) Denied or terminated under § 455.416. This must include—

(i) The regulatory basis for the denial or termination;

(ii) The facts of the case; and

(iii) An explanation of how the State reached its decision.

(2) Was required to deny or terminate under § 455.416 but declined to do so based on a best interests finding. This must include:

(i) The regulatory basis for the prospective denial or termination.

(ii) The facts of the case.

(iii) An explanation of how the State reached its decision, and reasons for the State's best interests determination.

(b) *Relationship to Termination.* The requirements of this section are in addition to, and not in lieu of, State reporting requirements under sections 1902(kk)(8) and 1902(a)(41) of the Act and apply only to denials or terminations in accordance with § 455.416.

§ 455.436 [Amended]

■ 49. Section 455.436 is amended by—

■ a. In paragraph (b), removing the phrase ''Excluded Parties List System (EPLS)'' and adding in its place the phrase ''System for Award Management (SAM)''; and

■ b. In paragraph (c), removing the acronym ''EPLS'' and adding in its place the acronym

''SAM''.

■ 50. Section 455.440 is revised to read as follows:

§ 455.440 National Provider Identifier.

(a) *Claims for ordered or referred services.* The State Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

(b) *General requirement.* A State Medicaid agency must collect, maintain, and use the National Provider Identifier (NPI) for each provider enrolled in the State's Medicaid program that is eligible to obtain an NPI as a covered health care provider under 45 CFR part 162.

(c) *Scope of use.* For providers subject to paragraph (b) of this section, the State Medicaid agency must collect, maintain, and use the provider's NPI as part of—

(1) Medicaid provider enrollment and revalidation in accordance with subpart E of this part;

(2) Claims processing in accordance with § 447.45;

(3) Managed care oversight pursuant to part 438 of this chapter;

(4) Program integrity activities, including but not limited to fraud and abuse investigations and reporting in accordance with subpart A of this part; and

(5) Reporting to CMS in accordance with § 455.17 and any other applicable reporting requirements.

(d) *Consistency across systems.* The State Medicaid agency must ensure that each provider's NPI is consistently maintained and used across all Medicaid provider enrollment, claims processing, managed care oversight, program integrity, and reporting systems.

■ 51. Section 455.450 is amended by revising its opening paragraph to read as follows:

§ 455.450 Screening levels for Medicaid providers.

A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of ''limited,'' ''moderate,'' or ''high.'' For provider types that also exist in Medicare, the State must assign such providers to the same or higher risk category applicable under Medicare in accordance with § 424.518. If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

■ 52. Section 455.460 is amended by—

■ a. In paragraph (a) introductory text removing the phrase ''a prospective or re-enrolling provider other than either of the following:'' and adding in its place the phrase ''a prospective, revalidating or re-enrolling provider other than the following:'';

■ b. Redesignating paragraphs (a)(2)(ii) introductory text, (a)(2)(ii)(A), and (a)(2)(ii)(B) as paragraphs (a)(2)(ii)(A) introductory text, (a)(2)(ii)(A)(*1*), and (a)(2)(ii)(A)(*2*), respectively;

■ c. In newly redesignated paragraph (a)(2)(ii)(A) introductory text removing the phrase ''Providers that have'' and adding in its place the phrase ''Subject to paragraph (a)(2)(ii)(B) of this section, providers that have''; and

■ d. Adding a new paragraph (a)(2)(ii)(B).

The addition reads as follows:

§ 455.460 Application fee.

(a) * * *

(2) * * *

(ii) * * *

(B) Paragraphs (a)(2)(ii)(A)(1) and (2) of this section do not apply if the State is screening the provider at a higher level under § 455.450 than the Medicare contractor or other State to which the provider paid the fee. In this situation, the State may collect a fee from the provider that represents the cost of this additional screening above and beyond the level of screening the Medicare contractor or State performed under § 455.450. However, the State shall document the reason(s) for the enhanced screening.

* * * * *

■ 53. Adding subparts G through J to part 455 to read as follows:

Subpart G—Administrative Requirements for Program Integrity Corrective Action Plans

Sec.

455.600 Purpose.
455.602 Program integrity corrective action plans.

Subpart G: Requirements for Program Integrity Corrective Action Plans

§ 455.600 Purpose.

This subpart establishes administrative requirements governing:

(a) State Medicaid program integrity corrective action plans (CAPs).

(b) This subpart only applies to Medicaid. Corrective action and withholding for failure to comply with CHIP requirements are governed by part 457 of this chapter, including § 457.204.

§ 455.602 Program integrity corrective action plans.

(a) If CMS identifies findings of non-compliance with Medicaid statutory and regulatory requirements as a result of a CMS program integrity audit, the final audit report will specify the findings, if any, for which the State is required to develop a Program Integrity CAP. If the final audit report requires a Program Integrity CAP for one or more findings, the State must develop a single Program Integrity CAP that addresses all such findings, as described in paragraph (b) of this section.

(b) If required under paragraph (a) of this section to develop a Program Integrity CAP, the State must address each finding of non-compliance for which the final audit report requires corrective action through a Program Integrity CAP and take the following actions:

(1) Conduct a root cause analysis to identify the specific programmatic causes to which each finding of non-compliance is attributed.

(2) Identify the specific corrective action(s) that will be implemented to address each finding of non-compliance and bring the State into compliance.

(3) Develop an implementation schedule for each corrective action and implement such corrective actions in accordance with the schedule. The implementation schedule must identify all of the following for each corrective action:

(i) Status of the corrective action.

(ii) Estimated or actual implementation date.

(iii) Contact information for all key personnel responsible for implementation.

(iv) Monitoring plan to track the progress of implementation of the corrective action.

(4) A plan for evaluating the effectiveness of each corrective action and how the corrective action will rectify the finding(s) of non-compliance.

(c) If the final audit report requires a Program Integrity CAP under paragraph (a) of this section, the State must submit the CAP to CMS no later than 30 calendar days after the date of the final audit report, unless CMS grants a good-cause extension.

(1) The Program Integrity CAP developed under paragraph (a) of this section is subject to CMS approval. If CMS determines that a submitted Program Integrity CAP does not satisfy the requirements of paragraph (b) of this section, CMS returns the CAP to the State for revision and resubmission.

(2) The State must provide updates on Program Integrity CAP implementation progress at each milestone timeframe identified in the implementation schedule for each corrective action under paragraph (b)(3) of this section, and upon request by CMS. Such updates must include the State's progress in implementing the corrective action in accordance with the approved implementation schedule and the evaluation of the effectiveness of the corrective action and how the corrective action is rectifying the finding or findings of non-compliance under paragraph (b)(4) of this section.

(d) Nothing in this section limits, delays, or conditions CMS' exercise of any other administrative or financial action otherwise authorized under Federal law. CMS may pursue such action before, concurrently with, or after requiring a Program Integrity CAP under this section, as appropriate.

Subpart H—Medicaid and CHIP Beneficiary Eligibility Audit Program

Sec.

455.700 Basis and scope.
455.702 Definitions.
455.704 General requirements.
455.706 Audit methods for audits with findings potentially subject to disallowance.
455.708 Protection of applicant and beneficiary information and due process rights.
455.710 Access to records.
455.712 Corrective action plans.

Subpart H—Medicaid and CHIP Beneficiary Eligibility Audit Program

§ 455.700 Basis and scope.

This subpart establishes requirements for Medicaid and CHIP beneficiary eligibility audits designed to reduce eligibility errors by reviewing States' eligibility processes and policies, and the appropriateness of eligibility determinations for sampled cases. A State is required to participate in an eligibility audit when selected by CMS, as set forth in this subpart. The statutory bases for this subpart are sections 1903(u), 2105(e), and 1936 of the Act.

§ 455.702 Definitions.

For purposes of this subpart, the following terms have the definitions:

Corrective action means a specific action that a State would be required to implement to address identified eligibility errors to achieve compliance with Federal requirements and Medicaid and CHIP State plans (or waiver of such plans).

Eligibility means meeting the State's categorical, financial, and non-financial criteria for receipt of benefits under the Medicaid or CHIP programs.

Eligibility audit means a CMS and Federal contractor conducted, primarily risk-based audit of States' Medicaid and CHIP point of application or renewal eligibility determinations, designed to verify compliance with Federal and State eligibility requirements, reduce eligibility errors, and assist States in improving their eligibility determination processes.

Eligibility determination has the same meaning as at § 435.4 for Medicaid, and § 457.301 for CHIP.

Eligibility error means an error resulting from the State's improper application of Federal or State requirements, causing an improper determination of a beneficiary's eligibility. For purposes of this definition, an eligibility error could include, but would not be limited to, authorizing an ineligible individual as eligible when they received services, providing certain ineligible services to an otherwise eligible individual, improperly denying an individual's Medicaid or CHIP application, improperly terminating a beneficiary from Medicaid or CHIP, or enrolling in managed care an individual ineligible for managed care.

Erroneous excess payments for medical assistance means the total of payments under the State plan (or waiver of such plan) with respect to ineligible individuals and families, and overpayments on behalf of eligible individuals and families by reason of errors in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

Observation means an instance where a beneficiary's or applicant's eligibility was correctly determined notwithstanding the State failing to follow Federal and State eligibility requirements.

§ 455.704 General requirements.

(a) When selected, a State must participate in a Medicaid and CHIP beneficiary eligibility audit upon written notification by CMS of an audit. In rare cases, CMS may grant a State an audit exemption for demonstrating extraordinary circumstances beyond the State agency's control that make audit participation impracticable during the applicable fiscal year audit period.

(1) Audit selection criteria include all of the following:

(A) Every State will undergo a Medicaid and CHIP beneficiary eligibility audit at least once every 5 years.

(B) In selecting States for audit, CMS prioritizes States determined to be at high-risk for eligibility errors.

(2) CMS issues an engagement letter to the relevant State Medicaid director, outlining the audit objectives, scope, applicable disallowance authorities, data and documentation request and corresponding data and documentation submission due dates.

(b) State participation during an eligibility audit includes the following:

(1) Providing the requested eligibility and enrollment data and documentation within 10 business days from the date the engagement letter was issued, unless granted an extension by CMS.

(2) Assigning at least two State subject matter experts to navigate the necessary information contained in the State's eligibility and enrollment systems in coordination with the auditors during the case review portion of the audit to allow CMS to verify if eligibility determinations were made in accordance with Federal and State requirements for the sampled cases.

(3) Providing requested copies of additional eligibility case records and any other necessary documentation for sampled cases and documentation within 5 business days of the written request unless granted an extension by CMS.

(4) Responding to the draft report within 10 business days, unless granted an extension by CMS, by providing a written response that indicates whether the State agrees or disagrees with each eligibility error. For any eligibility error with which the State disagrees, the State must provide a detailed written explanation of the basis for disagreement and submit supporting documentation to CMS to substantiate its position.

(5) Submitting a CAP to CMS for approval with proposed corrective actions to address each eligibility error, if applicable, by the deadline specified in the final audit report.

§ 455.706 Audit methods for audits with findings potentially subject to disallowance.

(a) The audit will include four statistically valid stratified random samples of Medicaid and CHIP beneficiaries selected from the universes of eligibility and enrollment data provided by the State. Samples are selected from all eligibility categories included in the Medicaid and CHIP programs.

(1)(i) One sample includes individuals who are enrolled in Medicaid whose eligibility was determined or redetermined and for whom the State made payments for services provided during the full fiscal year audit year.

(ii) The second sample include individuals whose Medicaid eligibility was denied or terminated during the full fiscal year audit period.

(iii) The third sample consists of individuals enrolled in CHIP whose eligibility was determined or redetermined and for whom the State made CHIP payments for services provided during the audit period.

(iv) The fourth sample consists of individuals whose CHIP eligibility was denied or terminated during the audit period.

(2) The State's Medicaid and CHIP information systems will be used to obtain data on beneficiaries and applicants in the sampling frames and their associated Medicaid and CHIP payments.

(3) A statistical software package would be used to generate random numbers to select samples from each stratum.

(4) Sample sizes will be designed to support statistically valid extrapolations of individuals associated with eligibility errors and their associated improper payments at a 90 percent confidence level, if applicable.

(b) The total number of individuals associated with eligibility errors extrapolated to the State's entire Medicaid and CHIP populations and the total extrapolated amount of erroneous excess payments made on behalf of individuals who were improperly enrolled in Medicaid or CHIP during the audit period will be estimated based on the lower limit of the 90 percent confidence interval, if applicable, using statistical software.

(c) Extrapolated error rates for the total dollar amount attributable to erroneous excess payments for medical assistance, as defined in section 1903(u)(1)(D)(i) of the Act, is calculated for both the Medicaid program and CHIP during the audit period using the lower limit of the 90 percent confidence interval, if applicable.

(d) The Federal share of payments determined to be inappropriately made for erroneous excess payments for medical assistance during the audit period are subject to potential disallowances if one or both of the calculated eligibility error rates described in § 455.706(c) exceed the allowable 3 percent threshold under

section 1903(u) of the Act, unless the State meets the good faith waiver requirements defined in § 455.804.

§ 455.708 Protection of applicant and beneficiary information and due process rights.

The State Medicaid agency performing activities for the eligibility audits specified in this subpart must do so in a manner that is consistent with all of the following:

(a) Part 431, subpart F of this chapter concerning the safeguarding of beneficiary and applicant information.

(b) 42 CFR 435.930(b), 435.917, 435.918;.part 431, subpart E; and 457.1110 of this chapter concerning the continuation of Medicaid of coverage for eligible individuals until the State has made a final determination of ineligibility and provided advance notice and fair hearing rights.

§ 455.710 Access to records.

The State, upon written request, must submit to CMS and its Federal contractors, all necessary records, including complete eligibility case documentation for sampled cases and all other available documents pertaining to eligibility determinations in effect during the audit period.

§ 455.712 Corrective action plans.

(a) The State is required to submit a CAP for approval in accordance with § 455.602, if applicable.

(b) After obtaining approval for a CAP, the State is required to make sufficient progress towards implementing the CAP within the established milestone timeframes as specified in § 455.602.

Subpart I—Medicaid and CHIP Beneficiary Eligibility-Related Disallowances

Sec.

455.800 Purpose.
455.802 Disallowance of Federal financial participation for eligibility errors.
455.804 Good faith waivers and notice to States.
455.806 Appeals.

Subpart I—Medicaid and CHIP Beneficiary Eligibility-Related Disallowances

§ 455.800 Purpose.

This section establishes rules and procedures for disallowing Federal financial participation (FFP) in erroneous medical and child health assistance payments due to eligibility improper payment errors, as identified through the Medicaid and CHIP beneficiary eligibility audits subject to disallowance established under Subpart H of this part.

§ 455.802 Disallowance of Federal financial participation for eligibility errors.

(a) After the State's eligibility error rates for Medicaid and CHIP have been calculated in accordance with § 455.706(c) during a beneficiary eligibility audit, if applicable, CMS computes the amount of the disallowances and adjusts the FFP payable to the State in accordance with the procedures in § 430.42.

(b) CMS computes the amount to be disallowed for Medicaid and CHIP separately as follows:

(1) Subtract the 3 percent allowable threshold from the lower limit of the State's Medicaid or CHIP eligibility error rate percentage.

(2) If the difference is greater than zero, the corresponding Federal share of medical assistance or child health assistance funds for the period are multiplied by that percentage. This product is the amount of the disallowance of FFP that will be adjusted in a future State expenditure report absent a good faith waiver in accordance with § 455.804.

§ 455.804 Good faith waivers and notice to States.

(a) If CMS is satisfied that the State did not meet the 3 percent allowable threshold despite a good faith effort, CMS may reduce the funds being disallowed, in whole or in part, based on the extent to which the State demonstrates compliance with the criteria in paragraph (b) of this section and the evidence submitted under paragraph (c) of this section.

(b) CMS may find that a State did not meet the 3 percent allowable threshold despite a good faith effort if all of the following requirements are met:

(1) The State implemented the eligibility-related elements of its most recent CMS-approved PERM CAP in accordance with § 431.992.

(2) Where applicable, the State submitted a CAP under § 455.712 in response to previous Medicaid and CHIP beneficiary eligibility audit findings, obtained CMS approval of that CAP, and is making sufficient progress implementing the approved CAP within its established milestone timeframes at the time of the good faith waiver determination.

(3)(i) The State has taken additional reasonable actions to prevent, identify, or mitigate eligibility errors it believed were necessary to meet the 3 percent threshold.

(ii) In determining whether a State took reasonable actions, CMS considers factors including, but not limited to, the following:

(A) Whether the State maintained reasonable pre-existing eligibility controls.

(B) Whether the same eligibility errors had been identified in previous audits or reviews.

(C) The timeliness and substance of the State's response after error identification.

(Dv) Immediate corrective actions already taken.

(Ev) Cooperation and transparency during CMS audits and reviews.

(c)(1) The State must submit evidence demonstrating its actions under paragraph (b) of this section within 30 calendar days of CMS' issuance of the final Medicaid and CHIP beneficiary eligibility audit report and notification of the associated disallowance amount, unless granted an extension by CMS.

(2) Evidence submission may include all of the following:

(i) Policy manuals.

(ii) Staff training records;

(iii) Documentation of eligibility and enrollment system enhancements.

(iv) Self-audit reports.

(v) Detailed CAPs with proof of implementation and effectiveness.

(d) Notwithstanding paragraphs (a) through (c) of this section, CMS may determine that a State is ineligible for a good faith waiver or is eligible for only a partial waiver where the information and evidence available to CMS demonstrates systemic or persistent program integrity failures inconsistent with a good faith effort during the audit period.

(e) Circumstances that may warrant a determination under paragraph (d) of this section include, but are not limited to any of the following:

(1) Repeated beneficiary eligibility audit or PERM findings involving the same or substantially similar errors.

(2) Failure to address or implement prior CMS audit recommendations related to eligibility determination errors.

(3) Known system defects, operational deficiencies, or policy weaknesses affecting eligibility determinations that remained unaddressed by the State during the audit period.

(4) Patterns of noncompliance identified across multiple Federal oversight activities.

(f) Each State that has an eligibility improper payment rate above the allowable threshold is notified by CMS in writing of the good faith waiver determination, including whether CMS granted a full waiver, a partial waiver, or no waiver, and, where applicable, the amount of the disallowance issued under § 455.802. This written notification would also include the

information specified in § 430.42(a), as appropriate, including notice of the State's right to request reconsideration of the disallowance.

§ 455.806 Appeals.

If a State disagrees with the determinations set forth in the written notice described in § 455.804(f), the State may request reconsideration or appeal within 60 calendar days of receipt of the notice. All processes regarding the notice of disallowance, reconsideration, retention of funds, and appeals will be governed by the procedures set forth in § 430.42 of this chapter.

Subpart J—Reporting and Returning of Overpayments in Medicaid Fee-for-Service

§ 455.900 Basis and scope.

This subpart sets forth the policies and procedures for reporting and returning self-identified overpayments to the Medicaid Fee-For-Service program as required by section 1128J(d) of the Act.

§ 455.902 Definitions.

For purposes of this subpart only—

Overpayment means any funds that a person received or retained under title XIX of the Act to which the person is not entitled under such title after applicable reconciliation.

Person means a provider of services or supplier who participates under a State plan (or waiver of such plan) established under title XIX of the Act.

§ 455.904 Requirements for reporting and returning of overpayments.

(a) *General.*

(1) A person that has received an overpayment must report and return the overpayment to the State, including a written reason for the overpayment, in the form and manner specified by the State in accordance with paragraph (c)(1) of this section.

(2) A person has identified an overpayment when the person knowingly receives or retains an overpayment. The term ''knowingly'' has the meaning set forth in 31 U.S.C. 3729(b)(1).

(b) *Deadline for reporting and returning overpayments.* A person who has received an overpayment must report and return the overpayment to the State by the later of either of the following:

(1) The date which is 60 days after the date on which the overpayment was identified.

(2) The date any corresponding cost report is due, if applicable.

(c) *State responsibilities.* A State must do all of the following:

(1) Establish a mechanism for a person to report and return to the State when an overpayment is identified, in accordance with paragraph (b) of this section.

(2) Return the Federal share of overpayments to CMS consistent with the requirements in 42 CFR 433.312.

(3) Maintain a record of all reported or received overpayments and make such records available to CMS upon request.

(d) *Reporting.* A person must use the mechanism established by the State in paragraph (c)(1) of this section to report and return an identified overpayment to the State. If the person calculates the overpayment amount using a statistical sampling methodology, the person must describe the statistically valid sampling and extrapolation methodology in the report.

(e) *Enforcement.* Any overpayment retained by a person after the deadline for reporting and returning the overpayment specified in paragraph (b) of this section is an obligation for purposes of the False Claims Act, 31 U.S.C. 3729(b)(3).

(f) *Lookback period.* An overpayment must be reported and returned in accordance with this section if a person identifies the overpayment, as defined in paragraph (a)(2) of this section, within 6 years of the date the overpayment was received.

PART 457—ALLOTMENTS AND GRANTS TO STATES

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

Authority: 42 U.S.C. 1302.

■ 55. Section 457.628 is amended by revising paragraph (a) to read as follows:

§ 457.628 Other applicable Federal regulations.

* * * * *

(a) HHS regulations in the following sections:

(1) Sections 431.950 through 431.1002 of this chapter (related to the PERM program).

(2) Sections 433.312 through 433.322 of this chapter (related to Overpayments).

(3) Section 433.38 of this chapter (Interest charge on disallowed claims of FFP).

(4) Sections 430.40 through 430.42 of this chapter (Deferral of claims for FFP and Disallowance of claims for FFP).

(5) Section 430.48 of this chapter (Repayment of Federal funds by installments).

(6) Sections 433.50 through 433.74 of this chapter (sources of non-Federal share and Health Care-Related Taxes and Provider Related Donations).

(7) Section 447.207 of this chapter (Retention of Payments).

(8) Sections 455.700 through 455.806 (related to the Beneficiary eligibility audit program) of this chapter apply to States CHIP programs in the same manner as they apply to States Medicaid programs.

* * * * *

■ 56. Section 457.935 is amended by adding paragraph (b)(8) to read as follows:

§ 457.935 Sanctions and related penalties.

(b) * * *

(8) Section 455.23 of this chapter.

* * * * *

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/IID AND CERTAIN NFs IN THE MEDICAID PROGRAM

■ 57. The authority citation for part 498 continues to read as follows:

Authority: 42 U.S.C. 1302, 1320a–7j, and 1395hh.

Source: 52 FR 22446, June 12, 1987, unless otherwise noted.

Section 498.3 is amended by—

■ a. Redesignating paragraph (b)(20) as new paragraph (b)(20)(i).

■ b. Removing the phrase ''§ 422.2 or'' from new paragraph (b)(20)(i).

■ c. Adding new paragraph (b)(20)(ii).

The addition reads as follows:

§ 498.3 Scope and applicability.

* * * * *

(b) * * *

(20) * * *

(ii) Before January 1, 2030, an individual or entity is to be included on the preclusion list as defined in *§ 422.2* of this chapter.

* * * * *

■ 58. Section 498.5 is amended by revising paragraph (n)(1)(i) to read as follows:

§ 498.5 Appeal rights.

* * * * *

(n) * * *

(1) * * *

(i)(A) Any individual or entity that is dissatisfied with an initial determination or revised initial determination that they are to be included on the preclusion list (as defined in *§ 423.100 of this chapter*) may request a reconsideration in accordance with *§ 498.22(a).* (B) Before January 1, 2030, any individual or entity

that is dissatisfied with an initial determination or revised initial determination that they are to be included on the preclusion list (as defined in *§ 422.2* of this chapter) may request a reconsideration in accordance with § 498.22(a).

* * * * *

Title 45—Public Welfare

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 59. The authority citation for part 155 continues to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083.

■ 60. Section 155.20 is amended by adding the definitions of ''Credible allegation of abusive conduct'' and ''Convicted'' in alphabetical order to read as follows:

Credible allegation of abusive conduct. A credible allegation of abusive conduct is an allegation from any source, including but not limited to the following:

(1) Consumer, Marketplace call center, or agent, broker, or web-broker complaints verified by further evidence;

(2) Data or information identified during investigation; or

(3) Patterns identified through data analysis.

Allegations are considered to be credible when they have indicia of reliability.

Convicted means that—

(1) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

(i) There is a post-trial motion or an appeal pending;', or(ii) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(2) A Federal or State court has accepted a plea of guilty or *nolo contendere* or an Alford plea by an individual or entity; or

(3) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

■ 61. Section 155.220 is amended by:

■ a. Revising paragraph (g)(1), adding paragraph (g)(1)(i), revising paragraphs (g)(3)(i) and (g)(3)(ii), adding paragraphs (g)(3)(iii) and (g)(3)(iv), and revising paragraphs (g)(4) and (g)(5);

■ b. Revising paragraph (h)(1) and adding new paragraphs (h)(1)(i), (h)(1)(ii), and (h)(1)(iii);

■ c. Revising paragraphs (j)(2)(i) and (j)(2)(ii) and adding new paragraph (j)(2)(ix); and

■ d. Revising paragraph (k).

The revisions and additions read as follows:

§ 155.220 Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(g) * * *

(1) HHS may terminate for cause an agent's, broker's, or web-broker's agreements with the Federally-facilitated Exchanges and State-based Exchanges on the Federal Platform (SBE–FPs) (required under paragraph (d) of this section and § 155.260(b)), if HHS determines that the agent, broker, or web-broker is noncompliant as described in paragraph (g)(2) of this section. In that case, HHS may also impose one or more of the penalties identified in paragraph (k)(1) of this section.

(i) Except for terminations made pursuant to paragraphs (g)(3)(ii) through (g)(3)(iv) of this section, when HHS makes a noncompliance determination under paragraph (g)(1), HHS will consider the factors identified in § 155.285(b)(1) and (2) to the extent relevant to the facts and circumstances of each case, as well as any additional relevant factors supported by the evidence when it: (A) Decides whether to terminate an agent, broker, or web-broker's agreements (described in paragraph (d) of this section and § 155.260(b)) for cause; or (B) Selects among the penalties identified in paragraph (k)(1) of this section, including the length of the penalty imposed under paragraph (k)(1)(i) of this section.

(2) * * *

(3) * * *

(i) Except as provided in paragraphs (g)(3)(ii) through (g)(3)(iv) of this section, HHS will first notify the agent, broker, or web-broker of a noncompliance determination made under paragraph (g)(1) of this section. The agent, broker, or web-broker will have 30 calendar days after the date of the notice to submit information to HHS refuting the noncompliance determination. After reviewing any refutation evidence submitted, HHS may terminate the agent, broker, or web-broker's agreements required under paragraph (d) of this section and § 155.260(b) for cause if HHS determines, based on the evidence available to HHS, that a preponderance of the evidence establishes that noncompliance occurred. The failure to submit evidence to refute does not preclude HHS from making such a determination based on the evidence otherwise available to HHS.

(ii) If an agent or broker fails to maintain the appropriate license under State law to act as an agent, broker, or insurance producer in every State where the agent or broker actively assists consumers with applying for advance payments of the premium tax credit or cost-sharing reductions, or with enrolling in QHPs through the Federally-facilitated Exchanges or SBE–FPs, HHS may immediately terminate the agreements (required under paragraph (d) of this section and § 155.260(b)) for cause upon notice to the agent or broker, without first providing the agent or broker an opportunity to refute the determination under paragraph (g)(3)(i) of this section.

(iii) HHS may deny registration to, or terminate the agreements for cause with any agent, broker, or web-broker who—

(A) Is currently terminated, suspended, or revoked (or otherwise barred or excluded) from participation in any Federal program; or

(B) Has a license that is currently revoked or suspended for conduct that may cause harm to consumers or program integrity in a State other than the State in which the agent, broker, or web-broker is enrolling consumers. This applies regardless of whether any appeal(s) of the exclusion, termination, suspension, or revocation is pending. HHS may take action under this paragraph (g)(3)(iii) of this section upon notice to the agent, broker, or web-broker, without first providing an opportunity to refute the determination under paragraph (g)(3)(i) of this section. If the agent, broker, or web-broker subsequently demonstrates to HHS that the exclusion, termination, suspension, or revocation has been vacated or reversed on appeal and no other grounds for denial of registration exist, HHS will permit the agent, broker, or web-broker to register with the Exchange.

(iv) HHS may deny registration to, or immediately terminate the agreements for cause with, any agent, broker, or web-broker who was convicted of a Federal or State misdemeanor or felony offense that HHS determines is detrimental to the best interests of the FFEs, SBE–FPs, or their consumers, regardless of whether the conviction has been appealed. HHS may take this action upon notice to the agent, broker, or web-broker, without first providing an opportunity to refute the determination under paragraph (g)(3)(i) of this section. If the agent, broker, or web-broker subsequently demonstrates

to HHS that the conviction has been vacated or reversed on appeal and no other grounds for denial of registration exist, HHS will permit the agent, broker, or web-broker to register with the Exchange.

(A) These misdemeanor or felony offenses include, but are not limited in scope or severity to—

(*1*) Misdemeanor and felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(*2*) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, identity theft, forgery, bribery, falsification or destruction of records, receiving stolen property, making false statements or claims, violation of consumer protection laws, and other similar crimes for which the individual was convicted.

(*3*) Any misdemeanor or felony that places the Federally-facilitated Exchanges, SBE–FPsor their consumers at immediate risk, such as a conviction of criminal neglect or misconduct.

(*4*) Any misdemeanor or felony that would result in mandatory exclusion under section 1128(a) of the Act.

(4) If HHS terminates the agreements (described in paragraph (d) of this section and § 155.260(b)), the agent, broker, or web-broker will no longer be registered with the Federally-facilitated Exchanges or SBE–FPs, or be permitted to assist with or facilitate enrollment of a qualified individual, qualified employer, or qualified employee in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchanges or SBE–FPs, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

(i) The agent, broker, or web-broker's agreements with the Exchange under § 155.260(b)(2) will also be terminated through the process set forth in that agreement.

(ii) The termination is effective on the date specified in the notice HHS sends to the agent, broker, or web-broker advising the agent, broker, or web-broker of the termination of the agreement.

(iii)The agent, broker, or web-broker must continue to protect any personally identifiable information accessed during the term of any agreement with a Federally-facilitated Exchanges and SBE–FPs.

(5) * * *

(i) Abusive conduct is any conduct that is likely to cause or has caused harm to the Federally-facilitated Exchanges, SBE–FPs, or their consumers. Abusive conduct includes, but is not limited to, any of the following:

(A) A violation of the standards of conduct at 45 CFR 155.220(j)(2).

(B) Providing the Federally-facilitated Exchanges or SBE–FPs with inaccurate application information related to the consumer's eligibility for Medicaid, CHIP, a QHP offered through the Exchange, advance premium tax credit, or cost-sharing reductions.

(C) A violation of any term or condition of the agreements with the Federally-facilitated Exchanges and SBE–FPs (required under paragraph (d) of this section and § 155.260(b)) that relates to the agent, broker, or web-broker's conduct toward consumers.

(D) Any other misleading or coercive conduct identified by HHS.

(ii) If HHS finds that an allegation of abusive conduct against an agent, broker, or web-broker is credible, as defined in 45 CFR 155.20, HHS may suspend the agent, broker, or web-broker's agreements required under paragraph (d) of this section and under § 155.260(b) for 90 calendar days.

(A) Suspension will be effective on the date of the notice that HHS sends to the agent, broker, or web-broker advising of the suspension of the agreements.

(B) The agent, broker, or web-broker may submit evidence, in a form and manner specified by HHS, to rebut the allegation that led to the suspension. The agent, broker, or web-broker must submit any such evidence within 30 calendar days of the suspension. HHS will review any evidence submitted and make a determination whether to lift the suspension within the 90-day period.

(iii) HHS may terminate for cause the agent, broker, or web-broker's agreements required under paragraph (d) of this section and § 155.260(b) if, after reviewing any rebuttal evidence submitted, HHS determines by a preponderance of the evidence that abusive conduct occurred.

(iv) During the suspension period under paragraph (g)(5)(ii) of this section and following termination of the agreements under paragraph (g)(5)(iii) of this section, the agent, broker, or web-broker will not be registered with the Federally-facilitated Exchanges and SBE–FPs, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent, broker, or web-broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges and SBE–FPs.

(6) The State department of insurance, or equivalent State licensing authority for agents or brokers, will be notified by HHS in cases of suspension, termination, or penalty imposed, under paragraphs (g) or (k)(1) of this section.

* * * * *

(h) * * *

(1) *Request for reconsideration.* An agent, broker, or web-broker may request reconsideration, in the manner and form established by HHS, of the following:

(i) HHS' decision to terminate the agent, broker, or web-broker's agreement with the Federally-facilitated Exchange under paragraph (g) of this section;

(ii) HHS' decision to deny registration with the Federally-facilitated Exchanges and SBE–FPs under paragraph (g)(3)(iii) or (iv) of this section; or

(iii) HHS' decision to impose a penalty under paragraph (k)(1)(i) of this section.

* * * * *

(j) * * *

(2) * * *

(i) Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges and SBE–FPs, and insurance affordability programs. Refrain from marketing or conduct that is misleading, coercive, or discriminates based on race, color, national origin, disability, age, or sex. Misleading or coercive conduct may include, but are not limited to, either of the following—

(A) Having a website that HHS determines could mislead a consumer into believing the consumer is visiting *HealthCare.gov,* an official Marketplace, ACA or Exchange enrollment website, certified Exchange enrollment partner website, or any other official website of the Federal or a State government, and

(B) Falsely claiming to represent the Federally-facilitated Exchange or State-based Exchanges on the Federal platform, or falsely suggesting that coverage from the Federally-facilitated Exchange or State-based Exchanges on the Federal platform is free.

(ii) * * *

* * * * * *

(E) * * *

(1) An agent, broker, or web-broker may not use or project, or ask a consumer to use or project, on the

Exchange eligibility application, the following:

(*i*) An annual income that is not based on any actual or reasonably expected source of income.

(*ii*) Income the consumer is unlikely to earn.

(*iii*) Income that omits one or more tax household members.

(*iv*) Income based on inappropriate modified adjusted gross income calculations, such as projecting income based on income after income tax withholding.

(*v*) A predetermined income amount that the consumer is coached, targeted, or steered towards by the agent, broker, or web-broker.

(F) Submitting application and enrollment data only for consumers who are not deceased at the time of enrollment.

(G) Accurately entering information provided and confirmed by the consumer pertaining to any existing minimum essential coverage as defined by 45 CFR part 156 Subpart G, that the consumer is eligible for or enrolled in.

(H) Accurately entering information provided and confirmed by the consumer pertaining to all tax household members. Agents, brokers, and web-brokers must ask consumers about their household composition to the same extent consumers are asked about household composition on the Exchange eligibility application and accurately report each consumer response.

(I) Accurately entering information provided and confirmed by the consumer regarding residence address pursuant to 45 CFR 155.305(a)(3).

(J) Accurately entering information provided and confirmed by the consumer regarding household contact information including names, phone number and mailing address, and if the consumer chooses to provide them, accurate email address and mobile phone number for text messages. Consumer contact information must only be the consumer's personal contact information and cannot be contact information accessible or controlled by an agent, broker, web-broker or any other non-consumer persons or entities.

(K) Using customer service channels that HHS determines do not mislead a consumer into believing the consumer is providing information to or enrolling through an official Exchange, Marketplace, or ACA customer service pathway or representative, or through certified Exchange enrollment partners.

* * * * *

(ix) Implement and maintain reasonable administrative, technical, and contractual safeguards designed to ensure that access and attempted access to the Federally-facilitated Exchanges and SBE–FPs, systems that support the Federally-facilitated Exchanges and SBE–FPs, and personally identifiable information obtained through the Federally-facilitated Exchanges and SBE–FPs by the individual or entity described in paragraph (j)(1) of this section and all employees, contractors, subcontractors, and other downstream entities acting on their behalf, occur only from locations within the United States, its territories, embassies, or military installations.

(A) Such reasonable safeguards must include safeguards to ensure that VPNs or other similar technologies do not route Exchange system traffic through a server, network, or other point located outside the United States, its territories, embassies, or military installations, regardless of whether the agent, broker, or web-broker is physically located inside the United States, its territories, embassies, or military installations at the time of access, and regardless of whether the technology causes the access to appear to originate from a location inside the United States, its territories, embassies, or military installations.

(B) An agent, broker, or web-broker will not be considered to have failed to satisfy the requirements of paragraph (j)(2)(ix) of this section due to unauthorized activity resulting from compromised credentials or inadvertent network activity that the agent, broker, or web-broker could not reasonably have known about or prevented through reasonable safeguards.

* * * * *

(4) Except for suspensions or terminations under paragraph (g)(5) of this section, if an agent, broker, or web-broker fails to provide correct information, the agent, broker, or web-broker will nonetheless be deemed in compliance with paragraphs (j)(2)(i) and (ii) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information and that the agent, broker, or web-broker acted in good faith. For suspensions or terminations under paragraph (g)(5) of this section, conduct resulting solely from inadvertent error, notwithstanding reasonable compliance, measures does not constitute abusive conduct.

* * * * *

(k) * * *

(1) If HHS determines that an agent, broker, or web-broker is noncompliant as described in paragraph (g)(2) of this section, or has engaged in abusive conduct as described in paragraph (g)(5) of this section, in addition to or as an alternative to any other available remedies, that agent, broker, or web-broker—

(i) * * *

(ii) * * *

(2) HHS will notify the agent, broker, or web-broker of the imposition of penalties under paragraph (k)(1)(i) of this section as part of the termination notice issued under paragraph (g) of this section. The proposed imposition of penalties under paragraph (k)(1)(ii) of this section will follow the process outlined under § 155.285.

* * * * *

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2026–23461 Filed 11–16–26; 4:15 pm]

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Part III

Department of Health and Human Services

45 CFR Parts 160 and 164
HIPAA Privacy Rule: Changes To Support Coordinated Care and Individual Engagement and Reduce Regulatory Burdens; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Parts 160 and 164

RIN 0945–AA00

HIPAA Privacy Rule: Changes To Support Coordinated Care and Individual Engagement and Reduce Regulatory Burdens

AGENCY: Office for Civil Rights (OCR), Office of the Secretary, Department of Health and Human Services.

ACTION: Final rule.

SUMMARY: The Department of Health and Human Services (HHS or ''Department'') is issuing this final rule to modify the Standards for Privacy of Individually Identifiable Health Information (''Privacy Rule'') under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. These modifications address standards that may impede the nationwide transition to value-based health care by limiting or discouraging individual access or care coordination and case management or posing other unnecessary burdens. The modifications in this final rule promote the essential sharing of individuals' protected health information (PHI) for care coordination and individual engagement while continuing to protect its privacy and security.

DATES:

Effective dates: The final rule is effective on January 19, 2027.

Compliance date: Persons subject to this regulation must comply with the applicable requirements of this final rule by July 19, 2027.

FOR FURTHER INFORMATION CONTACT: Marissa Gordon-Nguyen at (202) 240–3110 or (800) 537–7697 (TDD), or by email at *OCRPrivacy@hhs.gov.*

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Table of Acronyms

Term	Meaning
ACA	Patient Protection and Affordable Care Act.
ADA	Americans with Disabilities Act of 1990.
AHRQ	Agency for Healthcare Research and Quality.
APA	Administrative Procedure Act.
API	Application Programming Interface.
ASL	American Sign Language.
BJS	Bureau of Justice Statistics.
BLS	Bureau of Labor Statistics.
CAH	Critical Access Hospital.
CARES Act	Coronavirus Aid, Relief, and Economic Security (CARES) Act.
CEHRT	Certified EHR Technology.
CLIA	Clinical Laboratory Improvement Amendments of 1988.
CMS	Centers for Medicare & Medicaid Services.
COVID-19	Coronavirus Disease 2019.
Cures Act	21st Century Cures Act.
Department or HHS	U.S. Department of Health and Human Services.
DME	Durable Medical Equipment.
EHI	Electronic Health Information.
EHR	Electronic Health Record.[a]
E.O.	Executive Order.
ePHI	Electronic Protected Health Information.
FAQ	Frequently Asked Question.
GAO	Government Accountability Office.
HCBS	Home and Community Based Services.
Health IT	Health Information Technology.
HIE	Health Information Exchange.
HIN	Health Information Network.
HINTS	Health Information National Trends Survey.
HIPAA	Health Insurance Portability and Accountability Act of 1996.
HITECH Act	Health Information Technology for Economic and Clinical Health Act.
HTI	Health Data, Technology, and Interoperability.
ICR	Information Collection Request.
IIHI	Individually Identifiable Health Information.
IOM	Institute of Medicine.
MACRA	Medicare Access and CHIP Reauthorization Act of 2015.
NAICS	North American Industry Classification System.
NCVHS or Committee	National Committee on Vital and Health Statistics.
NOAA	National Oceanic and Atmospheric Administration.
NPP	Notice of Privacy Practices.
NPRM	Notice of Proposed Rulemaking.
OCR	Office for Civil Rights.
OIG	Office of Inspector General.
OMB	Office of Management and Budget.
ONC	Office of the National Coordinator for Health Information Technology.
PDMP	Prescription Drug Monitoring Program.

PHI	Protected Health Information.
PHSA	Public Health Service Act.
PRA	Paperwork Reduction Act of 1995.
QHIN	Qualified Health Information Network.
RFA	Regulatory Flexibility Act.
RFI	Request for Information.
RIA	Regulatory Impact Analysis.
SBA	Small Business Administration.
SMI	Serious Mental Illness.
SNF	Skilled Nursing Facility.
SSA	Social Security Act of 1935.
SSDI	Social Security Disability Insurance.
SSI	Supplemental Security Income.
SUD	Substance Use Disorder.
TEFCA	Trusted Exchange Framework and Common Agreement.
TPO	Treatment, Payment, and/or Health Care Operations.
TRS	Telecommunications Relay Services.
UMRA	Unfunded Mandates Reform Act of 1995.
U.S.C.	United States Code.
USPHS	U.S. Public Health Service.
VA	U.S. Department of Veterans Affairs.
VDT	View, Download, and Transmit.

[a] For purposes of this final rule, we use the term "EHR" to refer to the commonly understood meaning of the term; *i.e.*, a system that stores electronic health information across different health care settings. We use the term "electronic health record" when referring to the term defined in the HITECH Act and this final rule.

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I. Executive Summary

A. Overview

Empowering individuals to take control of their health is critical to delivering on the promise to Make America Healthy Again, which is central to the mission of the Department of Health and Human Services (HHS or ''Department''). Enabling individuals, their personal representatives, their health care providers, and others designated by the individuals to have unfettered access to their information is a necessary first step towards achieving this promise.

Many individuals rely on access to their health information—directly, through their health care providers, through patient or health plan member portals, or through the use of health apps—to monitor their chronic conditions, adhere to their treatment plans, find and address errors in their health records, and track their progress in wellness and disease management programs. This information provides the individual and their care team with insight into the current state of their health and enables them to set goals for improving it. Equally important, the efficient operation of the health care system depends upon the ability of covered entities [1] and their business associates [2] (collectively, ''regulated entities'') to promptly disclose an individual's protected health information [3] (PHI) to other regulated entities and certain others (*e.g.,* non-covered health care providers, social services agencies, family members) to ensure that individuals receive timely and appropriate care. For example, such disclosures enable health care providers to avoid ordering duplicative or unnecessary tests, which reduces waste and the overall cost of health care. They also facilitate the ability of health care providers to provide care promptly by avoiding long waits for approvals of coverage by health plans.

To foster electronic access to health information by individuals and health care providers, the Trump Administration has launched a series of initiatives to break down barriers to information sharing and form the building blocks for a digital ecosystem in which patients can view, manage, use, and share their health information through digital applications and other modern solutions. The goal of this digital ecosystem is to expand access to personalized health guidance for patients to improve prevention and chronic disease management, while maintaining the privacy and security of PHI in the ecosystem. For example, the Centers for Medicare & Medicaid Services (CMS) is taking bold steps to modernize the nation's digital health ecosystem with a focus on empowering Medicare beneficiaries through greater access to innovative health technologies.[4] As another example, the

[1] *See* 45 CFR 160.103 (definition of ''Covered entity'').

[2] *See* 45 CFR 160.103 (definition of ''Business associate'').

[3] *See* 45 CFR 160.103 (definition of ''Protected health information'').

[4] ''Health Technology Ecosystem,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Sept. 16, 2026), *https://www.cms.gov/priorities/health-technology-ecosystem/overview; see also* Press Release, ''White House, Tech Leaders Commit to Create Patient-Centric Healthcare Ecosystem,'' Centers for Medicare & Medicaid Services, U.S. Department of

Continued

Office of the National Coordinator for Health Information Technology [5] (ONC) adopted certification criteria for health information technology (''health IT'') that support real-time verification of an individual's prescription benefits and standardized electronic prior authorization.[6] The Department also has announced an intention to take an active enforcement stance against health care entities that restrict patients' engagement in their care by blocking the access, exchange, and use of certain health information.[7] As explained by then-Acting Inspector General Juliet T. Hodgkins, ''[p]roviders and certain health IT entities have a legal duty to ensure that information flows where and when it's needed.'' [8]

While it is important that individuals have access to their own health information—in a format of their choosing, including through their personal health apps—and covered entities can use and disclose that information for certain purposes, individuals also have an interest in the privacy of this highly personal information, given the potential for harm if it is shared with the wrong person(s). Thus, it is incumbent upon the Department to establish rules that both enable the use and disclosure of an individual's health information for beneficial purposes and protect the privacy (and security) of that information.

Consistent with these goals, this final rule modifies certain provisions of the Standards for Privacy of Individually Identifiable Health Information (''Privacy Rule''), issued pursuant to section 264 of the Administrative Simplification provisions of title II, subtitle F, of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[9] The Privacy Rule [10] is one of several rules, collectively known as the HIPAA Rules,[11] that establish the required protections for the privacy and security of individuals' PHI, which is individually identifiable health information [12] (IIHI) transmitted by or maintained in electronic media or any other form or medium, with certain exceptions.[13] This final rule supports access by individuals to their PHI and the use and disclosure of PHI by regulated entities for care coordination and case management, discussed in detail below. Specifically, this final rule amends provisions of the Privacy Rule that may present barriers to individual engagement and care coordination and case management—or impose other burdens without sufficiently compensating for, or offsetting, such burdens through privacy protections for PHI. These barriers may impede the transformation of the health care system from a system that pays for procedures and services to one that pays for high-quality health care and empowers individuals to take charge of their health. Consistent with the Department's historical approach to the HIPAA Rules, the amendments generally are technology neutral. Where appropriate, we discuss the application of these amendments, and the Privacy Rule as a whole, to current technology in preamble.

B. Summary of Major Provisions

After consideration of the public comments received in response to the 2021 Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement notice of proposed rulemaking (NPRM) (''2021 Privacy Rule NPRM''), the Department is modifying the Privacy Rule to support individual access and improve care coordination and case management by: [14]

- Modifying provisions on the individual's right of access to PHI by doing all of the following:
  - Adding definitions of the terms ''electronic health record'' and ''personal health application'' (''personal health app'').
  - Reducing the amount of time that covered entities have to respond to an access request to no more than 15 calendar days after receipt of the request (reduced from the current 30 days), with the opportunity for an extension of no more than 30 calendar days (retaining the current 30-day extension).
  - Clarifying the form and format required for responding to individuals' requests for PHI.
  - Reducing the burden of identity verification on individuals exercising their access rights.
  - Limiting the individual's right of access to direct the transmission of PHI to a person they designate to electronic copies of PHI in an electronic health record (''right of access to direct''), in accordance with a binding court decision.[15]
  - Requiring covered entities to inform individuals that they retain their

Health and Human Services (July 30, 2025), *https://www.cms.gov/newsroom/press-releases/white-house-tech-leaders-commit-create-patient-centric-healthcare-ecosystem.*

[5] The Assistant Secretary for Technology Policy (ASTP)/ONC is now referred to as ONC. *See* 91 FR 16204 (Apr. 1, 2026). Although at the time of specific references noted herein ONC was either referenced as ASTP/ONC or as ONC, we use ONC throughout this document for clarity, except where ASTP or ASTP/ONC is used in quoted material.

[6] 45 CFR 170.315(b)(4) and 170.315(g)(31)–(33); *see* 90 FR 36536, 36541–42 (Aug. 4, 2025); *see also* Thomas Keane et al., ''ASTP/ONC Rule Creates Prescription Drug Cost Transparency, Eases Administrative Burden, and Speeds Access to Care,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (July 31, 2025), *https://healthit.gov/blog/healthit-certification/astp-onc-rule-creates-prescription-drug-cost-transparency-eases-administrative-burden-and-speeds-access-to-care/;* Testimony of Thomas Keane, M.D., Assistant Secretary for Technology Policy; Office of the National Coordinator for Health Information Technology, Department of Health and Human Services, Hearing on Transforming Health Care with Data: Improving Patient Outcomes Through Next-Generation Care before Senate Health Education, Labor and Pensions Committee (Mar. 5, 2026), *https://www.help.senate.gov/imo/media/doc/0b360ae0-0290-e896-f8f3-1f230eb3dce7/Keane%20Testimony.pdf.*

[7] Press Release, ''HHS Announces Crackdown on Health Data Blocking,'' U.S. Department of Health and Human Services (Sept. 4, 2025), *https://www.hhs.gov/press-room/hhs-crackdown-health-data-blocking.html.*

[8] *Id.*

[9] Subtitle F of title II of HIPAA (Pub. L. 104–191, 110 Stat. 1936 (Aug. 21, 1996)) added a new part C to title XI of the SSA, Public Law 74–271, 49 Stat. 620 (Aug. 14, 1935) (*see* sections 1171–1179 of the SSA (codified at 42 U.S.C. 1320d–1320d–8)), as well as promulgating section 264 of HIPAA (codified at 42 U.S.C. 1320d–2 note), which authorizes the Secretary to promulgate regulations with respect to the privacy of individually identifiable health information. The Privacy Rule has subsequently been amended pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA), title I, section 105, Public Law 110–233, 122 Stat. 881 (May 21, 2008) (codified at 42 U.S.C. 2000ff), the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Public Law 111–5, 123 Stat. 226 (Feb. 17, 2009) (codified at 42 U.S.C. 1390w–4(O)(2)), and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law 116–136, 3221(i), 134 Stat. 378 (Mar. 27, 2020) (codified at 42 U.S.C. 290dd–2 note).

[10] 45 CFR part 160 and subparts A and E of part 164. For a history of the Privacy Rule, *see infra* Section II.B., ''Regulatory and Legal History.''

[11] *See also* the HIPAA Security Rule (''Security Rule''), 45 CFR part 160 and subparts A and C of part 164; the HIPAA Breach Notification Rule, 45 CFR part 164, subpart D; and the HIPAA Enforcement Rule, 45 CFR part 160, subparts C, D, and E.

[12] 42 U.S.C. 1320d; *see also* 45 CFR 160.103 (definition of ''Individually identifiable health information'').

[13] At times throughout this final rule, the Department uses the terms ''health information'' or ''individuals' health information'' to refer generically to health information pertaining to an individual or individuals. In contrast, the Department's use of the term ''IIHI'' refers to a category of health information defined in HIPAA, and ''PHI'' is used to refer specifically to a category of IIHI that is defined by, and subject to, the privacy and security standards promulgated in the HIPAA Rules.

[14] Additional revisions are not listed here because they are not considered major. Generally, the proposals being finalized that are not listed here make non-substantive changes. These proposals are reviewable in section IV. and the amendatory language in the last section of the final rule.

[15] Throughout this document, we use ''right of access to direct'' interchangeably with the full description of the right set forth in at new 45 CFR 164.524(d).

right to obtain copies of their PHI or direct electronic copies of PHI in an electronic health record to another person when a summary of PHI is offered in lieu of a copy.

○ Amending the permissible fee structure for responding to requests made pursuant to the right of access, including specifying when electronic PHI [16] (ePHI) must be provided to the individual at no charge.

○ Requiring covered entities to post estimated fee schedules on their websites for copies of PHI obtained under the right of access and with an individual's valid authorization.

• Amending the definition of health care operations to clarify the scope of permitted uses and disclosures for individual-level care coordination and case management that constitute health care operations.

• Clarifying the ability of covered entities to disclose PHI to social services agencies, community-based organizations, home and community-based services (HCBS) providers,[17] and other similar third parties [18] that provide health-related services, to facilitate care coordination and case management for individuals.

• Eliminating the requirement to obtain an individual's written acknowledgment that they have received a copy of a Notice of Privacy Practices (NPP) from a health care provider with whom they have a direct treatment relationship.

• Modifying the content requirements of the NPP to clarify for individuals their rights with respect to their PHI and how to exercise those rights.

• Expressly permitting disclosures to Telecommunications Relay Services (TRS) communications assistants for persons who are deaf, hard of hearing, or deaf-blind, or who have a speech disability, and modifying the definition of business associate to exclude TRS providers.

• Expanding the permission to use or disclose PHI of Armed Forces members in certain circumstances to all Uniformed Services, which then would include the U.S. Public Health Service (USPHS) Commissioned Corps and the National Oceanic and Atmospheric Administration (NOAA) Commissioned Corps.

The Department carefully considered the extent to which each of these modifications would affect privacy protections for health information and the likely benefits of making PHI more available for care coordination or case management. These and other considerations are fully described for each modification throughout this preamble and in detail in the Regulatory Impact Analysis (RIA).

C. Effective and Compliance Dates

1. 2021 Privacy Rule NPRM

In the 2021 Privacy Rule NPRM, the Department proposed an effective date for a final rule that would occur 60 days after publication, and a compliance date 180 days after the effective date.[19] Taken together, the two dates would give entities 240 days after publication to implement compliance measures. In the preamble to the proposed rule, the Department stated that it did not believe that the proposed rule would pose unique implementation challenges that would justify an extended compliance period (*i.e.,* a period longer than the standard 180 days provided in 45 CFR 160.105).[20]

2. Summary of Comments

While some commenters expressed support for our [21] proposed timeline, most urged us to postpone publication of this final rule or to extend the compliance period for a variety of reasons, such as the coronavirus disease 2019 public health emergency (''COVID–19 PHE'') and pending compliance dates for other Department regulations. Many requested that the Department coordinate compliance deadlines across its rulemakings. Several commenters encouraged the Department to delay enforcement of specific provisions of this final rule.

3. Final Rule

The effective date of this final rule is 60 days after publication. Accordingly, the final rule is effective on January 19, 2027.

Regulated entities will have 180 days beyond the effective date of the final rule to comply with its provisions. We understand that some regulated entities are concerned that they may encounter difficulties complying with the modified requirements within an 180-day period. However, we believe that providing a 180-day compliance period best comports with section 1175(b)(2) of the Social Security Act of 1935 (SSA) [22] and the implementing provision at 45 CFR 160.104(c)(1), which require the Secretary to provide at least a 180-day period for covered entities to comply with modifications to standards and implementation specifications in the HIPAA Rules. We also believe that providing a 180-day compliance period best protects individuals' privacy interests in a manner that reflects the importance of the priorities advanced by this final rule and their effects on individuals, regulated entities, and other persons, while minimizing any new burdens on regulated entities for implementing this final rule.

Section 160.104(a) permits the Department to adopt a modification to a standard or implementation specification adopted under the Privacy Rule no more frequently than once every 12 months. As discussed above, we are required to provide a compliance period of at least 180 days for any modification, but we are permitted to provide a longer compliance period based on the extent of the modification and the time needed to comply with the modification in determining the compliance date for the modification.[23] The Department makes every effort to consider the burden and cost of implementation for regulated entities when determining an appropriate compliance date. While we recognize that regulated entities will need to revise and implement changes to their policies and procedures in response to the modifications in this final rule, we do not believe that these changes are sufficiently significant that they require more than a 180-day compliance period.

Accordingly, we believe that a 180-day compliance period, combined with a 60-day effective date, is sufficient for regulated entities to make the changes needed to comply with the modifications in this final rule, with the exception of the provisions on business associate agreements, discussed separately, below.

To help reduce administrative burdens on regulated entities, the Department is modifying the provision addressing transition periods at 45 CFR 164.532(e) to afford regulated entities a transition period beyond the 180-day compliance period to modify business associate contracts or other written arrangements [24] (referred to, collectively, as ''business associate agreements'') that would qualify for the

[16] 45 CFR 160.103 (definition of ''Electronic protected health information'').

[17] For purposes of this final rule, the Department refers to HCBS providers as they are described and referenced in the context of the Medicaid program. *See, e.g.,* 42 CFR part 441, subparts G, J, K, and M.

[18] In this rule, the term ''third parties'' refers to a person who is not the individual (or the individual's personal representative) and is not part of a category of persons that is limited to regulated entities. For example, we describe social services agencies as third parties because only a subset of social services agencies may meet the definition of a covered entity.

[19] *See* 86 FR 6446, 6448 (Jan. 21, 2021).

[20] *See id.*

[21] In this final rule, ''we'' and ''our'' denote the Department.

[22] 42 U.S.C. 1320d–4.

[23] 45 CFR 160.104(c).

[24] 45 CFR 164.502(e).

longer transition period, as discussed further below.

4. Response to Public Comments

Comment: Many commenters urged the Department to extend the compliance date for this final rule for various reasons, including the need to focus resources on addressing the COVID–19 PHE and implementation of other Federal statutes and regulations, such as the CMS Interoperability and Patient Access Final Rule [25] and ONC's 21st Century Cures Act: [26] Interoperability, Information Blocking, and the ONC Health IT Certification Program (''Cures Act Final Rule'').[27] Some commenters recommended that the Department provide a longer compliance period because of cost and limitations on resources and time for revising policies, implementing technical changes, and training workforce members. Suggested compliance dates generally ranged from 1 to 2 years after the effective date. One commenter suggested that we provide regulated entities with additional time to comply with the modifications to the right of access because they believed that new processes and technological changes would be required to implement some of the proposals.

Response: As discussed above, we do not believe that the modifications required by this final rule generally will take longer than 180 days to implement. Additionally, the COVID–19 PHE officially ended in 2023, more than 2 years ago [28] and the regulations referenced by commenters most frequently had effective dates in 2020, more than 5 years ago. Our assessment of the feasibility of the implementation timeline would not change even if these events were not in the past. Accordingly, we are confident that a compliance date of July 19, 2027 provides regulated entities with sufficient time to comply with this final rule.

Comment: One commenter requested that we provide health plans with additional time for compliance because they are required to provide updated NPPs to their members.

Response: Where a health plan makes a material change to its NPP, 45 CFR 164.520(c)(1)(v) permits a health plan that posts its NPP on its website to provide the revised notice, or information about the material change and how to obtain the revised notice, in its next annual mailing to individuals then covered by the plan if it posts the change or its revised notice on its website by the effective date of the material change to the notice.[29] A health plan that does not post its NPP on its website must provide individuals with the revised notice or information about the material change and how to obtain the revised notice within 60 days of revising the notice.[30] Thus, the Privacy Rule already provides a health plan with additional time to provide individuals with their own copy of the revised NPP where it posts the revised NPP on its website within the allotted time.

Comment: A few commenters requested that the Department provide additional time for regulated entities to revise business associate agreements and other contracts affected by the provisions of this final rule.

Response: We recognize that 240 days may not be sufficient for regulated entities to both implement the modifications that the Department is finalizing as part of this rule and bring their business associate agreements into compliance. While compliant business associate agreements are important for ensuring that covered entities and business associates clearly identify the permissible uses and disclosures of PHI and each party's respective responsibilities,[31] our first priority is to ensure the timely implementation of the policies in this final rule. Accordingly, as discussed below, this final rule revises 45 CFR 164.532(e) to provide regulated entities a transition period for certain business associate agreements to help reduce administrative burdens on regulated entities.

D. Severability

The Department intends that any provisions of the Privacy Rule and its subparts that are unchanged by this final rule shall remain in full force and effect, even if other modified or new provisions in this final rule are held to be invalid or unenforceable, or are stayed pending future judicial or agency action.

The Department also believes that, if a court or further agency action deems invalid or unenforceable any language or section of a provision that is newly finalized or modified in this rulemaking, the remaining provisions that reference the language or section held invalid or unenforceable, but that are not directly related to a covered entity's ability to implement the remaining language or section, will remain in effect and be given the maximum regulatory effect permitted under the law.

The Department is finalizing significant changes related to the individual right of access. We believe these changes are severable such that the individual right of access as a whole or aspects of the right, as they existed until the effective date of this final rule, shall remain in effect should any changes finalized in this rulemaking related to the right as a whole or such aspects of that right be held invalid or unenforceable.

For example, the Department is adopting a new definition at 45 CFR 164.501 for the term ''electronic health record.'' While the Department believes that this new definition will aid in covered entities' and individuals' understanding of the full scope of obligations and rights under the Privacy Rule and the HITECH Act,[32] a covered entity's obligation to implement the right of access to direct [33] is not dependent on the adopted definition of electronic health record. Accordingly, the Department believes that the right of an individual to direct an electronic copy of PHI in an electronic health record to a person designated by the individual, finalized at 45 CFR 164.524(d), remains intact should the new definition be held invalid or unenforceable.

Similarly, the Department believes that the new definition of personal health app is severable from the obligation of a covered entity to provide access to the individual in a timely manner by, among other things, transmitting the requested copy of the PHI through the individual's personal health app, as codified at 45 CFR 164.524(c)(3).[34] Even without the definition of personal health app, covered entities and individuals retain the ability to agree to an acceptable form and format for a requested copy of PHI. Prior to this rulemaking, the Privacy Rule already provided individuals with

[25] 85 FR 25510 (May 1, 2020).

[26] Public Law 114–255, 130 Stat. 1033 (Dec. 13, 2016).

[27] 85 FR 25642 (May 1, 2020).

[28] Press Release, ''HHS Secretary Xavier Becerra Statement on End of the COVID–19 Public Health Emergency,'' U.S. Department of Health and Human Services (May 11, 2023), *https://us.pagefreezer.com/en-US/wa/browse/0a7f82bb-be6e-448a-ae11-373d22c37842?find-by-timestamp=2024-01-02T03:56:59Z&url=https:%2F%2Fwww.hhs.gov%2Fabout%2Fnews%2F2023%2F05%2F11%2Fhhs-secretary-xavier-becerra-statement-on-end-of-the-covid-19-public-health-emergency.html&timestamp=2024-01-02T03:43:14Z.*

[29] 45 CFR 164.520(c)(1)(v)(A).

[30] 45 CFR 164.520(c)(1)(v)(B).

[31] *See* 78 FR 5566, 5601 (Jan. 25, 2013).

[32] Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111–5, 123 Stat. 226 (Feb. 17, 2009) (codified at 42 U.S.C. 201 note).

[33] 42 U.S.C. 17935(e)(1).

[34] *See also* 45 CFR 164.524(c)(2)(ii).

a right to an electronic copy of their PHI that is maintained electronically in the electronic form and format requested by the individual, if it is readily producible, or if not, in a readable electronic form and format as agreed to by the covered entity and the individual. The requirement to provide PHI in the individual's chosen form and format, where readily producible, is a longstanding component of the individual right of access. Thus, the Department believes that individuals should retain the right to request copies of PHI through a personal health app, even if the definition of personal health app is held to be invalid or unenforceable.

We are adopting several provisions that address the fees that covered entities may charge to fulfill an individual's request for access to their PHI. The Department believes that if these new provisions are held to be invalid or unenforceable for any reason, such holdings would not interfere with the ability of covered entities to implement existing provisions related to fees. For example, at 45 CFR 164.524(c)(4)(ii), the Department prohibits a covered entity from charging a fee when the covered entity is unlikely to incur costs for providing the individual with copies of PHI, including when an individual requests—regardless of the manner in which the request is made—that the covered entity provide their PHI through a personal health app or when an individual seeks to exercise the right to inspect their own PHI. Should the new fee prohibitions be held invalid or unenforceable, the existing provisions at 45 CFR 164.524(c)(4) [35] should remain intact. Removing the new fee limitations would not affect a covered entity's ability to continue to implement the current fee requirements or other right of access obligations. Similar considerations apply to the newly finalized requirement at 45 CFR 164.524(c)(2)(iv)(B) that a covered entity inform an individual to whom it offers to provide a summary in lieu of a copy of PHI that the individual retains the right to obtain the copy. To the extent a court invalidates that requirement, the current existing provision permitting the covered entity to provide the summary in lieu of a copy remains.

Certain other new provisions also are wholly severable, including the examples below, which are illustrative and not exhaustive:

- If the new provision that excludes a provider of TRS from the definition of business associate is held to be invalid or unenforceable, the existing definition of business associate at 45 CFR 160.103 remains in effect.
- If the modified provisions that reference Uniformed Services instead of Armed Forces, military, or military services are held to be invalid or unenforceable, the standard permitting uses and disclosures of PHI for specialized government functions in 45 CFR 164.512(k) remains intact.
- If the provision at 45 CFR 164.512(m) that addresses disclosures to TRS is held to be invalid or unenforceable, the other provisions of 45 CFR 164.512 remain intact.
- If the modifications to 45 CFR 164.524(b)(1)(iii) that generally prohibit a covered entity from imposing measures that impede requests for access is held to be invalid or unenforceable, the ability of a covered entity to require an individual to make a request for access to the individual's PHI in writing provided that it informs the individual of the requirement in 45 CFR 164.524(b)(1)(ii) remains in effect.
- If the modifications to the amount of time that a covered entity has to respond to a request for access are held to be invalid or unenforceable, the prior existing requirements that address timeliness of responses to requests for access in 45 CFR 164.524(b)(2) remain in effect.
- If the provision at 45 CFR 164.524(c)(2)(iii) that addresses form and format requirements for requested copies of PHI is held to be invalid or unenforceable, the other paragraphs in 45 CFR 164.524(c)(2) remain intact.
- If the new provision at 45 CFR 164.525 that requires covered entities to provide notice of access and authorization fees is held to be invalid or unenforceable, all existing provisions for the individual right of access at 45 CFR 164.524 remain in effect.

II. Statutory and Regulatory Background

A. Statutory Authority and History

1. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

In 1996, Congress enacted HIPAA [36] to reform the health care system to ''improve portability and continuity of health insurance coverage in the group and individual markets'' [37] and to support the electronic exchange of health information. To enable health care system reform, Congress included requirements for standards to support the electronic exchange of health information. According to section 261 of HIPAA, ''[i]t is the purpose of this subtitle to improve [. . .] the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.'' [38] Congress applied HIPAA's Administrative Simplification provisions directly to three types of persons referred to in regulation as ''covered entities'': health plans, health care clearinghouses, and health care providers who transmit information electronically in connection with a transaction for which HHS has adopted a standard.[39]

Section 262(a) of HIPAA required the Secretary to adopt uniform standards ''to enable health information to be exchanged electronically.'' [40] Congress also directed the Secretary to adopt standards for, among other things: transactions and data elements relating to health information,[41] the security of that information,[42] and verification of electronic signatures.[43]

Congress recognized that the standardization of certain electronic health care transactions required by HIPAA posed risks to the privacy of confidential health information and viewed individual privacy, confidentiality, and data security as critical for orderly administrative simplification.[44] One Member of

[35] For purposes of this severability discussion, the reference to 45 CFR 164.524(c)(4) refers to the provisions at 45 CFR 164.524(c)(4)(i)-(iv) in effect prior to the amendments adopted in this final rule. This final rule renumbers those provisions as 45 CFR 164.524(c)(4)(A)–(D).

[36] Public Law 104–191, 110 Stat. 1936 (Aug. 21, 1996) (codified at 42 U.S.C. 201 note).

[37] *See* H.R. Rep. No. 104–496, at 66 (1996).

[38] Sec. 261 of Public Law 104–191, 110 Stat. 1936, 2021 (Aug. 21, 1996) (codified at 42 U.S.C. 1320d note); subtitle F of HIPAA also amended related provisions of the SSA.

[39] *See* sec. 262(a) of Public Law 104–191, 110 Stat. 2021, adding sec. 1172 to the SSA (codified at 42 U.S.C. 1320d–1); *see also* sec. 13404 of the American Recovery and Reinvestment Act of 2009, Public Law 111–5, 123 Stat. 115 (Feb. 17, 2009) (codified at 42 U.S.C. 17934) (applying privacy provisions and penalties to business associates of covered entities). The Department codified the term ''covered entity'' and defined it using these three categories of persons. 45 CFR 160.103.

[40] Sec. 262(a) of Public Law 104–191, 110 Stat. 2021, adding sec. 1173(a) (codified at 42 U.S.C. 1320d–2(a)(1)).

[41] 42 U.S.C. 1320d–2(a), (c), and (f).

[42] 42 U.S.C. 1320d–2(d).

[43] 42 U.S.C. 1320d–2(e).

[44] On a resolution waiving points of order against the Conference Report to H.R. 3103, members debated an ''erosion of privacy'' balanced against the administrative simplification provisions. Thus, from HIPAA's inception, privacy has been a central concern to be addressed as legislative changes eased disclosures of PHI. *See* 142 Cong. Rec. H9777 and H9780; *see also* H.R. Rep. No. 104–736, at 264–265 (1996); 142 Cong. Rec. H9780 (daily ed. Aug. 1,

Continued

Congress acknowledged that individuals should have ''control over who actually has access to their medical records.'' [45] According to another Member of Congress, privacy standards would create an additional layer of protection beyond the oath pledged by health care providers to keep information secure and, as described by another Member, would further protect information from being used in a ''malicious or discriminatory manner.'' [46] Moreover, Congress considered that health care reform required an approach that would not compromise privacy as health information became more accessible.[47] Additionally, another Member acknowledged that health plan data was often nonstandard, and the bill ''would facilitate the coordination of benefits between different systems.'' [48]

Section 264(a) of HIPAA directed the Secretary to submit to Congress detailed recommendations for Federal ''standards with respect to the privacy of individually identifiable health information [IIHI]'' within 1 year of HIPAA's enactment.[49] The statute made clear that the Secretary had the authority to promulgate regulations if Congress did not enact legislation covering these matters within 3 years.[50] Congress directed the Secretary to ensure that the regulations promulgated ''address at least'' the following three subjects: (1) the rights that an individual who is a subject of IIHI should have; (2) the procedures that should be established for the exercise of such rights; and (3) the uses and disclosures of such information that should be authorized or required.[51]

Additionally, Congress provided a clear statement that HIPAA's provisions would ''supersede any contrary provision of State law,'' with certain limited exceptions.[52] One exception to this general preemption authority is for state privacy laws that are contrary to and more stringent than the corresponding Federal standard, requirement, or implementation specification.[53] Thus, Congress provided for the Department to create privacy standards to safeguard health information while respecting the ability of states to provide individuals with additional health information privacy protections and rights.

Congress required the Secretary to rely on recommendations of the National Committee on Vital and Health Statistics (NCVHS or ''Committee'') when adopting standards,[54] thereby ensuring that the Secretary's decisions reflected public and expert involvement and advice in carrying out the requirements of section 264.[55] On June 27, 1997, NCVHS sent its initial recommendations to the Secretary. Among its recommendations was that legislation for health privacy should include some specific rights for individuals, including a right to be informed about uses of their health information and a right to request amendment of their records.[56] Additionally, NCVHS recommended that an individual have the right to access their health information.[57] As the Committee explained, a basic element of fair information practices for ''personal records maintained by third party record keepers—is a right of access by the subject of the record.'' [58] NCVHS further asserted that fair information practices for health information would provide secondary users of health information with knowledge about when they could have health information and when they could not, what their obligations would be, and what penalties would result if those obligations were ignored.[59]

NCVHS also supported ''limiting use and disclosure of identifiable information to the minimum amount necessary to accomplish the purpose. The Committee strongly believe[d] that when identifiable health information is made available for non-health uses, patients deserve a strong assurance that the data will not be used to harm them.'' [60] NCVHS also believed that users of health information should be required to justify their need for such information and accept reasonable substantive and procedural limitations on access.[61]

Congress anticipated that the Department's rulemaking under HIPAA would not remain static. Congress built in a mechanism to update or adapt the regulations to address evolving technology and health care practices, directing the Secretary to review and adopt modifications to the Administrative Simplification standards as determined appropriate, but not more frequently than once every 12 months.[62] That statutory directive complements the Secretary's general rulemaking authority to ''make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under [the Social Security Act].'' [63]

As discussed below, Congress did not adopt legislation on the privacy of IIHI within the period of time specified in HIPAA. As a result, it became the Secretary's obligation under HIPAA to adopt regulatory standards for the privacy of health information.

2. The Health Information Technology for Economic and Clinical Health (HITECH) Act

On February 17, 2009, Congress enacted the HITECH Act [64] to promote the nationwide adoption and standardization of health IT. The HITECH Act included additional privacy and security requirements for regulated entities and expanded certain rights of individuals with respect to their PHI. Among other things, the HITECH Act expanded the individual right of access to include the right of an

1996) (statement of Rep. Sawyer); 142 Cong. Rec. H9792 (daily ed. Aug. 1, 1996) (statement of Rep. McDermott); 142 Cong. Rec. S9515–17 (daily ed. Aug. 2, 1996) (statement of Sen. Simon).

[45] *See* statement of Sen. Simon, *supra* note 44.

[46] *See* statement of Rep. Sawyer, *supra* note 44; *see also* statement of Sen. Simon, *supra* note 44.

[47] *See* H.R. Rep. No. 104–496, at 100 (1996).

[48] *See* statement of Rep. Sawyer, *supra* note 44.

[49] Public Law 104–191, 110 Stat. 2021 (Aug. 21, 1996) (codified at 42 U.S.C. 1320d–2 note).

[50] *Id.*

[51] *Id.*

[52] 42 U.S.C. 1320d–7.

[53] 65 FR 82462, 82580 (Dec. 28, 2000) (the exception applies under section 1178(a)(2)(B) of the SSA and section 264(c)(2) of HIPAA); *see also* 42 U.S.C. 1320d–7. Other exceptions to the general preemption authority include: state laws that the Secretary of HHS determines are necessary to prevent fraud and abuse, to ensure appropriate state regulation of insurance and health plans, for state reporting on health care delivery or costs, or for other purposes; state laws that address controlled substances; state laws providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention; and state laws requiring a health plan to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals.

[54] NCVHS is HHS' statutory public advisory body on health data, statistics, and national health information policy. *See* ''National Committee on Vital and Health Statistics (NCVHS),'' U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (June 1, 2026), *https://www.cdc.gov/faca/committees/ncvhs.html; see also* ''NCVHS 60th Anniversary Symposium and History,'' U.S. Department of Health and Human Services, at 28–29 (Feb. 2011), *https://ncvhs.hhs.gov/wp-content/uploads/2014/05/60_years_of_difference.pdf.*

[55] *See* sec. 264(a) and (d) of Public Law 104–191, 110 Stat. 2033 (codified at 42 U.S.C. 1320d–2 note).

[56] *See* 62 FR 39844 (July 24, 1997), *https://www.govinfo.gov/content/pkg/FR-1997-07-24/html/97-19492.htm.*

[57] *Id.*

[58] *Id.*

[59] *Id.*

[60] *Id.*

[61] *Id.*

[62] Sec. 262(a) of Public Law 104–191, 110 Stat. 2021, adding sec. 1174(b)(1) (codified at 42 U.S.C. 1320d–3).

[63] Sec. 1102 of the SSA (codified at 42 U.S.C. 1302).

[64] Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111–5, 123 Stat. 226 (Feb. 17, 2009) (codified at 42 U.S.C. 201 note).

individual to direct a covered entity to transmit an electronic copy of PHI in an electronic health record to a person designated by the individual.[65] The HITECH Act also imposed a limit on fees that a covered entity is permitted to charge for certain requests to disclose PHI.[66] Additionally, the HITECH Act included clarifications to the standard requiring regulated entities to make reasonable efforts to limit most uses, disclosures, and requests for PHI to the minimum amount necessary to accomplish the purpose (''minimum necessary standard'').[67]

When enacting the HITECH Act, Congress understood that privacy and security standards were critical to the development of a connected health IT landscape, which itself was ''a necessary and vital component of health care reform.'' [68] The Purpose statement of an accompanying House of Representatives report [69] on the Energy and Commerce Recovery and Reinvestment Act [70] recognizes that ''[i]n addition to costs, concerns about the security and privacy of health information have also been regarded as an obstacle to the adoption of [health IT].'' The Senate Report for S. 336 [71] similarly acknowledges that ''[i]nformation technology systems linked securely and with strong privacy protections can improve the quality and efficiency of health care while producing significant cost savings.'' [72] The HITECH Act strengthened the privacy and security protections for health information to support Congress' goal of promoting widespread adoption and interoperability of health IT.[73]

In passing the HITECH Act, Congress instructed the Department that any new health IT standards adopted under section 3004 of the Public Health Service Act (PHSA) must take into account the privacy and security requirements of the HIPAA Rules.[74] Congress also affirmed that the existing HIPAA Rules were to remain in effect to the extent that they are consistent with the HITECH Act and directed the Secretary to revise the HIPAA Rules as necessary for consistency with the HITECH Act.[75] Congress confirmed that the new law was not intended to have any effect on authorities already granted under HIPAA to the Department, including section 264 of that statute and the regulations issued under that provision.[76]

3. Patient Protection and Affordable Care Act

On March 23, 2010, Congress enacted the Patient Protection and Affordable Care Act [77] (ACA). While not its primary focus,[78] the ACA amended the Administrative Simplification provisions of HIPAA. Specifically, it modified section 261 of HIPAA to clarify that, in addition to improving the Medicare and Medicaid programs and the efficiency and effectiveness of the health care system, the purpose of the Administrative Simplification provisions is ''to reduce the clerical burden on patients, health care providers, and health plans.'' [79] According to one Member of Congress, enactment of the ACA eliminated ''unnecessary administrative costs in [the] health care system,'' [80] while another Member of Congress asserted that the ACA was ''poised to provide access to quality health insurance for all Americans.'' [81] The ACA also modified section 261 of HIPAA to clarify that the standards for encouraging the development of a health information system are to be ''uniform.'' [82]

4. Coronavirus Aid, Relief, and Economic Security (CARES) Act

On March 27, 2020, Congress enacted the CARES Act.[83] Among other things, the CARES Act directed the Secretary to update the provisions of the Privacy Rule pertaining to the NPP to align with the provisions of the regulations on the Confidentiality of Substance Use Disorder Patient Records that address the required patient notice.[84]

B. Regulatory and Legal History

The Secretary has delegated the authority to administer the HIPAA Rules and to make decisions regarding their implementation, interpretation, and enforcement to the HHS Office for Civil Rights (OCR).[85] The Department exercised its authority to issue the Privacy Rule in 2000 and then to modify it several times—in 2002, 2013, 2014, 2016, and 2024.[86]

1. 2000 Privacy Rule

As directed by HIPAA, the Department provided a set of recommendations to Congress for a potential new law that would address the privacy of IIHI.[87] Congress did not enact legislation governing standards with respect to the privacy of IIHI within its 3-year self-imposed deadline. As a result, the Department published a proposed rule setting forth the required standards on November 3, 1999,[88] and issued the first final rule establishing ''Standards for Privacy of Individually Identifiable Health Information'' (''2000 Privacy Rule'') on December 28, 2000.[89]

The 2000 Privacy Rule set standards to protect the privacy of IIHI to ''begin to address growing public concerns that

[65] *See* 42 U.S.C. 17935(e).

[66] *See* 42 U.S.C. 17935(e)(3).

[67] *See* 42 U.S.C. 17935(b)(2).

[68] C. Stephen Redhead, ''The Health Information Technology for Economic and Clinical Health (HITECH) Act,'' Congressional Research Service, R40161 (2009), *https://crsreports.congress.gov/product/pdf/R/R40161/*9 (''[Health IT], which generally refers to the use of computer applications in medical practice, is widely viewed as a necessary and vital component of health care reform.'').

[69] H.R. Rep. No. 111–7, at 74 (2009), accompanying H.R. 629, 111th Congress (2009).

[70] H.R. 629, Energy and Commerce Recovery and Reinvestment Act of 2009, introduced in the House on January 22, 2009, contained nearly identical provisions to subtitle D of the HITECH Act.

[71] Congress enacted the American Recovery and Reinvestment Act of 2009, which included the HITECH Act, on February 17, 2009. While it was the House version of the bill, H.R. 1, that was enacted, the Senate version, S. 336, contained nearly identical provisions to subtitle D of the HITECH Act. Public Law 111–5, 111 Stat. 115 (2009).

[72] S. Rep. No. 111–3 accompanying S. 336, 111th Congress, at 59 (2009).

[73] Subtitle D of Title XIII of the HITECH Act (codified at 42 U.S.C. 17921, 42 U.S.C. 17931–17940, and 42 U.S.C. 17951–17953).

[74] Sec. 3009(a)(1)(B) of the PHSA, as added by sec. 13101 of the HITECH Act (codified at 42 U.S.C. 300jj–19(a)(1)).

[75] Sec. 13421(b) of the HITECH Act (codified at 42 U.S.C. 17951).

[76] Sec. 3009(a)(1)(A) of the PHSA, as added by sec. 13101 of the HITECH Act (codified at 42 U.S.C. 300jj–19(a)(1)).

[77] Public Law 111–148, 124 Stat. 119 (Mar. 23, 2010).

[78] *See* ''About the Affordable Care Act,'' U.S. Department of Health and Human Services (Mar. 17, 2022), *https://www.hhs.gov/healthcare/about-the-aca/index.html.*

[79] Sec. 1104(a) of Public Law 111–148, 124 Stat. 146 (Mar. 23, 2010) (codified at 42 U.S.C. 1320d note).

[80] 155 Cong. Rec. S11580 (Nov. 19, 2009) (statement of Sen. Cardin).

[81] 156 Cong. Rec. H1856 (daily ed. Mar. 21, 2010) (statement of Sen. Waxman).

[82] Sec. 1104(a) of Public Law 111–148, 124 Stat. 146 (Mar. 23, 2010) (codified at 42 U.S.C. 1320d note).

[83] Public Law 116–136, 134 Stat. 281 (Mar. 27, 2020).

[84] *See* sec. 3221(i)(2) of Public Law 116–136, 134 Stat. 378 (Mar. 27, 2020) (codified at 42 U.S.C. 290dd–2 note).

[85] *See* ''Office for Civil Rights; Statement of Delegation of Authority,'' U.S. Department of Health and Human Services, 65 FR 82381 (Dec. 28, 2000); ''Office for Civil Rights; Delegation of Authority,'' U.S. Department of Health and Human Services, 74 FR 38630 (Aug. 4, 2009).

[86] *See* 78 FR 5566 (Jan. 25, 2013); 79 FR 7290 (Feb. 6, 2014); 81 FR 382 (Jan. 6, 2016); 89 FR 32976 (Apr. 26, 2024).

[87] *See* ''Confidentiality of Individually Identifiable Health Information,'' Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Sept. 1997), *https://aspe.hhs.gov/reports/confidentiality-individually-identifiable-health-information.*

[88] 64 FR 59918 (Nov. 3, 1999).

[89] 65 FR 82462 (Dec. 28, 2000).

advances in electronic technology and evolution in the health care industry are resulting, or may result, in a substantial erosion of the privacy surrounding'' health information.[90] The use of the standards would improve the efficiency and effectiveness of public and private health programs and health care services by providing enhanced protections for IIHI.[91]

The 2000 Privacy Rule established ''general rules'' for uses and disclosures of PHI by covered entities, such as the circumstances in which a covered entity was required to limit its requests for PHI, or responses to such requests, to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure.[92] The 2000 Privacy Rule also specified the circumstances in which a covered entity was required to obtain an individual's consent, authorization, or the opportunity for the individual to agree or object.[93] Additionally, it established circumstances for when a covered entity is permitted to use or disclose PHI without an individual's consent, authorization, or opportunity to agree or object; how a covered entity is to determine what constitutes the minimum PHI necessary to accomplish the intended purpose of a requested use or disclosure; and verification of the identity of a person requesting PHI and the authority of such person to have access to PHI under the Privacy Rule.[94] In particular, the 2000 Privacy Rule permitted certain uses and disclosures of PHI, without the individual's authorization, for identified activities such as: public health activities, judicial and administrative proceedings, law enforcement purposes, to avert a serious threat to health or safety, and, in certain circumstances, to ensure the proper execution of the military mission.[95]

The 2000 Privacy Rule also established the rights of individuals with respect to their PHI, including the right to receive adequate notice of a covered entity's privacy practices, the right to request restrictions of uses and disclosures, the right to access (*i.e.,* to inspect and obtain a copy of) their PHI, the right to request an amendment of their PHI, and the right to receive an accounting of disclosures.[96] As part of the right of access, the 2000 Privacy Rule instituted requirements for timely action by covered entities, form and format of copies, the denial of access, and documentation in addition to imposing limitations on the fees a covered entity was permitted to charge for providing an individual with a copy of their PHI.[97]

The 2000 Privacy Rule codified at 45 CFR 160.104(a) the Secretary's statutory authority to modify any standard or implementation specification adopted under the Administrative Simplification provisions.[98] The Secretary first invoked this modification authority to amend the Privacy Rule in 2002 [99] and made additional modifications in 2013,[100] 2014,[101] 2016,[102] and 2024.[103]

2. 2002 Privacy Rule

After publication of the 2000 Privacy Rule, the Department received many inquiries and unsolicited comments about the Privacy Rule's effects and operation. As a result, the Department opened the 2000 Privacy Rule for further comment in February 2001, less than 1 month before the effective date and 25 months before the compliance date for most covered entities.[104] NCVHS' Subcommittee on Privacy, Confidentiality and Security held public hearings about the 2000 Privacy Rule. From those hearings, public comments, meetings requested by industry and other stakeholders, as well as other communications, the Department obtained additional information about concerns related to certain provisions and their potential unintended consequences for health care quality and access.[105] On March 27, 2002, the Department proposed modifications to the 2000 Privacy Rule that maintained strong protections for the privacy of IIHI, while clarifying misinterpretations, addressing the unintended negative effects of the 2000 Privacy Rule on health care quality or access to health care, and relieving unintended administrative burden.[106]

In response to comments on the proposed rule, the Department finalized modifications to the Privacy Rule on August 14, 2002 (''2002 Privacy Rule'').[107] The 2002 Privacy Rule addressed certain workability issues, including by clarifying distinctions between health care operations and marketing, and modified the minimum necessary standard to exclude disclosures authorized by individuals and clarify its operation. Additionally, the Department eliminated the consent requirement for uses and disclosures of PHI for treatment, payment, or health care operations (TPO). The consent changes were balanced by strengthening the NPP provisions to require direct treatment providers to make a good faith effort to obtain a written acknowledgment of receipt of the NPP, thereby preserving an individual's opportunity to raise questions about an entity's privacy policies previously provided in the consent requirements.[108] The Department also included modifications to the provisions permitting the use or disclosure of PHI for public health activities and for research activities without consent, authorization, or an opportunity to agree or object.

3. 2013 Omnibus Rule

Following the enactment of the HITECH Act, the Department proposed modifications to the Privacy, Security, and Enforcement Rules to implement the new statutory requirements and to improve the workability and effectiveness of these rules.[109]

On January 25, 2013, the Department issued the final rule ''Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules'' [110] (''2013 Omnibus Rule''), which implemented many of the new HITECH Act requirements, including strengthening individuals' privacy rights related to their PHI.

The Department also finalized regulatory provisions that were not required by the HITECH Act, but were necessary to address the workability and effectiveness of the Privacy Rule and to increase flexibility for and decrease burden on regulated entities.[111] As the

[90] *Id.*

[91] *Id.*

[92] *Id.*

[93] *Id.*

[94] *Id.*

[95] *Id.*

[96] *See* 45 CFR 164.520, 164.522, 164.524, 164.526, and 164.528.

[97] 65 FR 82462 (Dec. 28, 2000).

[98] *Id.*

[99] *See* 67 FR 53182 (Aug. 14, 2002).

[100] *See* 78 FR 5566 (Jan. 25, 2013).

[101] *See* 79 FR 7290 (Feb. 6, 2014).

[102] *See* 81 FR 382 (Jan. 6, 2016).

[103] *See* 89 FR 32976 (Apr. 26, 2024).

[104] 66 FR 12738 (Feb. 28, 2001).

[105] 67 FR 53182, 53183 (Aug. 14, 2002).

[106] 67 FR 14775 (Mar. 27, 2002).

[107] 67 FR 53182 (Aug. 14, 2002).

[108] *Id.*

[109] 75 FR 40868 (July 14, 2010).

[110] 78 FR 5566 (Jan. 25, 2013). In addition to finalizing requirements of the HITECH Act that were proposed in the July 14, 2010, NPRM, the Department adopted modifications to the previous Enforcement Rule modifications provided in an interim final rule, 74 FR 56123 (Oct. 30, 2009), and to the Breach Notification Rule provided in an interim final rule, 74 FR 42740 (Aug. 24, 2009). The Department also finalized previously proposed Privacy Rule modifications as required by the Genetic Information Nondiscrimination Act of 2008, 74 FR 51698 (Oct. 7, 2009).

[111] *See* 78 FR 5566 (Jan. 25, 2013) (explaining that the Department was using its general authority under HIPAA to make several changes to the Privacy Rule that were intended to increase

Department explained in the 2010 NPRM, information gleaned from contact with the public through various forums and through the process of enforcement supported the proposed technical corrections to improve workability, effectiveness, and flexibility.[112]

The Department also modified the Privacy Rule to implement the HITECH Act's provisions that extended direct liability for compliance with certain provisions of the Privacy Rule to business associates.[113]

In the 2013 Omnibus Rule, the Department issued regulations expanding the HITECH Act requirements to avoid ''a complex set of disparate requirements for access,'' such as different requirements for access to paper versus electronic records.[114] The Department strengthened the right of access by applying section 13405(e) of the HITECH Act uniformly to all PHI in one or more designated record sets, regardless of whether the PHI is in an electronic health record or the copy is in electronic form.[115] The Department also explained that the Privacy Rule already applied the right of access to PHI held in designated record sets and required a covered entity to provide the PHI in the ''form and format'' requested by the individual, including electronically, if ''readily producible.'' [116]

The 2013 Omnibus Rule also finalized provisions requiring covered entities to transmit a copy of an individual's PHI directly to a person designated by the individual if the individual's request for access directs the covered entity to do so.[117] The Department noted that, in contrast to other access requests by individuals pursuant to 45 CFR 164.524, requests to transmit a copy of PHI to another person must be in writing, signed by the individual, and clearly identify the designated person and where to send the copy of the PHI.[118]

With respect to fees for access, the 2000 Privacy Rule permitted a covered entity to impose only a reasonable, cost-based fee for a copy of PHI under the right of access. Additionally, section 13405(e)(2) of the HITECH Act provided that, where a covered entity uses or maintains an electronic health record, any fee for providing electronic copies (or summary or explanation) of PHI shall not be greater than the entity's labor costs in responding to the request. Therefore, to implement the fee provisions of the HITECH Act, the 2013 Omnibus Rule amended 45 CFR 164.524(c)(4) to provide that fees could include labor or supplies whether the PHI was in paper or electronic form.[119]

4. 2014 Privacy Rule

In 2011, the Department proposed modifications to the Privacy Rule, in conjunction with proposed modifications to the regulations under the Clinical Laboratory Improvement Amendments of 1988 [120] (CLIA), that were intended to provide individuals with a new way to obtain direct access to their PHI.[121] These proposals were based on recommendations from a Federal advisory committee that identified CLIA regulations as being perceived by some stakeholders as imposing barriers to the exchange of health information.[122]

In 2014, the Department adopted modifications to remove barriers to an individual's direct access to their own test reports from laboratories in a final rule entitled, ''CLIA Program and HIPAA Privacy Rule; Patients' Access to Test Reports'' [123] (''2014 Privacy Rule''). The Department acknowledged that the Privacy Rule already gave individuals the right to obtain access to their laboratory test reports from their covered health care providers, but explained that these changes gave patients a new option to obtain their test reports directly from the laboratory while maintaining strong protections for patients' privacy.[124]

The 2014 Privacy Rule eliminated the exception to an individual's right to access their PHI when it is held by a CLIA-certified or CLIA-exempt laboratory. Thus, both those laboratories that are subject to CLIA and those that are exempt from it have the same obligations as other types of covered health care providers with respect to providing individuals, or their personal representatives, with access to their PHI in accordance with the individual right of access.

5. 2016 HIPAA Access Guidance

On January 7, 2016, the Department issued guidance (''2016 Access Guidance'') to educate the public about the individual right of access at 45 CFR 164.524.[125] The 2016 Access Guidance explained the right of access to inspect and obtain PHI and the right of access to direct a copy of PHI to another person. It also clarified the pre-existing conditions and requirements of the individual access right, including its fee limitations and requirements with respect to the form and format and manner of access, as they applied to the right of access to direct. The guidance stated that the limitations on access fees applied, regardless of whether the individual requested that the copy of PHI be sent to the individual or directed the copy of PHI to a person designated by the individual.

6. 2018 HIPAA Rules Request for Information

In 2018, the Department published the ''Request for Information on Modifying HIPAA Rules to Improve Coordinated Care'' [126] (''2018 RFI'') to solicit public comments that offered recommendations for modifying existing regulations or guidance, or developing new guidance on reducing regulatory barriers to coordinated care. The 2018 RFI solicited public input on whether and how the Department could modify the HIPAA Rules to support care coordination and case management and promote value-based care, while preserving the privacy and security of PHI.

The Department solicited recommendations on how best to use the HIPAA Rules to support care coordination in three specific ways:

- Promoting information disclosure for care coordination and case management.

workability and flexibility, decrease burden, and better harmonize the requirements with those under other Departmental regulations). The Department's general authority to modify the Privacy Rule is codified in HIPAA section 264(c), and OCR conducts rulemaking under HIPAA based on authority granted by the Secretary.

[112] 75 FR 40868, 40871 (July 14, 2010).

[113] *See* 78 FR 5566 (Jan. 25, 2013); *see also* ''Direct Liability of Business Associates,'' Office for Civil Rights, U.S. Department of Health and Human Services (July 16, 2021), *https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/factsheet/index.html.*

[114] 75 FR 40868, 40901 (July 14, 2010).

[115] *Id.*

[116] 45 CFR 164.524(c)(2)(ii); *see also* 78 FR 5566, 5633 (Jan. 25, 2013).

[117] 45 CFR 164.524(c)(3)(ii); *see also* 78 FR 5566, 5634 (Jan. 25, 2013).

[118] 78 FR 5566, 5634 (Jan. 25, 2013).

[119] *Id.* at 5566, 5635–36.

[120] 42 U.S.C. 263a. CLIA and the implementing regulations established nationwide quality standards to ensure the accuracy, reliability, and timeliness of clinical laboratories' test results. The NPRM also proposed modifications to CLIA regulations to allow laboratories subject to CLIA to give a patient or the patient's personal representative access to the patient's completed test reports, using the laboratory's authentication process, on the patient's or patient's personal representative's request.

[121] 76 FR 56712 (Sept. 14, 2011).

[122] *Id.* at 56713.

[123] 79 FR 7290 (Feb. 6, 2014).

[124] *Id.* at 7291.

[125] *See* ''Individuals' Right under HIPAA to Access their Health Information 45 CFR 164.524,'' Office for Civil Rights, U.S. Department of Health and Human Services (Jan. 7, 2016). This guidance is no longer available on OCR's website. OCR will issue updated guidance on the right of access in the future.

[126] 83 FR 64302 (Dec. 14, 2018).

• Promoting parental and caregiver involvement and addressing the opioid crisis and serious mental illness (SMI).

• Modifying the NPP requirements for signatures and recordkeeping.

Specifically, the 2018 RFI sought input on individuals' right of access to their own PHI and the amount of time covered entities should be permitted to respond to such request for access. The 2018 RFI sought input to help determine whether and how to modify the Privacy Rule to address the opioid crisis and SMI and to promote family involvement in the care of loved ones experiencing these health situations. Additionally, the 2018 RFI also sought input on whether the Department should eliminate or modify the NPP signature and recordkeeping requirements associated with distribution of the NPP practices.

7. Ciox Health, LLC v. Azar

In 2020, the U.S. District Court for the District of Columbia, in *Ciox,* rejected modifications made to the Privacy Rule by the 2013 Omnibus Rule that required providers to deliver an individual's PHI to a person designated by the individual regardless of whether the PHI was contained in an electronic health record or the request was to transmit the PHI in an electronic format.[127] The court found that the right of access to direct PHI to a person designated by the individual, established by section 13405(e) of the HITECH Act,[128] did not extend to PHI in locations other than an electronic health record, and did not apply to requests to transmit such PHI in a non-electronic format, such as paper. Further, the court reviewed the 2016 Access Guidance and held that the Department's application of the individual fee limitations to an individual's request that a copy of their PHI be sent to a person designated by the individual was a legislative rule imposed in violation of the Administrative Procedure Act's (APA's) notice and comment requirement. Thus, the court vacated the 2016 Access Guidance insofar as it, without notice and comment rulemaking, extended the individual fee limitations to when an individual requests that a copy of their PHI be sent to a person designated by the individual.

8. 2021 Privacy Rule NPRM

In January 2021, the Department proposed modifications to select provisions of the Privacy Rule to reduce barriers to coordinated care and case management and limit the regulatory burdens of other provisions that do not sufficiently compensate for, or offset, such burdens through privacy protections.[129] As part of the 2021 Privacy Rule NPRM, the Department expressed concern that some regulatory barriers may impede the transformation of the health care system from a system that pays for procedures and services to a system of value-based health care that pays for quality care.[130]

The Department intended for the 2021 Privacy Rule NPRM to support the full scope of care coordination and case management activities to further the Department's goal of achieving value-based health care.[131] Some of the NPRM proposals included clarifying the scope of covered entities' abilities to disclose PHI to social service agencies and eliminating the requirement that a direct treatment provider make a good faith effort to obtain an individual's written acknowledgment of receipt of such provider's NPP. The Department carefully considered the extent to which each proposed modification would impact privacy protections compared to the likely benefit of making PHI more available for coordination of care or case management. The Department also proposed modifications to the individual right of access and fee limitations provisions that were consistent with the *Ciox* opinion.[132]

9. 2024 Part 2 Rule

Following the enactment of the CARES Act,[133] the Department proposed modifications to the Privacy Rule to align certain aspects of 42 CFR part 2 (''Part 2'') with the HIPAA Privacy Rule and the HITECH Act (''2022 Part 2 NPRM'').[134] The proposed modifications included requirements for covered entities and Part 2 programs to provide notice to individuals regarding privacy practices related to Part 2 records, including patients' rights and uses and disclosures that are permitted or required without authorization.[135] While the Department published a final rule adopting modifications to Part 2 in 2024,[136] the Department stated that corresponding modifications to the NPP would be included in a later HIPAA rulemaking.[137]

10. 2024 Privacy Rule

In 2023, the Department proposed modifications to the Privacy Rule (''2023 Privacy Rule NPRM'') to limit uses and disclosures of PHI for certain purposes where the use or disclosure of information is about reproductive health care.[138] Also among the proposed modifications were changes to the requirements for the NPP corresponding to, and consistent with, those proposed for uses and disclosures.[139]

On April 26, 2024, the Department adopted modifications related to uses and disclosures of PHI about reproductive health care and the NPP in the 2024 Privacy Rule.[140] The 2024 Privacy Rule also finalized certain modifications to the NPP provisions that were previously proposed in the 2022 Part 2 NPRM (''Part 2-related NPP provisions''). The Part 2-related NPP provisions were unrelated to the proposals contained in the 2023 Privacy Rule NPRM but were finalized at the same time to minimize burdens on covered entities by allowing them to address all required modifications to their NPPs at one time.[141]

The 2024 Privacy Rule had an effective date of June 25, 2024, and established December 23, 2024, as the compliance date for most of its modifications to the Privacy Rule.[142] The 2024 Privacy Rule established February 16, 2026, as the compliance date for all the NPP modifications.[143]

The 2024 Privacy Rule has generated several legal challenges.[144] On June 18, 2025, the U.S. District Court for the Northern District of Texas in *Carmen Purl* v. *U.S. Department of Health and Human Services* (''*Purl*''), issued an order vacating most of the 2024 Privacy Rule.[145] In fashioning its remedy, the

[127] *Ciox,* 435 F. Supp. 3d 30 (D.D.C. 2020).

[128] 42 U.S.C. 17935(e).

[129] 86 FR 6446 (Jan. 21, 2021).

[130] *Id.* at 6447.

[131] *Id.* at 6449.

[132] *Id.* at 6452. The Department did not appeal the *Ciox* decision.

[133] Public Law 116–136, 134 Stat. 281 (Mar. 27, 2020).

[134] 87 FR 74216 (Dec. 2, 2022). Part 2, also referred to as the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations, protects records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to SUD education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by the Federal government. *See also* 42 U.S.C. 290dd–2.

[135] *Id.* at 74224.

[136] 89 FR 12472 (Feb. 16, 2024).

[137] *Id.* at 12530.

[138] *See* 88 FR 23506 (Apr. 17, 2023).

[139] *Id.* at 23516.

[140] 89 FR 32976 (Apr. 26, 2024).

[141] *Id.*

[142] *Id.* at 32979.

[143] *Id.* at 32976, 33048.

[144] *See* Complaint, *Texas* v. *U.S. Department of Health and Human Services,* No. 5:24-cv-00204 (N.D. Tex. Sept. 4, 2024); Complaint, *Purl* v. *U.S. Department of Health and Human Services,* 787 F. Supp. 3d 284 (N.D. Tex. June 18, 2025); Complaint, *Missouri* v. *U.S. Department of Health and Human Services,* No. 4:25–cv–00077 (E.D. Mo. Jan. 17, 2025); Complaint, *Tennessee* v. *U.S. Department of Health and Human Services,* No. 3:25–cv–00025 (E.D. Tenn. Jan. 17, 2025).

[145] *See Purl,* 787 F. Supp. 3d at 331. An amended judgment, which did not alter the scope of the

court severed the Part 2-related NPP provisions from the rest of the 2024 Privacy Rule and did not vacate them. Thus, the Part 2-related NPP provisions and the compliance date for the provisions not vacated by the court remain in effect.[146]

III. Justification for This Rulemaking

A. An Effective Health Care System Requires That Individuals Have Access to Their Health Information and That Others Are Able To Use and Disclose Health Information About Individuals

To further empower individuals and achieve the promise of Make America Healthy Again, as described in the Executive Summary, the Department must take action to create systemic improvements in health care through the appropriate use and disclosure of health information. By building on the existing policy framework for patient access and interoperability, the Department can drive large-scale adoption of health management and care navigation applications, reduce barriers to information access and exchange, realize the potential of recent innovations in health care that promote better health outcomes, and accelerate progress toward a patient-centric learning health system.[147]

The Department's initiatives today build on the work of the Institute of Medicine[148] (IOM), which, in its 1998 landmark report on the quality of the U.S. health care system, identified six attributes of a high functioning health care system.[149] According to the IOM, health care should be: safe, effective, patient-centered, timely, efficient, and equitable because a system with these attributes would enable individuals to obtain care that is ''safer, more reliable, more responsive, more integrated, and more available.''[150] Not only would individuals benefit, but clinicians and others involved in the provision of health care would also experience increased satisfaction because they would be ''providing care that was more reliable, more responsive to [individuals], and more coordinated.''[151]

As part of its work, the IOM created a set of ten rules to guide the redesign of the health care system. The IOM's rules and report highlighted the importance of ensuring the bi-directional flow of information, not only between clinicians, but also between individuals and clinicians. According to the IOM, the health care system ''must be designed to serve the needs of [individuals], and to ensure that they are fully informed, retain control and participate in care delivery whenever possible, and receive care that is respectful of their values and preferences.''[152] Additionally, ''[it] must facilitate the application of scientific knowledge to practice, and provide clinicians with the tools and supports necessary to deliver evidence-based care consistently and safely.''[153] The IOM report made clear that, without improved communication and transfer of knowledge, health outcomes would suffer.

One of the IOM's recommendations highlighted the connection between high-quality health care, care coordination, and the timely flow of information. Specifically, Recommendation 4 encouraged stakeholders to redesign the health care process to prioritize the individual by ensuring that individuals are able to obtain the care that they need at a time and location that is convenient for them; in a manner that responds to their choices and preferences; and based on shared decision making that is informed by their access to their PHI, clinical knowledge, and evidence-based science. According to the IOM, this prioritization of the individual should occur while also limiting administrative burden and waste.

When taken together, Recommendation 4 and the goal of HIPAA as described by the Department[154] ultimately are the same: a health care system that ensures the best possible health outcomes for individuals in a manner that limits the administrative burdens. To achieve that goal, individuals and people involved in their care need to have prompt access to the individual's PHI in a manner that both protects the individual's privacy and minimizes burdens on individuals, health care providers and other participants in the health care sector, and other stakeholders.

1. Individuals Need To Have Access to Their Own Information for Many Purposes, Including Understanding Their Health Status, Coordinating Their Health Care, and Obtaining Government Benefits

As discussed in greater detail above, the right of individuals to access their PHI has been a central component of the Privacy Rule since its inception. NCVHS stated in its initial 1997 recommendations to the Secretary that, while the exact scope of this right—in particular, potential exceptions—was a subject of debate, committee members found universal agreement with the basic principle of individual access rights.[155] And later that same year, in its recommendations to Congress on the contents of privacy legislation, the Department counseled that individuals should be afforded a certain level of control over their health records. Specifically, the Department recommended that ''[p]atients should be able to see and get copies of their records [. . .]''[156] with limited exceptions.[157] The Department also recommended that such legislation include a limitation on Federal requirements to disclose health information to anyone other than the individual.[158] As we explained, ''[t]he ability to see one's own record is central to effective control of information [. . .].''[159] This recommendation was consistent with recommendations from at least as early as the 1970s to provide individuals with the right to access records about themselves.[160] As explained by the Department:

vacatur, was issued on July 3, 2025. With regard to the modifications to the NPP requirements at 45 CFR 164.520, the court vacated only the provisions that were deemed unlawful, namely 45 CFR 164.520(b)(1)(ii)(F), (G), and (H). The remaining modifications to the NPP requirements—specifically, the Part 2-related NPP provisions—were undisturbed and remain in effect. As a result of the court order, the Department cannot and is not enforcing the vacated provisions.

[146] *See Purl,* 787 F. Supp. 3d at 331.

[147] 90 FR 21034, 21036 (May 16, 2025).

[148] The IOM was renamed the National Academy of Medicine on July 1, 2015. *See* Press Release, ''Institute of Medicine to Become National Academy of Medicine,'' Institute of Medicine (Apr. 28, 2015), *https://web.archive.org/web/20190905015356/http://www.nationalacademies.org/hmd/Global/News%20Announcements/IOM-to-become-NAM-Press-Release.aspx.*

[149] ''Crossing the Quality Chasm: A New Health System for the 21st Century,'' Institute of Medicine (US) Committee on Quality of Health Care in America, at Executive Summary (2001), *https://www.ncbi.nlm.nih.gov/books/NBK222271/.*

[150] *Id.*

[151] *Id.*

[152] *Id.*

[153] *Id.*

[154] *See supra* Sec. II.A.1.

[155] Letter from NCVHS Chair Don E. Detmer to HHS Secretary Donna E. Shalala, at Patient Access and Amendment of Health Information (June 27, 1997) (forwarding NCVHS' recommendations), *https://web.archive.org/web/20240228021816/https://ncvhs.hhs.gov/rrp/june-27-1997-letter-to-the-secretary-with-recommendations-on-health-privacy-and-confidentiality/.*

[156] *See* ''Recommendations of the Secretary of Health and Human Services, pursuant to section 264 of the Health Insurance Portability and Accountability Act of 1996,'' Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Section I.G. (Sept. 10, 1997), *https://aspe.hhs.gov/reports/confidentiality-individually-identifiable-health-information.*

[157] *Id.* at II.C.2.

[158] *Id.* at I.D.

[159] *Id.* at II.C.2.

[160] *Id.* (citing recommendations made by the Secretary's Advisory Committee on Automated

Continued

[T]he right recommended here is not simply a right to fair procedure in an administrative transaction or criminal or civil legal action (which may be provided in any case by other law); it is a freestanding fair information practice right to see one's record at a time of one's choosing regardless of actual use in a proceeding or for decision making. It should be available unless there is a danger that patient access would impede the investigation.[161]

While Congress did not enact specific legislation on health information privacy, the Department's recommendations served as the underpinnings for its original Privacy Rule. Thus, the Department's recommendations to Congress, and the privacy considerations undergirding them, are instructive here.

Providing individuals with access to their health information is not only a fair information practice; it also is essential for the individual's ability to engage in shared decision making,[162] a fundamental component of an improved health care system. Shared decision making is ''a collaborative process in which [individuals] and clinicians work together to make healthcare decisions informed by evidence, the care team's knowledge and experience, and the [individual's] values, goals, preferences, and circumstances. Families and caregivers also play an important role in [shared decision making].'' [163] Ultimately, this means that, ''to effectively manage their health, individuals need to be able to access and use their health information when, where, and how they want, including sending it to the people and tools helping them to become or stay healthy—neighbors, friends, relatives, health care providers who are treating or consulting with the individual, or even third-party software tools used for self-management.'' [164] Thus, it is critical for individuals to be able to obtain access to their information promptly and efficiently.

Not only do individuals need access to their PHI, but research shows that individuals generally want to be able to access it and to have some level of control over the PHI that others are able to access.[165] According to the qualitative study of individuals with diabetes who engage with the U.S. Department of Veterans Affairs (VA) patient portal, ''having access to the patient portal puts control over health information into the hands of patients. When patients want to share information between providers, patients can send information themselves.'' [166] The evolution of the VA's capabilities for providing individuals with electronic access to their PHI also illustrates how technology has increasingly enabled individuals to obtain and use their health information. For example, the study describes how VA's My HealtheVet portal [167] and Blue Button [168] functionality enable individuals to access clinical information electronically, and how individuals use that information to support their care, including for care coordination between VA and non-VA health care providers.[169] Thus, allowing individuals to direct a covered entity to provide access to that individual's PHI to a person designated by the individual, for example, by using the functionalities of a patient or health plan member portal, enables coordination among people involved in the individual's care, including among health care providers. Sharing PHI in this manner can reduce duplicate and unnecessary testing, saving time and health care resources.[170]

Research also demonstrates that individuals are more likely to consent to disclosing their health information electronically through health information exchanges (HIEs) [171] when they have greater control over what health information is shared and with whom.[172] When individuals can exercise more control over disclosing their health information, the privacy concerns associated with requests for individuals to share their information are reduced and trust in health care professionals increases, which, in turn, results in higher consent rates.[173] Thus, providing individuals with greater control over who has access to their information, including the ability to direct copies of their information to another person, is likely to increase their willingness to agree to (or authorize, where required) disclosures of that information for other purposes, such as clinical research. We believe that the Department can foster this increased trust and willingness and the attendant benefits for health care and public health by improving individuals' ability to obtain, and direct the disclosure of, their information in a manner that is timely, efficient, and privacy protective.

2. Persons Involved in Caring for Individuals Need To Use Their PHI

Individuals are not alone in their need to use their PHI. Persons involved in caring for individuals—health care providers, family members, caregivers, community-based organizations, and others—also may need to obtain individuals' PHI to facilitate care coordination and case management and enable such individuals to obtain necessary health care and related services. Some of these persons may be covered entities, but others may not.

a. Improving Cooperation Is a Common Element in Existing Definitions of Care Coordination and Case Management

As we explained in the 2021 Privacy Rule NPRM, neither care coordination nor case management has a precise, commonly agreed upon definition. However, both terms have been interpreted broadly to refer to activities that are aimed at promoting cooperation among persons involved in caring for an individual, such as family members, caregivers, and community-based organizations, with the goal of ensuring the best possible health outcomes for the individual. For example, the Department's Office of Inspector General (OIG) defines ''coordination and management of care'' as the ''deliberate organization of patient care activities and sharing of information between two

Personal Data Systems and the Privacy Protection Study Commission in 1973 and 1977, respectively).

[161] *Id.*

[162] ''About Shared Decision Making,'' Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services (May 2023), *https://www.ahrq.gov/sdm/about/index.html.*

[163] *Id.*

[164] Karen B. DeSalvo, et al., ''When and Where You Need It Most: Your Rights to Access and Transmit Your Health Information,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Jan. 11, 2016), *https://www.healthit.gov/buzz-blog/privacy-and-security/your-rights-to-access-and-transmit-your-health-information.*

[165] Kelly Caine, et al., ''Designing a Patient-Centered User Interface for Access Decisions about EHR Data: Implications from Patient Interviews,'' Journal of General Internal Medicine, p. 7–16 (Dec. 6, 2014), *https://rdcu.be/eCVvN.*

[166] Maureen T. Stewart, et al., ''The Promise of Patient Portals for Individuals Living with Chronic Illness: Qualitative Study Identifying Pathways of Patient Engagement,'' Journal of Medical internet Research (July 2020), *https://www.jmir.org/2020/7/e17744/PDF.*

[167] ''Manage your health care with My HealtheVet,'' U.S. Department of Veterans Affairs, *https://www.va.gov/health-care/manage-health/.*

[168] ''Blue Button Resources: Center to Improve Veteran Involvement in Care (CIVIC),'' U.S. Department of Veterans Affairs, *https://www.portlandcoin.research.va.gov/BlueButton.asp.*

[169] ''The Promise of Patient Portals for Individuals Living with Chronic Illness: Qualitative Study Identifying Pathways of Patient Engagement,'' *supra* note 166.

[170] *Id.*

[171] An HIE is a type of health information organization. *See* 45 CFR 160.103 (definition of ''Business associate'' at (3)(i)). *See also* 45 CFR 171.102 (definition of ''Health information network or health information exchange'').

[172] Mohamed Adelhamid, ''Greater patient health information control to improve the sustainability of health information exchanges,'' Journal of Biomedical Informatics, p. 150–58 (July 2018), *https://www.sciencedirect.com/science/article/pii/S1532046418301084.*

[173] *Id.*

or more VBE [value-based enterprise] participants, one or more VBE participants and the VBE, or one or more VBE participants and patients, that is designed to achieve safer, more effective, or more efficient care to improve the health outcomes of the target patient population.'' [174]

CMS has described care coordination and management as ''the foundation of a value-based health care delivery system'' [175] and as including a range of activities that link individuals to services and improve communication flow.[176] In its 2014 guidance addressing a particular Medicaid benefit, CMS explained that the various definitions of this term share three key concepts:

- Comprehensive coordination of all services, including services delivered by systems other than the health system.
- Patient-centered coordination that is designed to meet the needs of the patient.
- Access and follow-up, which is described as ensuring the delivery of appropriate services and information flow among providers and back to the primary care provider.[177]

In a 2019 fact sheet on the Medicaid program's health home benefit, CMS described the following six mandatory core services to promote access to and coordination of care:

- Comprehensive care management.
- Care coordination.
- Health promotion.
- Comprehensive transitional care and follow-up.
- Individual and family support.
- Referral to community and social services.[178]

Additionally, the regulations that govern state Medicaid plans include a definition of ''case management services'' that is similar in meaning.[179] In the context of HCBS waivers, CMS has explained that case management usually entails (but is not limited to) conducting the following functions:

- Evaluation and/or re-evaluation of level of care.
- Assessment and/or reassessment of the need for waiver services.
- Development and/or review of the service plan.
- Coordination of multiple services and/or among multiple providers.
- Linking waiver participants to other Federal, state, and local programs.
- Monitoring the implementation of the service plan and participant health and welfare.
- Addressing problems in service provision.
- Monitoring compliance with HCBS settings criteria.
- Reporting, and following-up on, critical incidents.
- Responding to participant crises.
- For waivers with cost or service duration limits, monitoring to detect and resolve situations when the needs of an individual might exceed the limit(s) to ensure health and welfare of waiver participants.[180]

The Department's Agency for Healthcare Research and Quality (AHRQ) describes care coordination as ''a proactive approach to bringing together care professionals and providers to meet the needs of service users to ensure that they receive integrated, person-focused care across various settings,'' [181] that is a ''deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.'' [182] It explains that ''[o]rganizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.'' [183] AHRQ describes a broad approach to care coordination as involving commonly used practices to improve health care delivery, including teamwork, care management, medication management, health IT, and patient-selected health care homes.[184] AHRQ also describes specific activities to help achieve care coordination, such as creating a proactive care plan, patient monitoring and follow-up, supporting patient self-management goals, and linking to community resources.[185]

Another definition comes from the National Quality Forum,[186] an organization that works to improve health care outcomes, safety, and affordability through consensus on quality measurement and improvement standards and practices. It defines ''care coordination'' as ''the deliberate synchronization of activities and information to improve health outcomes to ensure patients' and families' needs and preferences for healthcare and community services are met over the course of their treatment and care.'' [187]

Definitions of ''case management'' are equally varied. The Case Management Society of America defines case management as ''a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.'' [188] The American Case Management Association describes case management as ''professional and collaborative, occurring in a variety of settings where medical care, mental health care, and social supports are delivered. Services are facilitated by diverse disciplines in conjunction with the care recipient and

[174] 42 CFR 1001.952(ee)(14)(i); *see* 85 FR 77684, 77721 (Dec. 2, 2020). Value-based care replaces traditional fee-for-service payments that focus on the volume of services, and instead rewards health care providers who deliver higher quality care, better population health, and lower health care costs. *See* ''Value-Based Care,'' sec. 6 of the Health IT Playbook, Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (May 20, 2025), *https://playbook.healthit.gov/playbook/value-based-care/.*

[175] 85 FR 77492, 77498 (Dec. 2, 2020).

[176] ''Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children & Adolescents,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, p. 3 (Sept. 2014), *https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf.*

[177] *Id.*

[178] ''Medicaid Health Homes: An Overview,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Jan. 2019), *https://www.chcs.org/media/HH-Fact-sheet-January-2019.pdf.*

[179] *See* 42 CFR 440.169.

[180] *See* ''CMS Waiver Applications,'' (The 1915(c) Application and Accompanying Materials—Instructions, Technical Guide and Review Criteria, Version 3.7 HCBS Waiver Application), Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (last accessed Oct. 26, 2026), *https://wms-mmdl.cms.gov/WMS/faces/portal.jsp.*

[181] ''Updating the Framework for the Agency for Healthcare Research and Quality's National Healthcare Quality and Disparities Report,'' Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, p. 30 (July 2025), *https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/updating-framework-qdr-technical-brief-50.pdf.*

[182] ''Care Coordination Measures Atlas,'' Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, p. 6 (updated June 2014), *https://www.ahrq.gov/sites/default/files/publications/files/ccm_atlas.pdf* (citing Kathryn M. McDonald, et al., ''Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7—Care Coordination, Technical Reviews,'' No. 9.7, conducted for AHRQ (2007)).

[183] *Id.*

[184] ''Care Coordination Measures Atlas,'' *supra* note 182.

[185] *Id.*

[186] *See* ''About Us,'' National Quality Forum (last accessed Feb. 26, 2026), *https://www.qualityforum.org/en-us/about-us.*

[187] ''Leveraging Electronic Health Record (EHR)-Sourced Measures to Improve Care Communication and Coordination,'' National Quality Forum, p. 5 (Sept. 19, 2022), *https://digitalassets.jointcommission.org/api/public/content/c0a04822de574f76995e60d1c3afcfae?v=4220bbc8.*

[188] ''The Impact of Case Management on the Healthcare System,'' Case Management Society of America (2024), *https://cmsa.org/wp-content/uploads/2024/05/FINAL-The-Impact-of-Case-Management-on-the-Healthcare-System-.pdf.*

their support system.'' Case management includes help with navigating ''complex systems to achieve mutual goals, advocate for those they serve, and recognize personal dignity, autonomy, and the right to self-determination.'' [189]

Despite the variation in definitions, the goal of care coordination and case management is generally the same: to improve health outcomes for individuals.

b. Care Coordination and Case Management Improve Health Outcomes and Decrease the Cost of Care

While the definitions of care coordination and case management may vary, they consistently recognize that access to an individual's PHI, gathered from disparate sources, is integral to improving health outcomes for individuals. Research on care coordination and case management generally demonstrates the benefits of exchanging PHI for care coordination and case management for individuals and for the health care system. A 2026 qualitative study based on interviews with twenty hospital and health care system leaders found that current HIEs represent an improvement over alternative means of sharing information between settings of care.[190] According to a 2019 literature review, the annual costs associated with the failure of care coordination (*i.e.,* unnecessary admissions or avoidable complications and readmissions) ranged from $27.2 billion to $78.2 billion, while the annual cost savings associated with five different care coordination interventions, including the use of a HIE, ranged from $29.6 billion to $38.2 billion.[191] These figures do not include costs associated with unnecessary testing or procedures, nor do they include savings from decreases resulting from related interventions.[192] A 2019 study of data collected from 2011 to 2014 examined the effects of electronic data exchange by hospitals in Florida with other health care providers on health outcomes for individuals who experienced an acute myocardial infarction and found that hospitals that participated in HIEs performed significantly better than hospitals that did not participate.[193] The study showed a greater decrease in 30-day all-cause readmissions for participating hospitals than non-participating hospitals and sustained decreases for readmissions at 45 days and 60 days.[194] The study also found an association between HIE participation, readmission reduction, and increased intensity in the inpatient treatment received by individuals who experienced an acute myocardial infarction, which, according to the study's authors, suggested that HIE participation may play a role in determining the cost trade-offs of inpatient care as opposed to readmission.[195] This further suggests that electronically exchanging information may have helped participating hospitals evaluate the most appropriate and cost-effective health care for each individual during their initial admission. As another example, a 2021 study found that there was a significant association between the use of an HIE by primary care physicians to obtain the PHI of individuals recently released from the hospital and visits to emergency departments and rehospitalizations.[196] In such cases, the individual's likelihood of visiting the emergency department was reduced by 53 percent, while the risk of rehospitalization was reduced by 61 percent.[197] Additionally, if the individual was rehospitalized, the median length of time between the hospital visits more than doubled, increasing from 99 days to 238 days.[198] A 2023 study of 2018 data found that Medicare beneficiaries with Alzheimer's disease were 23 percent less likely to die during a readmission where the readmission was fragmented [199] and the associated hospitals shared an HIE as compared with fragmented readmissions to hospitals that did not share an HIE.[200] Additionally, beneficiaries who experienced fragmented readmissions where the hospitals shared an HIE were more likely to be discharged home with home health, as opposed to a skilled nursing facility (SNF), regardless of whether they had Alzheimer's disease.[201] And in another example, researchers found that individuals enrolled in a certain Medicaid section 1115 demonstration project generally experienced improved health outcomes when participating sites implemented, among other things, health IT that enabled the electronic exchange of PHI.[202] Not only did health outcomes improve, but the cost of care decreased significantly.[203] The specific health IT adopted by the sites varied, including EHRs,[204] case management platforms, cloud-based storage, and

[189] ''Definition of Case Management,'' American Case Management Association (last accessed Jan. 13, 2026), *https://www.acmaweb.org/section.aspx?sID=4.*

[190] *See* Sara D. Turbow, et al., ''Better than nothing, far from perfect: hospital and healthcare system leaders' perspectives on health information exchanges,'' JAMIA Open, Volume 9, Issue 1, p. ooaf178 (Jan. 5, 2026), *https://pmc.ncbi.nlm.nih.gov/articles/PMC12794009/.*

[191] William H. Shrank, et al., ''Waste in the US Health Care System: Estimated Costs and Potential for Savings,'' JAMA, p. 1505 (Oct. 15, 2019), *https://vbidcenter.org/wp-content/uploads/2021/10/jama_shrank_2019_sc_190005.pdf* (Authors classified the interventions into the following categories: (1) emergency department-based strategies; (2) care coordination within accountable care organizations; (3) HIEs; (4) transitional care programs (focused on hospital-to-home transitions); and (5) effective care management for medically complex patients.).

[192] *Id.* (The literature review grouped articles that addressed costs of waste from overtreatment with articles that addressed the costs of waste from low-value care, rather than with articles that addressed ''failure of care coordination.'').

[193] Min Chen, et al., ''Does Health Information Exchange Improve Patient Outcomes? Empirical Evidence From Florida Hospitals,'' Health Affairs, p. 197–204 (Feb. 2019), *https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.05447.*

[194] *Id.* at 201.

[195] *Id.* at 202.

[196] Chantel Sloan-Aagard, et al., ''The Impact of Community Health Information Exchange Usage on Time to Reutilization of Hospital Services,'' Annals of Family Medicine, p. 19–26 (Jan./Feb. 2023), *https://www.annfammed.org/content/annalsfm/21/1/19.full.pdf.*

[197] *Id.*

[198] *Id.*

[199] A fragmented readmission occurs when an individual's admission and readmission are to different hospitals. *See* Sara D. Turbow, et al., ''Association of Fragmented Readmissions and Electronic Information Sharing With Discharge Destination Among Older Adults,'' JAMA Network Open, p. 2 (May 16, 2023), *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2804993.*

[200] *Id.*

[201] *Id.* (Discharges to home with home health cost less than discharges to SNFs and are associated with less risk for subsequent readmission.).

[202] ''Final Evaluation of California's Whole Person Care (WPC) Program,'' UCLA Center for Health Policy Research (Dec. 2022), *https://healthpolicy.ucla.edu/sites/default/files/2024-03/whole-person-care-final-evaluation-report-approved-with-signature_03_11_24.pdf.* In 2015, CMS approved a sec. 1115 demonstration for California's Medicaid program. The demonstration, conducted from 2016 through 2021, aimed to improve access, quality of care, and health outcomes for Medicaid enrollees who are high-risk and high utilizers of health care services with complex care needs to improve their overall health and well-being. While the study did not define ''high risk,'' participating sites were required to target one or more of the following six populations: (1) high utilizers of avoidable emergency department, hospitals, or nursing facilities (high utilizers); (2) individuals with two or more chronic physical conditions (chronic physical conditions); (3) individuals with severe mental illness and/or substance use disorders (SMI/SUD); (4) individuals experiencing homelessness (homeless); (5) individuals at-risk-of-homelessness; and (6) individuals recently released from institutions, including jail or prison (justice-involved). *Id.* at 27. Among the requirements for participant sites was that they implement health IT tools to enable the electronic exchange of PHI. *Id.* at 82.

[203] *Id.* at 230–44.

[204] For purposes of this final rule, we use the term ''EHR'' to refer to the commonly understood meaning of the term, *i.e.,* a system that stores electronic health information across different health care settings. We use the term ''electronic health record'' when referring to the term defined in the HITECH Act and this final rule. *See* 42 U.S.C. 17921(5) (definition of ''Electronic health record''); 45 CFR 164.501 (definition of ''Electronic health record'').

centralized repositories (*e.g.,* HIEs), but overall, the participant sites reported improvements in the selected health outcomes measured.[205] Accordingly, ensuring that persons involved in caring for individuals have access to the individuals' PHI is a critical component for enabling care coordination and case management.

A study also identified the ability of individuals to directly access PHI as an opportunity for improved program evaluation.[206] A 2019 study of the ties between entities in a network of health care organizations and social services agencies demonstrated the importance of integration between these organizations to network performance. According to study authors, ''more cohesive interorganizational networks of health care and social service organizations are associated with lower levels of potentially avoidable health care use and spending among beneficiaries.'' [207] The authors of a review of the effectiveness of initiatives to address health-related factors that influence health outcomes concluded that there is a ''need for policy incentives to more effectively integrate [such] data into EHR systems and foster stronger community partnerships to ensure broader, sustainable impact.'' [208] Thus, to improve the efficiency and effectiveness of the health care system, covered entities must be able to partner with and disclose PHI to social services and community-based organizations that are working to address health-related factors for care coordination and case management.

As then-HHS Deputy Secretary Eric D. Hargan explained before the Brookings Institution on January 30, 2019, care coordination is a necessary component of achieving value-based care:

> One of [the components of value-based care] is coordinated care and the drive to coordinated care provokes some obvious questions that point towards the need for broad-based regulatory reform in this area. Some of the questions and challenges that we got along the way [. . .] [include]: how can we expect physicians to act as navigators of the health system while also holding them accountable if their decision-making is hamstrung by outdated regulations; or how can we expect providers to get on board with payments based on outcomes if we're not willing to give them the freedom to experiment and coordinate with one another [. . .] how can we really make major steps in preventing and curing disease without also rethinking how regulations [. . .] could impede patients and providers working together in creative arrangements [. . .] ? [209]

Former Secretary Azar later praised the advancement of coordinated care with the publication of final rules on interoperability, access to health information, and certification of electronic health record technology.[210] The Secretary stated, ''[t]hese rules are the start of a new chapter in how patients experience American healthcare, opening up countless new opportunities for them to improve their own health, find the providers that meet their needs, and drive quality through greater coordination.'' [211] And, when announcing the publication of a final rule modifying regulations on the confidentiality of substance use disorder (SUD) treatment records to expand care coordination and quality, Secretary Azar explained, ''[t]his reform will help make it easier for Americans to discuss substance use disorders with their doctors, seek treatment, and find the road to recovery.'' [212]

More recently, Secretary Robert F. Kennedy Jr. noted, in his announcement of expanded enforcement of the information blocking regulations, ''[w]hen a patient visits an emergency room, doctors need to access that patient's medical history. They need to know about medications, blood types, allergies, and prior diagnoses. Otherwise, how can they provide the right care? Information technology should make this easy.'' [213] And at a recent U.S. Senate hearing, the National Coordinator for Health Information Technology, Dr. Thomas Keane explained:

> No patient should be treated like a stranger at their next health care encounter simply because their records did not follow them [. . .]. Access to data will [. . .] help inform providers' clinical decision making which can lead to improved care and patient safety [. . .]. In some cases, missing information is not just frustrating, it is dangerous. A patient with a known drug allergy who shows up at a new facility without their records may be prescribed improper medication that could have been avoided if their history were available.[214]

Thus, it is essential that HIPAA not only permit, but also encourage, the coordination of care where appropriate.

B. The Health Care Environment Has Changed Since the Privacy Rule's Right of Access and Care Coordination Provisions Were Last Revised

Over the course of the last decade, the U.S. health care system has changed significantly. The Department has modified the Privacy Rule a few times in the intervening years, but none of those modifications have addressed the reasons for the shift towards the electronic exchange of health information. While the Privacy Rule is technology neutral, the Department must consider the causes of the change in the U.S. health care system, such as the implementation of laws, spread of technology, and the breadth of research that encourage care coordination, to determine how the changes interact with the Privacy Rule and their implications for the goals of HIPAA.

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[205] *See* ''Final Evaluation of California's Whole Person Care (WPC) Program,'' *supra* note 202, at 85–87.

[206] Jessica M. Sautter, et al., ''Health outcomes reported by healthcare providers and clients of a community-based medically tailored meal program,'' BMC Nutrition, p. 10 (Nov. 4, 2024), *https://rdcu.be/e1oRR.*

[207] Amanda L. Brewster, et al., ''Collaboration in Health Care and Social Service Networks for Older Adults: Association with Health Care Utilization Measures,'' Medical Care, p. 331 (May 2019), *https://www.ovid.com/jnls/lww-medicalcare/pdf/10.1097/mlr.0000000000001097~collaboration-in-health-care-and-social-service-networks-for.*

[208] Pavani Rangachari, et al., ''Impact of hospital and health system initiatives to address Social Determinants of Health (SDOH) in the United States: a scoping review of the peer-reviewed literature,'' BMC Health Services Research (Mar. 5, 2025), *https://rdcu.be/e1m3E; see also* ''Better than nothing, far from perfect: hospital and healthcare system leaders' perspectives on health information exchanges,'' *supra* note 190 (finding that participating in a value-based model influenced institutional policies around information exchange—participants from value-based care organizations reflected that they have more incentives, and in some cases, requirements, to use the HIE system to perform population health tasks and to ensure that tests are not being duplicated).

[209] ''Reforming Stark/Anti-Kickback Policies,'' Brookings Institution, p. 7 (Jan. 30, 2019), *https://www.brookings.edu/wp-content/uploads/2019/02/es_20190130_stark_reform_transcript.pdf.*

[210] *See generally* 85 FR 25510 (May 1, 2020); 85 FR 25632 (May 1, 2020).

[211] Press Release, ''HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Mar. 9, 2020), *https://www.cms.gov/newsroom/press-releases/hhs-finalizes-historic-rules-provide-patients-more-control-their-health-data.*

[212] Press Release, ''Health Privacy Rule 42 CFR part 2 is Revised, Modernizing Care Coordination for Americans Seeking Treatment for Substance Use Disorders,'' Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (July 13, 2020), *https://www.samhsa.gov/newsroom/press-announcements/202007131115.*

[213] ''Secretary Kennedy Announces Expanded Enforcement of Health Care Information Blocking Regulations'' at 01:47, U.S. Department of Health and Human Services, YouTube (Sept. 3, 2025), *https://www.youtube.com/watch?v=u1N7bX0cgvI.*

[214] Testimony of Thomas Keane, M.D., *supra* note 6.

1. Newer Laws Build on HIPAA's Goal of Developing a Nationwide Information Network and Promote the Electronic Exchange of Health Information

a. Congress Has Enacted Legislation To Improve Health Outcomes Through Care Coordination Supported by the Electronic Exchange of Health Information and Individual Access to Health Information

Since the Privacy Rule's provisions that address the individual's right of access and care coordination were last revised, Congress has made significant changes in Federal law expressly to provide individuals and others with increased electronic access to PHI with the goal of improving health outcomes through various activities, including care coordination. Since 2013, Congress has enacted several pieces of legislation aimed at furthering this goal.[215] For example, in April 2015, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 [216] (MACRA), which declares the widespread exchange of health information through interoperable certified EHR technology (CEHRT) nationwide to be a national objective.[217] MACRA's definition of ''interoperability'' focuses on using health IT to exchange health information for coordinated care and improved health outcomes.[218] The statute also includes provisions to prevent the blocking of information sharing [219] and establish metrics for determining whether widespread interoperability [220] had been achieved.[221] As part of MACRA, Congress required the Secretary to establish a methodology for paying certain health care providers based on their performance.[222] Congress further directed that as part of this methodology, the Secretary was to establish and adopt performance measures on which incentive payments for the health care providers would be based, including measures of care coordination.[223] Additionally, MACRA expanded the ability of certain entities to use Medicare data for the purpose of improving the quality of patient care.[224] Congress also codified certain existing CMS initiatives on chronic care management services that enabled additional categories of health care professionals to bill for chronic care management services and requires the Secretary to conduct an education and outreach campaign to health care professionals and beneficiaries about these benefits.[225]

The following year, Congress enacted the Cures Act,[226] which encouraged certain persons, including covered entities and their business associates, to provide individuals with electronic access to their PHI and enable covered entities to more easily exchange ePHI.[227] For example, among the Cures Act's provisions were directions to the National Coordinator for Health Information Technology (''National Coordinator'') and OCR to jointly promote patient access to PHI in a form and manner that is both convenient to the individual and not burdensome for the involved health care provider.[228] The Cures Act also included directions to the National Coordinator and OCR to assist individuals and health care providers in understanding the right of access, including best practices for requesting their PHI in a computable format, such as using patient portals or applications and common cases when a health care provider is permitted to exchange and provide access to PHI.[229] As another example, Congress directed the Secretary to promote policies that ensure that a patient's electronic health information [230] (EHI) is accessible to the patient and their designee(s) in a manner that facilitates communication with the patient's health care providers and others, including researchers, consistent with the patient's consent.[231] The Cures Act also required the Department to issue guidance clarifying the permitted uses or disclosures of PHI for purposes of communicating with a patient's family member, caregiver, or other individual, to the extent that such family member, caregiver, or individual is involved in caring for the patient.[232]

Even more recently, Congress enacted the CARES Act.[233] The CARES Act enabled and encouraged care coordination and case management through targeted grant reauthorizations, regulatory requirements to facilitate information sharing, increased provider flexibility, the provision of additional funding for certain at-risk populations, and telehealth expansion. Among other things, Congress directed the Secretary to establish a grant program for the quality improvement activities of small health care providers and specifically permitted the grants to be used for activities related to increasing care coordination, enhancing chronic disease management, and improving patient health outcomes.[234] The CARES Act allocated almost $1 billion to the Administration for Community Living for services that include case management for older adults and individuals with disabilities.[235] Additionally, Congress directed the Secretary to provide grants for programs designed to support the training of health professionals in geriatrics with

[215] *See* Nora Wells, ''Digital Health Information Interoperability: Background and Selected Policy Considerations,'' Congressional Research Service, R49436 (Sept. 29, 2026) (discussing the Department's efforts to further interoperability in support of a learning health system).

[216] Public Law 114–10, 129 Stat. 87 (Apr. 16, 2015).

[217] Sec. 106(b)(1)(A) of Public Law 114–10, 129 Stat. 138 (Apr. 16, 2015).

[218] Sec. 106(b)(1)(B)(ii) of Public Law 114–10, 129 Stat. 139 (Apr. 16, 2015).

[219] Sec. 106(b)(2) of Public Law 114–10, 129 Stat. 139 (Apr. 16, 2015).

[220] Sec. 106(b)(1)(B)(i) of Public Law 114–10, 129 Stat. 139 (Apr. 16, 2015).

[221] Sec. 106(b)(1)(C) of Public Law 114–10, 129 Stat. 139 (Apr. 16, 2015).

[222] *See* sec. 101 of Public Law 114–10, 129 Stat. 89–128 (Apr. 16, 2015).

[223] *Id.*

[224] *See* sec. 105(a) of Public Law 114–10, 129 Stat. 133 (Apr. 16, 2015).

[225] *See* sec. 103(a) of Public Law 114–10, 129 Stat. 87, 131 (Apr. 16, 2015) (codified at 42 U.S.C. 1395w–4(b)).

[226] Public Law 114–255, 130 Stat. 1033 (Dec. 13, 2016).

[227] Among other things, the Cures Act directed the Secretary to use existing authorities to encourage partnerships between HIEs/health information networks (HINs) and health care providers, health plans, and other appropriate entities with the goal of enabling individuals to access their ePHI in a single, longitudinal format that is easy to understand, secure, and automatically updatable. It also directed the Secretary, in coordination with OCR to educate providers on how to leverage HIEs/HINs to provide individuals with access to their ePHI, clarify misunderstandings by health care providers about the use of HIEs/HINs for individual access, and, to the extent practicable, educate providers about HIEs/HINs that employ capabilities that enable individual access to ePHI. *See* sec. 4006(a) of Public Law 114–255, 130 Stat. 1181 (Dec. 13, 2016) (codified at 42 U.S.C. 300jj–19(c)).

[228] *See* sec. 4006(d) of Public Law 114–225, 130 Stat. 1182 (Dec. 13, 2016) (codified at 42 U.S.C. 300jj–19(d)).

[229] *See* sec. 4006(e)(1)(B) of Public Law 114–225, 130 Stat. 1182 (Dec. 13, 2016) (codified at 42 U.S.C. 300jj–19(e)(1)(B)).

[230] While the statute does not define ''electronic health information,'' for purposes of the information blocking regulations, ONC has defined it to mean, with reference to HIPAA Rules, ePHI that is subject to the right of access under 45 CFR 164.524. *See* 45 CFR 171.102.

[231] *See* sec. 4006(e) of Public Law 114–225, 130 Stat. 1182 (Dec. 13, 2016) (codified at 42 U.S.C. 300jj–19(e)).

[232] *See* sec. 11003(b)(3)(A) of Public Law 114–225, 130 Stat. 1271 (Dec. 13, 2016) (codified at 42 U.S.C. 1320d–2 note).

[233] Public Law 116–136, 134 Stat. 281 (Mar. 27, 2020).

[234] *See s*ec. 3213(4)(A) of Public Law 116–136, 134 Stat. 372 (Mar. 27, 2020) (codified at 42 U.S.C. 254c(g)(1)).

[235] *See* Public Law 116–136, 134 Stat. 559; *see also* Press Release, ''ACL Announces Nearly $1 Billion in CARES Act Grants to Support Older Adults and People with Disabilities in the Community During the COVID–19 Emergency,'' Administration for Community Living, U.S. Department of Health and Human Services (Apr. 21, 2020), *https://acl.gov/news-and-events/announcements/acl-announces-nearly-1-billion-cares-act-grants-support-older-adults.*

an emphasis on patient and family engagement, the integration of geriatrics with primary care and other appropriate specialties, and collaboration with community partners to address gaps in health care for older adults.[236] Congress also used the CARES Act to support the electronic exchange of health information by encouraging providers of SUD treatment to access state-based prescription drug monitoring programs [237] (PDMPs) when clinically appropriate.[238]

b. Using Its Statutory Authority, the Department Has Published Regulations That Require or Encourage Covered Entities and Business Associates To Adopt Technology That Enables the Electronic Exchange of Health Information, Individual Access to Health Information, and Care Coordination

To implement the requirements of the HITECH Act and other laws, the Department has published numerous rulemakings that also serve to further the electronic exchange of health information. For example, the Medicare and Medicaid EHR Incentive Programs were established in 2011 to incentivize the adoption and meaningful use of CEHRT by eligible hospitals, critical access hospitals (CAHs), and eligible professionals (''eligible health care providers'').[239] Stage 1 of the programs focused on a few specific goals, including electronically capturing health information in a structured format; using that information to track key clinical conditions and communicating that information for care coordination purposes; and using CEHRT to engage patients and families.[240] The goals of the programs' Stage 2 included encouraging the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible.[241] Stages 2 and 3 included increasingly robust expectations for health information exchange to support the goal that information follows the patient.[242] Stage 3 generally focused on the advanced use of EHR technology to promote improved patient outcomes and health information exchange and established a clear vision for how participation in the programs supported CMS' long-term system reform goals and the future use of EHRs across a multitude of health care providers.[243]

The Merit-based Incentive Payment System (MIPS), a part of the Quality Payment Program (QPP), replaced the Medicare EHR Incentive Program for eligible clinicians in 2017.[244] The goals of the QPP currently include the following:

- Advancing the sharing of health care information between allied providers and patients.
- Improving the care received by Medicare beneficiaries.
- Educating, engaging, and empowering patients as members of their care team.[245]

As part of the QPP, MIPS eligible clinicians must demonstrate that they are engaging in certain activities focused on promoting interoperability and engaging in care coordination.[246]

Additionally, in May 2020, CMS published the Interoperability and Patient Access Final Rule, designed to advance interoperability and patient access to health information.[247] This rule, part of the MyHealthEData initiative launched during the first Trump Administration,[248] focused on empowering patients to take charge of their own health care by requiring certain health plans that CMS regulates to provide individuals with certain information through an application programming interface [249] (API) (''Patient Access API'') based on specified electronic transaction standards, if requested by the individual.[250] To further advance the electronic exchange of information that supports effective transitions of care, the rule also requires that certain health care providers send event notifications at specified times to other providers engaged in the individual's care who need the information for treatment, care coordination, or quality improvement purposes.[251]

Building on this rule, in 2024, CMS published the Interoperability and Prior Authorization Final Rule,[252] which required that certain health plans do all of the following by the applicable compliance dates, generally beginning January 1, 2027 (or, for Medicaid and CHIP managed care plans, the rating period beginning on or after that date):

- Provide additional information to patients through the Patient Access API.[253]
- Maintain an API for the purpose of exchanging certain health information with other health plans to ensure patients have continued access to their health information when they change

[236] *See* sec. 3403 of Public Law 116–136, 134 Stat. 372 (codified at 42 U.S.C. 294c).

[237] A PDMP is an electronic database that tracks prescriptions of controlled substances. ''Prescription Drug Monitoring Programs (PDMPs),'' U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (May 7, 2024), *https://www.cdc.gov/overdose-prevention/php/interventions/prescription-drug-monitoring-programs.html.*

[238] *See* sec. 3221(k) of Public Law 116–136, 134 Stat. 379.

[239] The Medicare and Medicaid EHR Incentive Programs were also referred to as the Meaningful Use Programs. *See* 75 FR 44314 (July 28, 2010). Among the programs' initial requirements were all of the following: (1) performance or review of a security risk analysis in accordance with the requirements of the Security Rule; and (2) implementation of security updates as necessary and correction of identified security deficiencies as part of an eligible professional's risk management process. *See also* 77 FR 53968, 54002–03 (Sept. 4, 2012); ''Security Risk Analysis Tipsheet: Protecting Patients' Health Information,'' Centers for Medicare & Medicaid Services and Office for Civil Rights, U.S. Department of Health and Human Services (Dec. 2013), *www.cms.gov/files/document/security-risk-assessment-fact-sheetupdated-2014–04–18pdf.*

[240] *See* 75 FR 44314, 44321 (July 28, 2010).

[241] *See* 77 FR 53968, 53973 (Sept. 4, 2012).

[242] *Id.* In addition to the security-related requirements from Stage 1, Stage 2 added a requirement for eligible professionals to address the encryption and security of data at rest. *See* 77 FR 53968, 54002–03 (Sept. 4, 2012).

[243] *See* 80 FR 62762, 62765 (Oct. 16, 2015).

[244] *See* sec. 1903(t)(4)(A)(iii) of the SSA; *see also* 75 FR 44319, 44569–62 (July 28, 2010). CMS renamed the Medicare and Medicaid EHR Incentive Programs for eligible hospitals and CAHs as the Promoting Interoperability Programs as part of the FY2018 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System final rule. 83 FR 41144, 41150 (Aug. 17, 2018). The Medicaid Promoting Interoperability Program ended on Dec. 31, 2021. ''Promoting Interoperability Program,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Sept. 11, 2026), *https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs.*

[245] ''About QPP,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (last accessed Jan. 15, 2026), *https://qpp.cms.gov/get-started/what-is-qpp/about-qpp.*

[246] *See* 90 FR 49266, 49654–64, 49868–49903 (Nov. 5, 2025); *see also* ''Promoting Interoperability: Traditional MIPS Requirements,'' Quality Payment Program, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (last accessed Jan. 15, 2026), *https://qpp.cms.gov/reporting-requirements/ways-to-report/traditional-mips/promoting-interoperability;* ''APM Performance Pathway,'' Quality Payment Program, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (last accessed Feb. 10, 2026), *https://qpp.cms.gov/reporting-requirements/ways-to-report/app.*

[247] *See generally* 85 FR 25510 (May 1, 2020).

[248] Fact Sheet, ''Trump Administration Announces MyHealthEData Initiative at HIMSS18,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Mar. 6, 2018), *https://www.cms.gov/newsroom/fact-sheets/trump-administration-announces-myhealthedata-initiative-himss18.*

[249] *See* NIST definition of ''Application Programming Interface (API),'' Glossary, Computer Security Resource Center, National Institute for Standards and Technology, U.S. Department of Commerce, *https://csrc.nist.gov/glossary/term/application_programming_interface.*

[250] *See* 85 FR 25510, 25512 (May 1, 2020).

[251] *See* 42 CFR 482.24, 482.61, 485.638; *see also* 85 FR 25510, 25584–25603 (May 1, 2020).

[252] *See* 89 FR 8758 (Feb. 8, 2024).

[253] *See* 42 CFR 422.119; 42 CFR 431.60; 42 CFR 438.242; 42 CFR 457.730; 45 CFR 156.221(b); 89 FR 8758, 8768–87 (Feb. 8, 2024).

health plans and support continuity of care (''Payer-to-Payer API'').[254]

- Maintain an API for the purpose of exchanging certain health information with health care providers to ensure that providers have access to individuals' health information for care coordination purposes (''Provider Access API'').[255]
- Implement new processes for prior authorization to reduce the burden on patients, providers, and health plans (''Prior Authorization API'').[256]

More recently, CMS published the Interoperability Standards and Prior Authorization for Drugs Proposed Rule,[257] which would require that certain health plans implement APIs to support electronic prior authorization for drugs that require prior authorization.[258] The proposals in the NPRM would encourage care coordination by enabling a more seamless exchange of ePHI, requiring health plans to make prior authorization decisions more quickly, and increasing the transparency of the prior authorization process for drugs that require prior authorization.[259]

Relatedly, CMS also announced an effort to modernize the nation's digital health ecosystem, including an expansion of data-sharing capabilities.[260] As part of this effort, CMS announced a call to action through an interoperability framework, aimed at bringing together health data networks to increase the electronic exchange of health information.[261] The initial framework criteria included several goals, such as:

- Enabling patients to access their electronic medical information anywhere the information lives on the network using applications of their choosing.
- Sharing patient consent preferences with all involved parties and supporting such preferences when required by law or policy.
- Facilitating care coordination by supporting queries for treatment purposes where the requesting provider has had their identity verified.
- Ensuring the availability of chart notes and clinical documents in machine- and human-readable formats, as specified in the United States Core Data for Interoperability (USCDI), Version 3.[262]
- Providing or facilitating access to health information using APIs.[263]

ONC has also issued numerous regulations that advance care coordination and individuals' access to their PHI, specifically their ePHI. As authorized by the HITECH Act, ONC established a voluntary certification program for health IT [264] and established the initial set of health data technical standards, implementation specifications, and certification criteria in 2010.[265] ONC routinely updates the standards, implementation specifications, and certification criteria to encourage the adoption of functionalities that enable care coordination or individual access through the electronic exchange of PHI, among other purposes.[266] For example, in 2024, ONC published the Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (''HTI–1'') final rule.[267] The HTI–1 final rule implements, among other things, certain provisions of the Cures Act that directed the Secretary to update certain provisions of the ONC Health IT Certification Program.[268] More recently, in alignment with the goals of Executive Orders 14192 [269] and 14267,[270] ONC revised the ONC Health IT Certification Program to focus on API-enabled interoperability solutions.[271]

ONC also has promulgated regulations that implement section 4004 of the Cures Act, which defines information blocking practices and authorizes civil monetary penalties and appropriate disincentives for the entities subject to the definition (referred to as the ''information blocking regulations'').[272] Information blocking refers to practices by actors [273] that, except as required by law or covered by an exception, are likely to interfere with, prevent, or materially discourage the access, exchange, or use of EHI, and that otherwise meet the requisite regulatory requirements.[274] While ONC has established exceptions for actions that otherwise would constitute information blocking, as authorized by statute,[275] the exceptions are limited to activities that are deemed reasonable and necessary as required by statute.[276] Since publication of the initial regulations in 2020, ONC has modified the information blocking regulations several times, generally to promote the access, exchange, and use of EHI.[277]

And in 2022, also as authorized under the Cures Act,[278] ONC published Version 1.0 of the Common Agreement,[279] which launched the Trusted Exchange Framework and Common Agreement (TEFCA), a

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[254] *See* 42 CFR 422.121(b); 42 CFR 431.61(b); 42 CFR 457.731(b); 45 CFR 156.222(b); 89 FR 8758, 8820–58 (May 1, 2020).

[255] *See* 42 CFR 422.121(a); 42 CFR 431.61(a); 42 CFR 457.731(a); 45 CFR 156.222(a); 89 FR 8758, 8787–8820 (Feb. 8, 2024).

[256] *See* 42 CFR 431.80(b); 42 CFR 457.732(b); 45 CFR 156.223(b); 89 FR 8758, 8858–94 (Feb. 8, 2024).

[257] *See* 91 FR 19890 (Apr. 14, 2026).

[258] *Id.* at 19892.

[259] *Id.* at 19908–11.

[260] ''Health Technology Ecosystem: Overview,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Sept. 16, 2026), *https://www.cms.gov/priorities/health-technology-ecosystem/overview.*

[261] ''Health Technology System: Interoperability Framework,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Aug. 6, 2026), *https://www.cms.gov/health-technology-ecosystem/interoperability-framework.*

[262] The USCDI is a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. *See* ''United States Core Data for Interoperability (USCDI),'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (June 2025), *https://isp.healthit.gov/united-states-core-data-interoperability-uscdi#uscdi-v3.*

[263] ''Health Technology System: Interoperability Framework,'' *supra* note 261.

[264] *See* 45 CFR part 170, subparts A through E; 75 FR 36158 (June 24, 2010) (establishing a temporary certification program for health IT); 76 FR 1262 (Jan. 7, 2011).

[265] *See* 45 CFR part 170, subparts A–D; 75 FR 44590 (July 28, 2010).

[266] *See, e.g.,* 77 FR 54163 (Sept. 4, 2012); 80 FR 62602 (Oct. 16, 2015); 85 FR 25642 (May 1, 2020); 90 FR 36536 (Aug. 4, 2025).

[267] *See* 89 FR 1192 (Jan. 9, 2024).

[268] *See id.*

[269] 90 FR 9065 (Feb. 6, 2025).

[270] 90 FR 15629 (Apr. 9, 2025).

[271] *See* 91 FR 67916 (Oct. 28, 2026); *see also* ''Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI–5) Proposed Rule,'' Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Dec. 29, 2025), *https://www.healthit.gov/topic/laws-regulation-and-policy/health-data-technology-and-interoperability-astponc-deregulatory-actions-unleash-prosperity.*

[272] *See* 45 CFR part 171; 85 FR 25642 (May 1, 2020). OIG and CMS also play a role in administering and enforcing the information blocking regulations. *See* 88 FR 42820 (July 3, 2023); 89 FR 54662 (July 1, 2024).

[273] *See* 45 CFR 171.102 (definition of ''Actor'').

[274] *See* 45 CFR 171.102 (definition of ''Electronic health information'').

[275] *See* sec. 3022(a)(3) of the PHSA (42 U.S.C. 300jj–52(a)(3)).

[276] *See* 85 FR 25642, 25649 (May 1, 2020).

[277] *See, e.g.,* 89 FR 1192 (Jan. 9, 2024); 89 FR 101772 (Dec. 16, 2024); 89 FR 102512 (Dec. 17, 2024); 90 FR 36536 (Aug. 4, 2025).

[278] *See* sec. 4003(b) of the Cures Act, Public Law 114–255, 130 Stat. 1033, 1165, which amends sec. 3001(c) of the PHSA (codified at 42 U.S.C. 300jj–11(c)) (requiring the National Coordinator to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally).

[279] ''ONC Completes Critical 21st Century Cures Act Requirement, Publishes the Trusted Exchange Framework and the Common Agreement for Health Information Networks,'' The Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Jan. 18, 2022), *https://www.hhs.gov/about/news/2022/01/18/onc-completes-critical-21st-century-cures-act-requirement-publishes-trusted-exchange-framework-common-agreement-health-information-networks.html.*

mechanism to enable the nationwide exchange of EHI across disparate health information networks [280] (HINs).[281] Among other things, TEFCA provides individuals and others, such as health care providers, health plans, and public health agencies, with easier, more efficient, secure access to more health information and reduces the number of connections that individuals, health care providers, and certain other parties that are part of or interact with the health care system need, to obtain health information.[282] The initial use cases for TEFCA support the secure electronic exchange of information for activities that are central to care coordination and individual access and include TPO and individual access services, among others.[283]

The Department also, as required by the Cures Act,[284] has published several guidance documents and engaged in education campaigns designed to promote individual access and to support the electronic exchange of health information. For example, the Department published guidance on the application of the HIPAA Rules to cloud computing solutions [285] and in an electronic exchange environment.[286] The Department also issued guidance on the individual right of access, health apps, and APIs to address questions about the implementation of the individual right of access when using health apps and APIs,[287] as well as publishing guidance on how the HIPAA Rules would apply in specific scenarios involving the use of health apps.[288] Additionally, in conjunction with the Federal Trade Commission, the Department published an interactive tool designed to help developers of certain mobile apps understand the Federal laws and regulations that may apply to them.[289] OCR and ONC also partnered to develop a series of materials designed to educate individuals about the right of access and promote patient access to their health information in a manner that ensures that such information is available in a form convenient for the patient, in a reasonable manner, without burdening the health care provider involved.[290]

Additionally, as required by the CARES Act, the Department modified the regulations that govern the confidentiality and disclosure of SUD patient records protected by Part 2 to decrease burdens on patients and providers, improve coordination of care and access to care and treatment, and strengthen certain confidentiality protections for SUD patient records.[291] These revisions to Part 2 have improved alignment with the Privacy Rule and provided greater flexibility for disclosures of patient identifying information within the health care system, while continuing to protect the confidentiality of Part 2 records.[292]

This discussion is not an exhaustive list of the changes in Federal law that support care coordination and case management or individuals' access to their PHI. Rather, it demonstrates the breadth and depth of the Department's commitment to improving care coordination and case management and empowering individuals by ensuring ready access to their PHI. When viewed through that lens, it is clear that Federal law has evolved significantly since the relevant provisions of the Privacy Rule were last modified, with an increased emphasis on the electronic exchange of health information to improve and encourage care coordination and support individuals' access, including their ability to direct a covered entity (and in some cases, a business associate), to provide access to their health information to other persons.

2. Technology That Enables the Electronic Exchange of PHI Is More Widely Available Today Than It Was in 2013 When the Omnibus Final Rule Was Published

The implementation of the laws discussed above and the availability of consumer-focused technology has spurred the adoption of EHRs and other health IT by various participants in the health care system.[293] In 2008, before the enactment of the HITECH Act, less than 10 percent of non-Federal acute care hospitals had implemented what was referred to at the time as a ''Basic EHR'' [294] (*i.e.,* an EHR). By 2018, approximately 99 percent of non-Federal acute care hospitals had adopted a Basic EHR and a certified EHR.[295] The ability of regulated entities to exchange information electronically increased with this shift from paper-based to electronic methods of record-keeping and the adoption of transaction, code set, and interoperability standards. This ability increased again with the adoption of API-standards based access

[280] An HIN is a type of health information organization. *See* 45 CFR 160.103 (definition of ''Business associate'' at (3)(i)).

[281] *See* ''TEFCA™: What is the Trusted Exchange Framework and Common Agreement™?,'' The Sequoia Project (last accessed Jan. 16, 2026), *https://rce.sequoiaproject.org/tefca/.*

[282] ''Trusted Exchange Framework and Common Agreement™ (TEFCA™),'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, p. 1 (Nov. 2023), *https://www.healthit.gov/sites/default/files/page/2023-11/TEFCA_2-Pager_Digital_508.pdf.*

[283] ''TEFCA Framework: Exchange Purposes Explained,'' Sequoia Project (last accessed Oct. 8, 2026), *https://rce.sequoiaproject.org/exchange-purposes-explained/.* Currently, there are six approved Exchange Purposes under the Common Agreement: Government Benefits Determination; Health Care Operations; Individual Access Services; Payment; Public Health; and Treatment.

[284] *See* sec. 4006 of Public Law 114–255, 130 Stat. 1181 (Dec. 13, 2016) (directing the Department to issue guidance to health care providers on best practices for providing individuals with access to their PHI).

[285] ''Guidance on HIPAA & Cloud Computing,'' Office for Civil Rights, U.S. Department of Health and Human Services (Oct. 7, 2016), *https://www.hhs.gov/hipaa/for-professionals/special-topics/health-information-technology/cloud-computing/index.html.*

[286] ''Health Information Technology,'' Office for Civil Rights, U.S. Department of Health and Human Services (Sept. 2, 2020), *https://www.hhs.gov/hipaa/for-professionals/faq/health-information-technology/index.html.*

[287] ''The access right, health apps, & APIs,'' Office for Civil Rights, U.S. Department of Health and Human Services (Sept. 2, 2020).

[288] ''Health App Use Scenarios & HIPAA,'' Office for Civil Rights, U.S. Department of Health and Human Services (May 25, 2016), *https://www.hhs.gov/sites/default/files/ocr-health-app-developer-scenarios-2-2016.pdf.*

[289] ''Mobile Health App Interactive Tool,'' U.S. Federal Trade Commission (Nov. 2024), *https://www.ftc.gov/business-guidance/resources/mobile-health-apps-interactive-tool.*

[290] *See* ''Get it. Check it. Use it.,'' U.S. Department of Health and Human Services (July 11, 2017), *https://www.hhs.gov/hipaa/for-individuals/right-to-access/index.html.*

[291] *See generally* 89 FR 12472 (Feb. 16, 2024).

[292] *Id.* at 12472, 12479.

[293] *See* 75 FR 44314–44588 (July 28, 2010); *see also* 75 FR 2014–47 (Jan. 13, 2010); 75 FR 36158–36209 (June 24, 2010); 75 FR 44590–44654 (July 28, 2010); 76 FR 1262–1331 (Jan. 7, 2011).

[294] Wesley Barker, et al., ''ONC Data Brief: Non-Federal Acute Care Hospital Electronic Health Record Adoption, 2008–2024,'' The Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (June 2026), *https://healthit.gov/data/data-briefs/non-federal-acute-care-hospital-electronic-health-record-adoption-2008-2024/;* A Basic EHR includes computerized capabilities for patient demographics, physician notes, nursing assessments, patient problem lists, electronic lists of medications taken by patients, discharge summaries, advanced directives, orders for medications, viewing laboratory results, and viewing radiology results. *Id.* at Definitions.

[295] ''ONC Data Brief: Non-Federal Acute Care Hospital Electronic Health Record Adoption, 2008–2024'' *supra* note 294; When used here, ''certified EHR'' means EHR technology that meets the technological capability, functionality, and security requirements adopted by the Department as certification criteria at 45 CFR part 170; *see also* ''Certified EHR Technology,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (updated Sept. 10, 2024), *https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs/certified-ehr-technology#:~:text=In%20order%20to%20efficiently%20capture,the%20Medicare%20Promoting%20Interoperability%20Program* (''In order to efficiently capture and share patient data, health care providers need certified electronic health record (EHR) technology (CEHRT) that stores data in a structured format. Structured data allows health care providers to easily retrieve and transfer patient information and use the EHR in ways that can aid patient care.'').

and exchange and the implementation of the information blocking regulations in 2020.[296] In 2014, 41 percent of such hospitals routinely had electronic access to clinical information from outside providers or sources when treating a patient.[297] By 2023, 70 percent of non-Federal acute care hospitals engaged in all domains of interoperable exchange routinely or sometimes, a significant increase.[298] By 2024, more than 85 percent of non-Federal acute care hospitals were integrating third-party data into their EHRs for clinical or administrative purposes, while a similar percentage regularly were providing third parties with data from their EHRs.[299] In 2016, 38 percent of hospitals had enabled patients to access their health information using an application, and in 2018, 57 percent had enabled patient access to their clinical notes in their patient portal; by 2021, 70 percent of hospitals enabled patients to access their health information using an application, and 82 percent enabled patients to view their clinical notes in their patient portal.[300] By 2024, the percentage of hospitals that supported patient access through apps increased to 90 percent.[301]

Research has demonstrated the important role that patient and health plan member portals, one method of providing individual access encouraged by the Department,[302] currently play in increasing patient centeredness of care and health information-seeking self-efficacy for individuals.[303] In 2020, the Health Information National Trends Survey [304] (HINTS) found that more than half of individuals with a mobile health app used it to facilitate discussions with their health care provider that same year, while approximately the same percentage used their health app to make decisions about how to treat an illness or condition.[305] According to the 2024 HINTS, more than 75 percent of respondents reported being offered access to their PHI at least once during the previous year, and almost two-thirds of individuals reported accessing their records during that same time period.[306] Respondents also reported that proxy and caregiver access had more than doubled. Among individuals surveyed, 69 percent of patients with at least one chronic condition, and 76 percent of individuals with a recent cancer diagnosis, reported accessing their patient portal or online medical records in the previous year.[307]

Patient and health plan member portals are not the only technology that is more widely available today than it was in 2013. Health apps, while available in 2013, were not used or relied upon to the degree that they are today. The 2024 HINTS shows that 57 percent of respondents reported using an app to access their records during the year, a significant increase over the 38 percent that reported doing the same in 2020.[308] A 2023 study examined downloads of specific mobile health apps from the Google Play website [309] and data from HINTS 6 to learn about people's use of apps to access health information. Among the apps used by individuals to access their PHI reviewed in the study, almost 99 percent of the app downloads were for patient portal apps provided to the individual by a covered entity or business associate.[310] The remaining 1 percent of the app downloads were for personal health apps provided directly to individuals.[311] While a small percentage, this actually represented significant growth over 2021, with one app responsible for 77 percent of that growth.[312] Research by ONC indicated that, in 2022, 2 percent of individuals reported using a ''portal organizing app,'' that is an app that aggregates an individual's PHI from different patient portals or online medical records; by 2024, the figure had increased to 7 percent.[313] And the Department anticipates that this number will increase even further in response to the recent launch of the Medicare App Library, a centralized directory of vetted digital health care options for Medicare beneficiaries.[314] This suggests that mobile apps, particularly patient portal apps, are an entry point for individuals to obtain access to and engage with their PHI today. We anticipate that the use of both patient and health plan member portal apps and apps provided directly to individuals is likely to increase over time, particularly in light of the changes to Federal law in the last 10 years, as discussed below.

[296] *See* 85 FR 25642 (May 1, 2020); *see also* sec. 4003(b) and 4004 of Public Law 114–255, 130 Stat. 1165 and 1176 (Dec. 13, 2016) (codified at 42 U.S.C. 300jj–11(c) and 42 U.S.C. 300jj–52).

[297] Dustin Charles, et al., ''ONC Data Brief: Interoperability among U.S. Non-federal Acute Care Hospitals, 2014,'' The Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, p. 1 (Aug. 2015), *https://healthit.gov/wp-content/uploads/2017/03/onc_databrief25_interoperabilityv16final_081115.pdf.*

[298] Meghan Hufstader Gabriel, et al., ''ONC Data Brief: Interoperable Exchange of Patient Health Information Among U.S. Hospitals: 2023,'' The Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, p. 1 (May 2024), *https://healthit.gov/wp-content/uploads/2024/05/Interoperable-Exchange-of-Patient-Health-Information-Among-U.S.-Hospitals-2023.pdf.*

[299] Catherine Strawley, et al., ''ONC Data Brief: Hospital Use of APIs to Enable Data Sharing between EHRs and Third-Party Technology,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Feb. 2026), *https://healthit.gov/data/data-briefs/hospital-use-of-apis-to-enable-data-sharing-between-ehrs-and-third-party-technology/.*

[300] Wesley Barker, et al., ''ONC Data Brief: Hospital Capabilities to Enable Patient Electronic Access to Health Information, 2021,'' The Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, p. 2, 5 (Oct. 2022) (estimates based on non-Federal acute care hospitals and applications configured to meet the API specifications in the hospital's EHR), *https://healthit.gov/wp-content/uploads/2022/12/hospital_capabilities_to_enable_patient_access_ONC_DB2021-Updated.pdf.*

[301] ''ONC Data Brief: Hospital Use of APIs to Enable Data Sharing between EHRs and Third-Party Technology,'' *supra* note 299.

[302] Stage 1 of the Meaningful Use Program required eligible health care providers to provide electronic copies of health information or discharge instructions and timely access to health information. *See* 75 FR 44314, 44321 (July 28, 2010). Stage 2 replaced this objective with a requirement that eligible health care providers provide patients with the ability to view online, download, and transmit their health information within a specified period of time. 77 FR 53968, 53973 (Sept. 4, 2012). Stage 2 also required eligible health care professionals to use secure electronic messaging to communicate with patients on relevant health information. *Id.* at 54031.

[303] Maryum Zaidi, et al., ''Association Between Patient Portal Use and Perceived Patient-Centered Communication Among Adults With Cancer: Cross-section Survey Study,'' JMIR Cancer (Aug. 2022), *https://cancer.jmir.org/2022/3/e34745/PDF.*

[304] HINTS is a nationally representative survey of U.S. adults.

[305] Christian Johnson, et al., ''ONC Data Brief: Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2020,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Sept. 2021), *https://healthit.gov/data/data-briefs/individuals-access-and-use-patient-portals-and-smartphone-health-apps-2020/.*

[306] Chelsea Richwine, ''ONC Data Brief: Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2024,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, p. 8 (July 2025), *https://healthit.gov/data/data-briefs/individuals-access-and-use-patient-portals-and-smartphone-health-apps-2024/.*

[307] *Id.* at p. 3.

[308] *Id.* at p. 5.

[309] Google Play is the app store for users of Android devices and devices with the Chrome operating system.

[310] Wesley Barker, et al., ''Patient Usage of Apps to Access Online Medical Records,'' JAMA Network Open, p. 2 (Nov. 14, 2023), *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811823.* Patient portal apps, when used in reference to this study, includes apps developed by EHR vendors, health care providers, and health plans. *Id.*

[311] *Id.*

[312] *Id.*

[313] ''ONC Data Brief: Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2024,'' *supra* note 306, at p. 7.

[314] ''Medicare App Library,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Aug. 24, 2026), *https://www.cms.gov/priorities/health-technology-ecosystem/overview/medicare-app-library.*

3. Individuals Benefit When Their PHI Can Be Accessed and Exchanged Electronically

As technology enabling access to and exchange of PHI and other health information has evolved and been implemented widely, it has become apparent that providing individuals with access to their PHI electronically provides significant benefits to the individuals who take advantage of that access. Based on telephone interviews with 40 individuals living with diabetes who use the VA patient portal, individuals generally found patient portals to be ''useful for receiving help in managing symptoms, coordinating their care, and learning about their health.'' [315] Reading clinical notes and test results helped the individuals to understand their health information, to gauge the seriousness of their health issues, and to make decisions regarding their care plan.[316] Having access to test results enabled individuals to be proactive in response to those results.[317]

Recent studies have found the use of patient portals to be associated with improved health outcomes.[318] For example, a 2025 study examined the relationship between patient portal enrollment and retention in care and disease management, specifically human immunodeficiency virus (HIV) viral suppression, and found that an active patient portal account was associated with improved HIV care outcomes for people living with HIV, such as viral suppression and retention in care.[319] A 2024 analysis of data from HINTS 5 found that the use of patient portals by patients ''may build health information efficacy, which seems to promote communication between patients and health care providers,'' particularly for patients with low social support.[320] According to a 2023 study of adult patients' experiences with patient portals, among the benefits reported by patients were the ability to communicate with their providers electronically, viewing test results and visit summaries, managing appointments and receiving reminders, easy access to their health information, getting prescription refills and reviewing medications, and the ease of use and convenience.[321] This evidence suggests that there is a correlation between individual health outcomes and use of patient portals, raising the possibility that encouraging the use of technology that enables individuals and certain other persons to access the individual's PHI could positively affect health outcomes.

The integration of patient-reported information with PHI in EHRs also may allow for improved communication between individuals and their health care providers and facilitate better medication management. A 2022 publication evaluated the use of a particular application for medication management that was integrated into the patient portal of a health care provider's EHR. According to the study's authors, the individuals who were able to use the application benefited from ''real-time medication reconciliation and support for patient-provider communication,'' which enabled patients ''to pull and display the actual, up-to-date medication list for review with a pharmacist in the comfort and convenience of the patient's home setting,'' an innovation that was welcomed by patients.[322] It also enabled patients to learn about the falsehoods associated with medications, identify errors in their active medication list, and learn about the side effects and indications of medications.[323] And it alleviated concerns about newly prescribed medications, such as dosage and timing.[324] Based on an analysis of the 2022 HINTS, 42 percent of individuals who used an app to access their online medical records reported that they accessed those records at least six times in the previous year, while 28 percent of those who used only a web-based portal reported doing so.[325] According to ONC, this ''suggests [that] the use of apps may make it easier and more convenient for patients to track and engage with their health information.'' [326] Another 2022 publication studied the role that the type of portal access plays in promoting patient engagement and found that patients who accessed their medical records through a mobile health app, rather than solely through an online portal, were more likely to view online, download, and transmit their health information; interact with their providers; and interact with their PHI.[327] Participants who accessed their medical records through a mobile health app were more likely to use that information to make decisions about health care and download medical results or share them with another party. They also were more likely to use the app to add information to their medical records, correct their medical records, send secure messages to their providers, request prescription refills, and view medical results.[328] According to an ONC report, by 2024, nearly two-thirds of non-Federal acute care hospitals offered patients the ability to submit health information directly to the EHR.[329] This suggests that there will be even greater potential for improvements in care management as individuals grow accustomed to having this ability and this new channel for communication with health care providers.

The benefits to individuals of the electronic exchange of PHI are not limited to circumstances where the individuals themselves have access to the information. Individuals also may benefit from enabling access to their PHI in a portal or mobile health app for caregivers, family members, personal representatives, and other persons designated by the individual as being involved in their care. A 2024 HINTS showed that the number of persons who accessed the online medical record or patient portal of an individual for whom

[315] ''The Promise of Patient Portals for Individuals Living with Chronic Illness: Qualitative Study Identifying Pathways of Patient Engagement,'' *supra* note 166.

[316] *Id.*

[317] *Id.*

[318] *See also* Elisa H. Son, et al., ''Adult Patients' Experiences of Using a Patient Portal With a Focus on Perceived Benefits and Difficulties, and Perceptions on Privacy and Security: Qualitative Descriptive Study,'' JMIR Human Factors (Jan. 2023), *https://humanfactors.jmir.org/2023/1/e46044.*

[319] Jessica P. Ridgway, et al., ''Association Between Electronic Patient Portal Enrollment and HIV Care Outcomes Among People Living with HIV at an Urban Academic Medical Center,'' AIDS and Behavior (Aug. 10, 2025), *https://link.springer.com/article/10.1007/s10461-025-04869-7.*

[320] Suhwoo Ahn, et al., ''Patients' Use of Electronic Health Records Facilitates Patient-Centered Communication: Findings from the 2017 Health Information National Trends Survey,'' Journal of Medical internet Research (Nov. 2024), *https://www.jmir.org/2024/1/e50476.*

[321] ''Adult Patients' Experiences of Using a Patient Portal With a Focus on Perceived Benefits and Difficulties, and Perceptions on Privacy and Security: Qualitative Descriptive Study,'' *supra* note 318.

[322] Susan E. Spratt, et al., ''Feasibility of Electronic Health Record Integration of a SMART Application to Facilitate Patient-Provider Communication for Medication Management,'' CIN: Computers, Informatics, Nursing, p. 538–46, 544 (Aug. 2022), *https://journals.lww.com/cinjournal/fulltext/2022/08000/feasibility_of_electronic_health_record.6.aspx.*

[323] *Id.*

[324] *Id.*

[325] Catherine Strawley, et al., ''ONC Data Brief: Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2022,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, p. 9 (Oct. 2023), *https://healthit.gov/wp-content/uploads/2023/10/DB69_IndividualsAccess-UsePatientPortals_508.pdf.*

[326] *Id.*

[327] Theophile Ndabu, et al., ''The Role of Access Type and Age Group in the Breadth of Use of Patient Portals: Observational Study,'' Journal of Medical internet Research (Dec. 27, 2022), *https://pmc.ncbi.nlm.nih.gov/articles/PMC9832356/.*

[328] *Id.*

[329] ''ONC Data Brief: Hospital Use of APIs to Enable Data Sharing between EHRs and Third-Party Technology,'' *supra* note 300.

they are providing care or making health care decisions (proxy access or caregiver access) more than doubled between 2020 and 2024, from 24 to 51 percent.[330]

Research suggests that ''[r]outine assessment and support of family caregivers are elements of high-quality clinical care and robust systems of long-term services and supports.'' [331] Being able to directly access PHI in patient or health plan member portals or through mobile apps can provide caregivers with convenient and continuous access, which can increase their engagement in and understanding of the individual's condition and care.[332] Where appropriate, being able to use the patient or health plan member portal or app to interact with the individual's PHI or health care providers can enable those caregivers and others involved in caring for the individual to communicate directly with the individual's health care provider and provides greater legitimacy to their interactions with the covered entity when such access is obtained using their own unique identity credentials, rather than those of the individual.[333]

C. To Continue To Improve the Efficiency and Effectiveness of the Health Care System, the Department Must Modify the Privacy Rule To Address Issues That Impede Care Coordination and Individuals' Access to Their PHI

As our understanding of an effective and efficient health care system evolves and the health care environment changes, the Department must periodically reconsider whether the Privacy Rule is properly balancing the interests of individuals in the privacy of their PHI with the need for their PHI to be used or disclosed to improve their health outcomes and their ability to access their health information and to share it with others. As part of this examination, the Department must determine whether the Privacy Rule accurately reflects the obligations of regulated entities and the rights of individuals, whether regulated entities are correctly interpreting and applying the Privacy Rule, and whether the Privacy Rule unnecessarily imposes real or perceived barriers to the accomplishment of HIPAA's goals.

1. The Department Must Ensure that the Privacy Rule Accurately Reflects the Obligations of Regulated Entities and the Rights of Individuals

The Department's authority to adopt and modify standards relating to the privacy of individually identifiable health is limited to its authority under HIPAA,[334] the HITECH Act,[335] and certain other statutes.[336]

The APA generally requires that, when issuing a new regulation or modifying an existing one, the Department publish a NPRM in the **Federal Register**.[337] The notice must include, among other things, either the terms or substance of the proposed rule or a description of the subjects and issues involved.[338] The APA also generally requires that after the notice is published, the Department must provide interested persons with an opportunity to provide comment on the notice.[339]

As discussed above, Congress established, in section 13405(e) of the HITECH Act, that individuals have the right of access to direct a covered entity to transmit an electronic copy of PHI in an electronic health record to a person designated by the individual. In 2010, the Department issued an NPRM and solicited public comment on a proposal to extend that right to all PHI and for copies in any format. The Department finalized this proposal as part of the 2013 Omnibus Rule. However, in 2020, the court in *Ciox* vacated the Department's actions with respect to section 13405(e).[340] In light of the *Ciox* court's vacatur of this provision, the Department was required to propose to implement section 13405(e) in a manner that is consistent with the court's decision and seek comment on that proposal, which we did in the 2021 Privacy Rule NPRM. The Department now engages in final agency action—*i.e.,* publishes a final rule—to implement this right.

2. Regulated Entities Misinterpret the Privacy Rule in Ways That Are Inconsistent With an Efficient and Effective Health Care System

An efficient and effective health care system requires that PHI is used and disclosed appropriately. As discussed above, both Congress and the Department have taken steps to increase the efficiency and effectiveness of the health care system by making it easier to use and disclose PHI, while also protecting individuals' privacy. And yet, the Department continues to receive reports that covered entities are refusing to disclose PHI to individuals, other covered entities, family members, caregivers, and others, absent burdensome measures that are, at best, not required by the Privacy Rule, and at times, are inconsistent with the Privacy Rule and/or other laws that govern the use and disclosure of PHI.[341] In 2024, the right of access was among the top five issues alleged in the HIPAA complaints that the Department resolved.[342] As discussed in greater

[330] ''ONC Data Brief: Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2024,'' *supra* note 306, at p. 2.

[331] Jennifer L. Wolff, et al., ''Shared Access to Patient Portals for Older Adults: Implications for Privacy and Digital Health Equity,'' JMIR Aging (May 2022), *https://aging.jmir.org/2022/2/e34628/.*

[332] *Id.*

[333] *Id.*

[334] *See* Public Law 104–191, 110 Stat. 1936 (Aug. 21, 1996) (codified at 42 U.S.C. 201 note); *see also Association of American Physicians & Surgeons, Inc.* v. *U.S. Department of Health and Human Services,* 224 F. Supp. 2d 1115 (S.D. Tex. 2002) (holding that HIPAA falls within Congress' Commerce Clause authority).

[335] *See* Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111–5, 123 Stat. 226 (Feb. 17, 2009) (codified at 42 U.S.C. 201 note); sec. 2(a)(iii) of E.O. 14219, 90 FR 10583 (Feb. 25, 2025).

[336] *See* Genetic Information Nondiscrimination Act of 2008 (GINA), title I, sec. 105, Public Law 110–233, 122 Stat. 881 (May 21, 2008) (codified at 42 U.S.C. 2000ff); 21st Century Cures Act, Public Law 114–255, 130 Stat. 1033 (Dec. 13, 2016); CARES Act, Public Law 116–136, 134 Stat. 281 (Mar. 27, 2020); *see also* sec. 2(a)(iii) of E.O. 14219, 90 FR 10583 (Feb. 25, 2025).

[337] 5 U.S.C. 553(b).

[338] 5 U.S.C. 553(b)(3).

[339] 5 U.S.C. 553(c).

[340] *Ciox,* 435 F. Supp. 3d 30.

[341] *See, e.g.,* Steve Alder, ''Renown Health Pays $75,000 to Settle HIPAA Right of Access Case,'' The HIPAA Journal (Feb. 11, 2021), *https://www.hipaajournal.com/renown-health-pays-75000-to-settle-hipaa-right-of-access-case/;* Press Release, ''OCR Settles Sixteenth Investigation in HIPAA Right of Access Initiative,'' Office for Civil Rights, U.S. Department of Health and Human Services (Feb. 12, 2021), *https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/sharp/index.html;* Press Release, ''Eleven Enforcement Actions Uphold Patients' Rights Under HIPAA,'' Office for Civil Rights, U.S. Department of Health and Human Services (July 15, 2022); Press Release, ''HHS Civil Rights Office Resolves HIPAA Right of Access Investigation with $20,000 Settlement,'' Office for Civil Rights, U.S. Department of Health and Human Services (Dec. 15, 2022), *https://www.hhs.gov/about/news/2022/12/15/hhs-civil-rights-office-resolves-hipaa-right-of-access-investigation-with-20000-dollar-settlement.html;* Press Release, ''Lab Pays $16,500 Settlement to HHS, Resolving Potential HIPAA Violation over Medical Records Request,'' Office for Civil Rights, U.S. Department of Health and Human Services (Jan. 3, 2023), *https://www.hhs.gov/about/news/2023/01/03/lab-pays-16-thousand-5-hundred-dollar-settlement-to-hhs-resolving-potential-hipaa-violation.html;* Press Release, ''HHS Office for Civil Rights Imposes a $200,000 Penalty Against Oregon Health & Science University for Failure to Provide Timely Access to Patient Records,'' Office for Civil Rights, U.S. Department of Health and Human Services (Mar. 6, 2025), *https://www.hhs.gov/press-room/penalty-against-or-health-science-university.html;* Press Release, ''HHS' Office for Civil Rights Settles HIPAA Right of Access Investigation with Azul Vision, Inc.,'' Office for Civil Rights, U.S. Department of Health and Human Services (Aug. 27, 2026), *https://www.hhs.gov/press-room/hhs-ocr-settles-hipaa-investigation-with-azul-vision.html.*

[342] The number of complaints resolved in a given calendar year is the sum of administrative closures, technical assistance closures, and investigated closures. *See* ''Annual Report to Congress on HIPAA Privacy, Security, and Breach Notification

detail below, in the 2018 RFI and 2021 Privacy Rule NPRM, the Department has received public comments stating that covered entities often refuse to disclose PHI without a written authorization in situations where the Privacy Rule permits or requires such disclosures absent a written authorization, as well anecdotal reports of the same from other Federal agencies. For example, while the Privacy Rule permits (but does not require) a covered entity to obtain an individual's consent to disclose PHI for treatment purposes (*e.g.,* care coordination), some covered entities refuse to disclose PHI to a health care provider for these purposes without a written authorization.[343] Depending on the circumstances, requiring that the individual provide a written authorization—or in some cases, a written form that requires less information than a written authorization—could increase the burden on the individual and/or delay essential health care. Additionally, ONC has received 2,450 possible claims of information blocking against health care providers, HIEs/HINs, and health IT developers of certified health IT.[344] Of the 2,450 possible claims, approximately 63 percent were filed by patients.[345] Approximately 13 percent were filed by third parties (other than attorneys) on behalf of a patient, while approximately 10 percent were filed by health care providers.[346] An overwhelming majority of the claims—approximately 79 percent—were filed against health care providers,[347] most of whom are also covered entities. Almost 14 percent of complaints were filed against developers of health IT that have developed products that are on ONC's list of certified products.[348] Such developers are often business associates under the HIPAA Rules.[349] As Congress explicitly recognized, at least some of the allegations in these complaints also may indicate possible violations of the Privacy Rule.[350] For example, a health care provider's delay in responding to an individual's request for a copy of their ePHI may be a violation of both the information blocking regulations [351] and the Privacy Rule [352] where the health care provider is both an ''actor'' and a covered entity.[353] The Department also is aware that there may be instances in which the parents of minor children are not receiving access to their children's PHI to the extent required by the Privacy Rule or their access is substantially delayed.[354]

Additionally, as Congress has enacted and/or the Department has implemented the laws discussed above (*e.g.,* the Cures Act, the Interoperability and Patient Access Final Rule, the Cures Act Final Rule), questions have arisen regarding the ability of regulated entities to comply with these new statutes and regulations and the Privacy Rule. Far too often, regulated entities cite HIPAA or the HIPAA Rules as a reason that they cannot disclose PHI, even in circumstances where the Privacy Rule permits the requested disclosure. For example, when evaluating the success of California's section 1115 demonstration that required the implementation of health IT to encourage the exchange of PHI for care coordination, researchers found that among the most frequently cited barriers to the exchange of PHI among participant sites and their

Rule Compliance for Calendar Year 2024,'' Office for Civil Rights, U.S. Department of Health and Human Services, p. 9, *https://www.hhs.gov/sites/default/files/compliance-report-to-congress-2024.pdf.*

[343] 45 CFR 164.506(b) and (c)(2). HIPAA excepts, from its general preemption authority, contrary provisions of state law that impose requirements, standards, or implementation specifications that are more stringent than those of the Privacy Rule. *See* Health Insurance Portability and Accountability Act of 1996, sec. 264(c)(2) of Public Law 104–191, 110 Stat. 2033 (codified at 42 U.S.C. 1320d–2 note); 45 CFR 160.203(b). If a provision of state law provides greater privacy protection than a provision of the Privacy Rule, and it is possible for regulated entities to comply with both the state law and the Privacy Rule (*e.g.,* where a state law requires that a covered entity obtain an individual's consent before disclosing PHI for treatment purposes), there is no conflict between the laws, and no preemption. *See also* ''My state law provides greater privacy protections on patients' HIV information than the HIPAA Privacy Rule. Is this more protective state law preempted by the Privacy Rule?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #405 (Mar. 23, 2007), *https://www.hhs.gov/hipaa/for-professionals/faq/405/is-this-more-protective-state-law-preempted-by-the-privacy-rule/index.html.*

[344] *See* ''Information Blocking Claims: By the Numbers,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (July 2026), *https://www.healthit.gov/data/quickstats/information-blocking-claims-numbers;* 45 CFR 170.103 (definition of ''Actor''). For more information on the information blocking regulations, *see generally* 45 CFR 170.100 *et seq.* Most health care providers, HIE/HINs, and developers of certified health IT are either covered entities or business associates because they either: (1) perform a covered function for, or on behalf of, a covered entity (*e.g.,* an HIE/HIN transmits PHI on behalf of a health care provider); or (2) they provide a service that involves the disclosure of PHI from a covered entity or another business associate (*e.g.,* a developer of a certified EHR maintains the EHR software and may require access to the PHI to provide such maintenance services). *See* 45 CFR 160.103 (definitions of ''Covered entity'' and ''Business associate'').

[345] *See* ''Information Blocking Claims: By the Numbers,'' *supra* note 344.

[346] *Id.*

[347] *Id.*

[348] *Id.*

[349] *See* ''Health App Use Scenarios & HIPAA,'' Office for Civil Rights, U.S. Department of Health and Human Services (Feb. 2016), *https://www.hhs.gov/sites/default/files/ocr-health-app-developer-scenarios-2-2016.pdf.*

[350] The Cures Act specifically affords HHS OIG with the ability to refer instances of information blocking to OCR for resolution if OIG determines that a consultation regarding the Privacy Rule will resolve an information blocking claim. *See* sec. 4004 of the Cures Act, Public Law 114–255, 130 Stat. 1033, 1177 (Dec. 13, 2016), which amends subtitle C of title XXX of the PHSA (42 U.S.C. 300jj–51 *et seq.*) (codified at 42 U.S.C. 300jj–52(b)(3)).

[351] *See* ''When would a delay in fulfilling a request for access, exchange, or use of EHI be considered an interference under the information blocking regulation?,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Mar. 2021), *https://healthit.gov/faq/when-would-delay-fulfilling-request-access-exchange-or-use-ehi-be-considered-interference-under/.*

[352] *See* 45 CFR 164.524(b)(2).

[353] Although the information blocking regulations and the Privacy Rule impose similar obligations on covered health care providers, the obligations are not identical. Thus, a covered health care provider's delay in responding to a right of access request is not always a violation of both the information blocking regulations and the Privacy Rule. *Compare* 45 CFR part 171 *et seq. with* 45 CFR 164.524.

[354] *See* Letter to Colleagues from OCR Director Paula M. Stannard (Dec. 3, 2025) (reminding health care providers (and other covered entities) about HIPAA provisions that require them to provide parents access to their children's PHI, consistent with applicable law), *https://www.hhs.gov/sites/default/files/ocr-letter-hipaa-privacy-rule-and-parental-access-to-minor-childrens-medical-records.pdf;* 45 CFR 164.502(g)(3); Press Release, ''OCR Settles Nineteenth Investigation in HIPAA Right of Access Initiative,'' Office for Civil Rights, U.S. Department of Health and Human Services (June 2, 2021), *https://us.pagefreezer.com/en-US/wa/browse/0a7f82bb-be6e-448a-ae11-373d22c37842?find-by-timestamp=2022-12-24T06:33:59Z&url=https:%2F%2Fwww.hhs.gov%2Fabout%2Fnews%2F2021%2F06%2F02%2Focr-settles-nineteenth-investigation-hipaa-right-access-initiative.html&timestamp=2022-12-24T03:43:08Z;* Press Release, ''OCR Resolves Twentieth Investigation in HIPAA Right of Access Initiative with $80,000 Settlement,'' Office for Civil Rights, U.S. Department of Health and Human Services (Sept. 10, 2021), *https://us.pagefreezer.com/en-US/wa/browse/0a7f82bb-be6e-448a-ae11-373d22c37842?find-by-timestamp=2022-12-27T06:17:59Z&url=https:%2F%2Fwww.hhs.gov%2Fabout%2Fnews%2F2021%2F09%2F10%2Focr-resolves-twentieth-investigation-in-hipaa-right-of-access-initiative-with-settlement.html&timestamp=2022-12-27T03:43:10Z;* ''Eleven Enforcement Actions Uphold Patients' Rights Under HIPAA,'' *supra* note 341; Resolution Agreement and Corrective Action Plan, ''Optum Medical Care,'' Office for Civil Rights, U.S. Department of Health and Human Services (Nov. 15, 2023), *https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/optum-medical-care.html;* Notice of final determination, ''Hackensack Meridian Health, West Caldwell Care Center,'' Office for Civil Rights, U.S. Department of Health and Human Services (Jan. 12, 2024), *https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/hackensack-meridian-health-west-caldwell-care-center/index.html#nfd;* Press Release, ''HHS Office for Civil Rights Imposes a $70,000 Civil Monetary Penalty Against Gums Dental Care for Failure to Provide Timely Access to Patient Records,'' Office for Civil Rights, U.S. Department of Health and Human Services (Oct. 17, 2024), *https://www.hhs.gov/about/news/2024/10/17/hhs-office-civil-rights-imposes-70000-civil-monetary-penalty-against-gums-dental-care-failure-provide-timely-access-patient-records.html.*

partners was a fear of violating HIPAA or other data privacy laws, even where the disclosure of PHI would be between departments within the same agency.[355] More recently, a study published in 2025 examined key barriers and facilitators influencing compliance with certain substance abuse performance metrics.[356] The study found that ''[w]hile regulations like [. . .] [the Privacy Rule] offer privacy protections, inconsistencies in [its] interpretation contribute to uncertainty and reluctance to share data.'' [357] And as another example, despite evidence that individuals and family members are interested in shared access to the individual's PHI,[358] a 2022 study found that few individuals and family members have taken advantage of it. While the study did not examine the reasons for the wasted potential, the authors speculate that providers may hesitate to encourage shared access because of concerns that they might be in violation of the Privacy Rule.[359] This reluctance to share information for care coordination and with individuals, their family members, their personal representatives, and their caregivers is inefficient and decreases the effectiveness of the quality of the care that individuals receive. Thus, it is imperative that the Department clarify the relationship between the Privacy Rule and the laws enacted after its publication that similarly encourage the electronic exchange of health information for care coordination and support individual access.

3. Regulations That Unnecessarily Impose Real or Perceived Burdens Are Barriers to an Efficient and Effective Health Care System

Unnecessary or outdated regulations can impose significant costs on regulated entities, decreasing the resources available for high-quality health care.[360] Thus, it is incumbent upon the administering agency to periodically consider whether such regulations continue to serve their original purpose or whether they impose a significant cost without sufficient benefits to offset those costs.[361] An important component of Making America Healthy Again is preventing and treating chronic diseases. Accordingly, the Department must take steps to eliminate regulations or regulatory requirements that draw resources away from this goal. For example, based on overwhelming feedback from the public, the Department believes that, at this point, unnecessary administrative burdens are imposed on both individuals and workforce members without meaningful corresponding benefits by the requirement that, with limited exceptions, covered health care providers with a direct treatment relationship to an individual make a good faith effort to obtain a written acknowledgment from the individual that they have received a copy of the covered health care provider's NPP. As such, the Department believes that it is necessary to remove the requirement.

As another example, stakeholders have shared with the Department anecdotal accounts of a regulated entity refusing to allow a workforce member to use a TRS [362] communications assistant [363] to share PHI with other workforce members or outside persons as needed to perform their duties. While a longstanding frequently asked question (FAQ) addresses the use of TRS by a covered entity to communicate with individuals who are deaf, hard of hearing, or deaf-blind, or who have a speech disability and explicitly provides that a business associate agreement is not required in such circumstances, the FAQ does not address its use by workforce members (who are similarly situated) of a regulated entity to share PHI with other workforce members or outside parties as needed to perform their duties.[364] As discussed below, because of the unique legal status of TRS providers, requiring that regulated entities enter into business associate agreements with TRS providers so that workforce members can use them to share PHI with other workforce members or outside persons would increase the burden on regulated entities without sufficient benefits to offset the costs. Accordingly, the Department believes that it is necessary to modify the Privacy Rule to expressly exclude TRS providers from the definition of business associate.

And as another example, while the Privacy Rule generally permits covered entities to use and disclose PHI of Armed Services personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, subject to certain conditions,[365] it does not permit such uses and disclosures for other similarly situated personnel of nonmilitary Uniformed Services. Members of the USPHS Commissioned Corps and the NOAA Commissioned Corps are required to meet similar medical requirements and standards for mission readiness, but the absence of a Privacy Rule permission that applies to them means that it is more challenging and burdensome for the Departments of Health and Human Services (USPHS Commissioned Corps) and Commerce (NOAA Commissioned Corps) to use and disclose PHI to ensure the medical readiness and the ability of their respective Commissioned Corps to fulfill their respective missions. Modifying the Privacy Rule to reflect the similar roles and responsibilities of the USPHS and NOAA Commissioned Corps and the Armed Services will remove unnecessary burdens on USPHS and NOAA Commissioned Corps, reduce costs to the U.S. taxpayer, and facilitate the medical readiness of the Uniformed Services.

D. The Department Has Performed the Statutorily Required Consultations

In accordance with 42 U.S.C. 1320d–1(c)(2)(B),[366] the Department has determined that the requirement that the Secretary adopt standards [367] that

[355] *See* ''Final Evaluation of California's Whole Person Care (WPC) Program,'' *supra* note 202, at p. 91.

[356] Mengyi Wei, et al., ''Advancing Health Equity Through Substance Use Medical Record Data Sharing: Insights from Health Care Providers,'' International Journal of Environmental Research and Public Health (Mar. 21, 2025), *https://doi.org/10.3390/ijerph22040462.*

[357] *Id.*

[358] *See, e.g.,* Jennifer L. Wolff, et al., ''Sharing in Care: Engaging Care Partners in the Care and Communication of Breast Cancer Patients,'' Breast Cancer Research and Treatment (Aug. 2019), *https://europepmc.org/article/MED/31165374.*

[359] ''Shared Access to Patient Portals for Older Adults: Implications for Privacy and Digital Health Equity,'' *supra* note 331.

[360] *See* sec. 1 of E.O. 14192, 90 FR 9065 (Feb. 6, 2025); *see also* sec. 2(v) of E.O. 14219, 90 FR 10583 (Feb. 25, 2025).

[361] *See* sec. 2(v) of E.O. 14219, 90 FR 10583 (Feb. 25, 2025).

[362] TRS is a service that enables people who are deaf, hard of hearing, or deaf-blind, or who have a speech disability to communicate by either transliterating text or interpreting American Sign Language (ASL) to voice and vice versa. *See* ''Consumer Guide, Telecommunications Relay Service,'' Federal Communications Commission (Aug. 16, 2022), *https://www.fcc.gov/consumers/guides/telecommunications-relay-service-trs.*

[363] A TRS communications assistant facilitates telephone calls between individuals who are deaf, hard of hearing, or deaf-blind, or who have a speech disability, and others. *See* 47 CFR 64.601(a)(12) (definition of ''Communications assistant'').

[364] *See* ''When a covered entity, such as a doctor, uses a certified Telecommunications Relay Service to contact patients with hearing or speech impairments, is the Relay Service a business associate of the doctor?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #500 (Apr. 6, 2004), *https://www.hhs.gov/hipaa/for-professionals/faq/500/is-a-relay-service-a-business-associate-of-a-doctor/index.html.*

[365] *See* 45 CFR 164.512(k).

[366] *See* sec. 262 of HIPAA, Public Law 104–191, 110 Stat. 2024 (Aug. 21, 1996) (codified at 42 U.S.C. 1320d–1(c)(2)(B)(i)).

[367] *See* sec. 262 of HIPAA, Public Law 104–191, 110 Stat. 2024 (Aug. 21, 1996) (codified at 42 U.S.C.

have been developed, adopted, or modified by a standard setting organization [368] does not apply with respect to standards for the privacy of IIHI because no standard setting organization has developed, adopted, or modified such standards.

In accordance with 42 U.S.C. 1320d–1(c)(3) and (g), and 42 U.S.C. 1320d–2 note, the Department has consulted with the National Uniform Billing Committee, the National Uniform Claim Committee, the Workgroup for Electronic Data Interchange, the American Dental Association, NCVHS, the Attorney General, appropriate Federal and state agencies and private entities before adopting or modifying the standards relating to the privacy of IIHI.[369] Also, as required by 42 U.S.C. 1320d–1(f), the Department has relied on the recommendations of NCVHS in its development of this final rule.[370]

IV. Summary of Final Rule Provisions and Public Comments and Responses

The Department provides this section-by-section description of the final rule.

A. Individual Right of Access

General Policy Considerations

As discussed in the 2021 Privacy Rule NPRM and above, the ability of individuals to access and direct disclosures of their own health information, including PHI, is key to care coordination. Section 164.524 of the Privacy Rule generally requires most covered entities [371] to provide individuals, upon request, with access to their PHI in a designated record set [372] maintained by or for the covered entity. Business associates are not directly liable for most provisions of the right of access, including the right of access to direct.[373] However, they are contractually liable for all other Privacy Rule obligations that are included in their business associate agreements.[374] While many covered entities may delegate the responsibility for responding to access requests on their behalf to a business associate, the covered entity remains responsible for ensuring that its obligations under the right of access, including the right of access to direct, are met.[375]

The right of access includes the right to inspect or obtain a copy, or both, of the PHI, and to access the PHI in the form and format requested if readily producible, as well as the right of an individual to direct a covered entity to transmit an electronic copy of PHI in an electronic health record to a person designated by the individual.[376] Individuals have a right to access this PHI for as long as it is maintained by a covered entity, or by a business associate on behalf of a covered entity, regardless of the date the information was created; whether the information is maintained on paper or in an electronic information system [377] onsite, remotely, or archived, subject to certain limitations discussed below; or where the PHI originated (*e.g.,* from the covered entity, another health care provider, the individual). The individual right to inspect PHI in a designated record set, either in addition to obtaining copies or in lieu thereof, requires a covered entity to arrange with the individual a convenient time and place to inspect the PHI. Importantly, the right of access, including the right of access to direct, extends to an individual's personal representative (*i.e.,* someone authorized under state or other applicable law to act on behalf of the individual in making decisions related to health care), with limited exceptions.[378] The right of access excludes psychotherapy notes [379] and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.[380] However, the right of access does include the underlying PHI from the individual's designated record set (*i.e.,* medical, payment, or other records that are used to generate the types of records that are not subject to the individual's right of access).[381] The right of access does not require a covered entity to create new information, such as explanatory materials or analyses, that does not exist already in the designated record set.[382]

Under certain limited circumstances, a covered entity may deny an individual's request for access to all or a portion of the PHI requested.[383] In some of these circumstances, an individual has a right to have the denial of an access request reviewed by a licensed health care professional designated by the covered entity who

1320d(7)); 45 CFR 160.103 (definition of ''Standard'').

[368] *See* sec. 262 of HIPAA, Public Law 104–191, 110 Stat. 2024 (Aug. 21, 1996) (codified at 42 U.S.C. 1320d(8)); 45 CFR 160.103 (definition of ''Standard setting organization'').

[369] *See* sec. 262 of HIPAA, Public Law 104–191, 110 Stat. 2024 (Aug. 21, 1996) (codified at 42 U.S.C. 1320d–1(c)(2)(B)(i)); sec. 264(d) of HIPAA, Public Law 104–191, 110 Stat. 2034 (Aug. 21, 1996) (codified at 42 U.S.C. 1320d–2 note).

[370] *See* sec. 262 of HIPAA, Public Law 104–191, 110 Stat. 2024 (Aug. 21, 1996). NCVHS was convened virtually on Apr. 16, 2026, and among other things, unanimously recommended that the Secretary adopt the 2021 Privacy Rule NPRM ''consistent with documenting the proposed disclosure expansions to comply with HIPAA's minimum necessary [standard], [. . .] HITECH [. . .] Act of 2009 access rights, and other specific federal safeguards.'' *See* ''Meeting Minutes,'' National Committee on Vital and Health Statistics, U.S. Department of Health and Human Services (Apr. 16, 2026), *https://www.cdc.gov/faca/media/pdfs/2026/07/NCVHS-Public-Committee-Meeting-Summary-04.16.26.pdf.*

[371] The term ''covered entity'' includes health plans, health care clearinghouses, and most health care providers. *See* 45 CFR 160.103 (definition of ''Covered entity''). Health care clearinghouses are not subject to the same individual access requirements as health plans and covered health care providers. *See* 45 CFR 164.500(b)(1).

[372] *See* 45 CFR 164.501 (definition of ''Designated record set''). A designated record set may include records from multiple disparate systems and include records across an individual's lifespan, to the extent that they are maintained by or for the covered entity, which may be linked by a master patient index.

[373] *See* section 13404 of the HITECH Act, Public Law 111–5, 123 Stat. 264 (Feb. 17, 2009) (codified at 42 U.S.C. 17934); 45 CFR 164.502(a)(4)(ii); *see also* 78 FR 5566, 5598–99 (Jan. 25, 2013); ''Direct Liability of Business Associates,'' *supra* note 113.

[374] 78 FR 5566, 5591–92 (Jan. 25, 2013). We do not refer explicitly to business associates when discussing all provisions of the Privacy Rule that address uses and disclosures by covered entities. Such references are unnecessary because a business associate generally may only use or disclose PHI in the same manner as a covered entity. Therefore, any Privacy Rule limitation on how a covered entity may use or disclose PHI automatically extends to a business associate. *See id.* at 5597.

[375] However, under the Privacy Rule, a business associate is required to disclose PHI to the covered entity or, when specified in the business associate agreement, to the individual or individual's designee, as necessary to satisfy a covered entity's obligations under the right of access, including the right of access to direct, with respect to an individual's request for ePHI. Accordingly, a business associate is directly liable under the Privacy Rule if it fails to provide the covered entity, the individual, or the individual's designee (as dictated by the business associate agreement) with access to a copy of the ePHI required to satisfy individual's access request (or with respect to the right of access to direct, an electronic copy of the PHI in an electronic health record). *See* 45 CFR 164.502(a)(4)(ii); 78 FR 5566, 5598–99 (Jan. 25, 2013).

[376] In accordance with the court order in *Ciox,* the Department has not been enforcing a right of access to direct, to a person designated by the individual, non-electronic copies of PHI or copies of PHI that are not in an electronic health record. These types of disclosures continue to be permitted with a valid authorization or under another applicable Privacy Rule permission.

[377] *See* 45 CFR 164.304 (definition of ''Information system'').

[378] *See* 45 CFR 164.502(g) and 164.524(a)(3)(iii). Thus, where we use the term ''individual'' when discussing the right of access throughout this document, the term includes personal representatives.

[379] *See* 45 CFR 164.524(a)(1)(i); *see also* 45 CFR 164.501 (definition of ''Psychotherapy notes'').

[380] *See* 45 CFR 164.524(a)(1)(ii).

[381] *See* 65 FR 82462, 82554 (Dec. 28, 2000); *see also* 45 CFR 164.501 (definition of ''Designated record set''); ''Does an individual have a right under HIPAA to access more than just test results from a clinical laboratory?,'' U.S. Department of Health and Human Services, Office for Civil Rights (June 24, 2016), *https://www.hhs.gov/hipaa/for-professionals/faq/2049/does-an-individual-have-a-right-under/index.html.*

[382] *See* 79 FR 7290, 7303 (Feb. 6, 2014).

[383] *See* 45 CFR 164.524(a)(2) and (3).

did not participate in the original decision to deny the request.[384]

Despite extensive guidance and outreach on the right of access, the Department continues to hear that individuals often encounter barriers to exercising that right. These barriers frequently cause delays in, or denials of, individual access.[385] In addition to adding to the burden on individuals and the health care system, such delays or denials may inhibit care coordination, require duplication of tests and procedures, and contribute to worse health outcomes for individuals.[386]

After careful consideration of responses to the 2018 RFI and the Department's analysis of the Privacy Rule, we proposed to amend the Privacy Rule to strengthen the individual right of access and to remove barriers that may limit or discourage coordinated care or case management among covered entities and individuals, or that otherwise may impose regulatory burdens. Additionally, consistent with the court's decision in *Ciox,*[387] the Department proposed to modify aspects of the individual's right of access to direct.

Summary of Proposals To Modify the Individual Right of Access

The Department proposed to amend the individual right of access by incorporating definitions into the Privacy Rule that support the implementation of certain provisions of the HITECH Act by ensuring clarity. The proposed definitions for electronic health record and personal health application in 45 CFR 164.501 would build on language from the HITECH Act definitions of electronic health record [388] and personal health record.[389] We also proposed to strengthen the individual right of access by strengthening the right to inspect and obtain copies of PHI and by shortening the time limits for covered entities to respond to access requests. Additionally, the Department addressed requirements regarding the form and format in which covered entities must respond to individuals' requests for access by proposing to clarify that a ''readily producible'' copy of PHI would include a copy of ePHI requested through a secure, standards-based API using an app chosen by the individual, as well as a copy in any form and format required by applicable state and other laws. The Department also proposed that the individual right of access to direct a copy of PHI to a person designated by the individual be limited to a right to direct an electronic copy of PHI in an electronic health record to a person designated by the individual. To clearly distinguish between the scope and requirements of the individual right to inspect and obtain copies of PHI and the right of access to direct, the Department proposed to list these distinct rights of access in separate paragraphs in the regulatory text:

- The individual right to inspect and obtain copies of PHI within the current rule requires covered entities to provide the requested information (with some exceptions) within a specific time limit and allows covered entities to charge a limited fee for copies of such information. The 2021 Privacy Rule NPRM proposed to strengthen the individual right to inspect a copy of PHI at proposed 45 CFR 164.524(a)(1)(ii), while retaining the implementation specifications for the individual rights to inspect and obtain copies of PHI at 45 CFR 164.524(c).
- The right of an individual to direct the transmission of electronic copies of PHI in an electronic health record to a person designated by the individual is established by the HITECH Act and interpreted by the *Ciox* decision to apply only to PHI in an electronic health record. The Department proposed to codify the right of access to direct, with the *Ciox* limits, into regulatory text at 45 CFR 164.524(d).
- As part of the right of access to direct, the Department also proposed to create a pathway for individuals to direct the sharing of an electronic copy of PHI in an electronic health record among covered health care providers and health plans. The NPRM proposed to require a covered health care provider or health plan (''Requestor-Recipient''), at the individual's direction, to submit the individual's access request regarding their own ePHI to another covered health care provider (''Discloser''), requesting that the Discloser transmit the ePHI maintained by or on behalf of the Discloser in its electronic health record to the Requestor-Recipient.

Finally, with respect to fees charged by covered entities to individuals exercising the right of access, the Department proposed to adjust and clarify the fees that covered entities may charge for copies of PHI and require covered entities to provide advance notice of approximate fees for copies of PHI requested under the right of access or with an individual's valid authorization. The Department also proposed technical clarifications to the Privacy Rule provision requiring business associates to disclose PHI as needed for the covered entity to fulfill its obligations under the right of access.

1. Adding Definition of ''Electronic Health Record''

a. Issues To Address

Section 13405(e)(1) of the HITECH Act added a new right within the individual right of access that requires covered entities to transmit an electronic copy of PHI in an electronic health record to a person designated by an individual when directed to do so by the individual [390] and codified a definition of electronic health record that specifically applies to that Act's privacy and security provisions for regulated entities.[391] The HITECH Act defines ''electronic health record'' as ''an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.'' [392] However, the Privacy Rule currently does not define the term ''electronic health record.''

b. Proposed Rule

Accordingly, to effectively implement this right, discussed in greater detail below, the Department proposed to add a definition of electronic health record

[384] *See* 45 CFR 164.524(a)(3).

[385] *See* 86 FR 6446, 6459 (Jan. 21, 2021); *see also* Press Release, ''Four HIPAA Enforcement Actions Hold Healthcare Providers Accountable With Compliance,'' Office for Civil Rights, U.S. Department of Health and Human Services (Mar. 28, 2022), *https://www.hhs.gov/about/news/2022/03/28/four-hipaa-enforcement-actions-hold-healthcare-providers-accountable-with-compliance.html;* Press Release, ''HHS' Office for Civil Rights Settles HIPAA Right of Access Investigation with Concentra, Inc.,'' Office for Civil Rights, U.S. Department of Health and Human Services (Dec. 16, 2025), *https://www.hhs.gov/press-room/ocr-settles-with-concentra.html;* Press Release, ''HHS' Office for Civil Rights Settles HIPAA Right of Access Investigation with Azul Vision, Inc.,'' Office for Civil Rights, U.S. Department of Health and Human Services (Aug. 27, 2026), *https://www.hhs.gov/press-room/hhs-ocr-settles-hipaa-investigation-with-azul-vision.html.*

[386] *See, e.g.,* The Joint Commission, ''Safe Informed Care,'' *https://digitalassets.jointcommission.org/api/public/content/91d0580a0ff243099480e9bb48718cae?v=c0f3b5c2* (discussing National Performance Goal #7, providing safe and informed care to all patients, including the importance of ensuring patients receive information about their care to improve health outcomes); Dalia Alomar, et. al., ''The Impact of Patient Access to Electronic Health Records on Health Care Engagement: Systematic Review,'' Journal of Medical internet Research (Nov. 20, 2024), *https://pmc.ncbi.nlm.nih.gov/articles/PMC11618012/.*

[387] *Ciox,* 435 F. Supp. 3d at 38.

[388] 42 U.S.C. 17921(5) (definition of ''Electronic health record'').

[389] *Id.* at 17921(11) (definition of ''Personal health record'').

[390] *See* sec. 13405(e) of the HITECH Act, 123 Stat. 264 (Feb. 17, 2009) (codified at 42 U.S.C. 17935(e)).

[391] *See* sec. 13400(5) of the HITECH Act, 123 Stat. 259 (Feb. 17, 2009) (codified at 42 U.S.C. 17921(5)).

[392] *Id.*

in 45 CFR 164.501 that would be consistent with the HITECH Act definition. We also proposed, as part of the definition, to clarify some of the terms used within the definition that are not defined in the statute or the Privacy Rule.

For example, as we discussed in the 2021 Privacy Rule NPRM, the Privacy Rule does not define the term ''clinician,'' and the Department has not identified a uniform statutory or regulatory definition of the term. To minimize uncertainty about the scope of the term for purposes of the Privacy Rule, we explained that we intended to interpret ''authorized health care clinicians and staff'' to at least include covered health care providers who are able to access, modify, transmit, or otherwise use or disclose PHI in an electronic health record, and who have direct treatment relationships with individuals; and members of their workforce [393] who support the provision of such treatment by virtue of their qualifications or job role. Thus, under this interpretation, an electronic health record would include electronic records consulted by any covered health care provider, or a workforce member of such a covered health care provider, so long as the provider has a direct treatment relationship with individuals. The Department did not propose specifically to include covered health care providers who have indirect treatment relationships [394] with individuals.

With respect to the types of information in an electronic health record, the Department proposed to equate ''health-related information on an individual'' with the scope of the familiar, defined term, ''individually identifiable health information.'' [395] We also proposed to interpret the term ''health-related information'' as equating to the Privacy Rule's definition of ''health information.'' [396] Further, the Department proposed to interpret ''on an individual,'' to refer to information that is ''individually identifiable.''

c. Overview of Comments

Several commenters expressed support for the Department's proposed definition of an electronic health record. Many commenters urged us to adopt a common definition of electronic health record for the various components of the Department. Some commenters expressed concerns about the proposal to limit the definition of electronic health record to apply only where a health care provider has a direct treatment relationship with individuals because they asserted that health care providers who have an indirect treatment relationship with individuals also maintain electronic health records that contain PHI to which individuals should have access. Some commenters expressed opposition to the Department's proposal to equate ''health-related information'' to the Privacy Rule's definition of ''health information'' because it would include both clinical and non-clinical data.

d. Final Rule

The final rule adopts the new term ''electronic health record'' and its definition with two modifications. Consistent with the statutory definition, we are not including the word ''their'' in the definition. Thus, the definition will refer to ''authorized health care clinicians and staff.'' Additionally, we are modifying our interpretation of ''authorized health care clinicians'' specifically to include health care providers that have indirect treatment relationships with individuals. As we explained in the 2021 Privacy Rule NPRM, health care providers who have indirect treatment relationships generally deliver health care based on the orders of another health care provider.[397]

In the 2021 Privacy Rule NPRM, we also explained that we believed that the direct treatment provider would be the entity documenting information about services, products, or reports provided by an indirect treatment provider, and thus it would be appropriate to limit our interpretation of clinicians to direct treatment providers. However, we are persuaded by commenters that a health care provider who has an indirect treatment relationship with an individual may not provide all of their services, products, or reports to the health care provider who has the direct treatment relationship with the individual. For example, providers who furnish durable medical equipment (DME) generally do not provide all of the data recorded by the DME to the ordering health care provider. The same is true of providers of medical devices. And while clinical laboratories may send laboratory reports to the ordering clinician, the reports may not include every single lab value in their documentation. Thus, PHI in the electronic health record of the provider who has the direct treatment relationship may not include all of the PHI created by an indirect treatment provider. If our interpretation of clinicians is limited to only those providers with direct treatment relationships with individuals, the PHI to which an individual would be entitled to direct to a person they designate is thereby limited. Additionally, according to several commenters, distinguishing between health care providers with direct treatment relationships with individuals and those with indirect treatment relationships would create uncertainty about the scope of PHI included in the right of access to direct because direct and indirect treatment providers may create, receive, maintain, and transmit PHI in the same electronic health record. By including both health care providers with direct treatment relationships with individuals and those with indirect treatment relationships, we eliminate this uncertainty and maximize the amount of PHI included within the right of access to direct. Accordingly, the Department is modifying our interpretation of ''clinicians'' to include both health care providers that have a direct treatment relationship with individuals and health care providers that have an indirect treatment relationship with individuals.[398]

The HITECH Act does not define an electronic health record to mean a specific electronic information system, application, or software; rather, it defines it as an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.[399] Thus, whether information is part of an electronic health record is not dependent on the particular system, application, or place in which the information is maintained, but rather on whether it is health-related information about an individual and on who creates, gathers, manages, and consults it. For example, an electronic record maintained by a business associate for, or on behalf of, a covered entity may be part of the covered entity's electronic health record if the record otherwise meets the definition.

Accordingly, the scope of information included in an individual's electronic health record may vary across different health care providers because covered health care providers have substantial

[393] *See* 45 CFR 160.103 (definition of ''Workforce'').

[394] *See* 45 CFR 164.501 (definition of ''Indirect treatment relationship'').

[395] *See* 45 CFR 160.103 (definition of ''Individually identifiable health information'').

[396] *See* 45 CFR 160.103 (definition of ''Health information'').

[397] *See* 45 CFR 164.501 (definition of ''Indirect treatment relationship'').

[398] *Id.*

[399] *See* sec. 13400(5) of the HITECH Act, 123 Stat. 259 (Feb. 17, 2009) (codified at 42 U.S.C. 17921(5)).

flexibility in determining the appropriate composition of that electronic health record for their particular circumstances. Additionally, because the definition includes the term ''record,'' [400] which covered entities already understand from the definition of designated record set, this new definition is clear and workable. Accordingly, this definition is intended to provide a clear standard that health care providers can use to identify what PHI is subject to requirements of the HITECH Act that address PHI in an electronic health record. We believe that this new definition will improve understanding of whether certain aspects of a covered entity's electronic records are included in an electronic health record, which will enable a covered entity to assess whether such ePHI is subject to the right of access to direct.

For example, an electronic health record includes the work product of health care providers that have indirect treatment relationships with individuals, such as electronic lab test reports created by workforce members of a large health system who are licensed clinical laboratory personnel, and who perform clinical lab tests for patients treated by the health system. An electronic health record also includes electronic images taken by an imaging technician who is a workforce member of a radiology group practice and electronic reports of a pathologist who is employed by a small hospital where the reports contain the pathologist's analysis of tissue samples taken from an individual. Electronic billing records created, gathered, managed, and consulted by workforce members of a covered health care provider that has a direct treatment relationship with an individual (*e.g.,* a hospital) are included in the term electronic health record because health care billing information is health-related information.[401] Consistent with the modification we are making to the proposed definition, electronic billing records created, gathered, managed, and consulted by workforce members of a covered health care provider that has an indirect treatment relationship with an individual (*e.g.,* an independent clinical laboratory or single specialty radiology practice) also are included in an electronic health record.

e. Response to Public Comments

Comment: Several commenters expressed support for the Department's proposed definition of an electronic health record. One commenter expressed support for the proposal because they believed that the proposed definition would include all ePHI. Another commenter expressed support because they believed that it would expand upon and align with the way the term is used by health care providers. One commenter recommended that the Department define electronic health record as broadly as possible.

Many commenters expressed opposition to the proposal because they believed that it would be overly inclusive. Several commenters asserted that the proposed definition would not align with the common industry definition of an EHR; instead, according to some commenters, the proposed definition would better align with the definition of ''health information technology.'' Many commenters recommended that the Department limit the definition to one that would be consistent with the HITECH Act. Many also expressed concern that the proposed definition would include non-clinical information, such as billing records, that often is maintained separately from clinical information. According to commenters, combining information that is maintained in separate electronic information systems would be burdensome. One commenter asserted that billing records should be considered as part of an electronic health record only to the extent that such records are included in a designated record set. Another commenter stated that state law may prevent covered entities from disclosing personally identifiable information in billing records. Several commenters requested that the Department exclude certain types of information from the definition or clarify whether certain types of information would be included in the definition.

Response: The Department is finalizing its proposed definition of electronic health record with minimal modifications, as described above. The definition that we are adopting for the Privacy Rule is consistent with the HITECH Act, which provides a definition of electronic health record that applies specifically to the provisions that address the privacy and security of PHI. As explained above, that HITECH Act definition is ''an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.'' Where the HITECH Act did not specifically define terms used in the definition, we rely upon existing definitions of similar terms. For example, while the HITECH Act does not define ''health-related information on an individual,'' section 13101 of the HITECH Act defines ''health information'' by reference to section 1171(4) of the SSA,[402] in a manner that is consistent with the definition of the term contained in the Privacy Rule. Thus, we believe that it is reasonable to interpret the term ''health-related information'' to be at least as broad as ''health information.'' [403] As we explained in the 2021 Privacy Rule NPRM, ''health information'' includes not only clinical, but also billing and other data. Accordingly, the broader term ''health-related information'' could be expected to include such data and not be limited to clinical data.

We understand that other components of the Department may have adopted a variety of definitions of electronic health record or similar terms, such as ''certified EHR technology'' [404] or ''qualified electronic health record.'' [405] These terms also are defined in the HITECH Act. However, these definitions occur in Subtitle A of the HITECH Act, ''Promotion of Health Information Technology,'' and are codified in a new title (''Health Information Technology and Quality'') in the PHSA at 42 U.S.C. 300jj, while the definition of ''electronic health record'' is codified in 42 U.S.C. 17921 and occurs in Subtitle D of the HITECH Act, ''Privacy,'' the same subchapter that establishes the right of access to direct.[406]

Because Congress adopted a different term and definition for purposes of the HITECH Act's privacy and security provisions, the rule of statutory

[400] *See* 45 CFR 164.501 (definition of ''Designated record set'').

[401] *See* Kelly Devers, et al., ''The Feasibility of Using Electronic Health Data for Research on Small Populations,'' Urban Institute (prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services) (Sept. 2013), *https://aspe.hhs.gov/report/feasibility-using-electronic-health-data-research-small-populations.*

[402] *See* sec. 13101 of the HITECH Act, Public Law 111–5, 123 Stat. 228 (Feb. 17, 2009) (adding sec. 3000(4) to the PHSA, codified at 42 U.S.C. 300jj(4) (definition of ''Health information'' by reference to sec. 1171(4) of the SSA, codified at 42 U.S.C. 1320d(4)). Section 1171 was added to the Social Security Act by HIPAA.

[403] *See* 45 CFR 160.103 (definition of ''Health information'').

[404] Sec. 13101 of the HITECH Act, Public Law 111–5, 123 Stat. 228 (Feb. 17, 2009) (amending 42 U.S.C. 300jj) (definition of ''Certified EHR technology'').

[405] Sec. 13101 of the HITECH Act, Public Law 111–5, 123 Stat. 229 (Feb. 17, 2009) (amending 42 U.S.C. 300jj) (definition of ''Qualified electronic health record'').

[406] Sec. 13400(5) of the HITECH Act, Public Law 111–5, 123 Stat. 259 (Feb. 17, 2009) (codified at 42 U.S.C. 17921(5)) (definition of ''Electronic health record''); sec. 13405(e) of the HITECH Act, Public Law 111–5, 123 Stat. 264, 268 (Feb. 17, 2009) (codified at 42 U.S.C. 17935(e)) (''Access to certain information in electronic format'').

interpretation against surplusage (generally, a presumption that every clause and word in a statute should be given meaning and not be superfluous) guides us to interpret electronic health record as meaning something different in the context of the HIPAA Rules.[407] As discussed above, ''electronic health record'' is defined in the HITECH Act as ''an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.'' While both ''electronic health record'' and ''qualified electronic health record'' use the term ''an electronic record of health-related information on an individual,'' the latter definition is then arguably limited by additional descriptors:

> [E]lectronic record of health-related information on an individual that—(A) includes patient demographic and clinical health information, such as medical history and problem lists; and (B) has the capacity—(i) to provide clinical decision support; (ii) to support physician order entry; (iii) to capture and query information relevant to health care quality; and (iv) to exchange electronic health information with, and integrate such information from other sources.[408]

The definition of ''electronic health record,'' moreover, does not reference ''certified EHR technology'' (which is defined in part as a ''qualified electronic health record that is certified pursuant to section 3001(c)(5)'' and is, thus, also arguably limited).[409] In addition, the ''health-related information on an individual'' ''is created, gathered, managed, and consulted'' not only by ''authorized health care clinicians,'' but also by ''staff,'' which suggests that the electronic record would not be limited to clinical health information, but also would include information that nonclinical staff create, gather, manage, and consult, such as scheduling, prior authorization, referrals, billing, and other administrative information. Based on the statutory definition of ''electronic health record'' (and how it differs from the definitions of those other terms), we believe that Congress intended for electronic health record, when used in the context of the individual right of access, to refer to an electronic record of an individual's health, rather than a file about an individual in a specific system or technology, and we have interpreted it accordingly.

We clarify that, while the definition of an electronic health record may include PHI that is not part of the designated record set, as discussed below, the right of access, including the right of access to direct, does not extend to such information. Also, as discussed in detail below, it does not extend to psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.[410]

Regulated entities are required to identify and document which records are part of the designated record set.[411] For example, clinical laboratory test reports become part of the laboratory's designated record set when they are ''complete,'' which means that all results associated with an ordered test are finalized and ready for release. However, other information concerning the test may be part of the designated record set, and thus accessible to the individual even if the test report has not yet been completed, such as test orders, ordering provider information, billing information, and insurance information.[412]

The definition of electronic health record, like the definition of designated record set, is not dependent on a specific type of system or technology platform or where an organization maintains the information, with the caveat that PHI that is in an electronic health record necessarily is maintained electronically (and, thus, it is ePHI). Accordingly, an electronic health record is not limited to clinical data, but also includes billing and other non-clinical information about the individual. This interpretation is consistent with the scope of the term ''record'' within the definition of ''designated record set.'' [413]

Comment: A few commenters expressed opposition to the Department's proposal to define an electronic health record because they believed that the definition should focus on the information to be protected, rather than the technology used to create, receive, maintain, or transmit the information. One commenter asserted that the Department did not have the authority to interpret the statutory definition. One commenter recommended that the Department adopt a definition that complies with the *Ciox* decision, but that also requires a covered entity to provide—in response to a request from an individual to direct a covered entity to send an electronic copy of PHI in an electronic health record to a person designated by the individual—PHI that is similar in content and extent to the ePHI that the covered entity would be required to provide in response to an individual's request to obtain a copy of their PHI.

Response: As discussed above, the Department is adopting a definition of electronic health record to clarify the scope of the right of access to direct. The definition of electronic health record that we are codifying at 45 CFR 164.501 is consistent with the HITECH Act's definition of the term [414] and the *Ciox* decision. It includes additional language intended only to clarify the terms of the definition for consistency with terms already defined in the HIPAA Rules. The protections provided by the Privacy Rule for PHI are not dependent upon the manner or form and format in which PHI is created, received, maintained, or transmitted, and that remains unchanged by this final rule. Individuals have a right to access PHI in a designated record set, with limited exception. As discussed below, to the extent PHI is within the scope of the individual right of access (including being in the designated record set) and is in an electronic health record, as defined herein, the PHI is within scope of the right of access to direct.

Comment: More than half of the commenters urged us to adopt a common regulatory framework with one set of definitions to be used across the Department because they believed that having different definitions would be burdensome or confusing for regulated entities. One commenter urged the Department to incorporate the term ''electronic health information'' into the definition of electronic health record to

[407] The canon of statutory construction against surplusage supports giving effect to every word and clause in a statute and a reluctance to finding statutory terms to be duplicative or unnecessary. *See* ''Canons of Construction: A Brief Overview,'' Congressional Research Service (May 9, 2025), *https://www.congress.gov/crs-product/IF12992.*

[408] Sec. 13101 of the HITECH Act, Public Law 111–5, 123 Stat. 229 (Feb. 17, 2009) (adding sec. 3000(13) of the PHSA, codified at 42 U.S.C. 300jj).

[409] *Id.*

[410] *See* 45 CFR 164.524(a)(1)(i) and (ii).

[411] 45 CFR 164.524(e); *see also* 65 FR 82462, 82558 (Dec. 28, 2000).

[412] *See* 79 FR 7290, 7295 (Feb. 6, 2014). There is no requirement in the Privacy Rule that clinical laboratories interpret test results for patients. An individual has a right under the Privacy Rule merely to inspect or receive a copy (or direct the copy to a designated person), upon request, of the completed test reports (as well as other information in the designated record set) maintained by a laboratory that is a covered entity. Laboratories may continue to refer patients with questions about the test results back to their ordering or treating providers. However, while not required, a laboratory providing a test report to an individual that has requested access to the report may also provide educational or explanatory materials regarding the test results to individuals if it chooses to do so. Similarly, a laboratory that wishes to include a disclaimer, caveat, or other statement explaining the limitations of the laboratory data for diagnosis or treatment or other purposes may do so. *See* 79 FR 7290, 7303 (Feb. 6, 2014).

[413] *See* 45 CFR 164.501 (definition of ''Designated record set'').

[414] *See* sec. 13400(5) of the HITECH Act, Public Law 111–5, 123 Stat. 259 (Feb. 17, 2009) (codified at 42 U.S.C. 17921(5)) (definition of ''Electronic health record'').

clarify how the proposed definition relates to the information blocking regulations.

Response: We understand that other components of the Department may have adopted a variety of definitions of electronic health record or similar terms; however, we do not have the statutory authority to adopt such definitions here. The definition that we are adopting for the Privacy Rule is consistent with the HITECH Act, which specifically provides a definition of electronic health record that applies to the provisions that address the privacy and security of PHI. We do not believe that this definition conflicts with other laws. Rather, this definition supports the Department's goals of implementing the statutory right of individuals to direct an electronic copy of their PHI in an electronic health record to a person they designate as part of the right of access and enhancing care coordination and case management. Ensuring that individuals can access their PHI and direct such access to others is critical to monitoring various health conditions and improving patient health outcomes.[415] We decline to incorporate the term ''electronic health information'' [416] into the definition of electronic health record. The definition of EHI references definitions codified in the HIPAA Rules, such as ePHI; thus, incorporating EHI into a definition in the Privacy Rule is unnecessary and likely to increase confusion.

Comment: Commenters provided a variety of comments on the relationship between the definitions of electronic health record and designated record set. Several commenters recommended that the Department align the definition of electronic health record with the definition of ''designated record set'' to avoid confusion, to promote clarity, and to align it with the right of access. In contrast, several commenters recommended that the Department not align the definitions of electronic health record and designated record set because they believed that we lacked the statutory authority to do so and it would create confusion. A few commenters recommended that the Department provide additional guidance on the scope of the designated record set. One commenter recommended that the Department add a definition of ''electronic designated record set,'' rather than aligning the definitions of electronic health record and designated record set, asserting that this alternative approach would avoid confusion. A few commenters stated that the definition of electronic health record should be broader than the designated record set because an electronic health record could include PHI that is not part of the designated record set.

Response: The definition of electronic health record in 45 CFR 164.501 is consistent with the HITECH Act's definition that applies to its privacy and security provisions,[417] and includes additional language intended only to clarify the terms of the definition for consistency with terms defined in the HIPAA Rules. We agree with commenters that the right of access to direct should not extend to PHI about the individual that is outside of any designated record set. As discussed below, we are adopting modifications to clarify this within the right of access to direct at 45 CFR 164.524(d).

Comment: A few commenters recommended that the Department interpret the definition of electronic health record using existing terms from the HIPAA Rules to avoid confusion.

Response: We agree with the commenters that relying on existing terms, where appropriate, can help regulated entities better understand new obligations. Thus, we have relied upon existing terms to interpret the HITECH Act's definition of electronic health record to the extent possible and consistent with the statute.[418]

Comment: Some commenters requested that the Department clarify whether the proposed definition would apply only to covered health care providers or also to health plans.

Response: As explained above, an electronic health record is an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. We interpret ''authorized health care clinicians and staff'' to include health care providers who are able to access, modify, transmit, or otherwise use or disclose PHI in an electronic health record. This includes health care providers that have a direct or indirect treatment relationship with individuals,[419] as well as members of the health care provider's workforce [420] who support the provision of treatment. Thus, we intend for the definition of electronic health record to apply broadly, including to electronic records maintained by health care providers and, where applicable, health plans. Where a health plan is integrated with one or more covered health care providers, electronic records created, gathered, managed, and consulted by authorized health care clinicians and staff of those providers may constitute an electronic health record. A health plan's maintenance of claims, enrollment, utilization management, payment, or other administrative records does not, by itself, cause those records, or the electronic information system in which they are maintained, to constitute an electronic health record. Similarly, consultation of such records by a clinician or other professional employed by the health plan does not, by itself, cause the records to constitute an electronic health record.

Furthermore, the application of the definition in this final rule is limited by the scope of the right of access to direct, which is discussed elsewhere in this final rule.

Comment: One commenter requested that the Department clarify the scope of ''health-related information'' to reflect the current understanding of activities that are part of health care, such as information about activities to address the social determinants of health and interactions between individuals and unlicensed workforce members and volunteers. A few commenters recommended that ''health-related information'' include information about the price of health care. Another commenter recommended that the Department limit ''health-related information'' to clinical information that is electronically maintained in a designated record set.

Response: As discussed above, while the HITECH Act does not define ''health-related information on an individual,'' the Privacy Rule defines ''health information'' [421] in a manner that is consistent with the definition of

[415] *See* ''Privacy & Security,'' sec. 7 of the Health IT Playbook, Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Mar. 11, 2020), *https://playbook.healthit.gov/playbook/privacy-and-security/; see, e.g.,* The Promise of Patient Portals for Individuals Living with Chronic Illness: Qualitative Study Identifying Pathways of Patient Engagement,'' *supra* note 166; Elettra Carini, et al., ''The Impact of Digital Patient Portals on Health Outcomes, System Efficiency, and Patient Attitudes: Updated Systematic Literature Review,'' Journal of Medical Internet Research (Sept. 8, 2021), *https://www.jmir.org/2021/9/e26189/.*

[416] *See* 45 CFR 171.102 (definition of ''Electronic health information'').

[417] *See* sec. 13400(5) of the HITECH Act, Public Law 111–5, 123 Stat. 259 (Feb. 17, 2009) (codified at 42 U.S.C. 17921(5)) (definition of ''Electronic health record'').

[418] *See* 45 CFR 160.103 (definitions of ''Health information'' and ''Individually identifiable health information'') and 45 CFR 164.501 (definition of ''Designated record set'').

[419] *See* 45 CFR 164.501 (definitions of ''Direct treatment relationship'' and ''Indirect treatment relationship'').

[420] *See* 45 CFR 160.103 (definition of ''Workforce'').

[421] *See* sec. 262 of HIPAA, Public Law 104–191, 110 Stat. 2022 (Aug. 21, 1996) (codified at 42 U.S.C. 1320d(4)); *see also* 45 CFR 160.103 (definition of ''Health information'').

the term in section 262 of HIPAA. Thus, we believe that it is reasonable to interpret the term ''health-related information'' to be at least as broad as ''health information.'' [422] As we explained in the 2021 Privacy Rule NPRM, ''health information'' includes not only clinical, but also billing and other data. Accordingly, the broader term ''health-related information'' could be expected to include such data and not be limited to clinical data.

Comment: A few commenters expressed support for the Department's proposal to limit the interpretation of ''authorized clinicians and staff'' to those with a direct treatment relationship to individuals because they believed that it would be consistent with the HITECH Act. A few commenters urged the Department to clarify that the proposed definition would include only the records of direct treatment providers. One commenter expressed opposition to the Department's proposal because they believed that it was overly inclusive and suggested that it should be limited to health care providers responsible for providing direct services, alternative care providers, and allied health professionals.

Several commenters expressed concern that the Department proposed to limit the interpretation of ''authorized clinicians and staff'' to health care providers with a direct treatment relationship to individuals and questioned whether PHI received from providers with indirect treatment relationships would be included in the definition of electronic health record. A few commenters disputed the Department's assumption that PHI provided by indirect treatment providers always would be incorporated into the electronic health record of a direct treatment provider.

Several commenters requested that the Department provide specific examples of ''authorized clinicians.'' One commenter encouraged the Department to adopt a more plain language definition of ''clinician'' because other covered entities are facilitating care coordination at a population-level.

According to one commenter, defining the term ''clinician'' would clarify whether an electronic health record contains information outside of the designated record set.

Response: We are modifying our interpretation of authorized clinicians to include both health care providers that have a direct treatment relationship with individuals and those that have an indirect treatment relationship with individuals. The Department is persuaded by commenters who asserted that PHI that is created, received, maintained, or transmitted electronically by health care providers that have an indirect treatment relationship with individuals may not be integrated into the electronic health record of health care providers that have a direct treatment relationship with individuals. As a result, limiting the interpretation of authorized clinicians to direct treatment providers would narrow the scope of an electronic health record, and thus the right of access to direct, in a way that we did not intend.

We based our proposal on the assumption that all PHI created by an indirect treatment provider is securely and electronically shared with (and thus incorporated into the designated record set of) the referring or ordering direct treatment provider, and by extension, the individual has ready access to the PHI through the direct treatment provider's electronic health records. We understand that in some cases, PHI from an indirect covered health care provider may be incorporated into the direct treatment provider's electronic health record, without the direct treatment provider's involvement. However, we also understand from comments that, in many circumstances, indirect treatment providers create and share PHI with a direct treatment provider, who does not incorporate the PHI into their electronic health record. Additionally, we also understand that in some cases, the direct treatment provider who originally ordered clinical services, products, or reports that are produced by an indirect health care provider may not receive all PHI created by the indirect treatment provider (*e.g.,* PHI used to prepare a report), and thus that such PHI would not be in the designated record set of the direct treatment provider.

For example, radiologists generally have indirect treatment relationships with individuals because they deliver diagnostic services based on the orders of other health care providers (*e.g.,* internists, cardiologists, nephrologists, neurologists, obstetricians/gynecologists), and the results or products of those services (*e.g.,* reports, interpretations, images) typically are available to the individual through the direct treatment provider. The radiologist often sends only a report of their findings to the direct treatment provider, rather than providing them with access to the images upon which the report is based.[423] Individuals may seek to access such images for their records or to share with other health care providers or other persons. In such circumstances, the only option for individuals is to request copies of images directly from the radiologist or imaging center, the indirect treatment provider. Similarly, pathologists and clinical laboratories often are indirect treatment providers and generally are in possession of underlying PHI that may not be provided to direct treatment providers. Thus, individuals may need to obtain such PHI directly from pathologists or clinical laboratories, as well.

As another example, a direct treatment provider may be monitoring an individual's DME (*e.g.,* heart monitor), implantable medical device (*e.g.,* pacemaker), or remote monitoring technology. The provider of the DME generally has the complete set of PHI recorded by the monitors, while the direct treatment provider may be sent only summary information or alerts when monitors are malfunctioning. Individuals and direct treatment providers may require access to such PHI for a complete diagnosis and care plan.

To ensure that individuals have the right of access to direct a covered entity to transmit an electronic copy of the full scope of PHI that is consistent with the statute to a person designated by the individual, we believe that it is necessary and appropriate to specify that the definition of electronic health record applies to both health care providers that have a direct treatment relationship with individuals and those that have an indirect treatment relationship with individuals.

Comment: A few commenters urged the Department to include non-clinical workforce members of health care providers in its interpretation of ''staff.'' A few commenters expressed concern that the addition of ''and staff'' would create ambiguity and cause confusion because it would include non-clinicians.

Several commenters recommended that the Department incorporate role-based access into the proposed definition of electronic health record to clarify who is permitted to create, gather, manage, or consult it because they believed that a definition would need to consider workforce members who do not have a direct treatment relationship with individuals, but who may create, gather, manage, or consult the electronic health record for essential purposes (*e.g.,* payment, health care operations).

[422] *See* 45 CFR 160.103 (definition of ''Health information'').

[423] *See* 91 FR 4054 (Jan. 30, 2026).

Response: We interpret ''staff'' to mean workforce [424] members who support the provision of treatment, either directly or indirectly, by virtue of their qualifications or job role.[425] Thus, an electronic health record would include electronic records consulted by a workforce member of a covered health care provider where the workforce member is supporting the provision of treatment by the health care provider. Examples of workforce members that would be ''staff'' include, but are not limited to, medical residents, registration support personnel, schedulers, receptionists, administrative staff who support covered functions (*e.g.,* billing, prior authorization, scheduling, referrals), coding specialists, clinical laboratory personnel, home health assistants, office or practice managers, and care referral coordinators.

2. Adding Definition of ''Personal Health Application''

a. Issues To Address

Section 164.524(a) of the Privacy Rule currently establishes, with limited exceptions, the right of an individual to inspect or obtain (or both) a copy of their PHI to the extent such information is maintained in a designated record set of a covered entity. An individual's right of access exists regardless of the format in which the PHI is maintained, and the standards and implementation specifications that address individuals' requests for access and timely action by the covered entity (*e.g.,* provision of access, denial of access, and documentation) apply to an electronic environment in a similar manner as they do to a paper-based environment.[426]

b. Proposed Rule

The Department proposed to adopt and define a new term, ''personal health application,'' to support the right of an individual to obtain a copy of their PHI through a personal health app pursuant to the right of access, discussed below.

Under the proposed definition, the information in a personal health app would not be managed, shared, or controlled by a covered entity. Additionally, the information would not be managed by the app developer on behalf of or at the direction of a regulated entity (*e.g.,* a patient or health plan member portal used by a covered entity to manage individuals' access to the PHI it maintains) or another party, such as an entity that is not regulated under HIPAA that collects or manages PHI for its own purposes (*e.g.,* research organization). Instead, under the proposed definition, an individual (or their personal representative) would use a personal health app for the individual's own purposes, such as to monitor their health status and access their health information using the app. As we explained in the 2021 Privacy Rule NPRM, because the developer of a personal health app would not be acting on behalf of, or at the direction of, a regulated entity, the app developer would not be a business associate, and therefore, would not be subject to the federal privacy and security obligations of the HIPAA Rules. Also as described in the 2021 Privacy Rule NPRM, a personal health app would be a tool used by, or primarily for, the individual, as opposed to other health apps that contain information that is managed, shared, and controlled by other persons for their own purposes (*e.g.,* patient or health plan member portal, research). Thus, the proposed definition would have focused on apps where only the individual or their personal representative manages, shares, and controls the information and apps that enable the information to be managed, shared, and controlled primarily for the individual. It would not have included apps where the information is managed, shared, and controlled by or primarily for another party.

c. Overview of Comments

Commenters were evenly split in their views of this proposal. Some urged the Department to adopt a broader definition of personal health app (*e.g.,* including apps on the web, mobile devices, and desktop computers, as well as apps that enable individuals to manage and/or to generate insights from their health information), while others recommended that we adopt a narrower one (*e.g.,* to limit the definition to apps that incorporate certain privacy and security protections). Many commenters requested that the Department provide examples of technologies that would meet the proposed definition.

d. Final Rule

We are finalizing our proposal to adopt the new term, ''personal health application,'' at 45 CFR 164.501, with modifications for clarity and readability. Specifically, we are separating the clauses of the definition into two paragraphs, one that addresses what the term expressly includes and one that addresses what the term expressly excludes. Additionally, we are separating the clause that addresses what the term expressly excludes into two sub-paragraphs and clarifying that an electronic application is not a personal health app if the health information in such application is managed, shared, or controlled: (1) by or primarily for a covered entity; or (2) primarily for another person.

Further, we are removing the example of an app developer from the definition and replacing ''party'' with ''person.'' These modifications are not substantive but are made to align with our preference for providing non-exhaustive lists of examples in guidance, rather than in regulatory text, and using defined terms where possible.[427]

This definition is consistent with, and will help further, the Department's ongoing efforts to promote and support individuals' use of technology to exercise the right of access.[428] Individuals increasingly are choosing to use technology to access and manage their health information. Technology, such as personal health apps, that individuals can select to manage, share, and control their health information, gathered from one or more sources, empowers them to be more in control of decisions about their health and well-being. For example, individuals with access to their health information are better able to monitor chronic conditions, adhere to treatment plans, find and request that errors in their health records be amended, track progress in wellness or disease management programs, and directly contribute their health information to research.[429] With the increasing use of and continued advances in health IT, there are novel and increasing ways for individuals to quickly and easily access

[424] 45 CFR 160.103 (definition of ''Workforce'').

[425] *See* 45 CFR 164.501 (definition of ''Treatment'').

[426] *See* ''The HIPAA Privacy Rule's Right of Access and Health Information Technology,'' Office for Civil Rights, U.S. Department of Health and Human Services (Jan. 17, 2009), *https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/healthit/eaccess.pdf.*

[427] In the preamble to the NPRM, we stated that we were proposing to define a personal health application as ''an electronic application used by an individual to access health information about that individual in electronic form, which can be drawn from multiple sources, provided that such information is managed, shared, and controlled by or primarily for the individual, and not by or primarily for a covered entity or another party such as the application developer.'' *See* 86 FR 6446, 6457 (Jan. 21, 2021). This statement was in error because the proposed amendatory text did not include the unnecessary words ''in electronic form,'' nor does this final rule.

[428] *See* 78 FR 5566, 5631–32 (Jan. 25, 2013); 75 FR 40868, 40901 (July 14, 2010); 65 FR 82462, 82556–57 (Dec. 28, 2000); ''The HIPAA Privacy Rule's Right of Access and Health Information Technology,'' *supra* note 426.

[429] ''Privacy & Security,'' sec. 7 of the Health IT Playbook, Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Mar. 11, 2020), *https://playbook.healthit.gov/playbook/privacy-and-security/playbook.healthit.gov.*

their health information electronically, in real time, and on demand from a variety of sources. The Privacy Rule was designed to be technology neutral and does not mandate the use of any particular technologies, but instead establishes standards that can be met through a variety of means.[430] This approach enables the Department to address in the preamble how the definition applies to technologies in current use without revising the regulatory text solely to account for each new or developing technology. Accordingly, we decline to provide examples of specific technologies that meet the definition in the regulatory text. Rather, the Department believes that the definition we are finalizing provides flexibility to accelerate innovation,[431] empower individuals, and improve individual access to their PHI, while encouraging competition among technology developers.

While covered entities (and business associates acting for or on behalf of covered entities) may offer individuals the ability to access their PHI and other information using apps developed by or for the covered entities,[432] the information in such apps (*e.g.,* patient and health plan member portals) generally is managed, shared, and controlled by or primarily for those regulated entities.[433] Such entities determine, among other things, who can access the information in their apps, what information can be entered, and what happens to the information that is entered. In contrast, individuals generally make such decisions when it comes to personal health apps, subject to the app's terms and conditions or consumer privacy policy, which the individual generally has the opportunity to review and consider when they determine which app to use. For example, an individual selects the app that they prefer to use, the information that they wish to maintain in the app, and whether they prefer that information gathered from multiple sources be integrated or viewed separately. Thus, by limiting the definition to apps that provide an individual with the ability to manage, share, and control the health information that is in the app and to apps that enable the health information in the app to be managed, shared, and controlled by or primarily for the individual, we ensure that the definition encompasses only apps used by the individual or their personal representative, not other persons. This definition is consistent with how individuals view these technologies and supports individuals' ability to obtain all the PHI to which they are entitled under the right of access using the personal health app of their choosing. In contrast, where an app allows another person (*e.g.,* a medical product company conducting research) to manage, share, and control the individual's health information (but not primarily for the individual), requests from the individual to disclose PHI to the app may constitute a request pursuant to the right of access to direct (and would be subject to that right's limitations), depending on the nature and scope of the request.

A personal health app may not allow an individual to perform all three of the functions included in the definition, that is, manage, share, and control the individual's health information. Thus, the definition also allows for circumstances where one or more of those functions is performed by someone other than the individual (*e.g.,* the developer of a personal health app) primarily for the individual. An app connected to a fitness tracker selected by the individual for their own use generally contains information that is managed, shared, and controlled by or primarily for the individual, and thus, likely would meet the definition of a personal health app. As another example, a wellness app selected by the individual for their own use likely would meet the definition of a personal health app because the information in the app generally is managed, shared, and controlled by or primarily for the individual.

We explicitly exclude, from the definition of a personal health app, such apps that are used by individuals to access their health information where the information is managed, shared, or controlled: (1) by or primarily for a covered entity; or (2) primarily for another person. Because business associates, by definition, are acting for or on behalf of covered entities, the term personal health app excludes apps that contain information that is managed, shared, or controlled by a business associate that is acting as a business associate or a subcontractor of a business associate with respect to the app. Thus, by definition, personal health apps are not entities that are regulated under HIPAA.[434] The same holds true for developers of personal health apps with respect to such apps.[435] While a regulated entity may provide an individual with an app to access the patient or health plan member portal, the information in that app is not managed, shared, and controlled by or primarily for the individual. Rather, the information that resides in the app (generally supplied from the regulated entity's electronic information systems) is managed, shared, or controlled by or primarily for the regulated entity, even though the individual may benefit from it. Similarly, where a fitness tracker is provided to the individual by a covered entity, the developer of the app connected to the fitness tracker likely would be a business associate. Thus, the app would not meet the definition of a personal health app. As another example, while an entity managing clinical trials may provide an individual with an app to collect the individual's health information, the information in that app is not managed, shared, and controlled by or primarily for the individual. Rather, the information in such apps is managed, shared, or controlled primarily for the entity that is conducting the clinical trial for research purposes.

e. Responses to Public Comments

Comment: Several commenters expressed support for the proposed definition of personal health app. According to a few commenters, the proposed definition would enable workforce members to distinguish individual access requests from requests for disclosures that require an authorization. One commenter asserted that adding a definition of personal health app would provide clarity and account for new technologies with

[430] 65 FR 82567 (Dec. 28, 2000).

[431] *See, e.g.,* ''Early Adopters and All Pledgees,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Aug. 6, 2026), *https://www.cms.gov/health-tech-ecosystem/early-adopters.*

[432] Persons who develop apps for or on behalf of covered entities or business associates likely are business associates of the covered entity or subcontractors of the business associate because they likely create, receive, maintain, or transmit PHI on behalf of, or provide certain services involving access to PHI for, covered entities or business associates. Accordingly, such persons generally are regulated under the HIPAA Rules as business associates. *See* 45 CFR 160.103 (definition of ''Business associate); *see also* ''Health App Use Scenarios & HIPAA,'' Office for Civil Rights, U.S. Department of Health and Human Services (Feb. 2016), *https://www.hhs.gov/sites/default/files/ocr-health-app-developer-scenarios-2-2016.pdf.*

[433] We use the term PHI to refer exclusively to information that meets the definition in 45 CFR 160.103. We use the terms ''information'' and ''health information'' to address data that may include PHI and data that does not include PHI.

[434] Personal health apps may be regulated by other law. *See* ''Mobile Health App Interactive Tool,'' Federal Trade Commission and U.S. Department of Health and Human Services (Nov. 2024), *https://www.ftc.gov/business-guidance/resources/mobile-health-apps-interactive-tool.*

[435] Developers of personal health apps may be regulated under HIPAA as business associates with respect to other products or services that they offer.

minimal effects on the operations of covered entities.

A few commenters recommended that the Department clarify the scope of a personal health app. For example, a few commenters questioned whether the term would include electronic apps that are managed, shared, and controlled by an employer for an individual employee and whether it would apply to online or digital tools, platforms, or services that have the functional capabilities of a personal health app, but are not necessarily considered an app.

Several commenters asserted that the proposed definition would be too narrow. One commenter recommended that the Department expand the proposed definition to include apps on the web, mobile devices, and desktop computers, and apps that enable individuals to manage and/or to generate insights from their health information. One commenter recommended that the Department expand the proposed definition to include any app that offers services to individuals and maintains an individual's health information for their use and to explicitly include the ability to access price information.

A few commenters requested that the Department clarify whether apps recommended by health care providers would be considered personal health apps. One commenter recommended that the Department modify the definition to clarify that a personal health app accesses information for the individual.

A few commenters expressed opposition to the proposed definition because they believed that the Department should rely on the HITECH Act's definition of personal health record. One commenter recommended that the Department use the term ''personal health record'' because not all tools or services selected by individuals to manage and maintain their health information will be apps as the term generally is understood. The commenter provided examples of such tools and services, such as online platforms that are accessible by individuals through an internet browser. One commenter asserted that the Department should use personal health records and personal health apps as examples of forms and formats for individual access, rather than defining the term personal health app.

Response: As explained above, we are finalizing the definition of personal health app with a few modifications. Under this definition, a personal health app is a service offered directly to consumers. It is not a service offered to the individual by a covered entity or its business associate, such as an EHR vendor. Neither the covered entity nor its business associate manages, shares, or controls the information, nor does the app developer manage the information on behalf of or at the direction of a health care provider or health plan (*e.g.,* through a patient portal that the regulated entity uses to manage individuals' access to the PHI it maintains). An electronic application also would not be a personal health app where the app developer manages the information on behalf of or at the direction of another person or where another person collects or manages PHI for its own purposes (*e.g.,* a research organization). Instead, an individual (or their personal representative) uses a personal health app (*e.g.,* Individual Access Services [436] (IAS) provided by an IAS Provider in TEFCA (or other party to TEFCA that offers TEFCA IAS), a ''patient facing app'' [437] that connects to CMS Aligned Networks as a participant in the Medicare App Library,[438] fitness tracker, or wellness app) for the individual's own purposes, such as to monitor their own health status and access their own PHI using the app. For example, an individual might request that their health care providers send weight, vital signs, and other PHI to their chosen personal health app either to store in such app or direct it to others.

As we explained in the proposed rule, the definition of personal health app is similar to the HITECH Act definition of personal health record,[439] but specifically addresses a category of health apps, some of which also may be personal health records to the extent that they meet both definitions.[440]

The definition of personal health app generally is technology neutral, with the caveat that the app must be electronic. Thus, a personal health app may include electronic software, applications, or successor technologies. Using this technology, the individual (or their personal representative) is able to manage, store, and control their health information, gathered from one or more sources, including entities not regulated by HIPAA. These technologies often are described as ''direct-to-consumer,'' ''consumer-directed,'' or ''patient-facing.'' [441] They may include mobile apps, online tools, browsers or browser extensions, platforms, or services that provide individuals with the ability to manage, share, and control their own health information.

Some app developers and other technology developers may offer multiple products, including some that are offered directly to consumers and some that are offered to covered entities to provide to individuals. If a technology developer meets the definition of a covered entity or business associate with respect to a particular product (or, in the case of a hybrid entity, a product is offered through a designated health care component), that particular product or technology is not a personal health app; other products or technologies offered by the technology developer may meet the definition of a personal health app if the individual or their personal representative has the ability to manage, share, and control the health information through that product or technology. Technologies that contain an individual's health information would not meet the definition of a personal health app where the health information is managed, shared, or controlled primarily for a person other than the individual or their personal representative.

Comment: Several commenters recommended that the components of the Department align their definitions of a personal health app. One commenter asserted that the proposed definition would align with the information blocking regulations. A few commenters urged the Department to limit the definition to apps that incorporate certain privacy and security protections and/or standards.

Response: The definition of personal health app that we are finalizing is consistent with definitions of similar terms, such as the HITECH Act definition of personal health record,[442] but is tailored to the HIPAA Privacy Rule. The definition captures certain

[436] *See* definition of ''Individual Access Services (IAS),'' ''Common Agreement for Nationwide Health Information interoperability (Version 2.1),'' Assistant Security for Technology Policy and ONC TEFCA Recognized Coordinating Entity, section 1.1 (Nov. 2024), *https://healthit.gov/wp-content/uploads/2025/02/Common_Agreement_2.1.pdf.*

[437] *See* ''Health Tech Ecosystem Categories,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Aug. 5, 2026), *https://www.cms.gov/health-technology-ecosystem/categories.*

[438] *See* ''Requirements for the Medicare App Library,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (Aug. 24, 2026), *https://www.cms.gov/initiatives/health-technology-ecosystem/overview/medicare-app-library.*

[439] 42 U.S.C. 17921(11) (definition of ''Personal health record'').

[440] The same software could be a personal health app under the Privacy Rule definition and a personal health record under the HITECH Act for other purposes, to the extent it meets both definitions.

[441] *See, e.g.,* ''Early Adopters and All Pledgees,'' *supra* note 431.

[442] *See* 42 U.S.C. 17921(11) (definition of ''Personal health record''); *see also* 16 CFR 318.2 (definition of ''Personal health record'').

health apps, some of which also may be personal health records.

Under HIPAA and subtitle D of the HITECH Act, the Department's statutory authority is limited to covered entities and their business associates. A personal health app developer does not meet the definition of a business associate because it is not acting for, or on behalf of, a covered entity or business associate. Instead, the personal health app is a tool that is employed by or primarily for an individual (or their personal representative) to manage, share, and control the individual's health information. The Privacy Rule does not limit an individual's right of access based on the technology that the individual uses to obtain a copy of their PHI or how the information will be used or disclosed once the individual receives it. For instance, a covered entity is not permitted to deny an individual's right of access to their ePHI, where the individual requests that such access be provided through a personal health app, based solely on the covered entity's concerns that the app developer will not adequately protect the privacy of the individual's ePHI or because the app does not encrypt the individual's data at rest. Accordingly, we decline to limit the definition of personal health app to apps that meet certain privacy and security standards.

Comment: Several commenters asserted that covered health care providers would be unable to confirm who will manage, share, and control the ePHI being transmitted to an app. Several commenters requested that the Department provide guidance, including examples, of how to identify when health information about an individual that is in an app is managed, shared, and controlled by or primarily for the individual.

Response: We recognize that app developers may offer some products directly to consumers and some products to covered entities to provide to individuals. We also are aware that there may be situations where an organization has multiple service offerings that use the same technology platform. Covered entities will need to distinguish between requests for PHI submitted through apps that are personal health apps and those that are not, based on the processes and technology that the covered entity implements to enable apps to connect to a covered entity's electronic information systems and transmit requests for disclosures of PHI, including requests for access. For example, for covered entities that have implemented a Health IT Module certified under the ONC Health IT Certification Program to, for example, the certification criterion at 45 CFR 170.315(g)(10) (''Standardized API for patient and population services''), the health IT developer of that Health IT Module is required to maintain a standardized authentication and application authorization process to register and enable applications for use.[443] Similarly, a covered entity that participates in TEFCA should be able to identify, based on information provided to it through TEFCA, whether a request is submitted by an IAS Provider, and whether the request was submitted by the individual.[444] Based on the processes that a covered entity implements and the information provided by an app, covered entities will need to determine whether a request submitted through an app is a request of an individual exercising his or her right of access through a personal health app and, thus, the appropriate response and compliance posture.

3. Strengthening the Access Right To Inspect and Obtain Copies of PHI

a. Current Rule

The Privacy Rule's individual right of access at 45 CFR 164.524(a) includes an individual's right to inspect their PHI in a designated record set and their right to obtain a copy of that PHI.[445] Covered entities must arrange with an individual for a convenient time and place to inspect the PHI.[446]

b. Proposed Rule

In the 2021 Privacy Rule NPRM, the Department proposed to strengthen the right of an individual to inspect their PHI in a designated record set by making it a separate requirement from the right of an individual to obtain a copy of their PHI in a designated record set and adding more detail. Specifically, we proposed to include, within the right of an individual to inspect their PHI in a designated record set, the right to view, take notes, take photographs, and use other personal resources to capture the information.[447] The Department also proposed to clarify that a covered entity would not be required to allow an individual to connect a personal device to the covered entity's electronic information systems. Additionally, we proposed that a covered entity would be permitted to impose requirements to ensure that the individual's recordings would be limited to only the PHI to which the individual has a right of access.

c. Overview of Comments

Most commenters, regardless of whether they expressed support or opposition, raised concerns about the increased burdens of this proposal, such as the need to develop new policies and procedures to address how to protect the privacy and security of other individuals, workforce members, and EHR systems. Most commenters who expressed opposition to the proposal believed that it would increase risks to patient or workforce safety and create risks for intellectual property rights. Several commenters expressed concern that the proposal would require the dedication of additional resources, such as personnel and space, and interrupt workflows. According to commenters, the proposal was unnecessary because most individuals do not seek to access their PHI in person; rather, they prefer to access their PHI electronically.

d. Final Rule

The Department is not finalizing the proposed modifications to the right to inspect. Although the proposal was intended to reduce requests for covered entities to make copies of PHI, we agree with commenters who asserted that the proposal would be overly burdensome for covered entities to implement. Additionally, the existing right of inspection already permits individuals to inspect their PHI in person at a mutually convenient time and place; it does not preclude inspection from occurring in conjunction with a health care appointment. Further, the

[443] Section 4002(a) of the Cures Act requires certified health IT developers to publish APIs and allow health information from such technology to be accessed, exchanged, and used without special effort through the use of APIs or successor technology or standards, as provided for under applicable law. It also requires that a certified health IT developer provide through an API access to all data elements of a patient's electronic health record to the extent permissible under applicable privacy laws. *See* sec. 3001(c)(5) of the PHSA, as amended by sec. 4002(a) of the 21st Century Cures Act, Public Law 114–255, 130 Stat. 1159 (Dec. 13, 2016) (codified at 42 U.S.C. 300jj–11); 45 CFR 170.315(g)(10); 45 CFR 170.404(b)(1); *see also* Fact Sheet, ''Promoting an Open and Transparent API Ecosystem: API Conditions and Maintenance of Certification Requirements for Certified API Developers in the ONC Health IT Certification Program,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Nov. 2024), *https://healthit.gov/wp-content/uploads/2025/02/certification-api-condition-responsibilities-obligations-factsheet.pdf.*

[444] *See* definition of ''Individual Access Services Provider (IAS Provider),'' ''Common Agreement for Nationwide Health Information interoperability (Version 2.1)'', Assistant Security for Technology Policy and ONC TEFCA Recognized Coordinating Entity, section 1.1 (Nov. 2024), *https://healthit.gov/wp-content/uploads/2025/02/Common_Agreement_2.1.pdf;* ''Exchange Purpose (XP) Implementation SOP: Individual Access Services (IAS),'' Sequoia Project (Aug. 3, 2026), *https://rce.sequoiaproject.org/wp-content/uploads/2026/07/SOP-IAS-XP-v3_June2026_Clean_-5081.pdf.*

[445] 45 CFR 164.524(a)(1).

[446] *See* 45 CFR 164.524(c)(1)–(3).

[447] *See* proposed 45 CFR 164.524(a)(1)(ii).

Department has not received information or complaints from individuals indicating that they frequently face difficulties when they choose to record their health information using their own resources.

e. Responses to Public Comments

Comment: Several commenters expressed support for this proposal because it would provide individuals with access to their PHI in a way that did not depend on technology. Several commenters asserted that covered entities often deny caregivers access to PHI and that this proposal would provide an individual's caregiver with an easier path towards obtaining [448] access.

Response: The Department agrees that the right of inspection provides an individual or their personal representative with another way of obtaining access to the individual's PHI. Accordingly, we are preserving the right to inspect as it currently exists. Under the right to inspect, an individual or their personal representative may view the individual's PHI in a designated record set at a mutually convenient time and place.[449] The mutually convenient time and place for inspection may occur during a health care appointment, and a health care provider may voluntarily allow an individual (or their personal representative) to take photos or use other resources to view and capture images.

Comment: Some commenters expressed concerns about the ability of covered entities to establish policies and procedures that would enable individuals to exercise the proposed right to inspect their PHI without infringing on the privacy of others, including workforce members, or the security of ePHI in EHR systems. A few commenters asserted that individuals should not have access to the electronic information technology systems of covered entities.

Other commenters recommended that the Department require individuals to obtain permission before recording conversations with health care providers. Commenters also expressed concerns about the effect of the proposed change on legal protections for intellectual property and the intersection between this proposal and Federal or state recording laws.

Response: Although the Department is not finalizing the proposed changes to the right to inspect, the existing right does not prohibit covered entities from allowing individuals to use personal resources to capture their PHI. Generally, individuals should be able to use personal resources, such as a smartphone, camera, or other device, to capture information about themselves. However, a covered entity is permitted to establish reasonable policies and safeguards regarding an individual's use of such personal resources for copying PHI to ensure that such use does not interfere with the ability of the covered entity to provide health care to others. These policies and safeguards may also ensure that the individual's personal resources are used in a way that enables the individual to copy or otherwise memorialize only the PHI to which they are entitled under the right of access.

A covered entity is not permitted to establish policies and safeguards that impose unjustified or unreasonable barriers to individual access (*e.g.,* limiting individuals to paper copies of their PHI). However, a covered entity is not required to allow an individual to connect a personal device to the covered entity's electronic information systems (*e.g.,* insert an individual's USB drive into one of the covered entity's workstations, sign an individual's mobile device onto a covered entity's network).

The Department does not believe that individuals capturing their own PHI through video, still camera photos, or audio recordings would be inconsistent with Federal or state recording laws or intellectual property rights protections.

Comment: Some commenters expressed concern about the administrative burdens that this proposal would impose on covered entities, such as the potential disruptions to workflow, and the potential implications for the quality of care. Several commenters asserted that the proposed change would require significant resources, such as extra space and personnel.

Several commenters expressed concern that individuals exercising this proposed right would view PHI that has not been validated or reviewed for accuracy or that is incomplete. A few commenters asserted that covered entities could face liability if certain PHI was not included in the medical record when inspected. One commenter stated that requiring a health care provider to provide access to PHI in real-time could damage the integrity of the medical record because health care providers may hesitate to be candid in their documentation and diagnosis in such cases.

Response: The Department agrees that the proposed changes to the right to inspect could be overly burdensome to covered entities and disruptive to their workflow. Accordingly, we are not finalizing the proposal. The existing right of inspection allows, and the Department encourages, covered entities to provide individuals with on demand, in-person access to requested PHI where appropriate, in whole or in part (if certain access may be denied under the Privacy Rule), including at the point of care.

A covered entity may deny an individual access to all or a portion of PHI requested in only very limited circumstances.[450] For example, a covered entity may deny an individual access if the information requested is not part of a designated record set maintained by the covered entity (or by a business associate for a covered entity),[451] or if the information is excepted from the right of access.[452] As another example, a covered entity may deny an individual access to particular PHI if a licensed health care professional determines in the exercise of professional judgment that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.[453] Accordingly, a covered entity may deny an individual experiencing suicidal ideation access to such PHI as a health care provider determines in their professional judgment is reasonably likely to lead the individual to take their own life.[454] However, we stress that this ground is narrowly construed in order to protect individuals' autonomy interests and their right under the Privacy Rule to obtain information about themselves, which is fundamental in facilitating individuals' active participation in their own health care. General concerns about psychological or emotional harm (*e.g.,* concerns that the individual will not be able to understand the information or may be upset by it) are not sufficient to deny an individual access. In addition, the requested access must be reasonably likely to cause harm or endanger physical life or safety. Thus, concerns based on the mere possibility of harm are not sufficient to deny access.[455] As a result, we expect this ground for

[448] We use the term ''obtaining'' with respect to access to include both requesting and receiving access to such copies.

[449] *See* revised 45 CFR 164.524(c)(3); 65 FR 82462, 82557 (Dec. 28, 2000).

[450] *See* 45 CFR 164.524(a)(2) and (3); 164.524(e).

[451] This may include certain quality assessment or improvement records, patient safety activity records, or business planning, development, and management records that are used for business decisions more generally rather than to make decisions about individuals. *See* 65 FR 82462, 82554 (Dec. 28, 2000).

[452] *See* 45 CFR 164.524(a)(2)(i).

[453] *See* 45 CFR 164.524(a)(3)(i); 65 FR 82555–56 (Dec. 28, 2000).

[454] *See* 65 FR 82555 (Dec. 28, 2000).

[455] *Id.* at 82556, 82733.

denial to apply only in extremely rare circumstances.

Comment: Several commenters expressed opposition to the proposal because they believed that covered entities should be permitted, not required, to allow individuals to inspect their PHI. Several commenters who expressed opposition to the proposal recommended modifications. For example, some commenters recommended that the Department limit an individual's right to inspect their PHI to certain circumstances, while others recommended that the Department permit covered entities to limit the proposed right to inspect in certain circumstances. Still other commenters requested that the Department provide guidance on circumstances in which covered entities would be permitted to limit an individual's right to inspect.

Response: While in-person, point-of-care access to PHI may not always be appropriate or feasible, the Department declines to limit the existing right of an individual to inspect their PHI in a designated record set. Providing individuals with easy access to their PHI empowers them to make decisions about their health and well-being. Accordingly, as a process matter, covered entities should have in place reasonable procedures to enable individuals to inspect their PHI. The Department believes that responding to requests from individuals to inspect their PHI should impose minimal burden on the covered entity, particularly where the PHI requested is of the type easily accessed onsite or virtually by the covered entity itself in the ordinary course of business, such as during an in-person or virtual visit. The Department encourages covered entities to provide individuals with on demand access to PHI at the point of care where appropriate, in whole or in part (if access to certain PHI may be denied under the Privacy Rule).

Furthermore, where covered entities that are subject to the information blocking regulations employ practices that are likely to interfere with the access, exchange, or use of EHI, such practices may implicate the information blocking regulations.[456] This includes circumstances where an individual seeks to exercise their right to inspect and the requested PHI also meets the definition of EHI.[457]

Comment: One commenter recommended that, instead of creating a specific right to take photographs or videos, individuals should be given the option to take video or photographs, if both parties agree, at a mutually convenient time and place; and if the covered entity does not agree, require the covered entity to provide PHI in an alternative format.

Response: The Department is not modifying the Privacy Rule to include a specific right to take photographs, videos, or use other personal resources to capture PHI as part of an individual's right to inspect. The existing right to inspect does not place limitations on an individual's ability to record their PHI while they inspect it at a mutually convenient time and place. A covered entity may establish reasonable policies and safeguards regarding an individual's use of their own smartphone, camera, or other device for capturing PHI when exercising their right to inspect their PHI to ensure that equipment or technology used by individuals is not disruptive to the entity's operations and is used in a way that enables an individual to copy or otherwise memorialize only the PHI to which they are entitled under the right of access. An individual may inspect PHI in person (whether simply viewing or capturing it using a personal resource consistent with a covered entity's reasonable policies and safeguards), in addition to obtaining copies or in lieu thereof.

Comment: According to a few commenters, the proposal was unnecessary because individuals usually do not seek to access their PHI in person; instead, individuals generally prefer to access their PHI through patient portals or other electronic means.

Response: The Department agrees that the proposed changes are unnecessary, especially in light of (1) the burdens the proposal would impose on covered entities; and (2) the ability of an individual to capture their PHI in person using personal resources, to the extent consistent with a covered entity's reasonable policies and safeguards, while exercising the existing right to inspect their PHI in a designated record set. The Department also agrees that many individuals may prefer to access their PHI through patient or health plan member portals or other electronic means. With the increasing use of and continued advances in health IT, individuals often have the ability to access their PHI electronically quickly and easily, in real time, and on demand. Thus, the right to inspect PHI is not limited to in-person inspection. Rather, an individual may seek to exercise their right to inspect a copy of their PHI using remote communications technology (*e.g.,* communication app on a smartphone or other computing device). Accordingly, the right to inspect PHI can be a convenient method for individuals who choose to exercise their right of access in person or remotely.

Comment: A few commenters expressed support for the idea that covered entities should be permitted to provide individuals with copies of PHI in lieu of in-person inspection when necessary for public health and safety, during emergencies or otherwise.

Response: As explained above, the Department is not finalizing its proposals to add requirements to an individual's right to inspect their PHI in a designated record set. The Privacy Rule does not provide covered entities with the opportunity to deny or delay (beyond the permitted response period and extension) the right of an individual to inspect PHI, whether in person or otherwise, for public health and safety, during emergencies, or other circumstances. However, it does provide the opportunity for the covered entity to arrange with the individual for a time and place, which may be virtual, for the inspection that is mutually convenient.[458] Additionally, the covered entity is permitted to discuss the scope, format, and other aspects of the request for access with the individual as necessary to facilitate the timely provision of access.[459]

4. Modifying the Implementation Requirements for Requests for Access and Timely Action in Response to Requests for Access

a. Current Rule

Section 164.524(b)(1) requires a covered entity to permit an individual to request access to inspect or to obtain a copy of PHI about the individual that is maintained in a designated record set. It permits a covered entity to require individuals to make such a request in writing, provided that the covered entity informs individuals of such requirement. Section 164.524(b)(2) requires a covered entity to act on an individual's request for access no later than 30 days after receipt of the request, with an option to extend the time by an additional 30 days if they provide, during the initial 30-day period, a written explanation and the date by which the entity will complete its action on the request. The Department has long maintained that 30 calendar days is an outer limit.[460]

[456] 45 CFR 171.103.

[457] 45 CFR 171.102 (definition of ''Electronic health information'').

[458] *See* 45 CFR 164.524(c)(3)(i); 65 FR 82462, 82557 (Dec. 28, 2000).

[459] *Id.*

[460] *See* 65 FR 82462, 82556 (Dec. 28, 2000).

b. Proposed Rule

The Department proposed to modify the Privacy Rule to clarify that, while a covered entity may require an individual to make a request for access in writing, provided that it informs the individual of such a requirement, it may not impose unreasonable measures that impede the individual from obtaining access when a measure that is less burdensome for the individual is practicable for the entity. We also proposed to clarify that the writing could be in electronic or paper form and to include examples of reasonable and unreasonable measures in regulatory text. The Department proposed to modify the Privacy Rule to require that access be provided as soon as practicable, but no later than 15 calendar days after receipt of the request, with the possibility of one 15-calendar-day extension, provided that certain conditions are met. The Department also proposed that where another Federal or state law requires a covered entity to provide individuals with access to the PHI requested in less than 15 calendar days, we would deem the shorter time period to be practicable for purposes of proposed 45 CFR 164.524(b)(2)(i) and (d)(5).

Additionally, we proposed to add a new condition for the use of an extension that would require a covered entity to establish a written policy to prioritize urgent or other high-priority access requests (especially requests for health and safety and to support individual decisions about treatment options), to limit the need to use a 15-calendar-day extension for such requests. The Department also proposed to provide expressly at 45 CFR 164.524(c)(3) and 45 CFR 164.525(b) that, while a covered entity may discuss aspects of the access request with the individual before fulfilling the request, discussions to clarify the scope, format, and other aspects of the request would not extend the time limit for providing access.

c. Overview of Comments

Most commenters expressed concern that the proposed timeliness requirements would be overly burdensome and insufficiently flexible because of the varying complexity of requests. Even among commenters who were generally supportive, many recommended exceptions for certain types of requests or in certain circumstances (*e.g.,* natural disasters). While some commenters expressed support for the proposal to permit one 15-calendar-day extension if the covered entity adopted a policy to prioritize urgent or high-priority requests, most commenters expressed opposition to this proposal because they believed that it would be confusing and difficult to implement. Some of the commenters who expressed support for the proposal also requested that the Department clarify what would constitute a high priority or urgent request, including examples. Commenters who expressed opposition highlighted the burdens that they believed the proposal would create for both the covered entity and the individual. Commenters provided examples of circumstances that they believed would require additional time. Others expressed their belief that requiring the development and implementation of policies to prioritize responses to requests that are high priority or urgent access was unnecessary because such requests already are addressed by 45 CFR 164.506, which permits a covered entity to use or disclose PHI for TPO, without the individual's authorization, in certain circumstances.

d. Final Rule

We are adopting, with modification, the proposal to clarify the ability of covered entities to require individuals to make requests for access in writing. Specifically, we clarify, in paragraph (ii) of 45 CFR 164.524(b)(1) what we mean by ''in writing.'' We are not including the phrase ''electronic or paper form'' in regulatory text because the term ''form'' could be misinterpreted as requiring a particular form, template, document, or format that an individual must use to request access, which could cause confusion given other uses of the term ''form'' in 45 CFR 164.524. Instead, we clarify that ''in writing'' means that the request itself serves as documentation of the individual's exercise of the right of access, including when the request is submitted electronically or on paper. This language is intended to make clear that requests in writing do not need to be submitted on a particular form or in a particular format.

A request may be in writing when made through one or more written or electronic communications, so long as the communication(s) documents the individual's exercise of the right of access. For example, a request may be submitted using a handwritten letter, a paper form, an email, a secure message, a patient or health plan member portal, or another electronic mechanism. A request also qualifies as ''in writing'' if a covered entity receives a notification or other electronic transmission from a personal health app that contains the information necessary to document the individual's exercise of the right, such as information identifying the individual, the scope of the requested access, and information about where to send the requested PHI. For example, an access request sent through a Qualified Health Information Network [461] (QHIN) using TEFCA to a covered entity from an individual using an IAS Provider that is also a personal health app would constitute a written request where it documents the individual's exercise of their right of access. As another example, a request sent to a covered entity from an individual, through a patient facing app that connects to CMS Aligned Networks as a participant in the Medicare App Library, and such app is a personal health app, similarly would constitute a request that is in writing where it documents the individual's exercise of their right of access.

Covered entities are not required to adopt a particular electronic mechanism for receiving access requests or to receive electronic requests in a manner that the covered entity does not have the capability to support. The Department, however, strongly encourages covered entities to allow individuals to make requests for access electronically and to receive requests through electronic mechanisms that the covered entity has the capability to support.

Additionally, we are finalizing a new paragraph at 45 CFR 164.524(b)(1)(iii) to prevent a covered entity from imposing measures on an individual making requests for access that impede the individual from obtaining access (which includes measures for requesting such access) when there is a measure that is less burdensome for the individual and practicable for the entity. The finalized requirement does not include the term ''unreasonable'' because the regulatory text expressly describes the circumstances in which a measure is prohibited.

Further, we are not finalizing in regulatory text examples of reasonable or unreasonable measures. Including examples in the regulatory text could create the impression that the list is exhaustive, or that only the enumerated measures are permissible or impermissible. Instead, we reaffirm the examples provided in the 2021 NPRM and provide a non-exhaustive list of

[461] *See* 45 CFR 172.102 (definition of ''Qualified health information network''); definition of ''Qualified Health Information Network (QHIN),'' ''Common Agreement for Nationwide Health Information interoperability (Version 2.1),'' Assistant Security for Technology Policy and ONC TEFCA Recognized Coordinating Entity, section 1.1 (Nov. 2024), *https://healthit.gov/wp-content/uploads/2025/02/Common_Agreement_2.1.pdf; see also* ''Meet the Designated QHINs,'' The Sequoia Project, *https://rce.sequoiaproject.org/designated-qhins/.*

additional examples in this preamble to illustrate how the standard may apply in particular circumstances. For example, a covered entity may not require individuals to submit written requests or accept individuals' written requests only in a particular form (*e.g.,* only paper, only through a patient or health plan member portal) or delivered in a particular manner (*e.g.,* only in person at the covered entity's facility, only through the covered entity's online portal) when there is another measure for making such requests that is less burdensome for the individual and practicable for the entity (*e.g.,* emailing a request to a member of the covered entity's workforce responsible for handling requests for access). In addition, where a covered entity has the capability to receive requests for access submitted by the individual through a patient or health plan member portal, a personal health app from a secure standards-based API, or an HIO (*e.g.,* a QHIN), requiring the individual to use a more burdensome method to make the same request may impede access if receiving the request through that mechanism is practicable for the entity. When determining whether receiving requests electronically through such mechanisms is practicable, a covered entity may consider its technical capabilities, its obligations to protect the privacy of PHI under 45 CFR 164.530(c) and the security of ePHI under 45 CFR 164.306, and the costs of implementing such technical capabilities. We intend to issue additional guidance on access requests, including illustrative examples, to help regulated entities to understand the various ways in which requests might be made and the types of information that might need to included in different typ.

We also are adopting a modified version of the proposal to reduce the amount of time in which covered entities must respond to requests for individual access. Specifically, we are modifying 45 CFR 164.524(b)(2)(i) to require that a covered entity provide access to individuals ''as soon as practicable,'' but no later than 15 calendar days after receipt of a request. Relatedly, we are modifying 45 CFR 164.524(b)(2)(ii) to clarify that the 30-day extension that is permissible in certain circumstances refers to 30 calendar days. Additionally, we are adding a new 45 CFR 164.524(b)(2)(iii) to clarify that where Federal or state law requires a covered entity to provide an individual with access to the requested PHI in less than 15 calendar days, that shorter time period will be deemed practicable for purposes of 45 CFR 164.524(b)(2)(i). This will ensure that individuals receive more timely action on their access requests, while retaining the existing possibility of one 30-calendar-day extension (rather than the proposed 15-day extension) to accommodate more complex or difficult requests (*e.g.,* paper records that are archived offsite and not easily accessible, ePHI that may need to be retrieved from offline archival storage). The finalized requirement reduces the time within which covered entities must provide individuals with access to PHI, empowering individuals to take an active role in their care and facilitating care coordination and case management.

As discussed in the 2021 Privacy Rule NPRM, at least eight states require patients to be provided with copies of their health records in less time than the Privacy Rule's current 30-day limits,[462] and at least five states require the opportunity to view or inspect the record in fewer than 30 days.[463] Such requirements generally apply to health care providers, including hospitals and other health facilities, but not to health plans. Because most states do not impose time limits on covered entities that are as short as 15 days, access to PHI in such states will be markedly improved. Additionally, these shorter timelines support the Department's initiatives to implement statutory requirements aimed at empowering individuals to make more informed decisions about health care.[464] Shorter timelines also are consistent with individuals' needs and expectations. For example, most patients expect immediate online access to health information in their medical records, including tests results and clinician notes.[465] Easy online access to medical records—through patient or health plan member portals, personal health apps, or other mechanisms—is vital for those managing chronic conditions, new diagnoses, or another's care.[466]

For the same reasons, we also are adopting our proposal to apply these same timeliness requirements to requests from an individual to a covered entity to direct an electronic copy of PHI about the individual in an electronic health record to a person designated by the individual at new 45 CFR 164.524(d)(5).

Additionally, we are adopting our proposal to modify 45 CFR 164.524(c)(3) to reflect that discussions between the covered entity and the individual about the scope of an individual's request do not extend the amount of time that covered entities have to provide the requested access.

We are not finalizing the proposal to require that a covered entity implement a policy to prioritize certain types of requests. Based on public comments, covered entities already prioritize requests if an individual communicates the urgency of the request. Additionally, we are concerned that such a requirement could incentivize covered entities to require individuals to provide personal information about why a request is urgent, which would place a burden on individuals and could delay responses to such requests.

e. Response to Public Comments

Comment: Some commenters expressed support for the proposal for

[462] *See, e.g.,* Arizona, Ariz. Rev. Stat. 32–1264 (dentist, dental therapist, dental hygienist or denturist or a registered business entity) (15 business days to receive a copy); California, Cal. Health & Safety Code 123110 (health care provider) (15 days to receive a copy); Colorado, 3 Colo. Code Regs. 709–1 (dentists, dental therapists, and dental hygienists) (7 calendar days to receive a copy); Hawaii, Haw. Rev. Stat. 622–57 (10 working days to receive a copy if a patient's attorney requests records); Louisiana, La. Rev. Stat. 40:1165.1 (health care providers) (15 days to receive a copy), La. Rev. Stat. 40:2144 (hospitals) (15 days to receive a copy); New Jersey, N.J. Admin. Code 13:30–8.7 (dentists) (14 days to receive a copy); South Dakota, S.D. Admin. R. 20:43:11:04 (dentists, dental entities) (10 business days to receive a copy); Tennessee, Tenn. Code Ann. 63–2–101 (health care practitioners) (10 working days to receive a copy); Texas, Tex. Health & Safety Code 241.154 (hospitals) (15 days to receive a copy), Tex. Admin. Code 163.3 (physicians) (15 days to receive a copy), Tex. Health & Safety Code 181.102 (health care providers) (15 days to receive electronic copies if using an electronic health records system that is capable of fulfilling the request); and Washington, Wash. Rev. Code 70.02.080 (health care providers) (15 working days to receive a copy).

[463] *See, e.g.,* California, Cal. Health & Safety Code 123110 (5 business days to inspect); Colorado, 6 Colo. Code Regs. 1011:1:II–6.1 (licensed facilities and agencies (*e.g.,* hospitals, nursing facilities, ambulatory surgical centers, home care agencies)) (if a client is currently being provided services, 3 business days to inspect; if a client has been discharged, 10 business days to inspect); Nebraska, Neb. Rev. Stat. 71–8403 (health care providers) (10 days to inspect); Nevada, Nev. Rev. Stat. 629.061 (10 working days to inspect); New York, N.Y. Pub. Health Law 18(2)(a) (10 days to inspect); Texas, Tex. Health & Safety Code 241.154 (hospitals) (15 days to inspect); and Washington, Wash. Rev. Code 70.02.080 (health care providers) (15 working days to inspect).

[464] *See, e.g.,* 85 FR 25510 (May 1, 2020); 85 FR 25642 (May 1, 2020).

[465] *See* Bryan D. Steitz, et al., ''Perspectives of Patients About Immediate Access to Test Results Through an Online Patient Portal,'' JAMA Network Open (Mar. 20, 2023), *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2802672* (noting that online portals let patients quickly access test results and medical records, and most patients now expect immediate electronic access to this information, including clinician notes); *see also* ''ONC Data Brief: Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2024,'' *supra* note 306, at p. 5 (noting individuals' app-based access to online medical records continues to rise).

[466] ''ONC Data Brief: Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2024,'' *supra* note 306, at p. 1.

reasons such as strengthening an individual's right of access, enabling individuals to obtain PHI more easily, improving care coordination, and enabling plaintiffs in personal injury lawsuits to meet litigation-related deadlines. A few commenters asserted that the fact that some states require covered entities to provide individuals with access to their PHI in less time than is currently required by the Privacy Rule demonstrates that it is possible. Several commenters expressed support for the proposal but recommended that the Department require covered entities to provide access to ePHI more quickly than the proposed timeline because it would benefit individuals to have access to their PHI as quickly as possible and ePHI is easily transmitted by a covered entity to an individual.

Many commenters recommended that the Department include exceptions to the proposed requirement. Commenters recommended exceptions for exigent circumstances or infeasibility (*e.g.,* natural disasters); where a covered entity demonstrates that it has made a good faith effort to retrieve PHI to which it lacks immediate access; for certain health care providers that treat individuals who have been involuntarily committed; and for covered entities that have revenue of less than a certain amount.

Several commenters expressed support for the ''as soon as practicable language'' but expressed opposition to the 15-calendar-day timeline because of concerns about their ability to gather the requested PHI in less time than they currently have or about the time it takes them to obtain clarification from individuals where the requests that they receive are incomplete.

Many commenters expressed opposition to the proposal because they believed that it would be burdensome to implement. Commenters asserted that many covered entities use a manual process for responding to access requests because they rely on legacy systems, requested PHI may be maintained offsite and/or in a form or format that is not easily accessible, or the requested PHI may include sensitive information that is subject to privacy restrictions in other laws. According to these commenters, the manual process can require more than 15 days. Commenters also asserted that the proposal would require extensive changes to workflow, training, orientation, and documentation. One commenter asserted that some hospital records may not be complete within 15 days of an individual's discharge because of delays in completing certain records. Some commenters recommended that the Department adopt alternative timeframes. For example, a few commenters recommended that the Department adopt a 30-day timeliness requirement with the possibility of one 15-day extension. A few commenters urged the Department to modify the proposal to provide different timelines for ePHI and for PHI that is not ePHI.

Several commenters requested that the Department provide guidance on best practices for managing and fulfilling individual access requests within 30 days.

Response: As discussed above, the Department is adopting a modified version of its proposal to reduce the amount of time that a covered entity has to respond to a request made pursuant to the right of access, including the right of access to direct. The final rule requires a covered entity to respond to an individual's request for access as soon as practicable, but no later than 15 calendar days after receiving the request, with the possibility of one 30-calendar-day extension. The Department encourages covered entities to view the 15 calendar days as an outer limit, particularly for requests for electronic copies of ePHI. Indeed, a covered entity may have the capacity to provide individuals with almost instantaneous electronic access to the PHI requested through personal health apps (*e.g.,* a TEFCA IAS Provider, a patient facing app that connects to CMS Aligned Networks as a participant in the Medicare App Library), web portals, or similar electronic means. Further, individuals may reasonably expect a covered entity to be able to respond in a much faster timeframe when the covered entity is using health IT in its day-to-day operations.[467] For example, individuals may be accustomed to receiving treatment from health care providers who use tools that are embedded in their EHRs to make certain information available quickly.[468] Similarly, individuals may reasonably expect to obtain electronic access to PHI from their health plan in a faster timeframe when they request to receive their health information through an API.[469] Additionally, as discussed above, we clarify that where a Federal or state law requires a covered entity to provide individuals with access to the PHI requested in less than 15 calendar days, that shorter time period would be deemed practicable.[470]

We emphasize that the timeliness requirement applies regardless of the circumstances of the request. For example, the timeliness requirement applies without regard to the form or medium (*e.g.,* paper, electronic) in which the requested PHI is maintained. Negotiating with the individual about the form and format of the response does not extend the timeliness requirement. As another example, the

[467] *See* ''Gaps in Individuals' Information Exchange: Health IT Quick Stat,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Sept. 2025), *https://healthit.gov/data/quickstats/gaps-individuals-information-exchange/#overview* (stating that in 2024, about one in five individuals who went to the doctor in the past year reported that they had to wait longer for test results than they thought reasonable); ''Perspectives of Patients About Immediate Access to Test Results Through an Online Patient Portal,'' *supra* note 465 (explaining that most patients want unrestricted access to their medical records and prefer immediately receiving test results); ''ONC Data Brief: Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2024,'' *supra* note 306, at p. 5 (explaining that individuals' app-based access to online medical records continues to rise and that eighty-seven percent of individuals who were encouraged by their health care provider to accessed their patient portal did so at least once in 2024).

[468] Specifically, clinicians who participate in merit-based incentive payment systems (MIPS) must provide patients with the ability to electronically view, download, and transmit certain health information within 4 business days of the information becoming available to the clinician. Participating clinicians also must ensure that the patient (or their personal representative) can access the health information with any application that is configured to meet the technical specifications of the API in the clinician's CEHRT. ''Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category Measure 2025 Performance Period,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (last accessed Mar. 25, 2026), *https://qpp.cms.gov/reporting-requirements/ways-to-report/traditional-mips/promoting-interoperability.*

[469] Health plans regulated by CMS must maintain an API that permits certain apps to retrieve certain health information requested by an enrollee or that enrollee's personal representative no later than 1 business day. *See* 42 CFR 422.119, 431.60, 438.242, 457.730, 457.1233; 45 CFR 156.221; *see also* 85 FR 25510, 25632 (May 1, 2020); 89 FR 8758, 8974 (Feb. 8, 2024).

[470] *See, e.g.,* 85 FR 25642, 25813 (May 1, 2020) (explaining that actors are to make good faith efforts to work through common and understandable challenges and limitations to enable requestors to access, exchange, and use EHI as quickly and efficiently as possible); ''When would a delay in fulfilling a request for access, exchange, or use of EHI be considered an interference under the information blocking regulation?,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Mar. 2021), *https://healthit.gov/faq/when-would-delay-fulfilling-request-access-exchange-or-use-ehi-be-considered-interference-under/;* ''When a state or federal law or regulation, such as the HIPAA Privacy Rule, requires EHI be released by no later than a certain date after a request is made, is it safe to assume that any practices that result in the requested EHI's release within that other required timeframe will never be considered information blocking?,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Jan. 2021), *https://healthit.gov/faq/when-state-or-federal-law-or-regulation-such-hipaa-privacy-rule-requires-ehi-be-released-no/.*

timeliness requirement also applies to requests for PHI that is on paper, archived offsite and/or offline, and/or not otherwise easily accessible. If a covered entity is unable to provide access within 15 calendar days (*e.g.,* the information is archived offsite on paper and not easily accessible), the covered entity may extend the time to respond by no more than 30 calendar days. To extend the time, the covered entity must, within the initial 15 calendar days, inform the individual in writing of the reasons for the delay and the date by which the covered entity will provide access. Only one extension is permitted per access request.

In certain circumstances, because of the nature of a product or service (*e.g.,* mainstream genetic testing for cancer patients,[471] comprehensive genomic profiling of solid tumors,[472] or molecular biomarker testing [473]), 15 calendar days may not be sufficient to complete the product or service to which the individual has requested access. If the individual submits a request for access to the particular product or service that has not been completed and is not expected to be completed before the end of the 15-calendar-day period, the covered entity may notify the individual in writing within that 15-calendar-day period of the need and specific reason for the delay in providing access to PHI related to the completed product or service and the date by which the covered entity will complete its action on the request, in accordance with 45 CFR 164.524(b)(2)(ii)(A) and 164.524(d)(5)(ii)(B)(*1*). The Privacy Rule permits only one extension on such request, and the extension may not exceed an additional 30 calendar days. In the rare circumstance where 45 total calendar days is insufficient to satisfy the individual's request for access to PHI related to the completed product or service, the covered entity may, at the end of the 45-day period, satisfy the access request by providing the individual with access to the PHI that does exist at the time (*e.g.,* test requisitions, the underlying data being used to generate the reports, other completed test reports) in the designated record set.

However, to avoid this situation to the extent possible, where a covered entity knows that a particular product or service will take longer than the time permitted for responding to a right of access request, we encourage the covered entity to explain this circumstance to the individual. Upon informing an individual of this situation when they request access, the individual may be willing to withdraw or hold their request until a later time to ensure that they get access to the PHI that they want or need. If an individual chooses not to withdraw their request for access, the individual will then have a right, with respect to that request for access, only to obtain PHI in the designated record set at the time the request is fulfilled, which might not include the particular PHI requested because it is not yet available.[474] The individual can obtain the particular PHI requested by making another request for access at a later date. In these circumstances, we encourage covered entities to retain and respond to individuals' requests when the relevant product or service is completed and becomes part of the designated record set; however, they are not required to do so absent a new request.

Comment: Some commenters expressed concern about the ability of small health care providers to comply with the proposal because of limited staffing and other resources. A few commenters asserted that the proposal would have a negative effect on state government and Tribal entities in particular, because of their resource constraints and the associated burdens. These commenters provided examples of reasons why they believed this proposal was uniquely burdensome for them, such as weekend and holiday staffing challenges, their size, language translation needs, special programs, and other laws.

Response: The Department considered commenters' concerns about the potential burdens that the shorter time period may create. We believe that increasing the length of a possible extension to accommodate more complex or difficult requests from 15 calendar days, as proposed, to one 30-calendar-day extension, alleviates many of these concerns. To the extent that implementation burdens remain, the Department believes that the benefits to individuals (*e.g.,* their ability to direct their own health care, enhanced care coordination) outweigh the potential burdens on covered entities.

As discussed previously, the final rule requires that access be provided as soon as practicable, but in no case later than 15 calendar days after receipt of the request. It clarifies that the Department will deem fewer than 15 calendar days to be practicable where a Federal or state law requires such access to be provided more quickly. Where there is no specific law requiring faster access, the Department strongly encourages covered entities to provide individuals with access to their health information as quickly as possible within the allotted 15 calendar days. Moreover, even if regulated entities that also are subject to the information blocking regulations [475] fulfill requests for access within the time period required by the Privacy Rule, a practice that delays the fulfillment of such requests could constitute an interference under the information blocking regulations.[476]

Comment: Several commenters recommended that the Department align timeliness requirements across Federal programs that address aspects of the right of access.

Response: Implementation of certain requirements of the HITECH Act and Cures Act enables covered entities (and their business associates) that choose to use health IT to respond timelier to individual requests for ePHI. For example, developers of certified API technology must publish certain

[471] *See, e.g.,* Kyra Bokkers, et al., ''The Feasibility of Implementing Mainstream Germline Genetic Testing in Routine Cancer Care—A Systematic Review,'' Cancers (Basel), p. 7 (Feb. 19, 2022), *https://pmc.ncbi.nlm.nih.gov/articles/PMC8870548/.*

[472] *See, e.g.,* Adam H. Fox, et al., ''Turnaround Time of Comprehensive Genomic Profiling in Lung Cancer and Other Solid Tumors,'' JCO Oncology Practice (Jun. 18, 2026), *https://ascopubs.org/doi/10.1200/OP-25-01191?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.*

[473] *See, e.g.,* Xiao Wang, et al. ''Molecular Biomarker Testing Patterns and Turnaround Time in US Patients With Advanced Non–Small Cell Lung Cancer,'' Journal of the National Comprehensive Cancer Network (Oct. 10, 2025), *https://pmc.ncbi.nlm.nih.gov/articles/PMC13268203/.*

[474] *See* 79 FR 7290, 7295 (Feb. 6, 2014); *see also* ''Is a clinical laboratory required to provide an individual with access to a test report that is not yet complete?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #2067 (June 24, 2016), *https://www.hhs.gov/hipaa/for-professionals/faq/2067/is-a-clinical-laboratory-required-to-provide/index.html.*

[475] *See* 45 CFR 171.102 (definition of ''Actor'').

[476] Whether a practice that is likely to interfere with access, exchange, or use of EHI meets the statutory or regulatory definition of information blocking is a fact-specific determination. *See* 45 CFR 171.103. *See also* 85 FR 25642, 25649, 25808 (May 1, 2020); 89 FR 1192, 1384 (Jan. 9, 2024); ''When a state or federal law or regulation, such as the HIPAA Privacy Rule, requires EHI be released by no later than a certain date after a request is made, is it safe to assume that any practices that result in the requested EHI's release within that other required timeframe will never be considered information blocking?,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Jan. 2021), *https://healthit.gov/faq/when-state-or-federal-law-or-regulation-such-hipaa-privacy-rule-requires-ehi-be-released-no;*''How would any claim or report of information blocking be evaluated?,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Feb. 2022), *https://healthit.gov/faq/how-would-any-claim-or-report-information-blocking-be-evaluated/.*

information about their APIs that can be used by individuals to access certain information using a personal health application.[477] The Cures Act directed the Secretary to require, as a condition of certification and maintenance of certification for the ONC Health IT Certification program, that the developer of certified technology allows health information from such technology to be accessed, exchanged, and used without special effort through the use of APIs or successor technology or standards, as provided for under applicable law, including providing access to all data elements of a patient's electronic health record to the extent permissible under applicable privacy laws.[478] To achieve such access, exchange, or use without special effort, ONC issued regulations that require certified APIs, and the health care ecosystem in which they are deployed, to be standardized, transparent, and pro-competitive.[479] Where a developer of certified API technology institutes an authenticity verification process for API users, the developer must complete that process within 10 business days and subsequently register and enable the application for production use within 5 business days.[480] Accordingly, when regulated entities adopt health IT that includes certified API technology, individuals can more easily access their ePHI and covered entities can more easily respond to right of access requests.

To further encourage the use of ONC-certified and other secure, interoperable health IT with the goal of providing individuals with timelier access to their PHI, this final rule requires that access be provided ''as soon as practicable,'' but in no case later than 15 calendar days after receipt of the request. It clarifies that the Department will deem fewer than 15 calendar days to be practicable where Federal or state law requires such access to be provided more quickly. Accordingly, where other Federal regulations, such as the Interoperability and Patient Access Final Rule,[481] the Interoperability and Prior Authorization Final Rule,[482] and the Quality Payment Program,[483] require a covered entity to provide an individual with access to PHI in fewer than 15 days, the Department deems the shorter time period to be ''practicable'' and expects that covered entities will comply with such other law.[484] Thus, a failure to comply with such other law also could result in a violation of the timeliness requirements at 45 CFR 164.524(b)(2)(i) and 164.524(d)(5)(ii)(A). Where there is no specific law requiring access in fewer than 15 calendar days, covered entities still must provide individuals with access to their health information as soon as practicable (*i.e.,* in less than 15 calendar days if practicable). Furthermore, where regulated entities that are subject to the information blocking regulations engage in a practice that delays fulfilling access requests, such practice could constitute an interference under the information blocking regulations, even if the requests are fulfilled within the 15-calendar-day period required by this final rule.[485]

The Department strongly encourages covered entities to take advantage of technologies that enable individuals to have faster or even immediate access to the requested information, adoption of which would, in turn, make such expedited access ''practicable.''

Comment: Several commenters expressed concern that covered entities often take more than the permitted time to let individuals know that their request is incomplete and then reset the ''clock'' when the individuals submit an updated request.

Response: The time period for responding to a request for access begins on the date that a covered entity receives the request, and a covered entity must respond within 15 calendar days of receiving it. This 15-calendar-day period includes, for example, the time that it takes a covered entity to obtain any additional information from the individual or personal representative that it needs to act upon a request and the time that it takes a covered entity to obtain pertinent information from a business associate or forward the request to the business associate for action. It also includes the time that it takes to verify an individual or personal representative's identity, and in the case of a personal representative, their authority to obtain access to the requested PHI. Where a request is sent directly to a business associate and the business associate agreement provides that the business associate is responsible for responding to such requests, the 15-calendar-day period begins when the business associate receives the request from an individual.

If the covered entity is unable to act on a request within 15 calendar days of receiving the request, it may extend the deadline for up to an additional 30 calendar days by providing the individual with a written statement of the reasons for the delay and the date by which the covered entity will complete its action on the request. This written statement describing the extension must be provided within the standard (*i.e.,* pre-extension) deadline of 15 calendar days. A covered entity may extend the deadline only once for any given access request.

Comment: Several commenters expressed concern that the proposal would be burdensome for health plans for a variety of reasons, including that they offer multiple products, requests often require coordination across business associates, the PHI requested may span a long period of time, and they have multiple electronic information systems that maintain PHI. One commenter requested that the Department provide health plans with a longer implementation period for this proposal because it would require administrative and technological changes to implement a new process for responding to access requests.

Response: We are adopting a modified version of our proposal that requires covered entities to respond to a request for access as soon as practicable, but no later than 15 calendar days after receipt of the request, with the possibility of one 30-calendar-day extension. To the extent that a particular request meets the conditions for a one-time extension, the total amount of time permitted for acting on the request is 45 calendar days from receipt of the individual's request, which we believe is sufficient for most

[477] *See* 45 CFR 170.404(a)(1).

[478] Sec. 3001(c)(5) of the PHSA, as amended by sec. 4002(a) of the 21st Century Cures Act, Public Law 114–255, 130 Stat. 1159–60 (Dec. 13, 2016) (codified at 42 U.S.C. 300jj–11(c)(5)(D)(iv); 45 CFR 170.404(a)(1).

[479] *See* 84 FR 7424, 7477 (Mar. 4, 2019); 85 FR 25642, 25739–40 (May 1, 2020).

[480] *See* 45 CFR 170.404(b)(1).

[481] *See* 42 CFR 422.119, 431.60, 438.242, 457.730, 457.1233; 45 CFR 156.221; 85 FR 25510 (May 1, 2020).

[482] *See* 42 CFR 422.119, 431.60, 438.242, 457.730; 45 CFR 156.221; 89 FR 8758 (Feb. 8, 2024).

[483] *See* 42 CFR 414.1375; 90 FR 49266, 49654–64, 49868–49903 (Nov. 5, 2025); *see also* ''Promoting Interoperability: Traditional MIPS Requirements,'' *supra* note 246; ''APM Performance Pathway,'' *supra* note 246.

[484] *See generally* ''When would a delay in fulfilling a request for access, exchange, or use of EHI be considered an interference under the information blocking regulation?,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Mar. 2021), *https://healthit.gov/faq/when-would-delay-fulfilling-request-access-exchange-or-use-ehi-be-considered-interference-under/.*

[485] *See generally* 45 CFR part 171; *see also* ''When a state or federal law or regulation, such as the HIPAA Privacy Rule, requires EHI be released by no later than a certain date after a request is made, is it safe to assume that any practices that result in the requested EHI's release within that other required timeframe will never be considered information blocking?,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Jan. 2021), *https://healthit.gov/faq/when-state-or-federal-law-or-regulation-such-hipaa-privacy-rule-requires-ehi-be-released-no.*

requests today even without significant changes in covered entities' policies and procedures. Additionally, to comply with other laws, many covered entities already have implemented patient or health plan member portals and other solutions for providing individuals with access to their PHI in an electronic form and format quickly and easily. Thus, we do not believe that covered entities need additional time to implement this requirement.

The effective date of the final rule is 60 days after publication for all regulated entities. Regulated entities have an additional 180 days until the compliance date to establish and implement policies, procedures, and practices to achieve compliance with any new or modified standards. Regulated entities are permitted to comply earlier than the compliance date, but the Department will not take action against them for noncompliance with the finalized requirements that occur before the compliance date. Thus, regulated entities have 240 days to develop and implement policies and procedures for responding to such requests.

5. Addressing the Form and Format of Access

a. Current Rule

Section 164.524(c)(2) includes the requirements for the form and format of a covered entity's response to an individual's request for access to their PHI. Section 164.524(c)(2)(i) requires a covered entity to provide an individual with access to the individual's PHI in the form and format requested by the individual, if it is readily producible in the requested form and format. Where the covered entity cannot provide PHI in the requested form and format, 45 CFR 164.524(c)(2)(i) requires the covered entity to provide the individual with a readable hard copy or such other form and format as agreed to by the covered entity and individual. If the covered entity maintains the PHI electronically, 45 CFR 164.524(c)(2)(ii) requires a covered entity to provide the individual with access to the information in the requested electronic form and format, if it is readily producible in that form and format, or if not, in a readable electronic form and format as agreed to by the covered entity and individual.

The Department interprets the phrase ''readily producible in that form and format'' as referring to (1) how PHI is produced to the individual (or person designated by the individual to receive an electronic copy of the PHI in an electronic health record), and (2) the format of the PHI that is transmitted (*e.g.,* the type of electronic file, etc.). When an individual requests access to PHI in a particular form or format, the question for the covered entity is whether or not the entity is able to readily produce the copy in that format—which is a matter of capability, not willingness.[486] Thus, if a covered entity has the capability to readily produce the requested format, it is not permissible for the covered entity to deny the individual access to that format because the entity would prefer that the individual receive their PHI in a different format or follow other procedures for accessing records that are more customarily relied upon by the entity.[487]

For example, where an individual requests a paper copy of PHI maintained by the covered entity either electronically or on paper, it is expected that the covered entity will be able to provide the individual with the paper copy requested.[488] Where an individual requests an electronic copy of PHI that a covered entity maintains only on paper, the covered entity is required to provide the individual with an electronic copy if it is readily producible electronically (*e.g.,* the covered entity can readily scan the paper record into an electronic format).[489] In the event that an individual requests an electronic copy of PHI and a covered entity maintains PHI electronically, a covered entity is not required to purchase new software or equipment in order to accommodate every possible individual request.[490] However, the covered entity in this circumstance must have the capability to provide some form of electronic copy of PHI maintained electronically.[491] Where an individual declines to accept any of the electronic formats readily producible by the covered entity, the covered entity may satisfy the request for access by providing the individual with a readable hard copy of the PHI.[492]

The Privacy Rule also includes requirements that address whether and when covered entities can provide individuals with summaries or explanations of their requested PHI. Section 164.524(c)(2)(iii) permits a covered entity to provide the individual with a summary of the requested PHI in lieu of copies, or an explanation of the PHI to which access has been provided, if the individual has agreed in advance to such summary or explanation, and to the fees imposed, if any, by the covered entity to cover the costs of preparing the summary or explanation.

b. Proposed Rule

In the 2021 Privacy Rule NPRM, the Department proposed to modify the requirements for covered entities responding to requests for access to PHI in an electronic form and format. Specifically, the Department proposed to add a new subparagraph (iii) to 45 CFR 164.524(c)(2) that would deem PHI to be ''readily producible'' in a form and format where another applicable Federal or state law requires the entity to provide the access in the particular electronic form and format requested by the individual. To accommodate this new paragraph and address the requirements of the right of access to direct, we also proposed to redesignate 45 CFR 164.524(c)(2)(iii) as 45 CFR 164.524(c)(2)(iv) and 164.524(d)(4).

Additionally, we proposed to require at 45 CFR 164.524(c)(2)(iv)(B) and 164.524(d)(4)(ii) that when a covered entity offers a summary to an individual, or a person designated by the individual, in lieu of copies of the requested PHI, it must inform the individual that they retain the right to obtain a complete copy of the PHI. These proposed requirements would not apply when the covered entity offers a summary because it is denying the individual's request made pursuant to the right of access (including the right of access to direct) on unreviewable or reviewable grounds. For example, a covered entity would not be required to inform an individual that they retain the right to obtain a complete copy of their PHI where the covered entity denies the individual's request for access to PHI because the requested PHI was obtained from someone (other than a health care provider) under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.[493] In such

[486] *See* ''When an individual exercises her HIPAA right to get an electronic copy of her PHI, can the individual choose the electronic format of the copy?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #2056 (May 30, 2025), *https://www.hhs.gov/hipaa/for-professionals/faq/2056/when-an-individual-exercises-her-hipaa-right/index.html.*

[487] *Id.*

[488] *See* 78 FR 5566, 5633 (Jan. 25, 2013).

[489] *See* ''If an individual requests an electronic copy of the individual's PHI that the covered entity maintains only on paper, is the covered entity required to scan the paper records to create an electronic copy of the PHI for the individual?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #2055 (June 24, 2016), *https://www.hhs.gov/hipaa/for-professionals/faq/2055/if-an-individual-requests-an-electronic-copy/index.html.*

[490] *See* 78 FR 5566, 5633 (Jan. 25, 2013).

[491] *Id.*

[492] *Id.*

[493] *See* 45 CFR 164.524(a)(2)(v).

circumstances, the covered entity would be required to implement the specified procedures for such denial.[494]

c. Overview of Comments

Commenters expressed mixed views on these proposals, with most commenters expressing concern or opposition. Some commenters asserted that the proposal to deem ePHI readily producible in a particular form and format in certain circumstances would increase costs for health care providers because it would require changes to their EHRs. Many commenters expressed opposition to the Department's proposal because they believed that it would require covered entities to use secure, standards-based APIs to fulfill requests for access. In contrast, a few commenters expressed support for this proposal because they believed that it would require covered entities to use secure, standards-based APIs to fulfill requests for access.

A few commenters expressed support for the Department's proposals to require that covered entities inform individuals that they retain their right to request access to their PHI (including their right of access to direct) if they do not agree to receive the summary (or to direct the summary to the person designated by the individual) in lieu of a copy of the PHI.

Commenters expressed the need for transparency about the information personal health apps collect on individuals, and what the developers do with that information, and urged the Department to protect individuals' health information from exploitation. These commenters expressed concern that app developers that are not regulated entities may misuse individuals' health information. Many commenters who expressed opposition to providing individuals with a copy of their PHI through a personal health app pursuant to the individual's right of access recommended that the Department require covered entities or an app itself to notify individuals that their information is not protected by HIPAA under such circumstances.

d. Final Rule

The Department is finalizing the proposals to: (1) add a new 45 CFR 164.524(c)(2)(iii); (2) redesignate existing 45 CFR 164.524(c)(2)(iii) as 45 CFR 164.524(c)(2)(iv) and 164.524(d)(4) without modification; and (3) add new 45 CFR 164.524(c)(2)(iv)(B) and 164.524(d)(4)(ii). New paragraph (iii) of 45 CFR 164.524(c)(2) provides that if other Federal or state law requires an entity (which may include a business associate acting on behalf of a covered entity) to implement a technology or policy that has the effect of providing an individual with access to their PHI in a particular electronic form and format, such form and format would be deemed ''readily producible'' for the purposes of compliance in fulfilling requests for such PHI under 45 CFR 164.524(c)(2)(i) and (ii).

The Department believes that aligning the Privacy Rule with other applicable laws facilitates individual access and care coordination, and eases burdens on covered entities and individuals. The Department also believes that these modifications increase transparency about the obligations of covered entities to provide individuals with copies of their PHI. Moreover, we believe that these modifications will result in a more complete understanding of the right of individuals to access their PHI.

Further, we clarify that PHI is readily producible in a form and format where a covered entity makes PHI available in that form and format to other persons (*e.g.,* regulated entities), and where the level of risk to the security of the covered entity's ePHI and electronic information systems (or the business associate's electronic information systems when the ePHI is maintained or transmitted by the business associate for, or on behalf of, the covered entity) is no greater than it is when providing the PHI to such other persons in that same form and format. For example, where a covered entity (or a business associate acting for, or on behalf of a covered entity) provides ePHI to another covered entity through a secure, standards-based API that also is capable of transmitting ePHI to a personal health app without increasing the risk to the security of the covered entity's ePHI or electronic information systems, we consider the ePHI to be readily producible to the individual through their personal health app. Further, where a covered entity transmits a copy of PHI through a personal health app, we interpret this as a transmission to the individual. In other words, the Department interprets a request by an individual to receive a copy of their PHI through a personal health app as an exercise of their right to obtain a copy, rather than an exercise of the right of access to direct (discussed below).

A covered entity is not required to provide an individual with a copy of the individual's PHI to or through a personal health app if a copy is not readily producible to or through such application. In other words, this final rule does not independently require the implementation of technology or policies by covered entities for the purpose of gaining the ability to provide individuals with a copy of their PHI to or through a personal health app. Rather, it requires that covered entities use technology or policies that are required by other Federal or state laws, or that they have otherwise implemented, to provide individuals with copies of their PHI to or through personal health apps where individuals request copies in such form and format.

Relatedly, we encourage covered entities to provide individuals with an electronic copy of their ePHI in another standards-based interoperable electronic format if the requested ePHI is not readily producible in the requested electronic form and format. Where the ePHI is not available in another standards-based interoperable electronic form and format, we encourage covered entities to provide individuals with their ePHI in a machine-readable electronic form and format. This approach aligns with the Manner Exception in the information blocking regulations.[495] Only if the ePHI is not producible in a machine-readable electronic form and format should covered entities offer individuals a copy of their ePHI solely in a human-readable electronic form and format—unless the individual requests the copy in such form and format.

Additionally, 45 CFR 164.524(c)(2)(iv)(B) and 164.524(d)(4)(ii) require that, when a covered entity offers a summary in lieu of a copy of PHI, it must inform the individual that the individual retains the right of access, including the right of access to direct if they do not agree to receive the summary. To fully comply with the access provisions, a covered entity remains obligated to ensure that it is the individual, and not the covered entity, who decides whether a summary is an acceptable substitute for a copy or copies of the requested PHI.

e. Responses to Public Comments

Comment: A few commenters expressed support for the proposal because they believed that it would clarify that ''readily producible'' includes access through secure APIs and personal health apps.

In contrast, many commenters expressed opposition to the Department's assertion that ''readily producible'' could include the use of implemented secure, standards-based APIs to fulfill access requests if a Federal or state law requires an entity to implement a technology or policy that

[494] *See* 45 CFR 164.524(d) (redesignated as 45 CFR 164.524(e) in this final rule).

[495] *See* 45 CFR 171.301.

would have the effect of providing an individual with access to their PHI in that form and format. A few commenters expressed opposition to the proposal because they believed that such a requirement would exceed the Department's authority under HIPAA and would require reliance upon or changes to other Federal or state laws. These commenters additionally asserted that aligning the Privacy Rule with other laws or policies in this manner could undermine the ability of the Department to exercise enforcement discretion, causing conflicts or requiring modification to the Privacy Rule when such other laws are modified.

Some of these commenters asserted that API technology was not mature and would continue to evolve. According to commenters, this lack of maturity could harm patient care because API technology was not able to fully integrate into other technologies, delaying the ability of covered entities to respond to individuals' requests for ePHI or diverting resources from clinical initiatives. Several commenters expressed opposition to this proposal because they believed that it would require physicians to implement API technology. These commenters asserted that such a requirement would increase costs and burdens for health care providers, especially for small providers, for various reasons, including the complexity of integrating API technology with legacy systems.

Several commenters expressed opposition to the proposal because they believed that the proposed modification would increase the burden on covered health care providers.

Other commenters recommended that the Department modify the proposal to clarify that a covered entity would not have to provide access to ePHI in the form or format requested if an exception to information blocking applies.

Response: The Department believes that providing individuals with easy and prompt access to their PHI empowers them to make informed decisions about their health care, and that supporting the adoption of new technologies that enable such access is essential. The Privacy Rule generally is technology neutral; accordingly, we do not specifically require covered entities to adopt APIs or other technology that enables access through personal health apps. Additionally, we recognize that not all covered entities have implemented technology, such as secure, standards-based APIs that are consistent with ONC's certification criteria and with their Security Rule obligations, to enable access to requested PHI through personal health apps. However, where a covered entity has chosen, or is required by other Federal or state law, to implement such technology or participate in TEFCA or the CMS Aligned Networks to enable access to requested PHI,[496] we will deem that PHI to be readily producible in that form and format for purposes of the right of access. We recognize that even where covered entities have implemented such technology or elected to participate in networks that enable the electronic exchange of PHI, not all PHI will be readily producible in the requested electronic form and format. For example, today, not all images can be exchanged electronically. Where an individual requests a copy of PHI that includes such images to be sent to their personal health app, the Department would not deem such images to be readily producible through the personal health app. Instead, the covered entity would be required to produce the PHI that is readily producible in that form and format through a personal health app and to provide the individual with the balance of the PHI in a mutually agreed upon form and format.

The provision deeming ePHI to be readily producible in a form and format where other Federal or state law requires that ePHI be available in the particular form and format only implicates covered entities that are subject to such other laws (*e.g.,* the Interoperability and Patient Access Final Rule).[497] This provision does not require modifications to other Federal or state laws, nor does it affect the ability of the Secretary to exercise enforcement discretion. Where an exception to or exclusion from a Federal or state law applies to a covered entity, the covered entity would not be obligated under such law to provide access using a particular form or format that otherwise would be required by the law. However, if that form or format is readily producible for the covered entity, the covered entity is still required to provide ePHI in that form or format if requested by the individual under the Privacy Rule.

We clarify that requiring all personal health apps to complete a registration process before the covered entity transmits ePHI to the individual and/or their personal representative through such apps, would not constitute a denial of access in the form and format requested, provided that the registration process does not exclude or prevent a personal health app that is capable of securely connecting to the secure, standards-based API from so connecting.[498] Additionally, as discussed above, negotiations about the form and format of an individual's request do not extend the amount of time that covered entities have to respond to requests for access. Accordingly, a covered entity's decision to require personal health apps to register through the process described above cannot be used as a basis to exceed the timeliness requirements for requests made pursuant to the right of access. This holds true regardless of whether the request was to provide the individual with their PHI through a personal health app or to transmit it to a person designated by the individual pursuant to the right of access to direct.

Comment: A few commenters expressed concern about potential risks to the privacy and security of identifiable health information in personal health apps. A few commenters urged the Department either to work with private sector entities to develop a privacy and security trust framework or to warn individuals that APIs and health apps currently lack sufficient regulatory and technology-based privacy and security guardrails. One commenter asserted that the proposal would facilitate the development of a national privacy framework that would ensure that health care data obtained by third-party apps is held to high privacy and security standards. One commenter asserted that the Department should limit the ability of personal health apps to be used by others for financial gain. Another commenter recommended that developers of personal health apps be required to provide individuals with transparency about their data collection and use policies.

Response: As health IT proliferates and matures, the Department must take steps, where possible within its statutory authority, to require that regulated entities implement corresponding privacy and security measures.[499] However, as we have

[496] *See* Security Rule, 45 CFR part 160 and subparts A and C of part 164.

[497] *See* 85 FR 25510 (May 1, 2020).

[498] HIPAA does not grant authority to the Secretary to impose security standards on a personal health app that is not a covered entity or a business associate. However, the information blocking regulations, at 45 CFR 171.203, provide an exception to what is considered information blocking when the actor's practice that is likely to interfere with the access, exchange, or use of EHI is implemented to protect the security of EHI and meets the other requirements of that provision. An actor whose practices met the security exception at all relevant times would not be subject to an enforcement action for information blocking. *See* 85 FR 25642, 25649 (May 1, 2020).

[499] For example, in 2025, the Department proposed significant modifications to the Security

Continued

explained elsewhere in this final rule, a personal health app or its developer, by definition, is not acting on behalf of or at the direction of a regulated entity, and therefore would not be subject to the privacy and security obligations of the HIPAA Rules. At the same time, a covered entity must provide an individual with access to their PHI in the form and format requested by the individual, if it is readily producible in such form and format.[500] As discussed above, we are adopting the proposal to clarify that a requested form and format would be deemed readily producible for purposes of compliance with the Privacy Rule if other Federal or state law requires an entity to implement a technology or policy that has the effect of providing an individual with access to their PHI in a particular electronic form and format (*e.g.,* if a Federal law required the provision of access via secure, standards-based API).

Whether a particular mode of transmission or transfer is readily producible is based on the capabilities of the covered entity and the level of security risk that the mode of transmission or transfer may introduce to the PHI on the covered entity's electronic information systems.[501] A covered entity is not expected to tolerate unacceptable levels of risk to the security of the PHI on its systems when responding to requests for access under the Privacy Rule. Whether the individual's requested mode of transfer or transmission presents such an unacceptable level of risk to the covered entity's ePHI or its electronic information systems is informed by the covered entity's Security Rule risk analysis and risk management measures.[502] We believe that, generally, when a covered entity determines its electronic information systems' ability to transmit PHI or to provide read access to PHI through a personal health app, the risk to the security of ePHI in their electronic information systems is low. At the same time, a covered entity remains responsible for maintaining awareness of and protecting ePHI in the face of new security vulnerabilities and threats to the confidentiality, integrity, and availability of ePHI. Determining whether a covered entity that is subject to the information blocking regulations is compliant with the Security Rule and has met the conditions of the Security Exception of the information blocking regulations requires separate analyses.[503]

Whether a particular mode of transmission or transfer is readily producible is not based on the level of privacy or security risks to the PHI once it has left the covered entity's electronic information systems. Thus, under the individual right of access, an individual may request a covered entity to transmit their ePHI to a personal health app in an unsecure manner or through an unsecure channel.[504] For instance, an individual may request that their unencrypted ePHI be transmitted to an app as a matter of convenience. With respect to such apps, the covered entity may consider informing the individual of the potential risks involved when the individual makes the request.[505]

The Department acknowledges that not all covered entities have implemented secure, standards-based APIs to enable individuals to access their ePHI using personal health apps. The Department believes that email generally is considered readily producible by all covered entities (except in the limited case where email cannot accommodate the file size of requested images), and transmitting PHI in such a manner does not present unacceptable security risks to the electronic information systems of covered entities, even though there may be security risks to the PHI while in transit (*e.g.,* where an individual has requested to receive their PHI by, and accepted the risks associated with, unencrypted email).[506]

Comment: A few commenters expressed support for the proposal to require a covered entity to inform the individual who requests copies of PHI that the individual retains the right of access to direct a copy of ePHI in an electronic health record to a designated person and does not have to agree to a summary in lieu of access. One commenter expressed concern that the proposal could limit the ability of health care providers to restrict the access of parents or guardians to certain PHI. This commenter asserted that the proposal would conflict with certain state laws because they believed that the proposal would require the disclosure of a minor's full record, even where state law directs covered entities to provide parents/guardians with a summary of the minor's records.

Response: The Department proposed and is finalizing without modification the proposal to require that when a covered entity offers the individual a summary of their PHI in lieu of providing access, the covered entity must inform the individual that the individual retains the right to obtain a copy of the requested PHI (or to direct an electronic copy of PHI in an electronic health record to a person designated by the individual) if they do not agree to the summary.

The Privacy Rule establishes the right of an individual, or a personal representative acting on the individual's behalf, to access the individual's PHI.[507] The Privacy Rule provides that, if under applicable law, a parent, guardian, or other person acting *in loco parentis* has authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under the HIPAA Rules, with respect to PHI relevant to such personal representation.[508] In most cases, a parent is the personal representative of an unemancipated minor child and can exercise the minor child's rights with respect to PHI, because the parent usually has the authority to make health care decisions about their minor child.[509] Accordingly, the Privacy Rule generally gives the parent the right to access the minor child's medical records as the minor child's personal representative, unless one of the limited exceptions applies. This final rule does not change anything with respect to the exceptions or the grounds for a denial of access.[510] We believe that this modification is necessary to ensure that individuals remain aware of their rights and the obligations of covered entities with respect to their PHI.

Rule to strengthen protections for ePHI. *See* 90 FR 898 (Jan. 6, 2025).

[500] 45 CFR 164.524(c)(2) and (3).

[501] This discussion refers to covered entities because the Privacy Rule imposes the obligation to provide an individual with access to their PHI on covered entities. However, the concepts discussed herein apply equally to business associates that, on behalf of covered entities and pursuant to their business associate agreements, furnish individuals with access to their PHI.

[502] *See* 45 CFR 164.524(c)(2) and (3); 164.308(a)(1).

[503] *See* 45 CFR 171.303.

[504] *See* 45 CFR 164.524(a)(1), (c)(2)(ii), and (c)(3); *see also* ''Can a covered entity refuse to disclose ePHI to an app chosen by an individual because of concerns about how the app will use or disclose the ePHI it receives?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #3012 (Apr. 18, 2019), *https://www.hhs.gov/hipaa/for-professionals/faq/3012/can-a-covered-entity-refuse-to-disclose-ephi.html.*

[505] *See* 85 FR 25642, 25814 (May 1, 2020) (discussing how a covered entity that is also an actor may provide individuals with such information).

[506] *See* 90 FR 898, 969 (Jan. 6, 2025) (discussing risks associated with a request for access in a manner that does not support encryption, such as unencrypted email).

[507] 45 CFR 164.524.

[508] 45 CFR 164.502(g)(3)(i).

[509] *See* Letter to Colleagues from OCR Director Paula M. Stannard, *supra* note 354.

[510] 45 CFR 164.502(g), 164.524(a)(3) and (4), and 164.524(d)(2) and (3).

6. Addressing the Individual Right of Access to Direct Copies of PHI to a Person Designated by the Individual

a. Issues To Address

Section 13405(e)(1) of the HITECH Act expanded the individual right of access, codified at 45 CFR 164.524, to include the right of an individual to direct an electronic copy of their PHI in an electronic health record to a person designated by the individual, provided that the direction is clear, conspicuous, and specific.[511] Under the 2013 Omnibus Rule, which implemented certain provisions of the HITECH Act, the individual's (or their personal representative's) request to exercise the right of access to direct must be in writing, signed by the individual, and clearly identify the designated person and where to send the copy of the PHI.[512]

The 2013 Omnibus Rule also expanded the right of access to direct to encompass all PHI in a designated record set, regardless of whether the PHI is in an electronic health record.[513] The court in *Ciox* held that the Department had exceeded its authority under the HITECH Act and vacated the Department's expansion of the right beyond electronic copies of PHI in an electronic health record. Thus, the Department is revising the Privacy Rule to ensure that section 13405(e) of the HITECH Act is implemented consistent with the court's interpretation of the statute in *Ciox.*

b. Proposed Rule

The Department proposed to create a separate set of provisions, within the Privacy Rule section on the right of access, to address the individual's right of access to direct a covered health care provider to transmit an electronic copy of PHI in an electronic health record to a person designated by the individual. We proposed to require a covered health care provider to respond to an individual's request to exercise this right when the request is clear, conspicuous, and specific and to permit the request to be made orally or in writing (including electronically). Additionally, the Department proposed that only covered health care providers would be responsible for fulfilling an individual's request under the right of access to direct because the Department did not believe that other covered entities would have an electronic health record as we proposed to define it.

The Department also proposed to extend the right of access to direct to require a covered health care provider or health plan (the ''Requestor-Recipient''), at an individual's direction, to submit an individual's access request for their ePHI to another covered health care provider (the ''Discloser''), requesting that the Discloser transmit ePHI maintained by or on behalf of the Discloser in its electronic health record to the Requestor-Recipient. We proposed that this requirement would apply when an individual was an existing or prospective new patient or a current member (or dependent) of the Requestor-Recipient, and would be limited to directing electronic copies of PHI in an electronic health record back to the Requestor-Recipient.

c. Overview of Comments

Many commenters expressed opposition to the Department's proposal to limit the right of individuals to direct a copy of PHI to a designated person to only electronic copies of PHI in an electronic health record because they believed that it would eliminate individuals' right of access to direct non-electronic copies of PHI and PHI that is not in an electronic health record. Some commenters expressed concerns that the right of access to direct had been misused by other persons and that individuals sometimes were unaware of what PHI was being disclosed under this right, to whom, and for what purpose. Several commenters expressed support for limiting an individual's right of access to direct as proposed because they believed that it would ease compliance.

d. Final Rule

We are finalizing many of our proposals for 45 CFR 164.524(d), with modification, as described below. Consistent with the HITECH Act, the final rule adopts, with modification, the proposal to require a covered entity to transmit an electronic copy of PHI in an electronic health record to the person designated by the individual if directed to do so by an individual. While we do not believe that the definition of an electronic health record is relevant to all covered entities, we recognize that there are some circumstances where a covered entity other than a covered health care provider may have an electronic health record (*e.g.,* where a health plan is integrated with a health care provider and maintains PHI in the same electronic information systems as the health care provider). In such circumstances, both the health plan and the health care provider would be required to respond to requests made pursuant to the right of access to direct. Accordingly, the regulatory text reflects that the right of access to direct may apply to all covered entities that are subject to the right of access.[514]

As required by the HITECH Act, consistent with the court's decision in *Ciox,* the scope of this right is limited to requests for electronic copies and to PHI in an electronic health record. Thus, requests for a non-electronic copy of PHI or for PHI that is not in an electronic health record do not meet the conditions for the right of access to direct. Instead, in such circumstances, in order for the covered entity to transmit the requested PHI to another person, an individual would need to provide a covered entity with a valid authorization to disclose the requested PHI to that other person, absent an applicable Privacy Rule permission.

Section 13405(e) of the HITECH Act places the right of access to direct within 45 CFR 164.524, which contains the standard for the right of access. Thus, the final rule adopts a revised version of the proposed standard for the right of access to direct—also placing it within the section of the Privacy Rule that addresses the right of access—that more closely mirrors the standard for the individual right of access at 45 CFR 164.524(a) and incorporates the limitations of the right of access into the right of access to direct. Through these revisions, we clarify that, consistent with the HITECH Act and the *Ciox* decision, the right of access to direct is limited to PHI about the individual that is both in an electronic health record and in a designated record set. PHI that is in an electronic health record but not in a designated record set (*e.g.,* patient safety work product), or that is in a designated record set but not in an electronic health record (*e.g.,* paper records), is not subject to the right of access to direct. We also clarify that this right, like the broader right of access, excepts both psychotherapy notes and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, from the PHI in an electronic health record that an individual is entitled to direct to a person designated by the individual. Similarly, we clarify that, for purposes of the right of access to direct, an ''electronic copy'' has the same meaning as we interpret the term under the broader right of access.[515] The

[511] *See* sec. 13405(e) of the HITECH Act, 123 Stat. 264 (Feb. 17, 2009) (codified at 42 U.S.C. 17935(e)).

[512] 45 CFR 164.524(c)(3)(ii).

[513] *See* 78 FR 5566, 5631 (Jan. 25, 2013).

[514] Health care clearinghouses are not subject to the same individual access requirements as health plans and covered health care providers. *See* 45 CFR 164.500(b)(1).

[515] 78 FR 5566, 5631–34 (Jan. 15, 2013).

requirements of the individual right of access with respect to denials and timing also are mirrored in the right of access to direct. Thus, requests made pursuant to the right of access to direct can be denied for the same reasons as a request made pursuant to the individual right of access and must be addressed within the same amount of time, as discussed below.

Additionally, we eliminate references to a ''third party'' and replace them with the statutory language of ''a person designated by the individual.'' Not only does this language mirror the HITECH Act more closely, but it also emphasizes the purpose of the right—to strengthen individuals' control over disclosures of their PHI.

We are not finalizing the proposal to require a covered entity to respond to individuals' requests made pursuant to the right of access to direct when such requests are made orally. We are persuaded by public comments that implementing the proposed requirement for covered health care providers to respond to oral requests made pursuant to the right of access to direct would be difficult, would increase burdens on covered entities because of the work associated with verifying the accuracy of the request, and would increase the likelihood of miscommunication and erroneous responses to requests, leading to potential breaches of unsecured PHI (*e.g.,* misdirected records). Instead, we are finalizing the implementation specification at 45 CFR 164.524(d)(5) to more closely mirror the implementation specification at 45 CFR 164.524(b) by including both: (1) instructions for how a covered entity is to identify requests made pursuant to the relevant right; and (2) the amount of time that a covered entity has to act on such requests.

Consistent with the HITECH Act, the final rule adopts a new 45 CFR 164.524(d)(5)(i) that instructs a covered entity to permit an individual to direct an electronic copy of PHI about the individual in an electronic health record to a person designated by the individual where the request is clear, conspicuous, and specific. This section also clarifies that a covered entity is permitted to require an individual to make such a request in writing, provided that it informs the individual of such a requirement. For purposes of the right of access to direct, consistent with new 45 CFR 164.524(b)(1)(ii), ''in writing'' means that the request itself serves as documentation of the individual's exercise of the right of access to direct, including when the request is submitted electronically or on paper.

Individuals who request that a covered entity provide them or a person that the individual designates with access to their PHI are not required to execute a HIPAA authorization. As discussed above, a request to direct an electronic copy of PHI in an electronic health record to a person designated by the individual is sufficient when it is clear, conspicuous, and specific. Because a HIPAA authorization requires more information than is necessary or that may be relevant for individuals to exercise their access rights, including their right of access to direct,[516] requiring the execution of a HIPAA authorization may create impermissible obstacles to the exercise of this right. Where it is unclear, based on the form of a request, whether the request is an effort by the individual to exercise their right of access to direct or merely the individual's authorization to disclose PHI as requested by a third party, covered entities may seek clarification from the individual about whether the request was a direction from the individual or a request from the third party. The instructions about the amount of time a covered entity has to respond to a request made pursuant to the right of access to direct are now in 45 CFR 164.524(d)(5)(ii), mirroring the instructions for timeliness under the individual right of access at 45 CFR 164.524(b)(2). A covered entity's decision to require individuals to execute HIPAA authorizations for all requests for disclosures does not extend the amount of time that it has to respond to a request made pursuant to the right of access, including the right of access to direct. This is true even if the covered entity needs to contact an individual who requests an electronic copy of their PHI in an electronic health record to clarify whether the individual is intending to exercise their right of access to direct.

To eliminate redundancy, we are finalizing the proposal to consolidate the instructions to covered entities about how to address individual requests for a review of a denial of access at 45 CFR 164.524(e)(4) and clarifying that similar instructions apply where an individual requests a review of a denial of the right of access to direct for a reviewable ground. Accordingly, where a covered entity denies, on a reviewable ground, a request made pursuant to the individual right of access, including the right of access to direct, the covered entity must designate a licensed health care professional who was not directly involved in the denial to review the decision to deny access and promptly refer the request to such designated reviewing official. The designated reviewing official must determine, within a reasonable period of time, whether to deny the access request based on the standards for a reviewable ground for a denial. The covered entity must promptly provide written notice of the determination of the designated reviewing official and take any other required actions to carry it out.

The Department is not finalizing the proposal to require covered health care providers and health plans, at an individual's direction, to submit an individual's request made pursuant to the right of access to direct to another covered health care provider (the ''Discloser''), requesting that the Discloser transmit ePHI maintained by or on behalf of the Discloser in its electronic health record to the Requestor-Recipient. We are persuaded by public comments that the proposal would increase the burden on covered entities and be difficult to implement. The disclosures contemplated by the proposal already are permitted under the Privacy Rule (*e.g.,* for treatment purposes). Thus, the Department's decision not to finalize this proposal does not preclude covered entities from assisting an individual by submitting an access request for PHI to another covered entity on the individual's behalf, nor would it preclude the other covered entity from sending the requested PHI to the covered entity who assisted the individual in making the request.

e. Response to Public Comments

Comment: Several commenters expressed concern that the proposal to limit the right of access to direct to electronic copies of PHI in an electronic health record would decrease the utility of this right by decreasing the amount of PHI available to a person designated by the individual. According to commenters, this would limit the ability of individuals to meaningfully participate in their health care and to determine who has access to their information. A few commenters asserted that limiting the right of access to direct to PHI in an electronic health record would not address requests to direct to a designated person non-electronic PHI or PHI in health IT systems other than an EHR, thus requiring a covered health care provider to obtain an authorization before complying with such requests. A few commenters asserted that it would be difficult to distinguish between requests from an individual to direct an electronic copy of PHI in an electronic health record to a designated person from requests an individual makes that require an authorization.

[516] *See* 45 CFR 164.508(c).

Response: The Department is finalizing its proposal with minimal modifications, as described above. The court in *Ciox* held that the HITECH Act created a limited right of access to direct and the Department could not expand that right. Therefore, the final rule limits the right of access to direct PHI to an electronic copy of PHI in an electronic health record. The definition of electronic health record further limits the application of the right of access to direct because the HITECH Act specifies that an electronic health record is an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. As discussed above, we interpret such clinicians to include health care providers that have direct or indirect treatment relationships with individuals. Also as discussed above, we do not believe that the definition of an electronic health record applies to all covered entities, but we recognize that it may apply to more than covered health care providers. Thus, we are not limiting the right of access to direct to only covered health care providers. Furthermore, as explained above, we do not interpret PHI in an electronic health record as limited to PHI in a particular software or application. Rather, we interpret it to include all PHI that is in an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

As a process matter, to ensure compliance with the Privacy Rule, covered entities may wish to assume that a clear, conspicuous, and specific request made by an individual to transmit an electronic copy of PHI about the individual in an electronic health record to a person designated by the individual is a request made pursuant to the right of access to direct. Covered entities are encouraged to contact the individual making the request if there are any questions or concerns about the request, including about the authority of the person designated by the individual to have access to the PHI.

A request for PHI that is not in an electronic health record, or a request for a copy in a non-electronic format, would not meet the conditions of the right of access to direct. Thus, such requests should be treated as requests made pursuant to an authorization, provided that the request meets the requirements for a valid authorization at 45 CFR 164.508. Where such requests do not meet the requirements for a valid authorization, the Department encourages covered entities to consider whether another provision of the Privacy Rule would permit the disclosure, and if not, to contact individuals to explain the limitations of the right of access to direct and obtain the information that is needed for the request to constitute a valid authorization.

Comment: Many commenters asserted that disclosures to personal health apps should be treated as requests made pursuant to the right of access to direct, rather than either of the following: (1) a request made pursuant to the individual right of access, or (2) a request for disclosure pursuant to valid authorization.

Response: As explained above, we interpret a personal health app to be equivalent to the individual and a request from an individual to receive their PHI in a personal health app to constitute an individual request to obtain a copy of their PHI in a particular electronic form and format. In other words, when employed by the individual (or their personal representative), a personal health app, as defined in this final rule, is a technology or tool used by the individual (or their personal representative); the personal health app is not a person designated by the individual to receive PHI. Thus, when an individual requests that a covered entity transmit the individual's PHI to a personal health app, we interpret the request as being made pursuant to the individual right of access at 45 CFR 164.524(a), rather than a request made pursuant to the right of access to direct at 45 CFR 164.524(d). Where an individual requests that a covered entity transmit a copy of their PHI in an electronic health record to an app that is not offered by or on behalf of another regulated entity, and does not meet the definition of personal health app (because, for example, the information in the app is not managed, shared, and controlled by or primarily for the individual), we would interpret such request as being made pursuant to the right of access to direct (where the request meets the applicable requirements). As discussed above, the processes and technology that a covered entity implements will enable it to differentiate between the different types of apps that transmit requests for PHI through the covered entity's API.

Comment: Some commenters asserted that the right of access to direct is abused by third parties for commercial purposes. According to some commenters, in some cases, fraudulent requests are submitted to covered entities purportedly on behalf of individuals, creating additional burden for regulated entities because they must verify that the request was initiated by the individual. Some commenters recommended that the Department limit the scope of the proposal, or issue guidance to clarify its application, to specific categories of persons, purposes, or PHI; or limit the liability of health care providers when a request is for disclosure in certain circumstances. A few commenters asserted that Congress intended for section 13405(e) of the HITECH Act to facilitate the disclosure of PHI only for health care purposes and urged the Department to limit the right of access to direct to apply only where the person designated by the individual is a health care provider, social service organization with whom PHI may be shared for care coordination, or caregiver. One commenter expressed concern about their ability to comply with the proposal while also complying with other laws that restrict the disclosure of certain PHI (*e.g.,* state laws that limit the disclosure of records about an individual's mental health).

Many commenters expressed concern that the proposal would result in the disclosure of sensitive information to entities that are not regulated under the HIPAA Rules. Some commenters expressed concern that such disclosures would pose risks to the privacy and security of PHI. One commenter asserted that the proposal would impose an administrative burden and raise liability concerns for health care providers if the PHI is disclosed to a designated person and then used or disclosed inappropriately.

Several commenters requested that the Department either modify the Privacy Rule or issue guidance to clarify covered entities' obligations under the proposed right of access to direct in an environment where PHI is increasingly transmitted electronically and to a wider pool of recipients.

Response: As discussed above, Congress has enacted several laws that direct the Department to empower individuals by ensuring that they have access to and the ability to share their PHI. For example, as enacted by Congress, section 13405(e) of the HITECH Act provides individuals, as part of the right of access, the right of access to direct a covered entity to transmit an electronic copy of their PHI in an electronic health record to a person designated by the individual. The statute placed no limitations on the ability of the individual to choose the person to whom they direct electronic copies of their PHI in an electronic health record. In this final rule, the Department seeks to implement this right, as directed by Congress. Thus,

consistent with the HITECH Act and the Privacy Rule's longstanding right of access provisions, the purpose of an individual's request for access and/or the designated person to whom they choose to direct an electronic copy are not relevant factors when a covered entity responds to an individual's access request, including a request under the right of access to direct. Accordingly, a covered entity cannot deny an individual's request under the right of access to direct based solely on the covered entity's opinion of the person that the individual designates or the purpose(s) for which the individual requests the disclosure. For example, a covered entity may not deny an individual's request made pursuant to the right of access to direct merely because the covered entity does not agree with the individual's decision to direct a copy of their PHI to an attorney or other person. Prior to disclosing PHI, a covered entity is required to verify the identity of a person requesting PHI and the authority of that person to have access to PHI if the identity or authority of such person is not known to the covered entity. Elsewhere in this final rule, we finalize a prohibition against imposing an unreasonable identity verification requirement on an individual attempting to exercise the right of access and provide examples of both reasonable and unreasonable measures of identity verification. For example, it would be reasonable for a covered entity that receives a request made pursuant to the right of access to direct to contact the individual to verify that they intended to direct the copy to the particular person.

Comment: Many commenters recommended that all requests made pursuant to the right of access to direct should be in writing. Many commenters expressed opposition to the proposal to allow oral requests, with several commenters asserting that the proposal would be inconsistent with the HITECH Act because oral requests are not ''conspicuous.'' Some commenters expressed concern that the proposal could lead to increased risks to individual privacy, as well as fraud and abuse. Some commenters asserted that the proposal would pose an administrative burden or implementation challenge and provided examples, such as developing new processes for accepting, documenting, and tracking such requests, changing workflows, and training staff on the new processes.

Some commenters expressed concern about their ability to verify the identity of an individual making an oral request. A few commenters recommended that the Department impose limitations on oral requests, such as allowing individuals to make oral requests only in person except where making the request in person would present an undue burden for the individual or in urgent situations, provided that the request is later reduced to writing. A few commenters recommended that health care providers be permitted to verify the identity of individuals making oral requests. A few commenters stated that covered entities should have the flexibility to determine whether to accept oral requests for access.

Some commenters requested that the Department create a safe harbor to shield covered entities from liability for erroneous disclosures that may result from responding to an oral request for access. One commenter asserted that the proposal could create a conflict with state laws that require providers of behavioral health care to adopt additional due diligence practices, such as obtaining written consent from the individual, before disclosing PHI.

Several commenters requested that the Department provide guidance on how to operationalize this proposal and examples of what would constitute ''clear, conspicuous, and specific'' requests.

Response: As explained above, based on public comments, we are not finalizing the proposal to require covered entities to accept oral requests made pursuant to the right of access to direct. Instead, consistent with the HITECH Act, we require that the request be clear, conspicuous, and specific. We also are adopting language that permits a covered entity to require that the request be in writing, provided that it informs individuals of such requirement, consistent with the modification that we are making at 45 CFR 164.524(b)(1)(ii), which includes the clarification of what constitutes a request in writing.[517]

For example, we would consider a request to be clear, conspicuous, and specific if the individual sends an email to a covered health care provider requesting that the provider send to the individual's family member an email containing a report interpreting diagnostic images where the report is maintained in the provider's electronic health record, provided that the request included the family member's name and email address.[518] We would not consider this request to be clear, conspicuous, and specific if it did not contain the family member's name or email address. As another example, we would consider a request to be clear, conspicuous, and specific where the individual sends a message through a personal health app to a covered health care provider requesting that the provider send the individual's PHI in the provider's electronic health record to a file-sharing application used by the individual's attorney, provided that the message included the attorney's name and specific information about how and where to send the PHI. We would not consider this request to be clear, conspicuous, and specific if it did not include information about how to send the individual's PHI to the attorney's file-sharing application.

Where a verbal request meets the requirements of clear, conspicuous, and specific, a covered entity is permitted, but not required, to accept the request. For example, where an individual, in a discussion, tells the receptionist that they would like to have their PHI in an electronic health record emailed to a particular family member and the individual dictates the family member's email address or provides the email address in writing to the receptionist, such request could be considered clear, conspicuous, and specific. For such verbal requests, the covered entity would be responsible for adopting reasonable safeguards to document the request in writing to protect the information that is disclosed. For example, a reasonable safeguard would not need to require the covered entity to confirm that the individual provided the correct email address of the designated person, but it would require reasonable procedures to ensure that the covered entity correctly typed the email address.[519]

Comment: Several commenters expressed support for the proposal to require covered entities and health plans, at the individual's direction, to submit an individual's access request to another covered entity. A few commenters expressed support for this proposal because it would facilitate care coordination and access. One commenter requested guidance about how this access pathway would work in relation to the pathway for individuals to obtain access through a personal health app.

Many commenters expressed opposition to the proposal to require covered health care providers and plans, at an individual's direction, to submit to another covered entity the individual's request to transmit an electronic copy of

[517] *See* 45 CFR 164.524(b)(1).

[518] *See infra* for a discussion of reasonable measures that covered entities may implement to verify the identity of a person, including an individual who seeks to exercise the right of access to direct.

[519] *See* 78 FR 5566, 5635 (Jan. 25, 2013).

PHI in an electronic health record to a person designated by the individual. Some commenters asserted that the proposal would be burdensome or impracticable for health care, create additional paperwork, obligate health care providers to gather PHI that they do not need, potentially cause confusion, and unnecessarily delay responses to requests. A few commenters asserted that the proposal was unnecessary because the interoperability rules and standards designed to enable automated workflows already address the issue.

Several commenters asserted that the proposal would increase the risks to privacy, security, and health care delivery because of the amount of PHI that the Requestor-Recipient would be collecting. A few commenters expressed concern that the proposal would create a conflict with state laws on record collection and retention. Commenters suggested ways to address these risks, such as modifying the proposal to allow the Requestor-Recipient to exercise reasonable judgment when deciding whether to respond to the request, using a number of factors; requiring that the individual be a patient of the Discloser (as opposed to a former patient or prospective new patient); and permitting the Discloser to deny requests from a Requestor-Recipient when the Discloser determines, using professional judgment, that fulfilling the request is not in the best interests of the individual.

A few commenters requested that the Department clarify which party would be responsible for reporting the Discloser's failure to provide an electronic copy of the individual's PHI or to comply with timeliness requirements. A few commenters expressed concerns about the logistics of and liability for managing the PHI of prospective patients. One commenter asserted that the proposal would shift the burden of collecting PHI to health care providers, requiring them to mediate between an individual and multiple Disclosers, and expressed concern about the ability of small and rural health care providers, in particular, to perform this function.

Several commenters recommended that the Department clarify the circumstances under which a covered entity would be permitted to deny requests by an individual to submit the individual's access request to another covered entity on the individual's behalf and the processes for issuing denials. Several commenters requested that the Department provide additional information about how to determine when a request provides sufficient information to constitute a valid request. A few commenters requested that the Department clarify that covered entities would be permitted to make the requested disclosures only if consistent with applicable law.

Response: We are not finalizing the proposal to require covered health care providers and health plans (''Requestor-Recipient''), at an individual's direction, to submit to another covered entity (''Discloser'') the individual's request to transmit an electronic copy of the individual's PHI in an electronic health record. We are persuaded by the comments asserting that such a requirement likely would create unreasonable administrative burdens without meaningfully contributing to the Department's efforts to facilitate information sharing among entities in the health care system.[520] However, this does not preclude covered entities from assisting an individual by submitting an access request to another covered entity on the individual's behalf.

7. Adjusting Permitted Fees for Access to PHI and ePHI

a. Current Rule

The Privacy Rule allows covered entities to charge a reasonable, cost-based fee to fulfill access requests from individuals for copies of their PHI. Section 164.524(c)(4) limits the allowable fees to the costs of: (1) labor for copying (whether the PHI is in paper or electronic form); (2) supplies for creating the paper copy or electronic media if requested; (3) postage; and (4) preparing any agreed-upon summary or explanation of the requested PHI.

The labor portion of allowable fees for copying includes only labor for creating and delivering the electronic or paper copy in the form and format requested or agreed upon by the individual, after the PHI that is responsive to the request has been identified, retrieved or collected, and compiled and/or collated, and is ready to be copied.[521] Examples of allowable labor costs include, but are not limited to, costs associated with the following:

- Photocopying PHI that is on paper.
- Scanning PHI that is on paper into an electronic format.
- Converting electronic information in one format to a format requested by or agreed to by the individual.
- Transferring (*e.g.,*uploading, downloading, attaching, burning) ePHI from a covered entity's electronic information system to a web-based portal (where the PHI is not already maintained in or accessible through the portal), portable media, email, app, personal health record, or other manner of delivery of the PHI.
- Creating and executing a mailing or email with the responsive PHI.

Importantly, we recognized in the 2013 Omnibus Rule that covered entities would continue to improve their technological capabilities over time and that the costs of producing an electronic copy would be negligible.[522]

The labor portion of allowable fees for copying does not include costs associated with reviewing the request for access; searching for and retrieving the PHI, which includes locating and reviewing the PHI in the medical or other record; or segregating or otherwise preparing the PHI that is responsive to the request for a copy. Additionally, a covered entity may not pass on the administrative or other costs associated with outsourcing the function of responding to individual requests for access (*e.g.,* the cost of using a business associate to act on individual requests for access).[523]

b. Proposed Rule

The Department proposed to modify the provisions addressing access fees to establish a fee structure with two elements based on the type of access request.[524] The first proposed element described categories of access for which covered entities would not be permitted to charge a fee, and the second described the allowable costs that could be included when an access fee is permitted.[525]

[520] For example, a covered entity must disclose PHI to a person designated by the individual pursuant to the right of access to direct, where applicable. *See* 45 CFR 164.524(d). Additionally, a covered entity is permitted to assist that individual by submitting an access request for PHI to another covered entity on the individual's behalf. *See* 45 CFR 164.524(d)(5)(i). As discussed in Sec. III.B.1, the Department also has announced efforts to enforce the information blocking regulations and to modernize the nation's digital health ecosystem. *See* ''HHS Announces Crackdown on Health Data Blocking,'' *supra* note 7; ''White House, Tech Leaders Commit to Create Patient-Centric Healthcare Ecosystem,'' *supra* note 4.

[521] *See* ''What Labor Costs May a Covered Entity Include in the Fee That May Be Charged to Individuals to Provide Them with a Copy of Their PHI?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #2025 (June 24, 2016), *https://www.hhs.gov/hipaa/for-professionals/faq/2025/what-labor-costs-may-a-covered-entity-include/index.html.*

[522] 78 FR 5632, 5635 (Jan. 25, 2013).

[523] *See* ''May a Covered Entity That Uses a Business Associate to Act on Individual Requests for Access Pass on the Costs of Outsourcing This Function to Individuals When They Request Copies of Their PHI?,'' Office for Civil Rights, U.S. Department of Health and Human Services (June 24, 2016), *https://www.hhs.gov/hipaa/for-professionals/faq/may-a-covered-entity-that-uses-a-business-associate-to-act/index.html.*

[524] 86 FR 6446, 6464 (Jan. 21, 2021).

[525] *Id.* at 6464–65.

The Privacy Rule does not permit fees to be charged for inspection of PHI by the individual who is the subject of the PHI. The Department believes that a covered entity does not incur labor costs for copying and is unlikely to incur more than *de minimis* costs for supplies when providing the individual with the opportunity to inspect PHI in person. The same is true when an individual who, while inspecting their PHI, takes notes, or uses other personal devices or resources to memorialize, record, or otherwise capture the PHI. Likewise, the Department believes that there are circumstances in which a covered entity can provide an individual with access to PHI using technology without the involvement of their workforce members. We refer to such technologies as ''internet-based methods.'' When an individual uses an internet-based method to obtain access to their PHI, the covered entity likely incurs no allowable labor costs or expenses. For example, where an individual requests or agrees to access their PHI available through the View, Download, and Transmit (VDT) functionality of the CEHRT, we believe there are no labor costs and no costs for supplies to enable such access.[526] Thus, for example, a covered health care provider cannot charge an individual a fee when it fulfills an individual's HIPAA access request using the VDT functionality of the provider's CEHRT. Accordingly, at 45 CFR 164.524(c)(4)(ii), the Department proposed to specify two situations that would always be free of charge: (1) when an individual inspects PHI in person; and (2) when an individual uses an internet-based method to view or obtain a copy of their ePHI, including access through the covered entity's certified health IT or by a personal health app connecting to a secure, standards-based API, consistent with applicable Federal or state law.[527]

The Department proposed that access requests by an individual for an electronic or non-electronic copy of PHI through a non-internet-based method would remain subject to the individual access fee limitations of a reasonable, cost-based fee.[528] Accordingly, we proposed to modify 45 CFR 164.524(c)(4)(i) to permit a covered entity to charge a reasonable, cost-based fee, provided that the fee includes only the following costs:

- Labor for copying the PHI requested by the individual in electronic or non-electronic (*e.g.,* paper, film) form.
- Supplies for making non-electronic copies.
- Actual postage and shipping for mailing non-electronic copies.
- Preparing an explanation or summary of electronic or non-electronic PHI, if agreed to by the individual, when an individual requests an electronic or non-electronic copy of PHI about the individual through a non-internet-based method.

As explained above, the fee would not be permitted to include costs associated with verification; documentation; searching for and retrieving the PHI; maintaining systems; recouping capital for data access, storage, or infrastructure; or other costs not listed above even if such costs are authorized by state law. Pursuant to the HITECH Act, which limits the fees that a covered entity may impose for providing an individual with an electronic copy of PHI in an electronic health record to the covered entity's labor costs in responding to a request, covered entities would not be permitted to charge individuals for cost of electronic media or postage for providing electronic copies of PHI by any method.[529]

Additionally, we proposed at 45 CFR 164.524(d)(6) to permit covered entities to charge a reasonable, cost-based fee for a request made pursuant to the right of access to direct where the electronic copy would be provided using a method other than an internet-based method, provided that the fee includes only the following costs for labor: (1) copying the PHI requested by the individual in an electronic form; and (2) preparing of an explanation or summary of the ePHI, if agreed to by the individual.[530]

Finally, the Department solicited public comment on whether covered entities should be prohibited from charging fees for copies of PHI when requested to support applications for public benefits or when copies are directed to certain types of entities, such as those conducting clinical research.

c. Overview of Comments

Most commenters expressed general support for prohibiting fees for in-person and internet-based methods of accessing PHI. However, several commenters expressed opposition to prohibiting fees for in-person inspection and internet-based methods of access because they believed that there are costs to covered entities for providing access through either method. In response to the Department's comment solicitation related to public benefits, many commenters urged the Department to prohibit covered entities from charging a fee for a copy of PHI where the purpose of the request is to support an application for public benefits.

d. Final Rule

Consistent with section 13405(e) of the HITECH Act, this final rule adopts the proposal to modify the access fee provisions at 45 CFR 164.524(c)(4)(i) to provide that, where a covered entity is permitted to charge a reasonable, cost-based fee for responding to a request for PHI made pursuant to 45 CFR 164.524(a), the fee can include only the following costs:

- Labor for copying the PHI requested by the individual in electronic or non-electronic (*e.g.,* paper, film) form.
- Supplies for non-electronic copies.
- Actual postage and shipping for mailing non-electronic copies.
- Preparing an explanation or summary of electronic or non-electronic PHI, if agreed to by the individual when an individual requests an electronic or non-electronic copy of PHI about an individual.

Covered entities remain subject to the current limits on access fees for access requests by an individual for a non-electronic copy of PHI. This would include only labor for copying PHI in non-electronic form, supplies for creating the non-electronic copy, actual postage for mailed copies, and the costs of preparing a requested summary or explanation of the PHI. Additionally, they may charge reasonable, cost-based fees for access requests by an individual for an electronic copy of PHI through a method other than an internet-based method, limited to the costs of labor for making electronic copies of the PHI (*e.g.,* copying PHI onto electronic media) and preparing a summary or explanation as agreed to by the individual.

Additionally, this final rule adopts the proposal to modify 45 CFR 164.524(c)(4)(ii) to prohibit fees for in-person inspection and use of an internet-based method to view or obtain a copy of ePHI maintained by or on behalf of a covered entity. This change is consistent with section 13405(e) of the HITECH Act and the modification that we are making in this final rule to 45 CFR 164.524(c)(4)(i) to limit the fees that individuals may be charged for

[526] 45 CFR 170.315(e)(1); *see* 85 FR 25642, 25691 (May 1, 2020); 80 FR 62602, 62658 (Oct. 16, 2015); *see also* ''Quality Payment Program: Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category Measure—2023 Performance Period,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (last accessed Mar. 16, 2026), *https://qpp.cms.gov/docs/pi_specifications/Measure%20Specifications/2025-MIPS-Promoting-Interoperability-Measure-Provide-Patients-E-Access-to-Their-Health-Info.pdf.*

[527] 86 FR 6446, 6465 (Jan. 21, 2021).

[528] *Id.*

[529] *See* sec. 13405(e) of the HITECH Act.

[530] 86 FR 6446, 6465 (Jan. 21, 2021).

copies of their PHI to the costs described above. As discussed above, the Department believes that a covered entity does not incur labor costs for copying and is unlikely to incur more than *de minimis* costs for supplies when providing an individual with the opportunity to inspect, that is, review their PHI, rather than providing them with a copy.[531] Where the individual requests a copy of their PHI from the covered entity during an in-person inspection, the request should be viewed as an exercise of the individual's right to obtain a copy, subject to the fee limitations of that right, rather than the continued exercise of the individual's right to inspect their PHI.

Similarly, because we intend the term ''internet-based method'' to refer to internet-based processes for responding to requests for access automatically (*e.g.,* using VDT in a patient or health plan member portal, or a personal health app connection via a certified API technology), the Department anticipates that there will not be more than *de minimis* labor costs for copying the PHI that an individual requests using an internet-based method. We do not intend for the term internet-based method to include methods that provide an individual with their PHI, pursuant to the right of access, through the internet where there are labor costs for copying associated with the provision of the PHI in the form and format requested by the individual (*e.g.,* where a PDF is emailed to the individual at the request of the individual). Additionally, we do not anticipate that there will be supplies used to make non-electronic copies, or postage or shipping costs for mailing non-electronic copies, where an individual obtains access through the right of access to inspect or through an internet-based method.

Accordingly, this final rule supersedes the Department's previous interpretation of how to calculate the fees for copies of PHI provided in response to requests made pursuant to the right of access, including the explanation of the three methods for calculating this fee: actual costs, average costs, or a flat fee of $6.50, as provided in the 2016 guidance. Instead, in this final rule, we explain how covered entities are to calculate a reasonable, cost-based fee. Specifically, covered entities are permitted to charge individuals for the following costs in response to a request for access:

- Labor for copying the requested PHI.
- Supplies for creating a non-electronic copy of the requested PHI, where requested.
- Postage, where the individual has requested that a non-electronic copy, or a summary or explanation, be mailed.
- Preparing an explanation or summary of the PHI, if agreed to in advance by the individual.

The final rule provides covered entities with a ceiling of what can be charged for copies of PHI provided pursuant to the right of access, rather than a floor. Nothing in this final rule prevents regulated entities from charging individuals less than the maximum fee permitted under this final rule, and as discussed below, other laws may limit such fees even further. In particular, the Department encourages covered entities to consider the financial circumstances of the individual requesting the copy of PHI when determining whether it would be appropriate to charge the individual the maximum fee permitted by the Privacy Rule.

The modification to not permit fees for access when such access is provided through an internet-based method aligns with the Fees Exception to information blocking regulations, which does not protect an actor's practice of charging an individual (or their personal representative) a fee that is based in any part on electronic access to an individual's EHI[532] (*e.g.,* ePHI) by the individual or their personal representative.[533]

We are not addressing the proposal to limit the fees that a covered entity is permitted to charge in response to a request made pursuant to the right of access to direct in this final rule. We will continue to monitor the landscape with respect to the fees charged by covered entities for copies of PHI provided in response to a request made pursuant to the right of access to direct.

e. Responses to Public Comments

Comment: A few commenters expressed concern about the proposal to prohibit fees for in-person inspection of PHI, asserting that permitting individuals to inspect their PHI in-person would require a commitment of resources by covered entities, including staff and space. A few commenters requested that the Department establish limits on the number of paper copies that covered entities are required to provide for free. Other commenters expressed support for the proposal to prohibit covered entities from charging fees for access through patient portals but asserted that there may be costs for providing electronic copies of PHI when such access is through an internet-based method other than a patient portal. For example, a few commenters stated that resources generally are required to collect and merge records that are maintained in different electronic formats into a single record.

Response: As discussed elsewhere, we are not finalizing the proposal to modify the right to inspect. However, the right of an individual to inspect their PHI is a longstanding provision that remains in the Privacy Rule as part of the right of access, and nothing in this rule will increase costs to covered entities for providing such access. As discussed above, we do not believe that a covered entity incurs labor costs for copying PHI, or more than *de minimis* costs for supplies for creating a copy, when an individual exercises their right to inspect; thus, we are adopting our proposal not to permit a covered entity to impose a fee for such access.

While the Privacy Rule permits a covered entity to charge a fee in other circumstances, the Department encourages covered entities to provide individuals who request access to their information with copies of their PHI free of charge wherever possible. Providing individuals with access to their health information is a necessary component of delivering and paying for health care, and providing access to PHI for free is particularly vital in circumstances where the financial situation of an individual requesting access makes it difficult or impossible for the individual to afford the fee.

The Department believes that prohibiting fees for in-person inspection and internet-based methods of access is appropriate because we expect that such methods of access will generate at most nominal costs for which covered entities are permitted to charge individuals under the Privacy Rule, as modified by section 13405(e) of the HITECH Act. As discussed above, the Privacy Rule does not permit a covered entity to charge a fee for reviewing a request for access; searching for and retrieving the PHI, which includes locating and reviewing the PHI in the medical or other record; or segregating or otherwise preparing the responsive PHI, whether in electronic or non-electronic form. However, we emphasize that the requirement to provide free access does not apply to circumstances where the individual is using an online portal to submit a request for copies of PHI to be

[531] Such *de minimis* costs may include the cost of copying where the covered entity decides to make a copy to help fulfill an individual's request to inspect their PHI.

[532] *See* 45 CFR 171.102 (definition of ''Electronic health information'').

[533] *See* 45 CFR 171.302(a)(1)(ii) and (b)(2); 85 FR 25642, 25879–88 (May 1, 2020).

sent to him or her in a manner that would require the covered entity to incur costs for labor for copying, supplies, or postage that could be the basis for a reasonable, cost-based fee.

Comment: A few commenters expressed opposition to the Department's proposal to limit fees for providing PHI on portable electronic media to individuals to labor costs only. According to the commenters, covered entities should be permitted to charge individuals fees that cover any reasonable costs of providing access, including labor, supplies, media, or postage.

Response: We are finalizing the proposal to limit the fee that a covered entity is permitted to charge an individual for providing access to PHI on portable electronic media to labor costs only, consistent with a plain reading of section 13405(e) of the HITECH Act, as discussed above.[534] Covered entities are permitted to include, as part of a reasonable, cost-based fee, labor costs for copying PHI in an electronic health record to another electronic format (such as a PDF) or onto electronic media (*e.g.,* CD, USB drive), if requested by the individual or their personal representative.

Comment: Many commenters who receive access requests stated that they receive almost no requests for access via internet-based methods because almost all of the requests that they receive require manual processing. One commenter asserted that not all health care providers have the ability to electronically exchange PHI, which, according to the commenter, means that the proposal would lead to higher costs for those providers for providing access via internet-based methods.

Response: The Department interprets the term internet-based method to apply to the use of technology that relies on the internet, such as patient and health plan member portals, personal health apps, and APIs, as well as similar successor technologies, to obtain a copy of PHI without requiring a member of the covered entity's workforce to invest labor in making such a copy. As explained in the 2021 Privacy Rule NPRM, the Department does not intend to require covered entities to provide free access where the individual simply is using an online portal to submit a request for copies of PHI to be sent to the individual in a manner that would require the covered entity to incur allowable costs for supplies, postage, or labor for copying. The submission of an access request through an electronic method, or a request for electronic delivery of a copy, does not by itself mean that the individual is using an internet-based method for which no fee may be charged. Instead, as discussed above, the Department intends the term ''internet-based method'' to refer to automated processes for transmitting electronic copies. It does not include circumstances that involve labor for making copies on the part of a member of the covered entity's workforce.

One example of an internet-based method is using certain functionality of certified health IT to obtain copies of PHI (*e.g.,* using VDT in a patient or health plan member portal or a personal health app connection via a certified API technology). However, using certified health IT or certain functionality of the certified health IT is not a requirement for obtaining an electronic copy of PHI using an internet-based method. Providing an individual with a copy of ePHI that is in the USCDI through a personal health app that connects to a covered entity's secure, standards-based API is another example of an internet-based method. By contrast, an individual's request that a covered entity provide such individual with an electronic copy of PHI, that is not ePHI, through their personal health app, would not be a request to obtain PHI through an internet-based method because it would require a member of the covered entity's workforce to copy the PHI into an electronic form and format.

As discussed elsewhere in this final rule, the Privacy Rule does not require a covered entity to provide an individual with their PHI in a particular electronic form and format. However, the Privacy Rule does require a covered entity to provide an individual with their PHI in the electronic form and format requested by the individual if the requested PHI is readily producible in that form and format. Thus, if the individual requests that a copy of their PHI be sent to them using an internet-based method (*e.g.,* VDT or personal health app through a secure, standards-based API) and the requested PHI is available in that requested form and format, the covered entity must provide it to the individual (or their personal representative) in that form and format for free.

Comment: A few commenters recommended that the Department align its fee proposals with other Federal regulations, such as the information blocking regulations and the Interoperability and Patient Access Final Rule, while taking into consideration the financial implications for individuals and regulated entities. A few commenters requested guidance on how to apply the Privacy Rule's limitations on fees in states that also have laws that limit the fees that covered entities are permitted to charge for disclosures of PHI.

Response: The information blocking regulations are designed to operate in a manner consistent with the framework of the Privacy Rule and other laws providing privacy rights for patients, but are separate and distinct from such statutes and regulations. The information blocking regulations exclude from the definition of information blocking certain fees that an actor[535] elects to charge for the access, exchange, or use of EHI. The Fees Exception is available for fees for individual access to their EHI when its conditions are met as specified in the exception.[536] However, as ONC has explained, an actor's practice of charging an individual, their personal representative, or another person designated by the individual for electronic access to the individual's EHR would be inherently suspect under an information blocking review.[537] CMS's Interoperability and Patient Access Final Rule also includes certain fee limitations.[538]

With respect to state law, Congress provided that standards, requirements, and implementation specifications adopted under HIPAA would supersede any contrary provision of state law, with certain limited exceptions, such as for state privacy laws that are contrary to and more stringent than the corresponding Federal standard, requirement, or implementation specification.[539] Accordingly, unless a specific exception applies, a state law that is contrary to the Privacy Rule is preempted by the Federal requirements.

HIPAA excepts from its general preemption authority contrary provisions of state law that impose requirements, standards, or implementation specifications that are more stringent than those of the Privacy Rule.[540] Under the HIPAA Rules, with respect to the rights of an individual who is the subject of the PHI, more stringent laws include state laws that permit greater rights of access (*e.g.,* state law provides stricter limits on the fees that a covered entity is permitted to

[534] Sec. 13405(e) of the HITECH Act (codified at 42 U.S.C. 17935(e)).

[535] 45 CFR 171.102 (definition of ''Actor'').

[536] *See* 45 CFR 171.302.

[537] 85 FR 25642, 25792 (May 1, 2020); *see also* 85 FR 25886–87 (May 1, 2020).

[538] *See* 85 FR 25510 (May 1, 2020).

[539] *See* Health Insurance Portability and Accountability Act of 1996, sec. 264(c)(2) of Public Law 104–191, 110 Stat. 2033 (codified at 42 U.S.C. 1320d–2 note); 45 CFR 160.203(b).

[540] *See* 45 CFR 160.203(b).

charge for providing an individual with a copy of their PHI).[541] Thus, HIPAA does not override state laws that provide individuals with greater rights of access to their health information than the Privacy Rule does.[542] This includes state laws that: (1) prohibit fees for providing individuals with copies of their PHI; or (2) allow only lesser fees than what the Privacy Rule would allow to be charged for copies. Additionally, where it is possible for regulated entities to comply with both the state or other Federal law and the Privacy Rule (*e.g.,* where a state or other Federal law provides stricter limits on the fees that a covered entity is permitted to charge for providing an individual with a copy of their PHI), there is no conflict between the laws, and no preemption of the state law.[543]

Comment: Many commenters asserted that individuals should not be charged for transfers of PHI between health care providers. One commenter asserted that this proposal would decrease the ability of health care providers to provide free responses to requests for PHI related to health care.

Response: The Privacy Rule does not expressly address fees for disclosures between covered entities, such as provider-to-provider exchanges.[544]

The Department does not intend to change how covered entities charge for disclosing records to other covered entities. It is the Department's understanding that there frequently is no charge for permitted disclosures of PHI to another covered entity for core health care activities such as TPO. Furthermore, in some circumstances, other Federal or state laws may limit or restrict such charges.[545] The finalized provision is not intended to cause covered entities to begin charging fees for such disclosures; rather, its purpose is to recognize individuals as the center of their own health care and empower individuals to identify persons that they wish to have electronic copies of their PHI in an electronic health record.

Comment: Several commenters recommended that covered entities should be limited to charging indigent individuals who request their PHI to support an application for disability benefits $10.50 for electronic records and $20–$30 for paper records.

One commenter expressed support for providing copies of PHI for free, on a cost basis, or for $6.50 to individuals, providers, and personal representatives. A few commenters stated that charging $6.50 for anyone requesting copies of PHI would cause hospitals and medical offices to lose revenue.

One commenter requested that the Department establish a set fee for copies of PHI that is reasonable and cost-based to alleviate uncertainty, but asserted that $6.50 was insufficient because it was unusual to be asked to produce only ePHI. Instead, the commenter urged the Department to set a separate flat rate fee for copies of PHI that is non-electronic and to allow covered entities to charge either $6.50 or the separate fee for PHI that is not electronic where the request includes both ePHI and PHI that is not ePHI.

Some commenters expressed support for a flat rate of $6.50 for individuals, especially for electronic records. A few commenters expressed support for providing covered entities with the option of charging either the flat rate or using other methods to calculate fees. One commenter stated that it charged a flat rate of $6.50 for patients' right of access. According to the commenter, for requests that involve both ePHI and PHI that is not electronic, it charged a workers' compensation rate for paper records, a reduced half rate for electronic records, or, when applicable, a state-specific fee schedule.

A few commenters expressed opposition to the $6.50 rate because they believed that the amount was too low, unreasonable, or arbitrary. According to one commenter, retrieving records could take many hours or days, and the flat rate did not cover even half of the commenter's hourly rate for such record retrieval.

A few commenters stated that the $6.50 flat rate is too high for providing electronic records, which incurs little to no cost, or for requests for only one page, for example. One commenter noted that the flat rate would also be too low for someone requesting many pages.

Response: As explained above, in 2016, in response to requests for clarification, the Department issued guidance on how to calculate the limited fees that covered entities were permitted to charge individuals to provide them with a copy of their PHI. The guidance explained that covered entities could use any of three methods for calculating this fee: actual costs, average costs, or a flat fee of $6.50; and explained each option in detail. In the 2021 Privacy Rule NPRM, we sought comments on how covered entities were calculating allowable access fees and whether the Department should specify one or more of the methods included in the 2016 guidance, or another method, in regulatory text as the exclusive acceptable method(s) of calculating access fees.

Consistent with section 13405(e) of the HITECH Act, we are finalizing the proposal to permit covered entities to charge for requests made pursuant to 45 CFR 164.524(a), in certain circumstances, a reasonable, cost-based fee that includes only the cost of the following:

- Labor for copying the requested PHI.
- Supplies for creating a non-electronic copy of the requested PHI, where requested.
- Postage, where the individual has requested that a non-electronic copy, or a summary or explanation, be mailed.
- Preparing an explanation or summary of the PHI, if agreed to by the individual.

A covered entity is not permitted to impose a fee where an individual inspects PHI about themselves or accesses ePHI maintained by or on behalf of the covered entity using an internet-based method, such as a personal health app or patient or health plan member portal.

Accordingly, this final rule supersedes the Department's previous interpretation of how to calculate the fees for copies of PHI provided in response to requests made pursuant to the right of access, including the explanation of the three methods for calculating this fee: actual costs, average costs, or a flat fee of $6.50, as provided in the 2016 guidance. The rule explains how covered entities are to calculate a reasonable, cost-based fee. It provides covered entities with a ceiling of what can be charged for copies of PHI provided pursuant to the right of access, rather than a floor. Nothing in this final

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[541] *See* 45 CFR 160.202 (definition of ''More stringent'' at paragraph (2)).

[542] *See* 45 CFR 160.202; 160.203.

[543] *See also* ''A State law requires that a health care provider give individuals one free copy of their medical records but HIPAA permits the provider to charge a fee. Does HIPAA override the State law?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #2032 (June 24, 2016), *https://www.hhs.gov/hipaa/for-professionals/faq/2032/a-state-law-requires-that-a-health-care-provider-give-individuals/index.html.*

[544] Covered entities generally are prohibited from selling PHI. *See* 45 CFR 164.502(a)(5)(ii). Unless otherwise specified in 45 CFR 164.502(a)(5)(ii), covered entities are limited to charging a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI for a permitted purpose or a fee otherwise expressly permitted by other law.

[545] For example, Arizona prohibits a health care provider or contractor from charging fees to another health care provider for the purpose of providing continuing care to the patient to whom the medical record pertains. *See* Ariz. Rev. Stat. 12–2295(B)(1). As another example, in Maine, a health care entity may not require any fee for the transfer of any medical records related to a patient between health care entities unless the fee is disclosed to the patient and is directly related to the actual transfer costs. *See* 22 Me. Rev. Stat. 1718–E (Prohibition on fees for transferring a patient or a patient's medical records).

rule prevents regulated entities from charging individuals less than the maximum fee permitted under this final rule, and as discussed above, other laws may limit such fees even further.

The Department encourages covered entities to consider the financial circumstances of the individual requesting the copy of PHI when determining whether it would be appropriate to charge the individual the maximum fee permitted by the Privacy Rule. Ensuring individuals' access to their PHI is not solely about ensuring that they have the ability to request and obtain their health information in the form and format that they want in a timely manner; it is also about ensuring that such access is affordable. When the fee for obtaining access exceeds an individual's ability to pay that fee, the right of access may be rendered meaningless. A 2018 Government Accountability Office (GAO) report on challenges associated with individual access found that ''high fees can adversely affect patients' access to their medical records.'' [546] According to a patient advocate interviewed by the GAO, some patients cancel their requests when they learn of the potential costs.[547] Another advocate highlighted the inability of patients to afford the fees for access to their medical records, even where such fees are permitted under the Privacy Rule or applicable state law, particularly in situations where seriously ill patients have accumulated voluminous medical records.[548] Charging fees in these circumstances may be particularly concerning when fulfilling an individual's access request imposes minimal or no burden on a covered entity. For example, when PHI generally is available electronically, a covered entity may incur minimal or no costs in providing access to the requested PHI, yet the fees charged to individuals may still be unaffordable relative to their financial circumstances. In such cases, the fees charged may create a barrier to an individual's exercise of the right of access. Thus, affordability may affect an individual's ability to meaningfully exercise the right of access.

While we are not adopting a prohibition in this rule against charging a fee to an individual (or their personal representative) who seeks a copy of their PHI to support the individual's application for public benefits, we will continue to monitor the landscape with respect to access to PHI for these purposes and consider ways to facilitate applications for public benefits. Public benefit programs or government-funded assistance programs, such as Medicaid, Supplemental Nutrition Assistance Program (SNAP), Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), VA benefits, and housing assistance, generally provide individuals with limited means assistance with paying for basic living expenses (*e.g.,* food, health care, housing, utilities).[549] Individuals seeking records to support an application for such benefits may have limited financial resources and may be unable to afford fees for copies, particularly where their medical records are lengthy.[550] In such cases, fees may create a barrier to an individual's exercise of the right of access. Although we are not adopting a prohibition in this final rule, the Department encourages covered entities to consider individuals' financial circumstances and to limit fees where possible when a copy of PHI is requested to support an application for public benefits.

Separate requirements to provide individuals with notice of fees for copies of PHI provided pursuant to the right of access and a valid authorization are discussed below.

Comment: Commenters requested that the Department provide guidance on fees that covered entities are permitted to charge for providing PHI under the right of access and via an authorization.

Response: Fees for disclosures pursuant to an authorization generally are limited to: (1) a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI pursuant to the authorization; or (2) a fee otherwise expressly permitted by other law.[551] (If the covered entity wishes to charge a higher fee, the authorization must state that the disclosure will result in remuneration to the covered entity as required by 45 CFR 164.508(a)(4).[552]) The chart below provides a summary of how different types of disclosures and recipients of the PHI affect the fees that the Privacy Rule permits covered entities to charge for copies of PHI provided in response to 45 CFR 164.524(a). As explained above, we are not addressing allowable fees for copies provided to a person designated by an individual pursuant to 45 CFR 164.524(d).

[546] ''Medical Records: Fees and Challenges Associated with Patients' Access,'' GAO–18–386, Government Accountability Office, p.14 (May 2018), *https://www.gao.gov/assets/gao-18-386.pdf.*

[547] *Id.*

[548] *Id.*

[549] *See* ''Government benefits,'' U.S. General Services Administration (last accessed Mar. 3, 2026), *https://www.usa.gov/benefits.*

[550] For example, to obtain SSDI, individuals must be: (1) unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment; or (2) aged 55 or older, blind, and unable to work as a result. *See* 42 U.S.C. 416(i)(1); 42 U.S.C. 423(d)(1)(B). For 2026, to be eligible for SSDI, individuals cannot earn more than $1,690 per month from work, or $2,830 per month if the individual is blind. *See* ''Substantial Gainful Activity,'' U.S. Social Security Administration (last accessed Jan. 20, 2026), *https://www.ssa.gov/oact/cola/sga.html.* To qualify for SSI, individuals must meet all three of the following conditions: (1) be aged 65 or older or have a disability; (2) have an income that is less than the statutorily established threshold; and (3) have resources of less than the statutorily established threshold. *See* 42 U.S.C. 1382. Today, the income limit is generally $2,019 from work each month for individuals. *See* ''Who can get SSI,'' U.S. Social Security Administration (last accessed Jan. 20, 2026), *https://www.ssa.gov/ssi/eligibility.* The limit increases for couples and for children. *Id.*

[551] 45 CFR 164.502(a)(5)(ii)(B)(viii).

[552] 45 CFR 164.502(a)(5)(ii)(A).

Relevant Provision of the Privacy Rule	Type of Disclosure	Recipient of PHI	Allowable Fee
Right to inspect 45 CFR 164.524(a)	In-person inspection	Individual (or personal representative)	Free
Right of access 45 CFR 164.524(a)	Internet-based method of receiving copies of PHI (*e.g.*, using VDT, or a personal health app connection via a secure, standards-based API)	Individual (or personal representative)	Free
Right of access 45 CFR 164.524(a)	Non-internet-based method of receiving an electronic copy of PHI, in response to an access request (*e.g.*, by sending PHI copied onto electronic media through the U.S. Mail or via certified export functionality)[a]	Individual (or personal representative)	Reasonable, cost-based fee, limited to costs of labor for: (1) making copies
Right of access 45 CFR 164.524(a)	Non-electronic copy of PHI	Individual (or personal representative)	Reasonable, cost-based fee, limited to costs of: (1) labor for making copies; (2) supplies for copying; and (3) actual postage and shipping
Right of access 45 CFR 164.524(a)	Summary or explanation agreed to by the individual	Individual (or personal representative)	Reasonable, cost-based fee, limited to costs of: (1) labor for making copies; (2) supplies for copying; and (3) actual postage and shipping; and (4) preparing the summary or explanation as agreed to by the individual

8. Notice of Access and Authorization Fees

a. Issues To Address

As discussed above, the Privacy Rule allows covered entities to charge fees for copies of PHI in certain circumstances. Where a covered entity intends to charge an individual the limited fee that is permitted under the Privacy Rule, the covered entity should inform the individual in advance and should negotiate any details that will affect the form and format of the PHI that is produced in response to a request for access. Failure to provide advance notice of a fee may serve as a barrier to access because it deprives the individual of the opportunity to decide whether they need all of the requested PHI, or whether they can accomplish their purpose with only a subset of that PHI, particularly if the cost of the requested PHI is prohibitive. However, the Privacy Rule does not require a covered entity to provide an individual with advance notice of such fees, meaning that individuals and others often are surprised when they are charged fees for such copies that are significantly higher than they expect, and in some cases, can afford. In such circumstances, disputes could be avoided if the covered entity provided the individual with advance notice of any fees and the opportunity to modify their request. The Department has received anecdotal reports that individuals often lack clarity about the charges for copies of their PHI and that fee practices vary across covered entities.

b. Proposed Rule

To address these concerns and promote transparency and uniform application of the fee limitations, the Department proposed a new section at 45 CFR 164.525(a) that would require a covered entity to provide an individual with advance notice of approximate fees for copies of PHI under the right of access and with a valid authorization. Proposed 45 CFR 164.525(a)(1) would require covered entities to post a fee schedule on their website, if they have one, and make the fee schedule available to individuals at the point of service and upon request. It also would require the notice to include all types of access that are available free of charge and include a fee schedule specifying the standard fees for all of the following:

- Copies of PHI provided to individuals under the individual right of access, with respect to all readily producible electronic and non-electronic forms and formats for such copies.
- Copies of PHI about an individual in an electronic health record and directed to persons designated by the individual, with respect to all readily producible electronic forms and formats for such copies.
- Copies of PHI sent to a specified recipient with the individual's valid authorization, with respect to all available forms and formats for such copies.

The Department also proposed at 45 CFR 164.525(a)(2) to require that covered entities provide an individualized estimate to an individual of the approximate fees to be charged for the requested copies of PHI, upon request. Additionally, the Department proposed at 45 CFR 164.525(a)(3) to require covered entities to provide, upon an individual's request, an itemization of the charges for labor for copying, supplies, and postage, as applicable, which would constitute the total fee charged to the individual for copies of PHI.

c. Overview of Comments

Commenters expressed mixed views on these proposals. Many commenters asserted that advance notice of applicable fees would promote transparency, reduce the potential for unanticipated fees, and assist individuals in making decisions regarding their requests for copies of PHI. Generally, these commenters also stated that requiring information about standard fees to be publicly available would facilitate understanding of and compliance with the Privacy Rule's fee limitations.

Some commenters expressed opposition to all or parts of the proposal because they believed that it would pose a significant burden for covered entities and would be infeasible to implement. Some commenters also recommended that the Department clarify when itemized statements would be required and whether covered entities would be permitted to charge for the preparation of individualized estimates or itemized statements.

d. Final Rule

The Department finalizes proposed 45 CFR 164.525, with modifications discussed below, to require covered entities to provide advance notice of fees for copies of PHI requested under the right of access, including the right of access to direct, and for copies of PHI requested pursuant to a valid authorization. We are not finalizing the proposals to require that covered entities provide individualized estimates and itemized statements upon request. Specifically, the Department is finalizing 45 CFR 164.525 to require a covered entity to post a fee schedule on its website, if it has a website, and to make the fee schedule available to individuals at the point of service. As explained in the 2021 Privacy Rule NPRM, the Department expects that a covered entity will make their fee schedule available upon request, in paper or electronic form, at the point of service or at an office that is responsible for releasing medical records, and, as applicable, to provide such information verbally (*e.g.,* over the telephone). Making the fee schedule available at the point of service or a medical records office and upon request could include, for example, any of the following: posting the fee schedule on the wall, leaving paper copies on a table in the waiting room, keeping a copy at the reception desk to show an individual who requests it, printing a copy to give to an individual who requests it—or, if the individual requests an electronic copy of the fee schedule, emailing a copy to the individual. For covered entities, the point of service also could include a customer service call center that handles requests for records, or any location at which PHI is made available for individuals to inspect, as required under 45 CFR 164.524(a).

The Department also is adopting the proposal to require that the notice identify all types of access that are available free of charge and include a fee schedule specifying the standard fees that may be charged for copies of PHI provided under 45 CFR 164.524(a), for electronic copies requested pursuant to the right of access to direct at 45 CFR 164.524(d), and for disclosures pursuant to a valid authorization under 45 CFR 164.508. The standard fees included in the fee schedule are the charges associated with components of the fees for copies provided pursuant to the right of access and a valid authorization and how the covered entity uses those charges to determine the total fee. For example, to the extent that a covered entity charges fees for the following costs, the fee schedule must contain the covered entity's charge for labor for making a paper copy of an individual's PHI in response to a right of access request, the costs of any supplies that may be used to make non-electronic copies of the requested PHI, postage fees for mailing the non-electronic copy, any charges associated with preparing an explanation or summary of an individual's PHI when agreed to by the individual, as applicable, and explain that those charges are added together to determine the total fee.[553] Fees for labor may be displayed on the fee schedule as hourly charges.

The fee schedule also must list information about the circumstances in which covered entities are required to provide copies of PHI for free. Covered entities are encouraged to provide individuals with a fee schedule that is easy to understand and enables them to identify the most appropriate mechanism for requesting PHI. The Department recommends that, where possible, covered entities inform individuals, in advance, about average costs for copies of PHI that are commonly requested; however, this final rule does not require covered entities to do so.

The Department believes that requiring covered entities to make a fee schedule publicly available and accessible at the point of service is consistent with the goal of this Administration to increase pricing transparency in health care.[554] We believe that making the fee schedule publicly available and accessible at the point of service will increase individuals' awareness of potential charges for obtaining copies of their PHI, including when directing electronic copies of their PHI pursuant to the right of access to direct, and assist individuals in making decisions about the scope of their requests for copies of their PHI. The Department also believes that providing individuals with notice of a covered entity's standard fees in advance will promote consistency in how information about permissible fees

[553] 45 CFR 164.524(c)(4).

[554] *See, e.g.,* E.O. 14221, 90 FR 11005 (Feb. 28, 2025).

is made available. Additionally, we believe that readily available information about access fees will promote compliance with the Privacy Rule because covered entities will seek to avoid posting fee schedules that demonstrate noncompliance with the Privacy Rule's fee limitations or publicly misrepresent their business practices. Publicly posting information about fees also will empower individuals to insist on covered entities' compliance with such limitations.

The Department expects that this requirement will provide greater predictability regarding costs for copies of PHI and reduce the likelihood that individuals will encounter surprise charges, thereby supporting individuals' access to and use of their PHI. The Department also expects that the implementation of the requirement to post a general fee schedule will not impose substantial new operational burden because many covered entities already provide such a fee schedule and we assume that covered entities have a fee schedule for their own internal use, even if they do not post it publicly. Additionally, implementation of this requirement generally will be limited to making the covered entity's fee schedule available in a format that is understandable for individuals and others.

Finalizing these provisions does not give a covered entity the ability to withhold or deny an individual access to their PHI on the grounds that the individual has not paid the bill for health care services that the covered entity provided to the individual. As discussed elsewhere in this final rule, the ability of an individual to access their PHI is essential to the primary goals of HIPAA and the HITECH Act, one of which is a health care system that ensures the best possible outcomes for individuals in a manner that limits administrative burdens. The right of access ensures that individuals have an opportunity to identify and correct errors in their PHI [555] and fosters trust, transparency, and understanding between the individual and their health care providers.[556] This is why covered entities are permitted to make disclosures in certain circumstances, but are required to make disclosures when a request is made by the individual pursuant to the right of access. Covered entities may deny an access request only under one of the narrow exceptions specifically enumerated in the Privacy Rule.[557] None of the exceptions permit a covered entity to withhold or deny an individual's request made pursuant to the right of access because the individual has not paid for health care services provided to them by the covered entity.

The Department is not adopting the proposals to require individualized estimates or itemized statements of charges. We find persuasive the comments asserting that these proposals would require substantial operational changes and costs, as discussed below. The Department has determined that requiring a publicly available fee schedule provides an appropriate level of transparency and additional requirements are not warranted at this time, given the potential burden that they would impose.

e. Responses to Public Comments

Comment: Several commenters expressed support for the proposal because they believed that it would support price transparency and clarify applicable fees.

Some commenters expressed opposition to the proposal because they believed that it would be difficult or burdensome for health care providers to implement the requirements. One commenter asserted that the proposals to divide the right of access into the right of access and the right of access to direct would make it challenging for workforce members to identify which fee provisions apply, making it difficult to provide individualized fee estimates.

Several commenters raised concerns about the proposed requirements to provide individualized fee estimates and itemized statements. One commenter asserted that the proposals to require individualized estimates and itemized bills would be administratively burdensome and urged the Department to provide additional time to implement this proposal, if adopted. One commenter recommended that the access timeframes be tolled when an individual requests an individualized estimate.

A few commenters requested that the Department provide greater specificity about the circumstances in which covered entities would be required to provide an itemized statement of charges. One commenter recommended that covered entities be permitted to charge individuals a reasonable, cost-based fee for preparation of the advance estimate of fees and itemized bill.

Response: As discussed above, the Department is finalizing the proposal to require covered entities to post a fee schedule on their website, if they have one, that contains information about the standard fees for copies of PHI provided pursuant to the right of access to inspect and obtain a copy, the right of access to direct, and a valid authorization. We are also finalizing the proposal to require covered entities to make the fee schedule available to individuals at the point of service and upon request. We believe that this will promote transparency and clarify the fees that covered entities are permitted to charge for copies of PHI, in addition to assisting individuals in understanding the potential costs for copies of PHI, and will support compliance with the Privacy Rule's existing fee limitations. The Department expects that because many covered entities already maintain and provide fee schedules for copies of PHI, implementation of this requirement will require limited effort beyond making such schedules of standard fees publicly available.

The Department anticipates that the requirement to make a general fee schedule publicly available and accessible at the point of service will promote administrative efficiency. Standard fee schedules reduce the need for workforce members to respond to ad hoc inquiries regarding permissible charges and to provide repeated explanations of applicable fees.

At the same time, we are persuaded by commenters that expressed concern about the administrative and financial burdens associated with the proposed requirements to provide individualized fee estimates and itemized statements upon request. We find convincing the comments asserting that the implementation of these requirements would require substantial workflow changes and resources to enable workforce members to make request-specific determinations regarding the applicable fee provisions and to provide individualized calculations for each access or authorization request. Accordingly, the Department is not finalizing the proposals to require individualized estimates and itemized statements upon request.

The requirement to make a fee schedule publicly available and accessible at the point of service does not require covered entities to make request-specific determinations or apply different fee limitations on a case-by-case basis, meaning that it can be implemented without the level of operational burden that would be imposed by the proposal to require individualized estimates and itemized

[555] The Privacy Rule provides individuals with the right to request that a covered entity amend PHI or a record about the individual in a designated record set for as long as the PHI is maintained in the designated record set. *See* 45 CFR 164.526.

[556] 65 FR 82462, 82605–07 (Dec. 28, 2000).

[557] 45 CFR 164.524(a)(3) and (4); *see also* 65 FR 82556 (Dec. 28, 2000).

statements upon request. Thus, the Department concludes that the implementation timeframe provided is sufficient and does not warrant extension.

Because the Department believes that providing individuals with access to their PHI is an important component of delivering and paying for health care, we continue to encourage covered entities to waive permissible fees for copies of PHI or provide flexibility in payment (*e.g.,* delaying charges or accepting payment in installments, without delaying the provision of copies) for individuals who are unable to pay upfront or at all because of an emergency or a demonstrated financial hardship.

9. Modifying the General Rules for Required Disclosures of PHI by Business Associates

a. Current Rule

Section 164.502(a)(4)(ii) requires a business associate to disclose PHI to the covered entity, individual, or individual's designee, as necessary to satisfy a covered entity's obligations under 45 CFR 164.524(c)(2)(ii) and (3)(ii) with respect to an individual's request for an electronic copy of their PHI.

b. Proposed Rule

The Department proposed to add language to 45 CFR 164.502(a)(4)(ii) to clarify when a business associate must disclose PHI and to whom. Specifically, the proposed modification would clarify that a business associate is required to provide access to PHI directly to the individual (or the individual's personal representative),[558] or a person designated by the individual (subject to the limitations of the right of access to direct), if the business associate agreement provided that the business associate would provide such direct access. We explained that the proposed clarification was consistent with preamble to the 2013 Omnibus Rule [559] and subsequent guidance [560] and was not intended to be a substantive change.

c. Overview of Comments

Most commenters expressed support for this proposal. According to a few commenters, the proposed modification would clarify the role of a business associate with respect to requests for access, particularly considering the increasing maintenance of PHI by business associates. One commenter explained that the proposed modification would clarify the relationship between covered entities and business associates without creating unnecessary burden for either party. Another commenter asserted that the proposal would simplify business associate agreements and improve relationships between covered entities and business associates. A few commenters expressed opposition to the proposal because they believed that it would be inconsistent with the Cures Act and the requirements of the information blocking regulations.

d. Final Rule

The Department adopts the proposed revision of 45 CFR 164.502(a)(4)(ii) without modification, codifying our longstanding interpretation of this provision.[561]

While a covered entity is directly responsible for providing individuals access to their health information, a business associate may disclose PHI for purposes of the right of access to the individual (or personal representative) or the individual's designee when the terms of the business associate agreement expressly permit or require the business associate to disclose PHI on behalf of a covered entity for purposes of fulfilling an individual's right of access. The business associate agreement controls whether the business associate must disclose PHI either to the individual or individual's designee, or to the covered entity. This final rule clarifies that regulated entities should address in their business associate agreements which party is responsible for disclosing the requested PHI to an individual or their designee for purposes of the right of access.

Longstanding guidance explains that business associate agreements should specify whether the business associate is allowed to disclose PHI directly to an individual or an individual's designee to satisfy the covered entity's obligations.[562] For example, for a business associate to provide access directly to an individual, the covered entity must include in its business associate agreement that the business associate can do so. The sample provisions for a business associate agreement on the Department's website long have included a sample element that specifically addresses the issue clarified by this modification.[563]

A person who meets the definition of a business associate [564] must comply with the provisions of the HIPAA Rules that are applicable to business associates, regardless of whether they have executed the required business associate agreement with the entity using its services.[565] The existence or absence of a business associate agreement between a covered entity and a person does not determine whether the person is a business associate of that covered entity. If a business associate agreement has not been executed, a business associate still would be responsible for disclosing PHI to the covered entity, which would provide the PHI to the individual. In all cases, the covered entity remains ultimately responsible for ensuring that the requested PHI is provided to the individual or individual's designee to fulfill the right of access.[566]

The modification to 45 CFR 164.502(a)(4)(ii) does not allow regulated entities to use contractual arrangements to avoid other legal obligations to provide individuals with access to their health information, which may include PHI.[567] If there are other applicable laws that require a disclosure of PHI by a business associate, the business associate would need to comply with that law and ensure that any agreements which they enter into are consistent with those legal obligations.[568]

Furthermore, records that meet the definition of designated record set and are held by a business associate for or

[558] For purposes of 45 CFR 164.502(a)(4)(ii), an ''individual'' also includes the individual's ''personal representative,'' with limited exceptions. *See* 45 CFR 164.502(g) and 164.524(a)(3)(iii).

[559] *See* 78 FR 5566, 5598–99 (Jan. 25, 2013).

[560] *See* ''Direct Liability of Business Associates,'' *supra* note 113.

[561] *Id.*

[562] *See* ''Does the HIPAA Privacy Rule require a business associate to provide individuals with access to their protected health information or an accounting of disclosures, or an opportunity to amend protected health information?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #246 (Dec. 19, 2002), *https://www.hhs.gov/hipaa/for-professionals/faq/246/do-business-associates-have-obligations/index.html; see also* ''Direct Liability of Business Associates,'' *supra* note 113.

[563] ''Business Associate Contracts,'' Office for Civil Rights, U.S. Department of Health and Human Services (Jan. 25, 2013), *https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html.*

[564] 45 CFR 160.103 (definition of ''Business associate'').

[565] *See* 78 FR 5566, 5598–99 (Jan. 25, 2013).

[566] *Id.* at 5600.

[567] *See* 85 FR 25642, 25811 (May 1, 2020) (explaining that while the information blocking regulations do not require actors that are also covered entities or business associates to violate their business associate agreements or associated service level agreements, they also do not permit such agreements to be used in a discriminatory manner by an actor to forbid or limit disclosures that otherwise would be permitted by the Privacy Rule).

[568] *See* ''Does the HIPAA Privacy Rule preempt state laws?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #399 (Mar. 12, 2003), *https://www.hhs.gov/hipaa/for-professionals/faq/399/does-hipaa-preempt-state-laws/index.html.*

on behalf of a covered entity are part of the covered entity's designated record set.[569] Accordingly, a covered entity may not avoid its access obligations on the basis that its business associate maintains the requested PHI.

e. Responses to Public Comments

Comment: Several commenters expressed support for the proposed modification. According to a few commenters, it would clarify the role of a business associate with respect to requests for access. A few commenters asserted that the proposed modification would clarify the relationship between covered entities and business associates with minimal burden.

One commenter asserted that changing the process for requesting access to PHI to permit individuals to make such requests of business associates directly would be burdensome for individuals and covered entities.

A few commenters expressed opposition to the proposal because they believed that it would be inconsistent with section 4006 of the Cures Act, which requires the Secretary to consult with ONC and promote policies that ensure the accessibility of ''electronic health information,'' and with the information blocking regulations. One commenter recommended that we ensure that the Department's approach to individual access and business associate responsibilities for providing individual access is consistent across components of the Department. One commenter expressed concern that some business associate agreements prohibit business associates from disclosing PHI in response to individual requests for access to anyone other than the person that is the source of the data (*e.g.,* generally, the covered entity that engaged the business associate); this commenter recommended that the Department educate health care providers on how to leverage HIEs for individual access requests.

Response: As discussed above, we are finalizing the modification as proposed and consistent with our longstanding interpretation of this provision. This clarification does not create a new requirement under the Privacy Rule for business associates to respond directly to requests from individuals. Rather, it clarifies the two ways for a business associate to fulfill the regulatory requirement to disclose PHI as necessary for a covered entity to satisfy its obligations under the right of access: (1) provide the PHI to the covered entity; or (2) where the business associate agreement specifies, provide the PHI directly to the individual or the individual's designee.

Section 4006(b) of the Cures Act amended the HITECH Act to clarify that a business associate is permitted to provide an individual with access or a copy of PHI about the individual if the individual requests such access or copy from the business associate (or in the case where an individual exercises their right of access to direct, to grant or transmit such access or copy to a person designated by the individual).[570] Thus, the HITECH Act did not expressly require the business associate to make such disclosure, so there is no conflict with the revision that we are making in this final rule.

The Privacy Rule permits a business associate to use or disclose PHI only as permitted or required by its business associate agreement pursuant to 45 CFR 164.504(e)[571] or as required by law.[572] Accordingly, under the Privacy Rule, a business associate can make disclosures directly to individuals or their designees to fulfill a right of access request only if the business associate agreement permits or requires it. The Privacy Rule does not require that a business associate agreement permit or require a business associate to respond directly to requests for access, and the obligation for ensuring that responses are provided to such requests remains with the covered entity, regardless of any delegation made as part of the business associate agreement. However, not permitting a business associate to respond directly to requests for access may be a violation of another law. For example, a practice of a business associate that is also an actor[573] may implicate the information blocking regulations where the practice involves not responding to or fulfilling requests for access, exchange, or use of EHI,[574] if such access, exchange, or use of EHI is restricted by contracts or agreements and such restrictions are considered an interference.[575]

The information blocking regulations were designed to operate in a manner that is consistent with the Privacy Rule and other laws providing privacy rights for patients. Foremost, the definition of information blocking excludes practices that are ''required by law,'' including under the Privacy Rule (or other Federal or state law). However, if an actor is permitted to provide access, exchange, or use of EHI under the Privacy Rule (and other applicable laws), then the information blocking regulations may be implicated with respect to the actor's practice that is likely to interfere with access, exchange, or use of EHI unless an exception applies to the practice.[576]

B. Reducing Identity Verification Burden for Individuals Exercising the Right of Access

1. Issues To Address

Section 164.514(h) of the Privacy Rule requires, with limited exceptions, that a covered entity take reasonable steps to verify the identity of a person requesting PHI before disclosing the PHI to ensure that unauthorized persons do not obtain an individual's PHI.[577]

The Privacy Rule does not mandate any particular method of verification (*e.g.,* viewing an individual's driver's license at the point of service). Instead, it generally leaves the type and manner of the verification to the discretion and professional judgment of the covered entity, provided that the verification processes and measures do not create barriers to, or unreasonably delay, the individual from obtaining access to their PHI. Verification may be done verbally or in writing. In many circumstances, the type of verification may depend on how the individual is requesting and/or receiving access, such as in person, by phone (if permitted by the covered entity), by faxing or emailing the request

[569] *See* 65 FR 82462, 82489 (Dec. 28, 2000); 45 CFR 164.501 (definition of ''Designated record set'').

[570] 42 U.S.C. 17935(e)(2) (as amended by sec. 4006(b) of Pub. L. 114–255, 130 Stat. 1183 (Dec. 13, 2016)).

[571] 45 CFR 164.504(e) contains the standard and implementation specifications for business associate contracts, commonly referred to as business associate agreements.

[572] 45 CFR 164.502(a)(3); *see* 45 CFR 164.103 (definition of ''Required by law''). For example, the Privacy Rule does not relieve a business associate of its obligations to disclose PHI to a plan sponsor to the extent that such disclosure is required by section 408 of the Employee Retirement Income Security Act of 1974 (ERISA), where applicable.

[573] 45 CFR 171.102 (definition of ''Actor'').

[574] 45 CFR 171.102 (definition of ''Electronic health information'').

[575] 85 FR 25642, 25811–12 (May 1, 2020). Similarly, a practice of a covered entity that is also an actor may implicate the information blocking regulations where the practice results in the inability of a business associate to respond to or fulfill requests for access, exchange, or use of EHI, if such access, exchange, or use of EHI is the result of restrictions in contracts or agreements and such restrictions are considered an interference. As explained by ONC, the actions and processes (*e.g.,* negotiations) of the actors in reaching the business associate agreement and associated service level agreements would need to be reviewed to determine whether there was any action taken by an actor that is party to the agreement that was likely to interfere with the access, exchange, or use of EHI and whether the requisite intent requirement was met. *Id.*

[576] *Id.* at 25812.

[577] Disclosures made pursuant to 45 CFR 164.510 are excepted from this requirement. 45 CFR 164.514(h)(1)(i).

on the covered entity's supplied form, by secure online portal, or by other means. For example, if the covered entity requires that access requests be made on its own supplied form, the form could ask for basic information about the individual that would enable the covered entity to verify that the person requesting access is the subject of the information requested or is the individual's personal representative, provided that use of the form does not create a barrier to or unreasonably delay the individual from obtaining access to the individual's PHI. For covered entities providing individuals with access to their PHI through patient or health plan member portals, such portals already should be set up with appropriate authentication controls, as required by 45 CFR 164.312(d), to ensure that the person seeking access is the individual who is the subject of the PHI (or their personal representative).[578]

However, the Department continues to receive complaints and anecdotal accounts indicating that some covered entities are imposing burdensome requirements for identity verification on individuals seeking to obtain their PHI pursuant to the individual right of access. For example, some covered entities require individuals to receive their PHI in person, or even to obtain (at potentially added expense) a notarization on a written request, to exercise their right of access.

2. Proposed Rule

To address these barriers to an individual's access to their health information, the Department proposed to modify 45 CFR 164.514(h) by adding paragraph (2)(v) to expressly prohibit a covered entity from imposing unreasonable identity verification measures on an individual (or their personal representative) exercising a right under the Privacy Rule.[579]

In addition, the Department proposed to clarify that unreasonable verification measures are measures that cause an individual to expend unnecessary effort or expense when a less burdensome verification measure is practicable for the particular covered entity. The Department proposed to include in regulatory text examples of what is considered an unreasonable verification measure, including but not limited to: requiring individuals to obtain notarization of requests to exercise their Privacy Rule rights or requiring individuals to provide proof of identity in person when a more convenient method for remote verification is practicable for the covered entity.[580]

The Department explained that it would consider the entity's fulfillment of its Security Rule obligations in assessing whether a verification measure is practicable. As part of the assessment, we would consider the covered entity's size, complexity, and capabilities; technical infrastructure, hardware, and software security capabilities; the costs of security measures related to verification and of implementing measures that may be more convenient for individuals; and the probability and criticality of potential risks to ePHI in the covered entity's electronic information systems.[581]

As discussed above, we also proposed to clarify that a covered entity that implements a requirement for individuals to submit a request for access, including a request to direct an electronic copy of PHI in an electronic health record to a person designated by the individual, in writing, pursuant to 45 CFR 164.524(b)(1), would not be permitted to do so in a way that imposes unreasonable burdens on individuals. The Department proposed the change to ensure that individuals do not have to expend unnecessary effort or expense when other verification measures are practicable for the covered entity.

Consistent with the proposed verification provisions above, the Department also proposed to expressly prohibit a covered entity from imposing unreasonable measures for submitting a request for access, including the right of access to direct, in writing; the proposal provided that measures would be unreasonable if they impede the individual from obtaining access when a measure that is less burdensome for individuals is practicable for the particular covered entity. To help define ''unreasonable measures'' for covered entities, the Department proposed to include and compare, in regulatory text, non-exhaustive specific examples of reasonable and unreasonable measures that some covered entities have imposed (as described in public comments or individuals' complaints submitted to the Department) or may be likely to impose.

3. Overview of Comments

Most commenters expressed support for the proposed prohibition against imposing unreasonable identity verification measures. Some commenters asserted that the proposal would facilitate individuals' access to their PHI and provide covered entities with sufficient flexibility to determine appropriate identity verification measures. Several commenters cautioned the Department against enumerating specific methods or examples of appropriate measures for identity verification, while others urged the Department to preserve flexibility for covered entities to select verification measures appropriate to their operational environments. A few commenters expressed concern that limiting the available measures for identity verification could increase the risk to the privacy and security of PHI. Several comments requested clarification regarding identity verification for personal representatives.

Most commenters expressed support for the proposal to prohibit covered entities from imposing unreasonable measures on individuals making access requests, stating that it would strengthen the individual right of access. Many commenters reported that some covered entities refuse to receive requests submitted by email or only receive requests made through online portals even in circumstances when an individual could not reasonably use those systems. A few commenters expressed concern that allowing greater flexibility in request submission could increase administrative burden and requested that the Department clarify whether covered entities may continue to require requests in writing.

4. Final Rule

The Department is finalizing a modified version of the proposal to prohibit a covered entity from imposing unreasonable identity verification measures or imposing unreasonable measures that impede the submission of requests for access, including the right of access to direct. Specifically, the final rule adds paragraph (2)(v) of 45 CFR 164.514(h) to prohibit covered entities from imposing unreasonable verification measures that would impede an individual from exercising a right under the Privacy Rule. An unreasonable measure is one that causes an individual to expend unnecessary effort or resources when a less burdensome verification measure is practicable for the covered entity.

The Department is not finalizing in regulatory text examples of unreasonable measures. Instead, consistent with comments urging flexibility and to avoid establishing prescriptive limitations on reasonableness that may become outdated as technology evolves, the Department provides in this preamble a

[578] *See* 45 CFR 164.312(d).

[579] *See* 86 FR 6446, 6470–71 (Jan. 21, 2021).

[580] *See* 86 FR 6446, 6534 (Jan. 21, 2021).

[581] *See* 45 CFR 164.306(b)(2); 86 FR 6446, 6470 (Jan. 21, 2021).

non-exhaustive list of examples of measures that we currently consider unreasonable to illustrate how the standard applies.

As we discussed in the proposed rule, unreasonable identity verification measures include, but are not limited to, requiring an individual to do any of the following: (1) provide proof of identity in person when a method for remote verification is practicable for the covered entity and more convenient for the individual; (2) provide a ''wet'' signature when a signature is required and an electronic signature is valid under applicable law;[582] or (3) obtain notarization of the individual's signature on a written request to exercise their right of access, including the right of access to direct. Notarization requirements also may be unreasonable if imposed on a personal representative requesting access on an individual's behalf, in circumstances when the covered entity has sufficient documentation to verify the identity and authority of the personal representative or when a less burdensome verification measure is practicable.

As another example, we also would consider it to be unreasonable for a covered entity to refuse to accept a request for access from a personal health app where: (1) the request is made, using TEFCA, to a covered entity that participates in TEFCA; and (2) the covered entity has performed both of the following actions:

- Verifies, using technology that performs signature validation, that the cryptographically signed token[583] attached to the request was issued by a credential service provider[584] (CSP) that is certified to perform digital identity verification consistent with IAL2 and AAL2 as set forth in the most recent version of NIST Special Publication (SP) 800–63[585] (''SP 800–63'').
- Ensures that the demographic information verified by the CSP and included in the cryptographically signed token is consistent with the demographic information for the individual in the designated record set maintained by or for the covered entity.

Accordingly, a covered entity can meet its obligations under 45 CFR 164.514(h)(1) where the person requesting the disclosure of PHI is an individual seeking to exercise their right of access in the circumstances described above.

The same is true where the request is sent through CMS Aligned Networks to a covered entity that is a participant in the networks from a patient facing app that: (1) is a personal health app and (2) connects to the networks as a participant in the Medicare App Library.

The Department also is finalizing a modified version of the proposal to prohibit a covered entity from imposing measures that impede access requests.[586] The final rule clarifies that a covered entity may not impose measures that impede the individual from obtaining access when a measure that is less burdensome for the individual is practicable for the entity. The final rule also reiterates that a covered entity may require an individual to submit a request for access in writing, provided that it informs the individual of such a requirement, and clarifies that a request submitted electronically or on paper may satisfy such a requirement because the request itself serves as documentation of the individual's exercise of the right of access.[587]

Although the Department is not finalizing in regulatory text a list of examples of measures that impede access, we reaffirm the examples provided in the 2021 Privacy Rule NPRM and provide additional examples to assist regulated entities in understanding what we consider to be measures that impede an individual's access to their PHI. For example, requiring individuals to complete a form with only the limited information needed for the entity to provide access would be considered reasonable because it requests only the information necessary for verification and does not require the individual to expend unnecessary effort. In contrast, requiring individuals to fill out a form with the extensive information contained in a HIPAA authorization form may impose an unreasonable burden on individuals.

In addition, while we encourage covered entities to provide individuals with the option to submit access requests through patient and health plan member portals and other electronic methods (*e.g.,* email, personal health apps, through an HIN), it generally would be unreasonable for a covered entity to require that requests for access be made only through a particular electronic method when it would be practicable for the covered entity also to accept such requests in-person or through other electronic methods.[588] Unreasonable measures also include applying onerous or infeasible registration requirements for personal health apps (or other apps that are not being provided on behalf of or at the direction of the covered entity) that would create a barrier to or unreasonably delay registration beyond what is necessary for compliance with the Security Rule, such as requiring a person who does not meet the definition of a business associate to enter into a business associate agreement with the covered entity. Another example of an unreasonable measure would be preventing an individual's personal health app from registering with an endpoint (*e.g.,* API) that the covered entity makes public where the registration of such endpoint would not pose an unacceptable level of risk to the ePHI in the covered entity's (or its business associate's) electronic information systems, as informed by the covered entity's risk analysis.[589]

As explained in the 2021 Privacy Rule NPRM, under the Privacy Rule's requirements for individual access,

[582] *See* 78 FR 5566, 5633 (Jan. 25, 2013); ''How do HIPAA authorizations apply to an electronic health information exchange environment?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #554 (Dec. 15, 2008), *https://www.hhs.gov/hipaa/for-professionals/faq/554/how-do-hipaa-authorizations-apply-to-electronic-health-information/index.html;* ''How may the HIPAA Privacy Rule's requirements for verification of identity and authority be met in an electronic health information exchange environment?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #569 (Dec. 15, 2008), *https://www.hhs.gov/hipaa/for-professionals/faq/569/how-may-hipaas-requirements-for-verification-of-identity-be-met-electronically/index.html.*

[583] *See* NIST definition of ''token,'' Glossary, Computer Security Resource Center, National Institute for Standards and Technology, U.S. Department of Commerce, *https://csrc.nist.gov/glossary/term/token.*

[584] Generally, a credential service provider is an entity that performs digital identity verification. *See* NIST definition of ''credential service provider,'' Glossary, Computer Security Resource Center, National Institute for Standards and Technology, U.S. Department of Commerce, *https://csrc.nist.gov/glossary/term/credential_service_provider/.*

[585] The current and most recent version is SP 800–63–4. *See* ''Digital Identity Guidelines,'' National Institute of Standards and Technology, U.S. Department of Commerce (Aug. 26, 2025), *https://pages.nist.gov/800-63-4/.* For information on CSP certification, *see* ''International Identity Assurance Program,'' Kantara Initiative, *https://kantarainitiative.org/us-identity-certification-program/.* As of this publication, no CSPs are certified as meeting the requirements of SP 800–63–4. Accordingly, covered entities may rely on a cryptographically signed token CSP that is certified to perform digital identity verification consistent with IAL2 and AAL2 as set forth in NIST SP 800–63–3 until such time as there are CSPs certified to NIST SP 800–63–4.

[586] *See* new 45 CFR 164.524(b)(1)(iii).

[587] *See* new 45 CFR 164.524(b)(1)(ii).

[588] *See* new 45 CFR 164.514(h)(2)(v).

[589] *See* 45 CFR 164.308(a)(1). As discussed above, we believe that, generally, when a covered entity is in control of its electronic information systems' ability to transmit PHI or to provide read access to PHI through a personal health app, the risk to the security of ePHI in their electronic information systems is low. At the same time, a covered entity remains responsible for maintaining awareness of and protecting ePHI in the face of new security vulnerabilities and threats to the confidentiality, integrity, and availability of its ePHI.

covered entities generally must allow every application that wants to register with the API to provide access for an individual the ability to do so, assuming that it is practicable for the covered entities and absent any Security Rule concerns.[590] Therefore, a regulated entity that makes available a secure, standards-based API but denies registration, and therefore individual access, to an individual's personal health app, may be in violation of the Privacy Rule's requirements for the provision of individual access. For example, a health care provider may not prevent an app from registering solely because the app does not have a business associate relationship and agreement with the covered entity or because the app offers another service to individuals that competes with a service that the health care provider (or one of its business associates) offers.

As another example, it would be unreasonable for a covered entity that participates in TEFCA to refuse to accept an individual's request for access made through a personal health app that is a TEFCA IAS Provider, even though the request is not made on the covered entity's specific form, where both of the following conditions are met:

- The request meets the requirements at 45 CFR 164.524.
- The covered entity is able to verify the individual's identity consistent with its obligations at 45 CFR 164.514(h)(i), including by verifying the signature on and the demographic information in a cryptographically signed token as described above.

The same is true where the scenario relies upon CMS Aligned Networks and the covered entity and personal health app have the requisite relationship.

The final rule does not require covered entities to adopt particular methods of verification, nor does it require covered entities to implement the measure for verification that is least burdensome for an individual in every circumstance, if it is impracticable for the covered entities to do so. Covered entities retain discretion to select verification measures that are appropriate to their operational environment, provided that the measure does not impose unreasonable burdens on an individual's exercise of the right of access. Covered entities are encouraged to offer individuals multiple options for verifying their identity when the individual requests access.

[590] The Cures Act Final Rule provides exceptions to information blocking that are aligned with the HIPAA Rules to prevent harm, for privacy and security. This discussion is consistent with those provisions. *See* 85 FR 25642 (May 1, 2020).

5. Responses to Public Comments

Comment: Some commenters expressed support for the proposal to prohibit covered entities from imposing unreasonable measures for identity verification. Several commenters expressed support for the proposal because it would clarify the requirements while retaining flexibility for covered entities to determine the particular method of verification. Some commenters recommended that the Department require implementation of specific methods of identity verification and authentication. A few commenters expressed support for the proposal and urged the Department to require that identity verification be streamlined through patient portals and that requests for information be limited to the information needed to securely verify identity.

A few commenters expressed support for the proposal because they believed that it would facilitate individuals' access to their PHI by addressing obstacles that disproportionately burden members of minority groups and historically disadvantaged communities, including individuals with limited financial means or disabilities and caregivers for such individuals.

Response: The final rule adopts the proposal to prohibit a covered entity from imposing unreasonable identity verification measures. The Department declines to require specific methods for identity verification and authentication. Because of the varied circumstances of individuals and covered entities, a given measure for verifying an individual's identity or requesting access, such as using an online portal, may be convenient for some individuals and burdensome for others, and practicable for some covered entities but not for others. Given this variability, the Department declines to require that covered entities implement any particular measure or analyze and adopt the least burdensome measure possible for each individual.

Comment: Many commenters provided examples of what they considered to be reasonable or unreasonable measures and requested that the Department provide additional examples of reasonable or unreasonable measures. A few commenters recommended that the Department adopt a framework for evaluating the reasonableness of identity verification measures, while one commenter requested that the Department clarify that ''reasonableness'' would be determined based on a covered entity's business and operational environment. A few commenters recommended that the Department ensure that covered entities are able to match a patient's identity with their information.

Response: As discussed above, the Department is not including examples in regulatory text to avoid creating an impression of a complete list of reasonable or unreasonable measures of identity verification. Rather, we provide a non-exhaustive list of examples in preamble above. The standard for identity verification generally requires a covered entity (or a business associate on behalf of the covered entity) to verify the identity of a person requesting PHI and the authority of any such person to have access to PHI under the Privacy Rule, if the identity or authority of such person is not known to the covered entity. As we explained in the 2021 Privacy Rule NPRM, practicability considerations encompass those related to an entity's fulfillment of its Security Rule obligations, discussed above.[591]

Comment: One commenter stated that the identity verification standard should be the same whether access to PHI is requested by an individual or a personal representative, while another commenter recommended that the Department permit covered entities to employ different standards for identity verification for individuals and personal representatives.

Response: The Privacy Rule generally requires a covered entity to treat a person who has the authority under applicable law to act on behalf of an individual in making decisions related to health care as the individual's personal representative with respect to PHI relevant to such personal representation, with limited exception.[592] The final rule does not prescribe separate standards for identity verification for individuals and personal representatives, nor does it alter the existing requirement under 45 CFR 164.514(h) that a covered entity must verify the identity of a person requesting PHI and the authority of any such person to have access to PHI, if their identity (and authority) is not already known to the covered entity. The Department acknowledges that verification considerations may differ when a personal representative requests access to PHI on behalf of an individual. For example, a health care provider can require a copy of a power of attorney if a person represents that they have a health care power of attorney, or can ask questions to determine that an adult acting for a minor child has the requisite relationship to the child, provided that

[591] *See* 45 CFR 164.306(b)(2); 86 FR 6446, 6470 (Jan. 21, 2021).

[592] *See* 45 CFR 164.502(g).

such measures do not impose an unreasonable burden on the exercise of the individual's rights under the Privacy Rule.[593] However, it would be unreasonable for a covered entity to adopt procedures for identity verification that would unnecessarily delay the covered entity's response to a request for access made by an individual's personal representative where alternative procedures would enable the verification of the personal representative's identity and authority in a more timely manner. Additionally, requiring personal representatives to repeatedly submit documentation already on file, mandating in-person appearances when remote verification is practicable, or refusing to accept legally valid documentation submitted electronically may, depending on the circumstances, constitute unreasonable measures that interfere with the individual's right of access as exercised through a personal representative.

Comment: Some commenters expressed opposition to this proposal because they viewed it as burdensome or unclear. Several commenters urged the Department not to impose restrictions on the ability of covered entities to determine the type and manner of identity verification. One commenter recommended that the Department prohibit covered entities from requiring extensive validation protocols.

Response: As discussed above, the Department is finalizing a modified version of the proposal that does not include examples in the regulatory text of what is considered unreasonable to avoid establishing prescriptive limitations on reasonableness or creating the impression that specific methods of identity verification are required. By removing examples from the regulatory text and instead addressing them in this preamble, the final rule provides covered entities with the flexibility to adopt verification methods that evolve with technological and operational changes, while still making clear that they cannot employ identity verification measures that are unreasonable.

Comment: Some commenters expressed opposition to the proposal because they believed that it would lead to breaches of PHI. For example, commenters posed examples of malicious actors creating technology that is able to impersonate individuals or covered entities being unable to verify the identity of a minor's guardian. One commenter expressed concern that relaxing identity verification measures could lead to increased identity theft, fraud, or misidentification, while another commenter recommended that the Department clarify that a covered entity is permitted to reject a request if it is unable to verify a person's identity.

Response: The final rule does not require covered entities to relax identity verification requirements. Nothing in this final rule changes a covered entity's obligation under 45 CFR 164.514(h) to take reasonable steps to verify the identity and authority of a person requesting PHI before disclosing the PHI to help ensure that unauthorized persons do not obtain an individual's PHI.[594] Rather, the final rule prohibits covered entities from imposing measures that impede access requests or imposing unreasonable identity verification measures. Covered entities remain responsible for assessing security risks and are not required to adopt verification methods that would increase the likelihood of identity theft, fraud, or misidentification, nor are they required to fulfill an access request when they cannot verify the identity of the person making the request.

C. Amending the Definition of Health Care Operations To Clarify the Scope of Care Coordination and Case Management

1. Current Rule

The Privacy Rule expressly permits covered entities to use and disclose PHI, without an individual's valid authorization, for treatment and certain health care operations, among other important purposes.[595] The definitions of both ''treatment'' and ''health care operations'' include some care coordination and case management activities.[596]

As explained in preamble to the 2000 Privacy Rule, certain activities may be considered either health care operations or treatment, depending on whether the activities are population-wide or individual-specific activities, and if individual-specific, whether the communication with an individual occurs on behalf of a health care provider or a health plan.[597] For example, a telephone call by a nurse in a doctor's office to an individual to discuss follow-up care would be a treatment activity; however, the same activity performed by a nurse working for a health plan would be a health care operation.[598]

2. Proposed Rule

Despite the guidance in the 2000 Privacy Rule, we have received anecdotal reports that some covered entities have interpreted the definition of ''health care operations'' to include only population-based care coordination and case management, which would have the effect of excluding individual-level care coordination and case management by health plans.[599] In addition, some covered entities have expressed uncertainty about the ability of health care providers to disclose PHI to health plans for individual-level care coordination and case management without an individual's authorization.

Thus, the Department proposed to amend the definition of ''health care operations'' at 45 CFR 164.501 to clarify that it encompasses all care coordination and case management by health plans, whether individual-level or population-based. The Department explained that, as drafted, the placement of commas separating the list of activities following the term ''population-based activities'' permitted the interpretation that the term ''population-based activities'' modifies (*i.e.,* places a condition on) all of the activities listed between the semi-colons, including case management and care coordination, although the Department has not applied that interpretation to the definition of health care operations. Accordingly, the Department proposed to change the commas into semi-colons in paragraph (1) of the definition of ''health care operations'' at 45 CFR 164.501 to clearly convey that the activities listed are each separate types of health care operations.

3. Overview of Comments

Many individuals and organizations commented on the proposal to clarify the definition of ''heath care operations.'' Most commenters expressed general support for the proposal because they believed that the changes would clarify the scope of health care operations. They also believed that the proposed modifications would facilitate the sharing of PHI to support care coordination and case management.

Some commenters expressed opposition to the proposal because they believed that it would permit the use and disclosure of PHI for individual-

[593] *See* 65 FR 82462, 82547 (Dec. 28, 2000).

[594] *See* 45 CFR 164.514(h).

[595] *See* 45 CFR 164.506; 45 CFR 160.103 (definitions of ''Disclosure'' and ''Use'').

[596] *See* 45 CFR 164.501 (definitions of ''Treatment'' and ''Health care operations'').

[597] 65 FR 82462, 82627 (Dec. 28, 2000).

[598] *Id.*

[599] This final rule describes such activities as ''population-based'' and ''individual-level'' care coordination and case management, respectively.

level care coordination and case management without requiring an individual's authorization, thereby excluding individuals from the process of care coordination.

4. Final Rule

This final rule adopts the proposed clarification of the definition of ''health care operations'' to facilitate the intended range of care coordination and case management activities. The Department generally has interpreted the existing definition to permit health care providers to disclose PHI to health plans for individual-level care coordination and case management without an individual's authorization. However, covered entities have expressed uncertainty about the extent to which the definition applies to activities such as case management and care coordination by health plans or as part of value-based health care models. Therefore, it is necessary for the Department to expressly confirm that health care operations encompasses all care coordination and case management activities by health plans and covered health care providers, whether individual-level or population-based. Changing the punctuation in the definition accomplishes this goal, thereby improving the likelihood that covered entities will use and disclose PHI accordingly.

5. Responses to Public Comments

Comment: Many commenters expressed support for this proposal because it would facilitate both individual-level and population-based care coordination and case management. Several commenters asserted that the proposal would provide certainty to covered entities that are hesitant to disclose PHI for care coordination and case management without an individual's authorization. One commenter stated that clarifying the definition would decrease the burden for workforce members who previously requested individual authorizations for these disclosures. Another commenter suggested that the Department issue guidance to address this concern, rather than notice and comment rulemaking.

Several commenters expressed support for the Department's goal but recommended further revisions. For example, one commenter recommended that the Department add the phrase ''individual-level or population-based'' in front of the words ''case management and care coordination'' to provide additional clarity.

Response: The Department believes that the clarification that we are finalizing here addresses any uncertainty regarding whether PHI may be used or disclosed for individual-level care coordination and case management without an individual's authorization and reduces the burden of obtaining an individual's authorization when not required. This revision to the definition sufficiently clarifies the intended range of care coordination and case management, so it is not necessary to modify it further.

Comment: A few commenters who expressed support for the clarification to the definition of health care operations recommended that the Department define or provide greater clarity regarding the activities included in ''care coordination'' and ''case management'' to allow for more consistent interpretation of the terms. Some commenters requested that the Department explicitly include coordination of social services such as supportive housing for an individual with a disability, in the definition of health care operations.

Response: We decline to define ''care coordination'' and ''case management'' in this final rule. Both terms refer broadly to a set of activities aimed at promoting cooperation among people involved in caring for individuals, including family members, caregivers, and community-based organizations. Rather than proposing limiting definitions, the Department has, instead, provided an extensive discussion and a non-exhaustive list of examples of the types of activities it considers to be care coordination and case management activities.[600]

The Department also declines to include coordination of social services in the definition of ''health care operations'' in this final rule. Instead, to address questions about whether the Privacy Rule permits disclosures to social services organizations for care coordination and case management, the Department is adding a provision at 45 CFR 164.506(c)(6) to expressly permit disclosures of PHI for individual-level care coordination and case management that constitute treatment or health care operations, to certain types of organizations that provide health and human services.[601]

Comment: Some commenters expressed concern that the proposal would increase the ability of covered entities to use and disclose PHI for care coordination and case management without individual authorization. A few commenters expressed opposition to the Department's proposed clarification because they believed that it would exclude individuals from the process of care coordination. One commenter asserted that the proposal would expand access to individual-level PHI without accompanying safeguards and controls to protect an individual's privacy.

Response: This clarification does not expand the authority of covered entities to use or disclose PHI without a valid authorization. As we explained in the 2021 Privacy Rule NPRM, the Department has become aware that some covered entities may be interpreting the definition of health care operations in a manner that is inconsistent with the Department's intent. Thus, the Department does not consider this clarification to be a substantive modification because the final rule does not alter our interpretation of the definition. Rather, the modification to the definition merely clarifies the ability of covered entities to use and disclose PHI for individual-level care coordination and case management. For example, health plans may use and disclose PHI for individual-level care coordination and case management, and covered entities may disclose PHI to health plans for these purposes.

The Department appreciates commenters' concerns about protecting individuals' privacy and emphasizes that covered entities must apply the requirements of the minimum necessary standard for uses and disclosures of PHI for the purpose of health care operations. Additionally, individuals have a right to request restrictions on uses or disclosures for TPO under 45 CFR 164.522(a).[602]

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[600] *See supra* at sec. III.A.3.

[601] The permission would be consistent with existing OCR guidance addressing these types of disclosures by covered health care providers. *See* ''Does HIPAA permit health care providers to share protected health information (PHI) about an individual with mental illness with a third party that is not a health care provider for continuity of care purposes? For example, can a health care provider refer a homeless patient to a social services agency, such as a housing provider, when doing so may reveal that the basis for eligibility is related to mental health?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #3008 (Jan. 4, 2018), *https://www.hhs.gov/hipaa/for-professionals/faq/3008/does-hipaa-permit-health-care-providers-share-phi-individual-mental-illness-third-party-not-health-care-provider-continuity-care-purposes/index.html.*

[602] *See* 45 CFR 164.522(a)(1)(ii). Although covered entities must allow individuals to request restrictions of the use or disclosure of their PHI for TPO, covered entities generally are not required to agree with the requested restrictions, with limited exception. Specifically, covered entities are required to accept an individual's request to restrict the disclosure of PHI about the individual to a health plan if: (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise requirement by law; and (2) the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has

Comment: A few commenters expressed concern that the proposal could have unintended adverse consequences if implemented in conjunction with the proposal to modify the minimum necessary standard. For example, one commenter asserted that removing the minimum necessary standard for health care operations for care coordination and case management could allow health plans to gain unfettered access to a physician's EHR and empower health plans to make decisions about an individual's health care.

Response: The Department is not finalizing the proposed exception to the minimum necessary standard for health care operations uses and disclosures of PHI related to individual-level care coordination and case management, as discussed below. Retaining the current minimum necessary standard addresses concerns that the modification to the definition of health care operations weakens individuals' privacy protections. Therefore, covered entities who engage in care coordination and case management as health care operations must limit the PHI that they use or disclose to the minimum necessary to accomplish the intended purpose of the use or disclosure.

D. Creating an Exception to the Minimum Necessary Standard for Disclosures for Individual-Level Care Coordination and Case Management

1. Current Rule

Section 164.502(b) requires covered entities to use, disclose, and request only the minimum amount of PHI necessary for the purposes of TPO, except for disclosures to or requests by a health care provider for treatment, where the minimum necessary requirement does not apply.

The Department has long considered care coordination to be part of an individual's treatment and interpreted the Privacy Rule to permit health care providers to disclose PHI in support of an individual's health care to service providers who may not be covered entities and who may not be health care providers.[603] Health plans also coordinate an individual's care when managing and paying for health plan benefits; however, these activities are considered health care operations activities (and therefore subject to the minimum necessary standard) because most health plans do not provide treatment.[604]

2. Proposed Rule

The Department proposed to create an exception to the minimum necessary standard for disclosures to, or requests by, a health plan or covered health care provider for care coordination and case management. The proposed exception would apply only to individual-level activities for care coordination and case management activities. In conjunction with the proposal to clarify that the definition of health care operations includes individual-level care coordination and case management described above, this proposed exception would permit health plans to request, use, and disclose PHI without limitation for such health care operations, including disclosures to persons who are not covered entities and who are not health care providers. For covered health care providers, the proposal would specify that the existing exception for disclosures to, or requests by, a health care provider for treatment includes case management and care coordination. The proposed exception would relieve covered entities from the requirement to make determinations about the minimum information necessary when the request is from, or the disclosure is made to, a covered health care provider or health plan to support individual-level care coordination and case management activities.

3. Overview of Comments

Commenters were evenly split in their views of the proposal. Commenters who expressed support for this proposal asserted that it would facilitate care coordination, improve outcomes, and provide clarification, while commenters who expressed opposition did so because they believed that it would decrease an individual's privacy.

4. Final Rule

This final rule does not adopt the proposed exception to the minimum necessary standard for individual-level care coordination and case management. The Department is persuaded by public comments that asserted that providing an exception to the minimum necessary standard for certain health care operations would erode individuals' confidence in the privacy of their PHI and their willingness to fully engage with the health care system. Additionally, we believe that other modifications that we are making in this final rule, such as modification to the definition of health care operations, will facilitate the ability of health plans to perform beneficial individual-level care coordination and case management activities.

5. Responses to Public Comments

Comment: Many commenters who expressed support for this proposal asserted that it would facilitate care coordination, improve outcomes, and clarify that disclosures of all PHI, rather than the minimum necessary, is permissible to health care providers and health plans for the purpose of individual-level care coordination and case management. Some commenters provided examples of the types of activities that they believed that this proposal would facilitate. According to one commenter, the proposal would eliminate concerns about determining the purpose of certain requests that could be for either treatment or health care operations. One commenter asserted that this proposal would not alter the practice of covered entities to request the minimum PHI necessary to accomplish their purpose. A few commenters expressed their belief that the proposal would reduce the administrative burden on covered entities. One commenter expressed support for the proposal because they believed that it would reduce impediments to the disclosure of PHI using HIEs. Another commenter asserted that the proposal would enable covered entities to transition from providing care on a fee-for-service basis to providing care based on value.

Response: The Department agrees with commenters that it is important for the Privacy Rule to permit the disclosure of PHI to facilitate care coordination and improve health care outcomes. However, we have determined that such aims can be achieved by means other than creating a new exception to the minimum necessary standard. Specifically, elsewhere in this rule, we are finalizing

paid the covered entity in full. *See* 45 CFR 164.522(a)(1)(vi).

[603] *See* ''Does HIPAA permit health care providers to share protected health information (PHI) about an individual with mental illness with a third party that is not a health care provider for continuity of care purposes? For example, can a health care provider refer a homeless patient to a social services agency, such as a housing provider, when doing so may reveal that the basis for eligibility is related to mental health?,'' *supra* note 601.

[604] Managed care organizations generally integrate both the delivery and financing of health care, as opposed to most health plans, which solely pay for health care. Therefore, managed care organizations may operate as both health plans and health care providers. *See* Julie J. Welch, ''Managed Care: The Dominant Paradigm in US Healthcare,'' Journal of The American Health Information Management Association (Nov. 21, 2024), *https://journal.ahima.org/Portals/0/archives/AHIMA%20files/Managed%20Care_%20The%20Dominant%20Paradigm%20in%20US%20Healthcare.pdf;* Samuel R. Falkson, et al., ''Health Maintenance Organization,'' in StatPearls (StatPearls Publishing 2026) (updated Mar. 6, 2023), *https://www.ncbi.nlm.nih.gov/sites/books/NBK554454.*

our proposals to modify the definition of health care operations and to expressly permit the disclosure of PHI to social services agencies, community-based organizations, HCBS providers,[605] and other similar entities. We are not convinced that excepting, from the minimum necessary standard, disclosures for individual-level care coordination and case management when performed for the purpose of health care operations would provide sufficient benefits to outweigh the interests of individuals in limiting the PHI that is shared with health plans.

Comment: Many commenters expressed opposition to the proposal because of concerns that it would decrease an individual's privacy. Relatedly, several commenters asserted that the proposal would deter individuals from seeking treatment or erode individuals' trust in their health care providers. Several commenters expressed opposition to the proposal because they believed that increasing disclosures of PHI for care coordination or case management could harm individuals in a variety of ways, such as increased disclosures to entities that are not regulated under HIPAA, denials of public benefits, discrimination, and breaches. A few commenters asserted that PHI should not be disclosed for care coordination or case management without an individual's consent. According to a few commenters, obtaining an individual's authorization before disclosing PHI for care coordination or case management does not prevent or delay the provision of health care to an individual.

Several commenters expressed opposition to the proposal because it would permit health plans to have access to more PHI than they currently are able to obtain. Several commenters expressed opposition to the idea that health plans need access to more than the minimum necessary PHI for care coordination and case management. Several commenters asserted that the proposal would lead to an increase in coverage denials by health plans. One commenter expressed opposition to this proposal because they believed that it would lead to an increase in requests from health plans for the disclosure of PHI, leading to an increase in burden on health care providers.

Response: The Department agrees with the comments expressing concern that allowing health plans to have access to more than the minimum PHI necessary to accomplish their purpose likely would raise concerns for individuals, whether warranted or not, thereby eroding trust in the health care system. We also agree that, where the Privacy Rule permits disclosures of PHI beyond the minimum necessary for a particular purpose, there is the potential for an increase in the risk of unintended adverse consequences (*e.g.,* more PHI exposed in the event of a breach), regardless of who receives the PHI. At the same time, we recognize that health plans need a certain amount of PHI to perform routine functions, such as case management, care coordination, medical review, auditing, and provider credentialing. Therefore, in light of commenters' concerns, the Department believes that existing restrictions on the use and disclosure of PHI (*e.g.,* the prohibition on the use of genetic information for underwriting purposes, limitations on the use and disclosure of psychotherapy notes) strike an appropriate balance of protecting individuals' privacy interests while permitting uses and disclosures of PHI that are needed for health plans' legitimate purposes, including payment and health care operations. Accordingly, we are not finalizing our proposal to provide an exception to the minimum necessary standard for requests by or disclosures to health plans for individual-level activities for care coordination and case management.

Comment: A few commenters expressed concerns about the potential for health plans to use the proposed exception to gain access to large amounts of PHI to create de-identified data sets for sale and potential re-identification. According to these commenters, this would make PHI available for a variety of applications without authorization from individuals. These commenters urged the Department to implement protections to prevent the disclosure of such de-identified datasets and the re-identification of PHI before finalizing this proposal.

Response: As discussed above, the Department is not finalizing the proposed exception to the minimum necessary standard. With respect to concerns about re-identification of de-identified data, the de-identification standard requires that the information does not identify an individual and there is no reasonable basis to believe that the information can be used to identify an individual.[606] In other words, PHI is not de-identified under the Privacy Rule if there is a reasonable basis to believe that it can be re-identified.

Comment: Several commenters expressed concerns about whether health care providers would be able to deny a request for PHI from health plans when the request meets the requirements of the permission for health care operations and the proposed exception to the minimum necessary standard, given the requirements of the information blocking regulations. One commenter recommended that the Department clarify how the information blocking regulations and the HIPAA Rules work in concert to ensure appropriate oversight and enforcement of the information blocking regulations.

Response: As discussed above, the Department is not finalizing the proposed modification to the minimum necessary standard because we do not believe that it is a necessary or effective mechanism to facilitate the ability of covered entities to support individual-level care coordination and case management. The information blocking regulations exclude from the definition of information blocking reasonable and necessary practices that advance the privacy interests of individuals.[607] For example, the information blocking regulations accommodate circumstances where the Privacy Rule requires that certain preconditions (*e.g.,* the minimum necessary standard) be met before permitting the use or disclosure of PHI.[608] For more information about the interaction of the information blocking regulations with the HIPAA Rules and other laws protecting individuals' privacy interests, see the discussion of the Privacy Exception in the Cures Act Final Rule.[609]

E. Clarifying the Scope of Covered Entities' Abilities To Disclose PHI to Certain Third Parties for Individual-Level Care Coordination and Case Management That Constitutes Treatment or Health Care Operations

1. Current Rule

Section 164.506 of the Privacy Rule sets forth the circumstances in which a covered entity is permitted to use and disclose PHI for TPO. Under 45 CFR 164.506(a), covered entities are permitted to use or disclose PHI without an individual's authorization for TPO,

[605] *See generally* 42 CFR part 441, subparts G, J, K, and M.

[606] *See* 45 CFR 164.514.

[607] *See* 85 FR 25642, 85 FR 25845–59 (May 1, 2020).

[608] *See* ''Would it be information blocking if an actor does not fulfill a request to access, exchange, or use EHI in order to comply with federal privacy laws that require certain conditions to have been met prior to disclosure?,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, IB FAQ #48 (Apr. 2023), *https://healthit.gov/faq/would-it-be-information-blocking-if-actor-does-not-fulfill-request-access-exchange-or-use-ehi/.*

[609] 89 FR 1192, 1351–52 (Jan. 9, 2024).

subject to the applicable conditions and other requirements of the Privacy Rule. Section 164.506(b)(1) of the Privacy Rule permits, but does not require, covered entities to obtain an individual's consent to use or disclose PHI for TPO.[610]

The implementation specifications for using and disclosing PHI for TPO are in 45 CFR 164.506(c) of the Privacy Rule. Under 45 CFR 164.506(c)(1), a covered entity may use or disclose PHI for its own TPO. Sections 164.506(c)(2) and (c)(4) permit a covered entity to disclose PHI for the treatment activities of another health care provider and for specified health care operations of another covered entity, respectively, when the applicable conditions are met.

The Privacy Rule's definitions of both treatment and health care operations expressly include care coordination and case management activities.[611] Consistent with these definitions, the Department previously explained that a covered health care provider may disclose PHI for treatment purposes without an individual's authorization when coordinating or managing an individual's care with third parties that provide services related to the individual's health, including public- or private-sector entities that provide health-related social and community-based services.[612] For example, a covered health care provider is able to make a disclosure to a provider of HCBS[613] to treat an individual who is older or has a disability if it is for the coordination or management of that individual's treatment by the health care provider.[614] As another example, a health care provider may disclose to a senior center or adult day care provider the minimum PHI necessary to help coordinate health-related services for an individual, such as arranging for a home aide or helping the individual with their prescribed at-home or post-discharge treatment protocol. Likewise, the Privacy Rule also would permit the disclosure of PHI to facilitate care coordination and case management as part of a health plan's health care operations, such as when a health plan discloses to a senior wellness center the minimum PHI necessary where the individual is enrolled in the plan's wellness program. For example, if an individual plan member enrolls in a health plan's diabetes management program, the health plan may disclose only the minimum necessary amount of PHI to a senior center that is administering the wellness program for care coordination purposes, such as the member's demographic information and relevant diagnosis. The health plan would not be permitted to disclose PHI beyond the minimum necessary, such as unrelated diagnoses and other nongermane health information.

Section 164.502(b) contains the minimum necessary standard, which governs how much PHI a covered entity is permitted to disclose based on the purpose of the request, and the exceptions to that standard.[615] Disclosures to, or requests by, a health care provider for treatment purposes are excepted from the minimum necessary standard.[616] If a disclosure for treatment is made to an entity that is not a health care provider, this exception to the minimum necessary standard does not apply, and the covered entity must limit the disclosure to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure. Disclosures for health care operations are likewise subject to the minimum necessary standard, unless an exception applies.

2. Proposed Rule

The Department long has interpreted the Privacy Rule as permitting a covered entity to use or disclose an individual's PHI without authorization for many care coordination and case management activities, even where such disclosure is to a third party that is not subject to the HIPAA Rules. However, as discussed in the 2021 Privacy Rule NPRM, we have become aware that some covered entities are uncertain about whether the Privacy Rule permits disclosures of PHI for these purposes to certain third parties without an individual's authorization and are requiring authorizations for such disclosures.

To address this uncertainty, the Department proposed to clarify that the Privacy Rule permits covered entities to disclose PHI to social services agencies, community-based organizations, HCBS providers, and similar third parties that provide health or human services to specific individuals for individual-level care coordination and case management, either as a treatment[617] activity of a covered health care provider or as a health care operations[618] activity of a covered health care provider or health plan. The Department proposed to make this clarification by adding paragraph 45 CFR 164.506(c)(6) that would identify such entities as permissible recipients of PHI for these purposes. The Department proposed to limit the scope of this permission to disclosures by covered entities for individual-level care coordination and case management that constitute treatment or health care operations, rather than including population-based activities, to ensure that the disclosures made under this permission would be akin to disclosures for treatment, which individuals expect to occur without the need to provide an authorization or consent.

3. Overview of Comments

Most commenters expressed support for the Department's proposal to expressly permit disclosures of PHI to third parties for individual-level care coordination and case management that constitute treatment or health care operations because they believed that it would enhance the ability of health care providers and health plans to provide case management and care coordination for individuals. Commenters who expressed opposition to the proposal recommended that disclosures for individual-level care coordination and case management require an

[610] *See* 67 FR 53182, 53209–11 (Aug. 14, 2002) (explaining the differences between a consent that a covered entity chooses to obtain to use or disclose PHI for TPO, as compared to an authorization that is described in 45 CFR 164.508); *see also* ''What is the difference between ''consent'' and ''authorization'' under the HIPAA Privacy Rule?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #264 (Mar. 23, 2007), *https://www.hhs.gov/hipaa/for-professionals/faq/264/what-is-the-difference-between-consent-and-authorization/index.html.*

[611] 45 CFR 164.501 (definitions of ''Health care operations'' and ''Treatment'').

[612] *See* ''Does HIPAA permit health care providers to share protected health information (PHI) about an individual with mental illness with a third party that is not a health care provider for continuity of care purposes? For example, can a health care provider refer a homeless patient to a social services agency, such as a housing provider, when doing so may reveal that the basis for eligibility is related to mental health?,'' *supra* note 601. However, the disclosure of patient information for treatment and other purposes may be subject to other laws, including 42 CFR part 2 for certain SUD patient records.

[613] *See, e.g.,* 42 CFR 440.180. HCBS provides opportunities for Medicaid beneficiaries to receive services in their own homes or communities. Some HCBS providers may be health care providers within the definition at 45 CFR 160.103, some provide only human services (*e.g.,* non-medical transportation services), and some provide both types of services. *See* ''Home- and Community-Based Services,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (May 6, 2026), *https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services.*

[614] *See* 45 CFR 164.506(c).

[615] *See* 45 CFR 164.502(b). Certain provisions of 45 CFR 164.514(d) also address the minimum necessary requirement.

[616] 45 CFR 164.502(b)(2)(i).

[617] 45 CFR 164.501 (definition of ''Treatment'').

[618] 45 CFR 164.501 (definition of ''Health care operations''). As discussed in detail above, this final rule includes a modification to the punctuation in paragraph (1) of the definition of health care operations to clarify that care coordination and case management are not limited to ''population-based activities.''

individual's authorization. A few commenters asserted that this proposal would increase the administrative burden on covered entities because they believed that it would lead to an increase in requests, additional contracts, and difficulties complying with other Federal and state laws. Some commenters expressed concerns about the ability of such organizations to safeguard the privacy and security of the information disclosed to them by regulated entities pursuant to this proposal, as well as their ability to use and redisclose such information because they generally are not subject to the HIPAA Rules.

4. Final Rule

The Department is finalizing its proposal to adopt 45 CFR 164.506(c)(6) without modification. This section clarifies that the Privacy Rule permits covered entities to disclose PHI, without an individual's authorization, to social service agencies, community-based organizations, HCBS providers, and similar third parties for individual-level care coordination and case management activities that constitute treatment or health care operations. This clarification will facilitate the treatment and health care operations of the disclosing covered entities in circumstances where a disclosure will serve the health care or health-related needs of individuals.

The Privacy Rule has long permitted disclosures of PHI to such entities for treatment or, in certain circumstances, health care operations.[619] Rather than changing the Department's interpretation of these permitted disclosures, this final rule adds express language at 45 CFR 164.506(c)(6) to provide greater clarity about the scope of these existing permissions. The inclusion of this language in regulatory text ensures that covered entities understand their ability to disclose PHI to coordinate and manage care for individuals across clinical and community-based settings without an individual's authorization, where the Privacy Rule permits such disclosures. This clarification is consistent with the Department's longstanding approach of permitting uses and disclosures of PHI for TPO without authorization to avoid interfering with the ability of individuals to access quality and effective health care, while continuing to protect individuals' privacy.[620]

This express permission to disclose PHI to third parties for care coordination and case management that constitute treatment or health care operations eliminates confusion about a covered entity's ability to make such disclosures to improve individuals' health care. For example, a covered health care provider may disclose the minimum necessary PHI of an individual, who is transitioning from a long-term care facility into community living, to a social service agency that arranges housing, day programs, and other health-related services that the individual may need upon discharge. The covered provider also may disclose the minimum necessary PHI, for example, to a community-based organization that facilitates transportation, life skills training, and nutrition services that are needed to support the individual's health care. Likewise, a health plan may disclose the minimum necessary PHI to a transition coordinator[621] to verify an individual's eligibility for certain services and streamline care coordination.

The Department is limiting the scope of this permission to disclosures by covered entities for individual-level care coordination and case management that constitute treatment or health care operations, rather than population-based activities. The limitation to individual-level activities in 45 CFR 164.506(c)(6) does not affect a covered entity's ability to make disclosures for population-based activities where such disclosures are otherwise permitted by 45 CFR 164.506(c)(1) or another applicable provision of this Privacy Rule. This limitation is intended to ensure that the scope of the permission at 45 CFR 164.506(c)(6) remains consistent with the privacy expectations of individuals. Covered entities remain subject to all applicable conditions and requirements of the Privacy Rule, including the minimum necessary standard, as applicable.

Nothing in this final rule alters an individual's right under 45 CFR 164.522(a) to request restrictions on a use or disclosure of PHI for TPO. While a covered entity generally is not required to agree to such restrictions, it must act in accordance with any restriction to which it does agree. In addition, although covered entities are not required to obtain an individual's authorization or consent for disclosures permitted under 45 CFR 164.506(c)(6), disclosures for individual-level care coordination and case management activities that constitute treatment or health care operations should remain consistent with the covered entity's NPP.

5. Responses to Public Comments

Comment: Some commenters expressed support for this proposal because they believed that it would remove barriers to care coordination and improve the quality of care. These commenters also asserted that it would reduce the burden on individuals and health care providers because it would reduce reliance on written authorizations where the Privacy Rule already permits disclosures without authorization.

Response: The Department is adopting the proposal to add an implementation specification for TPO to provide greater clarity regarding covered entities' ability to disclose PHI without an individual's authorization to social services agencies, community-based organizations, HCBS providers, and other similar third parties for individual-level care coordination and case management that constitute treatment or health care operations. This clarification reduces unnecessary administrative burdens that can delay or impede coordination of care by decreasing the need for consultations with legal or compliance offices about whether authorizations are required for these disclosures. The Department also expects that this clarification will facilitate and encourage greater wraparound support and more targeted care for individuals who need health-related social or supportive services. For example, if a health care provider refers an individual with diabetes to a food bank, the health care provider could disclose the minimum necessary PHI about the individual to the food bank to enable the food bank to provide appropriate dietary accommodation or nutrition support.

Comment: While many commenters expressed support for limiting the proposal to individual-level care coordination and case management that constitute treatment or health care operations, several commenters recommended that the Department

[619] 65 FR 82497, 82628 (Dec. 28, 2000).

[620] *See* 67 FR 53182, 53215 (Aug. 14, 2002).

[621] *See* Deficit Reduction Act of 2005, sec. 6071 of Public Law 109–171, 120 Stat. 102 (Feb. 8, 2006) (enacting the Money Follows the Person (MFP) demonstration project to transition Medicaid beneficiaries from long-term institutional care to home-and community-based settings). Pursuant to MFP, states have developed transition programs, and hired transition coordinators, to assist individuals. *See* Debra Lipson, et al., ''Implications of State Program Features for Attaining MFP Transition Goals,'' Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (prepared by Mathematica Policy Research, Inc.) (June 2009), *https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/mfptransitiongoalsjun26.pdf. See, e.g.,* ''Transition Process,'' Colorado Department of Health Care Policy & Financing (2026), *https://hcpf.colorado.gov/transition-process* (explaining that, for Colorado Medicaid recipients transitioning out of a nursing facility back into the community, transition coordinators assist recipients in finding necessary community supports, create transition plans, and provide post-transition supports).

expand the proposal to permit disclosures of PHI to community-based organizations for population-level activities.

Response: The Department is limiting 45 CFR 164.506(c)(6) to disclosures for individual-level care coordination and case management activities that constitute treatment or health care operations. The Department believes that the limitation to individual-level activities will ensure that disclosures made pursuant to 45 CFR 164.506(c)(6) are consistent with the types of treatment and health care operations disclosures that individuals generally expect to occur without the need to provide an authorization and will protect individuals' privacy interests. Limiting the provision in this manner also preserves existing privacy protections and ensures that the scope of permissible disclosures remains tied to the care of a specific individual.

Comment: Some commenters recommended that the Department clarify the types of organizations to which covered entities would be permitted to disclose PHI, the circumstances in which such disclosures may be made, or the services contemplated, and provide examples. Some recommended that the types of organizations identified be interpreted broadly to allow for maximum flexibility. One commenter expressed concern that the proposal would restrict who is permitted to receive PHI for care coordination and case management.

Response: Section 164.506(c)(6) permits disclosures to social services agencies, community-based organizations, HCBS providers, and similar third parties that provide health or human services to specific individuals for individual-level care coordination and case management that constitute treatment or health care operations. The Department believes that the plain regulatory language provides sufficient clarity to allow covered entities to determine whether a potential recipient of PHI falls within the scope of the provision. This approach preserves flexibility and avoids unintentionally excluding organizations that provide care coordination and case management services in a variety of settings. The Department believes that these categories of entities encompass organizations serving many types of individuals across communities, consistent with the purpose of facilitating individual-level care coordination and case management.

This provision does not restrict the ability of a covered entity to disclose PHI for care coordination and case management. Rather, this provision clarifies that an individual's authorization is not required for disclosures to third parties for individual-level care coordination and case management activities that constitute treatment or health care operations. A covered entity is still permitted, but not required, to obtain an individual's consent to disclose the individual's PHI for TPO.[622]

Comment: Commenters expressed mixed views about whether the proposal should be limited to circumstances in which a particular service or provider is identified in an individual's care plan or where a screening assessment has been conducted. Commenters who expressed opposition to such conditions generally did so because they believed that additional requirements or conditions would increase the administrative burden for health care providers or community-based organizations, while commenters who expressed support for imposing such conditions generally did so because they believed that it would be more protective of individuals' privacy. A few commenters recommended that disclosures be limited to circumstances where there is shared care planning between individuals and health care providers. Some commenters urged the Department to specify that a covered entity may make disclosures based on their good faith belief that the disclosure is in the best interests of the individual. Another commenter asserted that regulated entities should disclose PHI to a community-based organization only if the organization requests the disclosure.

Many commenters raised concerns about the potential negative effects of disclosures to certain types of organizations on health disparities. One commenter asserted that while they supported screening for social needs and documenting such needs in an individual's care plan, requiring documentation of such information in the individual's care plan would serve to further entrench inequities.

Response: The Department is not adopting additional conditions or prerequisites on disclosures permitted under 45 CFR 164.506(c)(6) that would impede timely coordination of services for individuals. The Privacy Rule already permits uses and disclosures of PHI for treatment and health care operations, subject to existing conditions and limitations, including the minimum necessary standard where applicable. The addition of 45 CFR 164.506(c)(6) removes uncertainty and eases care transitions. The Department believes that imposing additional conditions or prerequisites such as care plan documentation, screening assessments, or shared care planning would create barriers to care coordination and case management and increase the administrative burden for health care providers and community-based organizations.

Comment: Several commenters requested clarification of how the proposal would interact with other laws that regulate the use and disclosure of certain health information about individuals that also may be PHI, such as 42 CFR part 2 (''Part 2''), the information blocking regulations, and state laws. A few commenters requested that the Department expressly state that this provision would not require such disclosures and it would allow covered entities to implement consent processes where required by other laws. One commenter expressed support for this proposal to the extent that it would not affect the obligations of Part 2 programs.

Response: The Privacy Rule creates a Federal floor of protection for the privacy of PHI. It preempts state laws that are contrary to a standard, requirement, or implementation specification adopted under the Privacy Rule, with certain exceptions. As discussed above, Congress excepted from HIPAA's general preemption authority contrary provisions of state law that impose requirements, standards, or implementation specifications that are more stringent than those of the Privacy Rule.[623] If a provision of state or other Federal law provides greater privacy protection than a provision of the Privacy Rule, and it is possible for regulated entities to comply with both the state or other Federal law and the Privacy Rule (*e.g.,* where a state or other Federal law requires an individual's authorization for a disclosure that the Privacy Rule would permit without authorization), there is no conflict between the laws, and no preemption as to the state law. Accordingly, nothing in this final rule affects the obligations of covered entities to comply with applicable state or other Federal laws that restrict the disclosure of sensitive information, including information about SUD or other sensitive health issues, nor does it change the compliance obligations of covered entities subject to other Federal laws. For example, the permission in this section does not remove the obligations of covered entities that are also federally funded SUD treatment programs (*i.e.,* Part 2 programs) to

[622] 45 CFR 164.506(b).

[623] *See id.*

obtain patient consent when using or disclosing Part 2 records for treatment, payment, and health care operations purposes.

Similarly, 45 CFR 164.506(c) does not prevent or relieve covered entities from complying with the information blocking regulations. Section 3022(a)(1) of the PHSA generally defines information blocking as a practice that, except as required by law or specified by the Secretary pursuant to rulemaking, is likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI.[624] Section 3022(a)(1)(A) excludes from the definition of information blocking practices that are required by law, circumstances where one or more elements of the definition is not met, and circumstances where the practice is covered by one of the exceptions for reasonable and necessary activities.[625] For example, if a covered entity is required by a state or Federal law to satisfy a precondition (such as obtaining patient consent or authorization) before providing access to, exchanging, or using EHI, the covered entity may choose not to provide access to, exchange, or use such EHI if the precondition has not been satisfied under certain circumstances.[626]

Comment: Several commenters raised questions about the ability of social services agencies, community-based organizations, HCBS providers, and similar entities to exchange information electronically. Some commenters recommended that the Department provide support or guidance to facilitate electronic information exchange or compliance with HIPAA requirements for policies and procedures. Several commenters recommended that the Department provide resources to enable data segmentation. One commenter expressed concern that technical limitations of EHR systems may make it difficult for covered entities to limit the disclosures of PHI to the minimum necessary. Another commenter requested clarification that covered entities would be permitted to disclose PHI electronically, including through HIEs/HINs.[627]

Response: The Privacy Rule regulates the use and disclosure of PHI maintained in any form or medium. The Department does not prescribe specific means by which covered entities must use or disclose PHI and does not regulate the technical capabilities of entities that are not subject to HIPAA.

A covered entity may use an HIO, such as an HIE/HIN, to facilitate the exchange of PHI for individual-level care coordination and case management that constitute treatment or health care operations, provided that it has a business associate agreement with the HIO that requires the HIO to protect the information.[628] As discussed above, covered entities remain responsible for complying with the minimum necessary standard, as applicable, when disclosing PHI under 45 CFR 164.506(c)(6). However, some of the requests or disclosures to or through the HIO by a covered entity may not be subject to the minimum necessary standard, such as disclosures for the treatment activities of a health care provider. For electronic disclosures by a covered entity to and through an HIO that are subject to the minimum necessary standard, such as for a payment or health care operations purpose, the Privacy Rule would require that the minimum necessary standard be applied to that exchange and that the business associate agreement limit the disclosures by the HIO of, and requests for, PHI accordingly.[629]

Comment: Some commenters expressed concerns about the ability of social services agencies, community-based organizations, HCBS providers, or other similar third parties to safeguard the privacy and security of the information disclosed to them by covered entities pursuant to this proposal. A few commenters recommended that the Department specify that the disclosure of PHI should be limited to persons who have implemented appropriate privacy and security measures or that the Department provide guidance on how the information should be safeguarded after PHI has been disclosed. Several commenters expressed concerns about the ability of third parties to re-disclose an individual's PHI without limitation and urged the Department to take steps to limit re-disclosures of PHI by entities that are not regulated under HIPAA.

Some commenters expressed concerns about potential liability for covered entities if there is a breach after disclosure of PHI to such organizations. A few of these commenters recommended that the Department provide a safe harbor or assurances for covered entities that disclose PHI to social services agencies in the event of a subsequent improper use or disclosure, while another suggested that the Department provide a safe harbor for regulated entities that adopt software that assigns labels to PHI to govern how that PHI may be accessed, used, or disclosed.

Response: The Department declines to require that disclosures under 45 CFR 164.506(c)(6) be limited to entities that have implemented particular privacy or security measures. The Department also declines to establish a safe harbor or impose additional conditions related to the potential liability of covered entities based on actions taken by persons who receive PHI and are not regulated under HIPAA. A safe harbor is unnecessary because a covered entity is not liable for subsequent breaches or improper use of health information by the person who receives it, including a person who is not regulated under HIPAA. We have determined that imposing such conditions could impede timely and effective care coordination and case management because it would require covered entities to assess, verify, or monitor the privacy and security practices of a wide range of persons who are not regulated under HIPAA and may not have standardized or readily assessable frameworks to facilitate such reviews. Requiring covered entities to evaluate privacy or security practices of such persons could not only delay or deter necessary information sharing and

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[624] *See* Public Law 114–255, 130 Stat. 1176 (Dec. 13, 2016) (codified at 42 U.S.C. 300jj–52).

[625] *See* 42 U.S.C. 300jj–52(a)(1) (excluding from the definition of ''information blocking'' practices that are likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI if they are ''required by law''); 85 FR 25642, 25794 (May 1, 2020) (explaining that ''required by law'' specifically refers to interferences that are explicitly required by state or Federal law); *see also* 89 FR 1192, 1351 (Jan. 9, 2024) (affirming that where applicable law prohibits access, exchange, or use of information, practices in compliance with such law are not considered to be information blocking and citing to compliance with the Privacy Rule as an example of an applicable law); *see also* ''Information Blocking Exceptions,'' Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (Apr. 2024), *https://healthit.gov/wp-content/uploads/2024/04/IB_Exceptions_Fact_Sheet_508.pdf.*

[626] *See* ''Information Blocking Exceptions,'' *supra note* 625; *see also* ''Would it be information blocking if an act or does not fulfill a request to access, exchange , or use EHI in order to comply with federal privacy laws that require certain conditions to have been met prior to disclosure?,'' *supra note* 608.

[627] *See* 45 CFR 171.102 (definition of ''Health information network or health information exchange'').

[628] *See* 45 CFR 164.502(e) and 164.504(e); *see also* ''May a covered health care provider disclose electronic protected health information (PHI) through a health information organization (HIO) to another health care provider for treatment?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #541 (July 26, 2013), *https://www.hhs.gov/hipaa/for-professionals/faq/541/may-a-covered-health-care-provider-disclose-electronic-protected-health-information/index.html.*

[629] *See* ''How may the HIPAA Privacy Rule's minimum necessary standard apply to electronic health information exchange through a networked environment?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #545 (July 26, 2013), *https://www.hhs.gov/hipaa/for-professionals/faq/545/how-may-hipaas-minimum-necessary-standard-apply-to-electronic-information/index.html.*

create barriers to integrated care, but it also could increase the compliance burden for regulated entities.

Regulated entities remain subject to all applicable requirements of the Privacy and the Security Rules. This includes the obligation to implement reasonable safeguards, to limit disclosures to the minimum necessary PHI as applicable, and to determine whether a recipient is acting as a business associate, in which case a business associate agreement must be in place prior to disclosure.

Comment: Several commenters requested that the Department clarify whether covered entities would be required to enter into business associate agreements with the third parties contemplated in this proposal before making a disclosure. Some commenters recommended that the Department require covered entities to execute written agreements with third parties to limit their use or redisclosure of PHI. A few commenters expressed concern that requiring agreements would increase administrative burden and impede care coordination.

Response: Section 164.506(c)(6) does not impose any new requirements regarding business associate agreements. A covered entity is required to enter into a business associate agreement with a person or organization only when that person or organization meets the definition of a business associate.[630] As discussed above, there may be instances where disclosures for individual-level care coordination and case management that constitute treatment or health care operations under 45 CFR 164.506(c)(6) will be made to business associates engaged by a covered entity to provide health-related services on behalf of the covered entity. In those circumstances, a business associate agreement must be in place prior to the disclosure of PHI. In other circumstances, the person who receives the PHI will not be performing covered functions or activities for or on behalf of the covered entity; it will be providing services to the individual on its own behalf. In such cases, the person who receives the PHI does not meet the definition of a business associate, and a business associate agreement is not required.

Furthermore, the Department declines to require regulated entities to execute additional written agreements with third parties as a condition of disclosures under new 45 CFR 164.506(c)(6). Requiring such agreements would increase administrative burden and risk delaying or impeding care coordination and case management activities. Covered entities remain responsible for complying with the applicable conditions and requirements of the Privacy Rule, including determining whether a person who receives PHI is acting as a business associate and ensuring that a business associate agreement is in place when required.

Comment: A few commenters requested that the Department add definitions or further clarify certain terms related to the proposed permission. For example, some commenters requested a definition of ''social service agencies'' with examples of the types of services contemplated.

Response: The Department is not adopting any additional definitions or exclusions in connection with this provision. The Privacy Rule already defines the terms treatment and health care operations, and those definitions expressly encompass care coordination and case management activities. The Department believes that the robust description and discussion of other definitions for care coordination and case management above affords the regulated community sufficient information with which to determine whether a recipient is engaged in the contemplated activities. As discussed in the 2021 Privacy Rule NPRM, the third parties contemplated by this provision may include a range of organizations that provide health or human services to specific individuals. The third party receiving PHI under this provision does not have to be a health care provider and may instead provide health-related social or other supportive services, such as food or sheltered housing needed to address health risks and conditions. For example, a covered health care provider may disclose the minimum necessary PHI to a senior center or adult day care provider to coordinate health-related services as part of treatment, and a health plan may disclose the minimum necessary PHI to a senior wellness center to coordinate care for an enrolled individual as part of the plan's health care operations.[631]

The Department does not believe that adding definitions or enumerated lists of entities or services would improve clarity and is concerned that doing so could inadvertently limit the application of this provision in varied clinical and community contexts. Covered entities remain responsible for determining whether a disclosure falls within treatment or health care operations and whether the recipient is engaged in individual-level care coordination or case management activities.

Comment: Many commenters expressed concern about the potential risks of this proposal to an individual's privacy. Some commenters recommended that an individual's consent or authorization be required before disclosures to social services agencies and similar third parties for care coordination and case management are made or that individuals be given an opportunity to object to such disclosures. According to some commenters, disclosures of PHI without an individual's consent could alienate individuals, lead to lower engagement with care, or result in care avoidance. A few commenters recommended that covered entities be required to notify individuals of such disclosures in advance. One commenter asserted that it would be reasonable for a clinician to explain to the individual the disclosures that would be made and the implications of disclosing PHI to entities not regulated under HIPAA.

Response: While the Department appreciates commenters' concerns about protecting individuals' privacy interests, we decline to require consent, authorization, advance notice (other than what is required in an NPP),[632] or an opportunity to object as a condition of disclosures permitted under this provision. The Privacy Rule already permits disclosures without authorization for treatment and, in certain circumstances, health care operations, and this final rule clarifies the applicability of those existing permissions to disclosures that are made for these purposes to social services agencies, community-based organizations, HCBS providers, and similar third parties, consistent with longstanding guidance.

Section 164.506(c)(6) is limited to disclosures for individual-level care coordination and case management that constitute treatment or health care operations, rather than population-level activities, and such disclosures remain subject to the minimum necessary standard, where applicable. The limitation to individual-level activities ensures that the disclosures made under this permission are comparable to disclosures for treatment, which individuals expect to occur without

[630] 45 CFR 160.103 (definition of ''Business associate'').

[631] 86 FR 6475–76 (Jan. 21, 2021).

[632] The Privacy Rule requires that the NPP contain a description, including at least one example, of the types of uses and disclosures the covered entity is permitted to make for treatment and health care operations (as well as for payment), among other information, and the description must include sufficient detail to place the individual on notice of the uses and disclosures that are permitted or required. *See* 45 CFR 164.520(b)(1)(ii)(A) and (D).

their authorization or consent. The right to request restrictions on disclosures for TPO purposes also remains available for individuals to request limitations on such disclosures.[633]

Comment: A few commenters expressed concern that the proposed provision could permit disclosures of PHI to law enforcement or child welfare agencies. Several commenters identified examples of potential harms that they believed could result from this proposal, including discrimination, increased health disparities and inequities, and loss of privacy.

Response: This provision does not permit disclosures of PHI to law enforcement or child welfare agencies for law enforcement or investigatory purposes. The Privacy Rule's existing provisions governing disclosures for law enforcement, public health, or other public policy purposes remain unchanged by this final rule and continue to apply independently of 45 CFR 164.506(c)(6).

The Privacy Rule does not permit a regulated entity to disclose PHI for law enforcement purposes without an individual's authorization unless the disclosure is made pursuant to process and as otherwise required by law,[634] or another express permission applies.[635] Additionally, disclosures to child welfare or protective services agencies are permitted only under the applicable provisions of the Privacy Rule, including disclosures for public health activities and for reports of child abuse, domestic violence, and neglect.[636] Section 164.506(c)(6) does not expand or alter these existing permissions.

Comment: Some commenters requested clarification of how this proposal would interact with the proposed modification to the minimum necessary standard or recommended modifications that would require the application of the minimum necessary standard to the proposal.

Response: As discussed in this final rule, the Department is not finalizing the proposed exception to the minimum necessary standard for health care operations uses and disclosures related to individual-level care coordination and case management.[637] This final rule does not alter the minimum necessary requirements.

The applicability of the minimum necessary standard for disclosures of PHI to a third party for individual-level care coordination and case management is governed by 45 CFR 164.502(b). Disclosures to or requests by a health care provider for the treatment activities of either the requesting health care provider or another health care provider are not subject to the minimum necessary standard. Disclosures of PHI for treatment to third parties that are not health care providers and for health care operations remain subject to the minimum necessary standard. Thus, if the minimum necessary standard applies, a covered entity must take reasonable steps to limit the disclosure of PHI to the minimum necessary to accomplish the intended purpose.[638]

F. Encouraging Disclosures of PHI When Needed To Help Individuals Experiencing Substance Use Disorder (Including Opioid Use Disorder), Serious Mental Illness, and in Emergency Circumstances

1. Current Rule

Sections 164.502(g) and 164.510–164.514 of the Privacy Rule permit covered entities to disclose PHI in certain circumstances when an individual is unable to agree or object to the disclosure of their PHI or where a disclosure may be needed to prevent or lessen a threat to health or safety. In such circumstances, the Privacy Rule provides for the exercise of professional judgment when determining whether such disclosure should be made.

Disclosures to Personal Representatives

Under 45 CFR 164.502(g), a personal representative generally is a person with authority under applicable law (*e.g.,* state law) to act on behalf of an individual in making decisions related to health care.[639] In many circumstances, the parent or guardian of an unemancipated minor child is treated as the child's personal representative under applicable law. In circumstances where state or other applicable law does not treat a parent as an unemancipated minor child's personal representative, 45 CFR 164.502(g)(3)(ii)(C) permits, but does not require, covered entities to provide PHI under the right of access to a parent, guardian or other person acting *in loco parentis,* if the action is consistent with state or other applicable law and the decision to disclose the child's PHI is based on the professional judgment of a licensed health care professional.

Uses and Disclosures Requiring an Opportunity for the Individual To Agree or Object

Section 164.510 of the Privacy Rule generally requires that covered entities must provide an individual with the opportunity to agree or object before using or disclosing the individual's PHI for inclusion in a facility directory or disclosing PHI to family members, caregivers, or others involved in care or payment for care. However, individuals are not always able to agree or object to such uses or disclosures, particularly in emergency situations. Accordingly, 45 CFR 164.510(a)(3) permits a covered health care provider to disclose in its facility directory certain PHI, including name, location within the facility, general condition, and religious affiliation to clergy and persons who ask for the individual by name, when the individual cannot agree or object because of incapacity or an emergency treatment circumstance, if providing this information meets both of the following conditions:

- The disclosure is consistent with a prior expressed preference of the individual, if any, that is known to the covered health care provider.
- The disclosure is in the individual's best interests, as determined by the covered health care provider, in the exercise of professional judgment.

For similar reasons, 45 CFR 164.510(b)(2)(iii) permits a covered entity to disclose relevant PHI about an individual who is present and has decision-making capacity, if the covered entity can reasonably infer, based on the exercise of professional judgment, that the individual does not object to the disclosure. Further, 45 CFR 164.510(b)(3) permits a covered entity to disclose relevant PHI about an individual who is not present or cannot agree or object because of incapacity or an emergency circumstance to family members and other caregivers involved in the individual's care or payment for care, if the covered entity, based on professional judgment, determines that the disclosure is in the best interests of the individual.

Disclosures To Avert a Threat to Health or Safety

Section 164.512(j) of the Privacy Rule permits covered entities, consistent with applicable law and standards of ethical conduct, to use or disclose PHI when

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[633] *See* 45 CFR 164.522(a).

[634] *See* 45 CFR 164.512(f)(1).

[635] *See* ''When does the Privacy Rule allow covered entities to disclose protected health information to law enforcement officials?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #505 (Dec. 28, 2022), *https://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html.*

[636] *See* 45 CFR 164.512(b)(1)(ii) and (c).

[637] *See* proposed 45 CFR 164.502(b)(2)(i).

[638] *See* 45 CFR 164.502(b) and 164.514(d); *see also* ''Minimum Necessary Requirement,'' Office for Civil Rights, U.S. Department of Health and Human Services (Apr. 4, 2003), *https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/minimum-necessary-requirement/index.html.*

[639] 45 CFR 164.502(g)(3)(i) and (g)(5) contain the exceptions to this general rule.

necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.[640] To ''lessen'' a threat could mean, for example, to reduce the severity of the threatened harm, or the likelihood of the anticipated harm occurring. The permission is intended to accommodate, and be consistent with, a ''duty to warn'' others of a threat as established in case law (and in some states, statutory requirements).[641] Certain conditions apply, including that the recipient of the PHI must be reasonably able to prevent or lessen the threat, or the use or disclosure must be necessary for law enforcement to identify or apprehend the subject individual.[642] In the case of a disclosure to law enforcement, additional conditions include that the individual made a statement admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim, or that circumstances demonstrate that the subject individual escaped from a correctional institution or lawful custody, as defined in the Privacy Rule.[643]

Identity Verification

Section 164.514(h)(2)(iv) of the Privacy Rule generally requires covered entities to verify the identity and authority of a person requesting PHI.[644] In certain situations, the circumstances surrounding the disclosure itself may accomplish the verification without having to collect additional documents or rely on a preestablished procedure.[645] Accordingly, 45 CFR 164.514(h)(2)(iv) provides that a covered entity's obligation to verify a requestor's identity is met if the covered entity relies on an exercise of professional judgment pursuant to 45 CFR 164.510, or acts on a good faith belief in making a disclosure pursuant to 45 CFR 164.512(j) to prevent or lessen certain serious and imminent threats.

2. Proposed Rule

As we explained in the 2021 Privacy Rule NPRM,[646] support from family members, friends, and caregivers is essential for many individuals who are experiencing SUD[647] or SMI.[648] However, family members and caregivers need sufficient information to provide this support.

To address these concerns, the Department has issued extensive guidance on the circumstances in which the Privacy Rule permits disclosures of PHI to an individual's friends, family, and others.[649] For example, guidance issued in 2017 addresses the permission for covered health care providers to disclose PHI to an individual's friends, family, and others involved in the individual's care or payment for that care when the individual has experienced an overdose and is unable to agree or object to uses and disclosures of PHI.[650] The guidance clarifies that a health care provider may use professional judgment to talk to the parents of an individual who has been incapacitated by an opioid overdose about the overdose and related medical information, but generally cannot share PHI unrelated to the overdose without the individual's agreement.[651] The guidance further clarifies when a covered health care provider may rely on the permission at 45 CFR 164.512(j) in an overdose situation. Additionally, in response to the Cures Act,[652] OCR compiled a full suite of guidance and materials on its website related to mental and behavioral health for health care professionals and consumers.[653] As we explained in the 2021 Privacy Rule NPRM, although the guidance focuses primarily on overdose situations, the provisions apply equally to the disclosure of PHI during other health emergencies or dangerous situations.

Despite this extensive guidance, the Department continued to receive reports that covered entities were reluctant to disclose PHI to persons involved in the care of individuals experiencing SUD or SMI, even when the Privacy Rule permits such disclosures. Accordingly, in the 2021 Privacy Rule NPRM, we proposed to replace ''exercise of professional judgment'' with ''good faith belief'' as the standard pursuant to which covered entities would be permitted to make certain uses and disclosures in the best interests of individuals in 45 CFR 164.502(g)(3)(ii)(C), 164.510(a)(3), 164.510(b)(2)(iii), 164.510(b)(3), and 164.514(h)(2)(iv). In these five provisions, the proposed new standard in 45 CFR 164.502(k) would include a presumption of a covered entity's good faith that could be overcome with evidence of bad faith. Under this proposal, disclosures for any improper purpose, such as crime, fraud, or personal enrichment, would be considered ''bad faith'' disclosures. Additionally, in 45 CFR 164.512(j), we proposed to replace ''serious and imminent'' threat with ''serious and reasonably foreseeable,'' define reasonably foreseeable based on an ordinary person's understanding, and add a provision for heightened

[640] 45 CFR 164.512(j)(1)(i)(A).

[641] *See* 65 FR 82462, 82538 (Dec. 28, 2000); *see also* state law requirements compiled at *https://www.ncsl.org/health/mental-health-professionals-duty-to-warn.* To the extent that state or other law requires a disclosure (*e.g.,* as part of a statutory duty to warn), the Privacy Rule would permit the disclosure under its permission for uses and disclosures of PHI required by law. *See* 45 CFR 164.512(a). However, not all states have enacted such requirements, and those that do apply a variety of different standards. In contrast, HIPAA's disclosure permission applies a uniform permissive standard to covered entities nationwide.

[642] *See* 45 CFR 164.512(j)(1)(ii).

[643] *Id.; see also* 45 CFR 164.501 (definition of ''Correctional institution'').

[644] *See* 65 FR 82462, 82546–47 (Dec. 28, 2000). When considered with 45 CFR 164.530(i) and (j), the Privacy Rule generally requires covered entities to establish and use written policies and procedures reasonably designed to verify the identity and authority of the person requesting PHI.

[645] *Id.*

[646] *See* 86 FR 6446, 6477 (Jan. 21, 2021).

[647] SUDs occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. *See* ''Co-Occurring Disorders and Other Health Conditions,'' Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (Dec. 22, 2025), *https://www.samhsa.gov/find-help/disorders.*

[648] SMI is defined by someone over 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. For minors, the term ''Serious Emotional Disturbance'' refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. *Id.*

[649] *See* ''Information Related to Mental and Behavioral Health, including Opioid Overdose,'' Office for Civil Rights, U.S. Department of Health and Human Services (Feb. 13, 2026), *https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html.*

[650] ''When does HIPAA allow a doctor to notify an individual's family, friends, or caregivers that a patient has overdosed?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #3001 (Jan. 4, 2018), *https://www.hhs.gov/hipaa/for-professionals/faq/3001/when-does-hipaa-allow-doctor-notify-individuals-family-friends-caregivers-patient-has-overdosed/index.html.*

[651] ''How HIPAA Allows Doctors to Respond to the Opioid Crisis,'' Office for Civil Rights, U.S. Department of Health and Human Services (2017), *https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/hipaa-opioid-crisis.pdf.*

[652] Section 11001 of the Cures Act includes a ''sense of Congress'' that clarification was needed regarding the Privacy Rule's existing permitted uses and disclosures of PHI by health care professionals to communicate with caregivers of adults with SMI to facilitate treatment, while section 11003(b) directed the Secretary, acting through the Director of OCR, to issue guidance clarifying the circumstances in which a covered entity may disclose PHI, including those that are based on the exercise of professional judgment regarding the best interests of a patient when the patient is incapacitated or in an emergency situation, and the circumstances in which a covered entity may disclose PHI to a patient's family and other caregivers. *See* Public Law 114–255, 130 Stat. 1270 (Dec. 13, 2016) (codified at 42 U.S.C. 1320d–2 note).

[653] *See* ''Information Related to Mental and Behavioral Health, including Opioid Overdose,'' *supra* note 649.

deference to decisions about such disclosures by workforce members with specialized training, expertise, or experience.

3. Overview of Comments

The commenters expressed support for and opposition to these proposals in even numbers. Family members and caregivers of individuals experiencing SUD or mental illness generally expressed support for the proposals about good faith and preventing harm and threatened harm because they believed that the proposed modifications would encourage health care providers to provide PHI to the family members and caregivers without fear of violating HIPAA, particularly during emergencies, crises, and circumstances in which the individual is incapacitated. In contrast, many commenters expressed opposition to the proposal because they believed that it would decrease an individual's privacy and autonomy. Many of these commenters asserted that the proposed modifications would lead to discrimination, shame, stigma, interference with efforts to seek care, and care avoidance.

4. Final Rule

The Department is not finalizing the proposed changes to the standards for good faith and professional judgment in 45 CFR 164.502 and 164.510–514. Upon review and analysis of public comments, the Department is not persuaded that the proposed changes would provide the clarity sought. We also are concerned that finalizing the proposals could increase complexity and burden for covered entities while chilling access to care. The Department believes that additional technical assistance and public education about the Privacy Rule's provisions that permit covered entities to disclose PHI to an individual's family and caregivers would better address any misunderstandings about the scope of the existing permissions.

5. Responses to Public Comments

Comment: Many commenters expressed support for the proposal to replace the ''professional judgment'' standard with a ''good faith'' standard because they believed that it would reduce barriers that prevent family members and caregivers from assisting loved ones experiencing SUD or SMI. They described challenges under the current rule, including a lack of notification to family members and caregivers when the individual is discharged, difficulty locating loved ones, and their inability to obtain the information that they need to support individuals who cannot care for themselves. Commenters asserted that the proposed changes would improve access to care, enable earlier intervention, and facilitate more effective coordination between families and clinicians.

Response: The Department recognizes the difficulties families and caregivers face when caring for individuals with SUD and SMI. However, after reviewing the comments, the Department has determined that replacing ''professional judgment'' with a ''good faith'' standard likely would introduce ambiguity without improving outcomes. The equal proportion of comments expressing support for and opposition to the proposals reinforces the need for a measured approach to balancing the privacy interests of individuals with the need for disclosure in urgent situations. The Department is persuaded that the existing provisions provide the appropriate balance. Rather than finalizing the proposed changes, the Department intends to emphasize outreach and technical assistance to covered entities to improve their understanding of existing permissions to disclose PHI to family, friends, and caregivers.

Comment: Some commenters asserted that the proposal to adopt a good faith standard would help health care providers, family members, and caregivers respond effectively during emergencies. According to these commenters, this proposal would reduce providers' concerns about violating the Privacy Rule, alleviate confusion about what the Privacy Rule permits, and facilitate appropriate disclosures of PHI. A few commenters stated that the proposal would reduce the refusal of covered entities to disclose PHI and improve continuity of care.

Response: The Department acknowledges commenters' interest in reducing uncertainty involving disclosures allowed under 45 CFR 164.502(g), 164.510, and 164.512(j). However, the Department has determined that altering the disclosure standard likely will not resolve concerns about the hesitancy of covered entities to disclose PHI and, in fact, could create additional challenges. Instead, we will continue to focus on providing outreach and technical assistance to address these concerns.

Comment: A few commenters recommended various further modifications, such as applying good faith based on the belief that disclosure will improve the individual's care or benefit the individual. Others suggested that the Department add exceptions that would permit a covered entity to override an individual's prior expressed preference in certain circumstances.

A few commenters requested that the Department clarify what would constitute good faith under the proposed standard and how the proposal would interact with information blocking regulations, protect sensitive PHI, and apply to non-clinical workforce members, such as peer counselors. A few commenters suggested that the Department provide safe harbors for disclosures made in good faith, and a few requested that the Department provide guidance on how to address situations in which an individual's previously expressed disclosure preferences may have changed.

Response: As discussed above, the Department is not finalizing the proposals to replace the professional judgment standard with a good faith standard. The Department's decision not to finalize the proposed changes to the professional judgment is based, in part, on the lack of clear consensus on whether the modifications would offer meaningful improvements to individuals' health care and access to care.

Comment: Several commenters expressed support for the Department's proposal to revise 45 CFR 164.512(j) by replacing ''serious and imminent'' with ''serious and reasonably foreseeable.'' These commenters asserted that this proposal would allow for earlier intervention and help prevent escalations in harm. A few commenters requested that the Department give greater deference to harm assessments made by health care professionals with specialized clinical or behavioral health training.

Response: Rather than providing the certitude sought by commenters, the Department has determined that revising the threat standard in 45 CFR 164.512(j) could increase uncertainty about when disclosures are appropriate. Accordingly, the Department is not finalizing this proposed revision. Instead, we refer stakeholders to guidance issued by OCR on applying the serious and imminent threat standard for individuals with mental health conditions and SUD.[654]

Comment: A few commenters who expressed support for the proposals requested that the Department clarify

[654] ''HIPAA Privacy Rule and Sharing Information Related to Mental Health'' Office for Civil Rights, U.S. Department of Health and Human Services (Feb. 13, 2026), *https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf.*

the interaction of the proposed changes with state laws or consider preempting stricter state requirements to ensure consistency.

Response: The preemption provisions of HIPAA are statutory; thus, they are not subject to modification by the Department. HIPAA excepts from its general preemption authority contrary provisions of state law that impose requirements, standards, or implementation specifications that are more stringent than those of the Privacy Rule.[655] In addition, if a provision of state or other Federal law provides greater privacy protection (*e.g.,* a state or Federal law that requires an individual's consent or authorization before a covered entity is permitted to disclose PHI) than a provision of the Privacy Rule, and it is possible for regulated entities to comply with both the state or other Federal law and the Privacy Rule, there is no conflict between the laws and no preemption of state law.

Comment: Several commenters urged the Department to better align the HIPAA Rules and Part 2 to reduce barriers to coordinated care for individuals with SUD.

Response: The Privacy Rule does not conflict with Part 2 in circumstances where it is possible for regulated entities to comply with both Part 2 and the Privacy Rule. Thus, where the HIPAA Rules and Part 2 both apply, the Privacy Rule permissions for disclosure without authorization to family members, caregivers, and others do not negate Part 2's general requirement to obtain a patient's written consent for the disclosure of Part 2 records.[656] Where an exception to Part 2's general requirement applies, a Privacy Rule permission also may apply, subject to the conditions of the applicable Part 2 exception. For example, Part 2 permits disclosure without patient consent for a bona fide medical emergency, subject to the condition that the disclosure be documented afterwards, while the Privacy Rule permits—but does not require—a broader range of disclosures without an individual's authorization for treatment purposes, including emergency medical treatment. Accordingly, a covered entity that is also subject to Part 2 can be in compliance with both regulations when it makes the more limited disclosure permitted by Part 2 for a bona fide medical emergency and meets the applicable requirements and conditions of both the Part 2 exception and Privacy Rule permission.

To address concerns about the alignment between Part 2 and the HIPAA Rules, the Department published two final rules in early 2024. The Confidentiality of Substance Use Disorder (SUD) Patient Records Final Rule, published on February 16, 2024,[657] and the 2024 Privacy Rule, published April 26, 2024,[658] implemented section 3221 of the CARES Act and modified the requirements of the NPP to align it with the Part 2 Patient Notice. This final rule makes additional modifications to the NPP, discussed in detail below, to further align it with the Part 2 Patient Notice.

Comment: A few commenters asserted that the proposal to replace the professional judgment standard would not discourage individuals from seeking care and that a good faith approach could improve care coordination. A few commenters urged the Department to expand the definition of incapacity to include individuals who cannot exercise sound judgment because they have been diagnosed with dementia, psychosis, or another SMI.

Response: The Department is concerned that modifying the professional judgment standard for disclosing PHI to an individual's family, friends, and caregivers or altering the definition of incapacity could introduce more ambiguity and result in unintended consequences. Although an individual who has been diagnosed with dementia, psychosis, or other SMI may lack decision-making capacity in some circumstances, a diagnosis of SMI, by itself, does not determine whether an individual can make independent decisions.[659] Neither 45 CFR 164.510 nor 45 CFR 164.512 requires a legal determination of incapacity; instead, an individual's inability to make decisions about uses and disclosures of their PHI may be transient or situational. For example, an individual with SMI may temporarily lack decision-making capacity when their symptoms are untreated, but their decision-making capabilities may resume upon treatment.[660]

Comment: Some commenters expressed opposition to the proposal to replace the professional judgment standard with a good faith standard because they believed that it would weaken privacy protections for individuals' PHI, increase stigma associated with SUD and SMI, and deter individuals from seeking care. These commenters asserted that broad disclosure permissions could particularly harm individuals in certain situations (*e.g.,* individuals seeking sensitive health care services such as mental health care and SUD treatment).

A few commenters asserted that the proposal to replace the professional judgment standard was unnecessary because the Privacy Rule already permits appropriate disclosures to family members or caregivers. According to these commenters, it is misinformation, not regulatory limits, that leads to inappropriate refusals to disclose PHI.

Several commenters expressed opposition to the Department's proposal to replace professional judgment with good faith because they believed that clinical expertise should guide decisions about the appropriateness of disclosures of PHI to family, friends, and caregivers. These commenters also asserted that a good faith standard would be subjective and difficult to enforce. Several commenters expressed concern that the proposal would allow non-clinical workforce members to make disclosure decisions without sufficient knowledge of an individual's circumstances. Other commenters observed that covered entities sometimes lack information about family dynamics.

Some commenters expressed opposition to the proposal to include a presumption of good faith and stated that individuals would struggle to prove bad faith without a requirement that covered entities document the rationale for their decision.

A few commenters expressed their opposition to the implementation of a good faith standard for identity verification because they believed that family members would not need to provide proof of their identity under such a standard.

Response: As discussed above, the Privacy Rule already permits many of the disclosures sought by family members and caregivers. OCR has longstanding guidance on these topics, including those that specifically address circumstances involving individuals that have been diagnosed with mental and behavioral health conditions, such

[655] *See* 45 CFR 160.203(b).

[656] Part 2 generally prohibits the disclosure of a patient's Part 2 records absent the patient's written consent, or a court order and subpoena, except in certain limited circumstances, such as in a bona fide medical emergency; for scientific research; for management audits, financial audits, and program evaluation; and to public health authorities. *See* 42 CFR 2.13 and 2.51–2.54.

[657] 89 FR 12472 (Feb. 16, 2024).

[658] 89 FR 32976 (Apr. 26, 2024). The vacatur of most of the 2024 Privacy Rule left intact the provisions of the rule related to Part 2. *See Purl,* 787 F. Supp. 3d 284.

[659] *See* Dilip V. Jeste, et al., ''Supported Decision Making in Serious Mental Illness,'' Psychiatry, p. 3 (Aug. 15, 2018), *https://pmc.ncbi.nlm.nih.gov/articles/PMC6093283/pdf/nihms-1502003.pdf.*

[660] *Id.*

as SMI and SUD.[661] The Department agrees that maintaining trust and confidentiality is essential for individuals to seek health care and that decisions to disclose PHI about individuals in certain circumstances may require the exercise of clinical expertise. The Department is persuaded by concerns about the potential chilling effect of the proposals to replace the professional judgment standard at 45 CFR 164.502(g) and 45 CFR 164.510–512 with a good faith standard on the willingness of individuals to seek or obtain health care, as well as concerns that the proposals might cause additional confusion or limit an individual's exercise of their autonomy. Accordingly, we are not finalizing the proposed changes to the professional judgment standard in 45 CFR 164.502(g) and 45 CFR 164.510–512. Moreover, commenters have convinced us that the current provisions in the Privacy Rule are sufficient to permit appropriate disclosures to family members or caregivers.

Comment: Many commenters expressed their belief that covered entities should honor the expressed privacy preferences of individuals except in true emergencies.

Response: The Privacy Rule requires that a covered entity honor an individual's expressed privacy preferences in certain circumstances.[662] While not required in many circumstances, the Department generally encourages covered entities to take an individual's expressed privacy preferences into consideration before making permitted disclosures.

G. Modifying Notice of Privacy Practices Requirements To Reduce Regulatory Burden and Increase Transparency

1. Current Rule

The Privacy Rule generally requires that certain covered entities provide individuals with an NPP to ensure that they understand how the covered entity may use and disclose their PHI, their rights, and the covered entity's legal duties with respect to PHI.[663] There are limited exceptions to this general requirement. For example, a correctional institution[664] that is a covered entity is not required to provide individuals who are inmates[665] with a copy of its NPP.[666]

Section 164.520(b) of the Privacy Rule describes the contents of the NPP, both required and optional, including descriptions of the types of permitted uses and disclosures of individuals' PHI. For example, the NPP must describe how the covered entity is permitted to use and disclose PHI for TPO,[667] as well as each of the other purposes for which the covered entity is permitted or required to use or disclose PHI without the individual's written authorization.[668] Additionally, the NPP must include a statement that the covered entity is required by law to maintain the privacy of PHI and abide by the terms of the current notice.[669] It also must include a statement of the individual's rights with respect to PHI, including the right to inspect or obtain a copy of their PHI, or both, and a brief description of how the individual may exercise these rights.[670] If the covered entity intends to use or disclose PHI to engage in certain activities, such as fundraising, the NPP must contain statements informing the individual of such activities.[671]

Section 164.520(c) of the Privacy Rule sets forth the circumstances in which a covered entity must provide the NPP to an individual. Under 45 CFR 164.520(c)(2)(ii), a covered health care provider that has a direct treatment relationship with an individual generally must make a good faith effort to obtain a written acknowledgment of receipt of the provider's NPP. If the provider is unable to do so, it must document its good faith efforts and the reason for not obtaining the acknowledgment and maintain such documentation for six years.[672] Those same requirements apply to an NPP sent electronically.[673]

2. Proposed Rule

The Department has proposed changes to the NPP requirements several times in recent years, including in the 2021 Privacy Rule NPRM and the 2022 Part 2 NPRM.[674] Some of those proposals were finalized in the 2024 Privacy Rule, while others remain outstanding. This final rule addresses those outstanding proposals, as summarized below.

Of significance, we proposed to eliminate 45 CFR 164.520(c)(2)(ii), which requires a covered health care provider that has a direct treatment relationship with an individual to obtain a written acknowledgment of receipt of the NPP. Removing this provision also would eliminate the requirement that if the covered health care provider is unable to obtain the written acknowledgment, it must document its good faith effort and the reason for not obtaining the acknowledgment.[675] Similarly, the Department proposed to remove, from 45 CFR 164.520(c)(2)(iii),[676] the same requirements for an NPP sent electronically. We also proposed to remove the requirement at 45 CFR 164.520(e) to retain copies of such documentation for 6 years, pursuant to 45 CFR 164.530(j)(2).

To ensure that individuals are informed about a covered entity's privacy practices, we proposed to replace the written acknowledgment with a right for the individual to discuss the NPP with a person designated by the covered entity. Additionally, we proposed at 45 CFR 164.520(b)(1)(vii) to require the covered entity to include the designated contact person's email address and a statement specifying that the designated person is available to answer questions about the NPP.

The Department also proposed to modify the prominent and specific language in the NPP header to help increase individuals' understanding of a covered entity's privacy practices and their rights with respect to their PHI. We proposed to modify the required header to specify that the notice provides information to individuals about: (1) how to access their health information; (2) how to file a HIPAA complaint; and (3) their rights to their medical information, including an individual's right to receive a copy of the notice and to discuss its contents with a designated person. Additionally, in preamble, we explained that we were considering adding a requirement that the header specify whether the designated contact

[661] ''Information Related to Mental and Behavioral Health, Including Opioid Overdose,'' *supra* note 649; *see also* ''Does the HIPAA Privacy Rule permit a doctor to discuss a patient's health status, treatment, or payment arrangements with the patient's family and friends?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #488 (Nov. 3, 2003), *https://www.hhs.gov/hipaa/for-professionals/faq/488/does-hipaa-permit-a-doctor-to-discuss-a-patients-health-status-with-the-patients-family-and-friends/index.html.*

[662] *See* 45 CFR 164.510 and 164.522(a).

[663] *See* 45 CFR 164.520. Section 164.520 applies only to certain covered entities, as opposed to all covered entities or both covered entities and their business associates. *See also* 45 CFR 164.500(b) with respect to the applicability of 45 CFR 164.520 to health care clearinghouses.

[664] *See* 45 CFR 164.501 (definition of ''Correctional institution'').

[665] *See* 45 CFR 164.501 (definition of ''Inmate'').

[666] 45 CFR 164.520(a)(4).

[667] 45 CFR 164.520(b)(1)(ii)(A).

[668] 45 CFR 164.520(b)(1)(ii)(B).

[669] 45 CFR 164.520(b)(1)(v)(A) and (B).

[670] 45 CFR 164.520(b)(1)(iv).

[671] 45 CFR 164.520(b)(1)(iii).

[672] *See* 45 CFR 164.520(e) and 45 CFR 164.530(j)(2).

[673] 45 CFR 164.520(c)(3)(iii).

[674] Many of these changes were proposed in both the 2021 Privacy Rule NPRM and the 2022 Part 2 NPRM.

[675] *See* 45 CFR 164.520(c)(2)(ii).

[676] This modification was not discussed in the preamble of the 2021 Privacy Rule NPRM but was included in the amendatory text.

person is available onsite. The Department also proposed to require that the header include a phone number and email address the individual can use to reach the designated person. And in the 2022 Part 2 NPRM, the Department proposed to make a non-substantive modification to change the word ''Medical'' to ''Health'' throughout the header to refer to the type of information covered by the NPP.[677]

Consistent with the proposed language in the header, the Department proposed to modify the required element of an NPP that addresses the right of access. The Department proposed to require that an NPP describe how an individual can exercise the right to obtain a copy of their records at limited cost or, in some cases, free of charge, and the right of access to direct.

Additionally, the Department proposed at 45 CFR 164.520(b)(2)(iii) to permit covered entities to include in the NPP information to address circumstances in which individuals seek to direct their PHI to a designated person, when the request does not meet the conditions of the right of access to direct under 45 CFR 164.524(d).

Finally, in the 2022 Part 2 NPRM, the Department proposed to remove the provision that excepts individuals who are inmates of correctional institutions that are covered entities from the requirement that covered entities must provide individuals with an NPP.[678] The Department explained that we no longer believed there to be a safety or security risk associated with providing inmates an NPP.

3. Overview of Comments

Most commenters asserted that the requirement to obtain a written acknowledgment increases the administrative burden on covered entities and is misunderstood by individuals. Commenters were evenly divided on their views of the proposed content modifications to the NPP. Several commenters stated that the proposed NPP changes would increase administrative burdens. A few commenters expressed opposition to the proposal to provide individuals with the right to discuss the NPP with a designated contact person because they believed that it would be more burdensome than obtaining the written acknowledgment. According to these commenters, the proposal was unnecessary because individuals always have had the ability to ask questions about the NPP. Several commenters expressed support for creating a right for an individual to discuss the NPP with a designated person because they believed that it would increase individuals' understanding of their privacy rights. Some commenters asserted that the proposed header modifications would draw attention to the items of greatest relevance to the individual.

A few commenters expressed support for the Department's proposal that would eliminate the provision that excepts individuals who are inmates of correctional institutions that are covered entities from the requirement that covered entities must provide individuals with an NPP because they believed that such individuals would benefit from transparency about how their health information is used and disclosed. One commenter asserted that providing the NPP would increase the burden on workforce members with minimal benefit to the individual who is an inmate.

4. Final Rule

The Department is finalizing our proposals to modify the NPP provisions, including certain proposals included in the 2022 Part 2 NPRM, with minor modifications as described below. Specifically, we are removing the requirement at 45 CFR 164.520(c)(2)(ii) for a covered health care provider with a direct treatment relationship to an individual to obtain a written acknowledgment of receipt of the NPP. Removing this provision also eliminates the requirement that if a covered entity is unable to obtain the written acknowledgment, it must document its good faith efforts and the reason for not obtaining the acknowledgment. Relatedly, we are removing the parallel requirement at 45 CFR 164.520(c)(3)(iii) for an NPP sent electronically. We also are removing the requirement at 45 CFR 164.520(e) to retain copies of such documentation for 6 years. Removing these NPP requirements eliminates a significant documentation and storage burden for health care providers and increases the resources available for providing high-quality health care. These modifications also will remove the burden on covered entities to document a good faith effort to obtain the written acknowledgment in situations where the individual is unconscious or otherwise incapacitated or cannot sign the acknowledgment because of communication barriers. Moreover, eliminating these requirements will remove confusion for individuals about the purpose of the written acknowledgment or whether it is required for treatment, in addition to removing confusion for workforce members who may erroneously believe that individuals must sign the acknowledgment to obtain care. Eliminating these requirements does not affect the obligation of a covered entity to document compliance with the notice requirements by retaining copies of the versions of the notice issued by the covered entity consistent with 45 CFR 164.530(j).[679]

As discussed above, covered entities must include in the NPP information about individuals' rights under the Privacy Rule and how individuals may exercise those rights with respect to the covered entity.[680] Thus, to ensure that individuals understand and can make decisions based on the information in the NPP, the Department is finalizing the proposal to replace the written acknowledgment requirement with a new provision at 45 CFR 164.520(b)(1)(iv)(G), which requires the NPP to state the individual's right to discuss the NPP with a person designated by the covered entity. A covered entity can satisfy the right to discuss the NPP in a variety of ways. For example, the covered entity could have one or more workforce members with knowledge of the NPP available onsite during business hours to answer questions or could offer to schedule meetings or calls with individuals within a reasonable time period of receiving their requests to discuss (whether a request is made in person, by telephone, or by email). As another example, a covered entity could implement technology, such as super intelligence (SI),[681] in a manner that is compliant with the Privacy and Security Rules, to receive and triage questions from individuals on its NPP, provided that individuals have the option to discuss the NPP with a workforce member knowledgeable about the covered entity's privacy practices to address their questions. Additionally, we are finalizing language to permit covered entities to name either an office or a specific contact person to align the NPP with the Part 2 Patient Notice.[682]

We believe that having a designated contact person or office with whom an individual can discuss their privacy rights will be more effective for

[677] 87 FR 74216, 74237 (Dec. 2, 2022).

[678] At the time the proposal was made, the provision was at 45 CFR 164.520(a)(3). While the 2024 Part 2 Final Rule did not address this proposal, it adopted other modifications, which led to the redesignation of this provision as 45 CFR 164.520(a)(4). *See also* 87 FR 74216, 74237 (Dec. 2, 2022).

[679] *See* 67 FR 53182, 53261 (Aug. 14, 2002).

[680] 45 CFR 164.520(b)(1)(iv).

[681] *See* 91 FR 63129 (Oct. 2, 2026).

[682] *See* 42 CFR 2.22. The Patient Notice applies to Part 2 programs under 42 CFR part 2.

enhancing an individual's understanding of their privacy rights than signing an acknowledgment that they received the NPP. Accordingly, we encourage covered entities to identify as the designated person or office responsible for providing further information and answering questions a person or office that is knowledgeable about the covered entity's privacy practices and HIPAA complaint process, rather than a general customer service contact.

Relatedly, the Department is finalizing its proposal to modify 45 CFR 164.520(b)(1)(vii), which requires a covered entity to provide contact information for their designated contact person or office, including the person or office's email address. We also are finalizing the proposal to require that the NPP specify that the designated contact person or office responsible for providing further information is available to answer questions about the covered entity's privacy practices and receive complaints as required by 45 CFR 164.530(a)(1)(ii).

We adopt our proposal, with a minor modification, to revise 45 CFR 164.520(b)(1)(iv)(C) to describe how an individual can exercise the right of access to obtain a copy of their records at limited cost or, in some cases, free of charge, and the right of access to direct.[683] The Department believes that this modification provides individuals with additional information about how to access their PHI to manage their own health care and payment for care, further empowering them. Consistent with modifications made elsewhere to this final rule, we are replacing ''third party'' with ''person designated by the individual.'' This language aligns with the language of the HITECH Act and emphasizes that the individual themselves (or their personal representative) is seeking the disclosure, not a third party.[684]

To ensure consistency with how NPP content is presented to individuals, the Privacy Rule requires that covered entities use a specific header for their NPP. Accordingly, to improve clarity in the NPP for individuals, the Department is finalizing the proposal to modify 45 CFR 164.520(b)(1)(i) to require that the header state that the NPP provides information about: (1) how to access their health information; (2) how to file a HIPAA complaint; and (3) their rights to their health information, including an individual's right to receive a copy of the notice, and to discuss its contents with a designated person or office. Consistent with the modification to permit covered entities to list a specific office as the designated contact rather than a person, the Department also is finalizing the proposal to modify the header to give covered entities the option to include the contact information of an office rather than a person. We are not finalizing our proposal, described in the preamble, to require that the contact be onsite because we believe it is sufficient for individuals to have the contact person or office's telephone number and email address. However, the Department encourages covered entities to have the designated contact person or someone from the designated office available onsite or otherwise easily reachable during operating hours to promptly answer individuals' questions about the NPP and receive HIPAA complaints.

The Department is also finalizing the proposal to modify the header of the NPP to change the word ''Medical'' to ''Health,'' to align with the modification to the Part 2 Patient Notice. As discussed in the 2022 Part 2 NPRM, this change does not modify substantive requirements. Instead, it will more accurately reflect and clarify that the information covered by the notice is not limited to the information in an individual's medical record.

The Department believes that providing this information at the beginning of the NPP will improve individuals' awareness of their Privacy Rule rights, what they can do if they suspect a violation of the Privacy Rule, and how to contact a designated person or office to ask questions.

The Department also is modifying 45 CFR 164.520(b)(2)(iii) to add a new optional element for a covered entity to include information addressing an individual's alternatives when they seek to direct their PHI to a designated person, but their request is outside the scope of the right of access to direct.[685] This optional element will help increase awareness that individuals retain the right to obtain the PHI directly from the covered entity and give it to a person of their choosing. Alternately, it will inform individuals that they can request that the covered entity send a copy of PHI directly to a designated person using a valid authorization. While this provision is optional, the Department encourages covered entities to include in the NPP information about how an individual can send PHI to a person the individual designates in such circumstances. For example, if an individual requests that a paper copy of PHI in an electronic health record be sent to another person, the covered entity could address in this optional NPP provision how the individual may obtain that information, such as through a request made pursuant to the right of access and send it to the other person themselves, or how to request that the covered entity send the information to the other person pursuant to a valid authorization. We are finalizing this provision as proposed, with one minor modification, replacing ''third party'' with ''person designated by the individual'' to ensure consistency with modifications discussed elsewhere in this final rule.

The Department also is finalizing the proposal that we made in the 2022 Part 2 NPRM to remove the exception at 45 CFR 164.520(a)(4), ''exception for inmates.'' Thus, covered entities that serve correctional institutions, and correctional institutions that are covered entities, will be required to provide individuals who are inmates with a copy of the NPP. Consistent with a goal of section 3221 of the CARES Act, this modification aligns the NPP with the Part 2 Patient Notice, which does not include an exception regarding the provision of the notice to individuals who are inmates. Removing this exception ensures that individuals who are inmates receive an NPP that is consistent with what is provided to other individuals while also retaining the limitation on the ability of individuals who are inmates to exercise the right of access to ensure the safety and security of correctional facility personnel and others.[686] Furthermore, providing individuals who are inmates with an NPP affords inmates greater transparency on how the correctional institution, or a covered entity that serves a correctional institution, may use and disclose their PHI, such entities' legal duties with respect to PHI, and the individuals' rights with respect to their PHI, without changing other rights or duties unrelated to the NPP.

5. Responses to Public Comments

Comment: Most commenters expressed support for the proposal to eliminate the requirement to obtain a signed acknowledgment of the NPP, stating that the requirement is an administrative burden and causes confusion for individuals without providing any meaningful benefit. A few commenters recommended that the Department provide covered entities

[683] *See* 45 CFR 164.524.

[684] *See* sec. 13405(e) of the HITECH Act, 123 Stat. 268 (Feb. 17, 2009) (codified at 42 U.S.C. 17935(e)).

[685] *See* 45 CFR 164.524(d).

[686] *See* 45 CFR 164.524(a)(2)(ii). The Department continues to believe that this limitation is necessary to address potential security concerns that are unique to inmates.

with the ability to obtain an individual's acknowledgment through alternative mechanisms, such as verbal and electronic confirmation. A few commenters expressed opposition to the proposal because they believed that the acknowledgment requirement ensures that individuals receive the NPP and are aware of the covered entity's privacy practices.

Response: Eliminating the requirement to obtain a written acknowledgment of receipt of the NPP will reduce the covered entity's administrative burden, improve workflow congestion, and allow more time for individuals to discuss the NPP with the designated person or office. The Department is not replacing the requirement to obtain a written acknowledgment with an alternative mechanism, such as obtaining verbal or written confirmation of receipt, because such requirement would add unnecessary complexity. Importantly, removing the requirement to obtain a written acknowledgment does not remove the requirement for covered entities to provide individuals, including inmates, with an NPP to ensure that they are aware of the entity's privacy practices and know how to contact a designated person or office to answer any questions about the NPP or submit a HIPAA complaint. This modification also does not affect an individual's ability to access an NPP that is posted on a covered entity's website, consistent with the Privacy Rule's requirements for the website posting of NPPs.[687] Removal of this requirement does not prevent a covered entity from continuing to document that it has provided individuals with an NPP if it wishes to do so.

Comment: Several commenters expressed support for the Department's proposal to create a right for an individual to discuss the NPP with a designated contact person. A few commenters recommended that the Department permit the designated person to be a group or a department, rather than requiring that it be a particular person, because it would allow the covered entity to identify the specific person who is best able to respond to each inquiry. One commenter recommended that the Department require that the designated contact person meet certain minimum qualifications.

Some commenters expressed opposition to the proposal because they believed that it would be burdensome and unnecessary. According to these commenters, this proposal would replace the documentation burden with an increase in workforce time and burden on workflow.

Response: The Department is adopting a modified version of the proposal that requires covered entities to designate a person or office as the contact for discussing the NPP with individuals and accepting HIPAA complaints. While the definition of ''person'' in the HIPAA Rules is broad enough to refer to an office, we are persuaded by public comments that this modification is necessary to clarify that covered entities may designate an office or a workforce member as the contact.[688] This modification is consistent with other instances in the Privacy Rule that refer to ''person or office.'' [689]

According to commenters, individuals generally do not ask questions about the NPP. Based on these comments, we do not expect that covered entities will receive many questions about their privacy practices. Thus, the Department believes that having a designated person or office available to answer questions about the NPP will create less administrative burden than obtaining a written acknowledgment of receipt of the NPP or documenting good faith efforts and the reason for not obtaining the acknowledgment. Furthermore, the final rule provides flexibility by permitting covered entities to choose to designate either a person or office as the contact. The Department has long stated that duties may be delegated and shared, so long as there is one point of accountability for the covered entity's privacy practices to ensure that individuals are able to speak to a knowledgeable person.[690] Thus, although the Department recommends that the designated person or office be versed in the entity's privacy practices and HIPAA complaint process, we are not requiring that the designated contact person or office must meet certain minimum qualifications to answer questions about the NPP or receive HIPAA complaints. Providing a designated contact person or office recognizes the importance of assuring patients that their PHI is being protected and shared appropriately. Additionally, it engenders trust and encourages open dialogue between individuals and covered entities.

Comment: Some commenters expressed support for the proposal to modify the header because it would draw attention to the items of greatest relevance to individuals, thereby improving individuals' understanding of, and ability to exercise, the rights afforded to them by the Privacy Rule. Some commenters expressed opposition to the proposal to modify the header because of an increased administrative burden associated with modifying the NPP.

Response: The Department is adopting the proposal to revise the header because it will make it easier for individuals to quickly see and improve their understanding of the entity's privacy practices in the NPP. We acknowledge that updating the NPP will create a one-time burden for covered entities; however, we believe that eliminating the recurring requirement to obtain and document the written acknowledgment, or the covered entity's good faith effort and reason for not obtaining the acknowledgment, will more than offset this burden.

Comment: A few commenters recommended that the Department update the model NPP to: (1) address how an individual's information may be used and disclosed within the health care system and by business associates; and (2) include examples related to health care operations and psychotherapy notes.

Response: The Department intends to update the model NPPs and model Part 2 Patient Notice, which addresses SUD patient records, to reflect the changes herein prior to the compliance date for this final rule.[691]

Comment: One commenter expressed support for the Department's proposal to make it optional for covered entities to include in the NPP information about how an individual who seeks to direct a copy of their PHI to a designated person can instead obtain a copy of PHI themselves or request that the covered entity send a copy of the PHI to a designated person using a valid authorization if the request does not meet the conditions of 45 CFR 164.524(d) because of the variability of options and fees.

Response: Allowing covered entities to include in the NPP a thorough explanation of individuals' options of obtaining access to and sharing their

[687] *See* 45 CFR 164.520(c)(3)(i).

[688] *See* 45 CFR 164.501 (definition of ''Person'').

[689] *See, e.g.,* 45 CFR 164.520(b)(1)(vii), 45 CFR 164.524(d)(2)(iii) (redesignated by this final rule to 45 CFR 164.524(e)(2)(iii)), 45 CFR 164.526(d)(1)(iv), and 45 CFR 164.530(a)(1)(ii)).

[690] 65 FR 82462, 82744 (Dec. 28, 2000) (discussing that covered entities are organized differently and have different information systems, which is why the Department did not delegate who within a covered entity must be the privacy official).

[691] ''Model Notices of Privacy Practices,'' Office for Civil Rights, U.S. Department of Health and Human Services (Feb. 13, 2026), *https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/index.html.*

PHI with others informs and empowers individuals to make such decisions in a thoughtful and educated manner. Covered entities that choose to include this information are not required to include in the NPP information about their fees for disclosing such PHI. Elsewhere in this final rule, we discuss the decision to finalize the proposal to require covered entities to make available a fee schedule that applies to requests made pursuant to the right of access and valid authorizations.

Comment: One commenter expressed opposition to the proposal to remove the exception to the requirement to provide individuals with a copy of the NPP for individuals who are inmates of correctional facilities that are covered entities because they believed issuing the NPP to such individuals would mean that they would have the same health information privacy rights as individuals who are not inmates. The commenter also expressed concern about potential safety and security risks associated with sharing information about scheduled appointments or surgeries with an individual who is an inmate or family or friends of an individual who is an inmate.

Response: We are finalizing this provision as proposed in the 2022 Part 2 NPRM. Individuals who are inmates are afforded the same health information privacy rights under the Privacy Rule as other individuals, with limited exceptions. For example, a correctional institution that is a covered entity may limit the disclosure of PHI in response to an inmate's right of access request if such disclosure would jeopardize the health, safety, or security of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate.[692] And while an inmate's personal representative (which could be a family member or friend) may be able to obtain a copy of PHI on the inmate's behalf in some cases where a covered entity may deny access to the individual, this has been true since the 2000 Privacy Rule.[693] Additionally, while the NPP is provided to each individual, it does not include information about the individual; rather, it addresses the covered entity's privacy practices and individuals' rights and how to exercise them.

H. Permitting Disclosures for Telecommunications Relay Services for People Who Are Deaf, Hard of Hearing, or Deaf-Blind, or Who Have a Speech Disability

1. Current Rule

As we explained in the 2021 Privacy Rule NPRM, TRS providers facilitate telephone calls between individuals who are deaf, hard of hearing, or deaf-blind, or who have a speech disability, and others.[694] Federally regulated common carriers (*e.g.,* operators of all landline and mobile telephone services) must provide TRS to individuals in the general public who are deaf, hard of hearing, or deaf-blind, or who have a speech disability.[695] TRS providers facilitate such communications by using a communications assistant who transliterates conversations (or in some cases, interprets using American Sign Language (ASL)).[696] The communications assistant relays information, which may include PHI, between a person who uses text or video and another person, who may be communicating by voice or who also may be using TRS.[697] All TRS providers must comply with standards for operators established by the Federal Communications Commission pursuant to Title IV of the Americans with Disabilities Act of 1990 (ADA), as amended,[698] including protecting the confidentiality of all relayed communications.[699]

The Privacy Rule currently does not explicitly permit the use and disclosure of PHI for purposes expressly related to TRS, nor does it explicitly address whether a TRS communications assistant is a business associate. However, the Department previously explained in guidance that a covered entity is permitted to disclose an individual's PHI to a TRS communications assistant when communicating with the individual without the need for a business associate agreement with the TRS provider.[700] As explained in the guidance, the Privacy Rule permits disclosures to TRS communications assistants under 45 CFR 164.510(b) because individuals have an opportunity to agree or object to disclosures of PHI to a TRS communications assistant at the beginning of a call, and the individuals are effectively identifying the communications assistant as involved in their care if the individuals do not object. Additionally, the guidance also explains that the TRS provider is not acting for or on behalf of the covered entity when it provides such relay services. Thus, the TRS provider is not a business associate.

Also as explained in the 2021 Privacy Rule NPRM, the Department has become aware that advances in technology now allow people who are deaf, hard of hearing, or deaf-blind, or who have a speech disability to communicate with the help of a TRS communications assistant in a seamless manner, with immediate connection and instantaneous transliteration of text or interpretation of ASL to voice and vice versa, such that the other party to the call may not know that a person is using a TRS communications assistant. Additionally, TRS is used not only to connect individuals with workforce members of regulated entities, but also to assist in communications between workforce members of regulated entities. For these reasons, the assumption that individuals always would have the opportunity to agree or object to a use or disclosure of PHI to a TRS communications assistant no longer holds when it is a workforce member of the regulated entity, rather than an individual, who needs the TRS services to assist with communications.

2. Proposed Rule

The Department proposed to add a new subsection (v) to paragraph (4) of the definition of business associate at 45 CFR 160.103 that would exclude TRS providers from the definition of business associate. This proposal would ensure that regulated entities would not need to analyze whether they need business associate agreements with TRS providers, nor would they need to enter into and implement such agreements.

[692] *See* 45 CFR 164.524(a)(2)(ii).

[693] 45 CFR 164.502(g)(1); *see* 45 CFR 164.502(g)(2)–(5) (exceptions to this general rule); *see also* 65 FR 82462, 82732 (Dec. 28, 2000).

[694] *See* ''Consumer Guide, Telecommunications Relay Service,'' *supra* note 362.

[695] *See* 47 U.S.C. 225(b).

[696] *See* 47 CFR 64.601(a)(12).

[697] *See generally* ''Consumer Guide, Telecommunications Relay Service,'' *supra* note 362. TRS types include Text-to-Voice, Voice Carry Over, Speech-to-Speech Relay, Shared Non-English Language Relay, Captioned Telephone Service, internet Protocol Captioned Telephone Service, internet Protocol Relay Service, and Video Relay Service. *Id.*

[698] Public Law 101–336, 104 Stat. 327 (July 26, 1990) as amended (codified at 47 U.S.C. 225); 47 CFR 64.604(c)(5)(iii)(K).

[699] Except in very limited circumstances specified in FCC regulations, TRS communications assistants are not permitted to keep notes of the contents of a call after a call, unless the caller requests that the communications assistant retain such information to facilitate the completion of subsequent calls. In no case may the communications assistant retain such information after the completion of the subsequent call(s). *See* 47 CFR 64.604(a)(2).

[700] ''When a covered entity, such as a doctor, uses a certified Telecommunications Relay Service to contact patients with hearing or speech impairments, is the Relay Service a business associate of the doctor?,'' *supra* note 364.

The Department also proposed to add a new paragraph (m) to 45 CFR 164.512 that would expressly permit covered entities to disclose PHI to TRS communications assistants, as defined at 47 CFR 64.601(a)(12).[701] This proposed permission would cover all disclosures to TRS communications assistants related to any covered functions performed by, for, or on behalf of covered entities.

Together, the proposed modifications to 45 CFR 160.103 and 164.512 would help to ensure that workforce members and individuals who are deaf, hard of hearing, deaf-blind, or who have a speech disability are able to communicate easily using TRS for care coordination and other purposes.

3. Overview of Comments

The Department received relatively few comments on this proposal. Commenters generally expressed support for the proposal because they asserted that it would facilitate care coordination for individuals who are deaf, hard of hearing, deaf-blind, or who have a speech disability, as well as enable regulated entities and their workforce members, who may be deaf, hard of hearing, deaf-blind, or have a speech disability, to communicate with individuals and each other using TRS.

4. Final Rule

Consistent with the Department's proposal, this final rule modifies the definition of business associate at 45 CFR 160.103 by adding a new subsection (v) to paragraph (4) to expressly exclude TRS providers from the definition of business associate. Additionally, it permits regulated entities to disclose PHI to TRS communications assistants to conduct covered functions by adding a new paragraph (m) to 45 CFR 164.512. Section 164.512(m)(1) permits covered entities to disclose PHI to TRS communications assistants to conduct covered functions, while 45 CFR 164.512(m)(2) expressly permits business associates to disclose PHI to TRS communications assistants to conduct covered functions for, or on behalf of, a covered entity. The language that we are adopting is modified from the proposed language for 45 CFR 164.512(m) to clarify in regulatory text that business associates can make such disclosures regardless of whether their business associate agreements address the ability of the business associates to disclose PHI to TRS communications assistants for the purposes described above. This modification is consistent with the intended scope of the Department's proposal, as described in preamble to the 2021 Privacy Rule,[702] and helps further our goals of reducing administrative burden on regulated entities and facilitating communications for persons who rely on TRS communications assistants.

As of 2024, hearing loss was the third most common chronic physical condition in the United States,[703] affecting more than 37.9 million Americans [704] and projected to rise to over 70 million by 2060.[705] Further, hearing loss that is disabling is experienced by 5 percent of adults aged 45 to 54, 10 percent of those aged 55–64, 22 percent of those aged 65 to 74, and 55 percent of adults over the age of 75.[706] Moreover, in this same time period, over 17 million adults experienced difficulties using their voice in the 12 months preceding this time period while over 9 million adults experienced the problem for a period of 1 week or longer.[707] With respect to vision loss, according to estimates from the 2024 National Health Interview Survey, 49.5 million American Adults age 18 and older reported experiencing some degree of vision loss. Of these, 3.8 million adults have a lot of trouble seeing, even when wearing glasses, and 420,000 cannot see at all.[708] Thus, the need for TRS communications assistants to aid such individuals in communicating with regulated entities, and workforce members of regulated entities in communicating with each other and outside parties, is likely to increase in the near future.

Accordingly, the Department believes that this modification to the Privacy Rule promotes access to health care for individuals who are deaf, hard of hearing, deaf-blind, or who have a speech disability and will facilitate the compliance of regulated entities with applicable Federal and state disability laws. Additionally, we believe that clarifying that regulated entities are permitted to disclose PHI to TRS communications assistants to conduct covered functions eliminates confusion and enables persons who are deaf, hard of hearing, deaf-blind, or who have a speech disability to be employed in the health care industry without imposing on regulated entities the need for a business associate agreement, while presenting no real risk to the privacy and confidentiality of PHI.

5. Responses to Public Comments

Comment: Commenters almost universally expressed support for the proposal to exclude TRS providers from the definition of a ''business associate'' and clarify that regulated entities are not required to enter into business associate agreements with TRS providers in order to disclose PHI to them. According to commenters, this proposal would eliminate the administrative burden associated with implementing a business associate agreement, enabling regulated entities to more easily make necessary disclosures to TRS communications assistants for patient care. Many commenters asserted that it would reduce burden for patients who are deaf, hard of hearing, deaf-blind, or who have a speech disability. These commenters expressed uncertainty about whether regulated entities must enter into business associate agreements with TRS providers, which has caused some regulated entities to be reluctant to communicate via TRS or to require business associate agreements from TRS providers. According to commenters, this uncertainty has resulted in delays to the timely provision of health care for affected individuals. Commenters asserted that this proposal would alleviate concerns about potential violations of the ADA [709] and the burdens imposed on affected individuals in circumstances where

[701] The proposed regulatory text in the 2021 Privacy Rule NPRM incorrectly stated that the definition of ''communications assistant'' was at 47 CFR 64.601(a)(10).

[702] 86 FR 6446, 6487 (Jan. 21, 2021).

[703] *See* ''About Occupational Hearing Loss,'' National Institute for Occupational Safety and Health, U.S. Centers for Disease Control and Prevention (May 15, 2024), *https://www.cdc.gov/niosh/noise/about/index.html.*

[704] David B. Rein, et al., ''The prevalence of bilateral hearing loss in the United States in 2019: a small area estimation modelling approach for obtaining national, state, and county level estimates by demographic subgroup,'' The Lancet Regional Health—Americas, p. 5 (Feb. 2024), *https://www.thelancet.com/action/showPdf?pii=S2667-193X%2823%2900244-2.*

[705] *See* Adele M. Goman, et al., ''Addressing Estimated Hearing Loss in Adults in 2060,'' JAMA Otolaryngology Head & Neck Surgery (July 2017), *https://jamanetwork.com/journals/jamaotolaryngology/fullarticle/2606784.*

[706] ''Quick Statistics about Hearing, Balance, & Dizziness,'' National Institute on Deafness and other Communication Disorders, U.S. Department of Health and Human Services (Sept. 20, 2024), *https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing.*

[707] *See id.;* ''Quick Statistics About Voice, Speech, and Language,'' National Institute on Deafness and other Communication Disorders, U.S. Department of Health and Human Services (July 8, 2025), *https://www.nidcd.nih.gov/health/statistics/quick-statistics-voice-speech-language.*

[708] ''Facts and Figures on Adults with Vision Loss from the National Health Interview Survey (NHIS),'' American Foundation for the Blind (Mar. 2026), *https://www.afb.org/research-and-initiatives/statistics/adults-vision-loss-nhis.*

[709] Public Law 101–336, 104 Stat. 327 (July 26, 1990) (codified as amended at 42 U.S.C. 12101 *et seq.*). The ADA prohibits discrimination based on disability.

covered entities did not implement accessible telephone systems.

One commenter opined that the proposal would not result in any adverse consequences, such as posing significant risks to individuals' privacy or undue burdens on regulated entities.

Response: The Department agrees that this modification reduces barriers to both health care for individuals who are deaf, hard of hearing, deaf-blind, or who have a speech disability, and employment for such persons. The Department also agrees that eliminating the need to implement a business associate agreement with TRS providers will reduce the administrative burden on regulated entities, namely the amount of time and other resources associated with determining whether a business associate agreement is necessary and implementing such business associate agreements. Additionally, we are unaware of any potential unintended, adverse consequences that would be created by this proposal.

Accordingly, we are finalizing these modifications.

Comment: One commenter recommended that the Department modify the proposal to permit covered entities to disclose PHI to TRS communications assistants to the same extent as during a traditional voice call. The commenter expressed concern that regulated entities otherwise might conclude that the minimum necessary standard applies to the disclosure of PHI when using a TRS communications assistant.

Response: The Department declines to modify the proposal as requested because the recommended language could cause uncertainty about the scope of the permission. This final rule permits a regulated entity to disclose PHI when necessary to conduct a function covered by the HIPAA Administrative Simplification provisions but does not permit it to disclose PHI beyond such functions. Further, the Department believes that the finalized text vests discretion with the disclosing regulated entity to ensure that the amount of PHI disclosed is consistent with the purpose for which it is disclosed. The minimum necessary standard at 45 CFR 164.502(b) will continue to be applicable consistent with its requirements.

I. Expanding the Permission To Use and Disclose the PHI of Armed Forces Personnel To Cover All Uniformed Services Personnel

1. Current Rule

Section 164.512(k) of the Privacy Rule contains the standard for uses and disclosures of PHI for specialized government functions, including U.S. military and veteran activities. Paragraph (k)(1)(i) of this section specifically permits covered entities to use and disclose the PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. Application of the permission requires the military authority to publish notice in the **Federal Register** of the appropriate military command authorities and the purposes for which the PHI may be used or disclosed.[710] Section 164.512(k)(1)(ii) permits a component of the Departments of Defense or Homeland Security that is a covered entity to disclose to the VA the PHI of an individual who is a member of the Armed Forces upon the separation or discharge of the individual from military service for the purpose of a VA determination of eligibility or benefits entitlement. These permissions enable covered entities to use and disclose the PHI of Armed Services personnel, under certain conditions, to avoid the burden and obstacles of obtaining individuals' authorizations when the balance of privacy interests and societal values weighs toward permitting the use or disclosure of PHI without authorization for specialized purposes.[711] When taken together, they ensure that the PHI of members of the Armed Forces is made available for operations that tie directly to military and VA operations.

2. Proposed Rule

As we explained in the 2021 Privacy Rule NPRM, according to the Directors of the USPHS and NOAA Commissioned Corps, the existing provision limits the ability of the USPHS and NOAA Commissioned Corps to facilitate care coordination and case management for Commissioned Corps personnel.[712] Such care coordination and case management are important for ensuring that personnel meet medical readiness standards and are able to fulfill the Commissioned Corps' respective missions. Accordingly, the Department proposed to expand the applicability of 45 CFR 164.512(k)(1) from the Armed Forces to all Uniformed Services, which—in addition to the Armed Forces—includes HHS's USPHS Commissioned Corps and the Department of Commerce's NOAA Commissioned Corps. This would permit covered entities to use and disclose PHI for mission requirements and veteran eligibility of members of these Services without individual authorization. The Department proposed to modify 45 CFR 164.512(k)(1)(i) to permit covered entities to use and disclose the PHI of individuals who are members of the USPHS or NOAA Commissioned Corps for activities deemed necessary by appropriate Service authorities to assure the proper execution of the missions of the respective Commissioned Corps. The Department also proposed to modify 45 CFR 164.512(k)(1)(ii) to permit a component of either the Department of Commerce or HHS that is a covered entity to disclose PHI to the VA concerning members of their respective Commissioned Corps in the same manner that is currently allowed for the Departments of Defense and Homeland Security with respect to the Armed Forces under their respective jurisdictions.

3. Overview of Comments

The Department received relatively few comments on this proposal, but the comments that we received generally expressed support for it.

4. Final Rule

The final rule adopts the proposal to expand the permission for covered entities to use and disclose PHI of members of the Armed Services to include members of all Uniformed Services, with minor modifications to account for the organizational structure of the Department of Defense.[713] Additionally, because Uniformed Services includes the USPHS and NOAA Commissioned Corps, the final rule adopts the modification to permit a covered component of either the Department of Commerce or Health and Human Services to disclose PHI to the VA at 45 CFR 164.512(k)(1)(ii).

The Uniformed Services are composed of the Armed Forces (Army, Navy, Air Force, Marine Corps, Space Force, Coast Guard) plus the USPHS and NOAA Commissioned Corps. While members of the USPHS and NOAA

[710] *See* 45 CFR 164.512(k)(1)(i).

[711] *See* 65 FR 82462, 82704–05, 82817 (Dec. 28, 2000).

[712] *See* 86 FR 6446, 6487 (Jan. 21, 2021).

[713] The Department of Defense may also be referred to as the Department of War. *See* 90 FR 43893 (Sept. 10, 2025).

Commissioned Corps are not members of the Armed Forces, they maintain similar obligations to those of the Armed Services. For example, for the USPHS, 42 U.S.C. 204(a) establishes both a Regular Corps and Ready Reserve Corps to be available for deployment in certain specified circumstances. Paragraph (1) of 42 U.S.C. 402(a) requires the Secretary to establish requirements to ensure the readiness of both Corps' components for response to urgent or emergency public health care needs that cannot otherwise be met at the Federal, state, and local levels; and any member who fails to maintain fitness is subject to disciplinary actions. Under 42 U.S.C. 217, the President may, by Executive Order, in time of war, or of emergency involving the national defense, declare the USPHS Commissioned Corps to be a military service. Similarly, section 3007 of title 33 of the U.S. Code requires the Secretary of the Department of Commerce to ensure a ''high physical state of readiness'' by establishing physical fitness standards for NOAA personnel that are substantially equivalent to those prescribed for Coast Guard personnel. Section 3030 of 33 U.S.C. provides that officers of NOAA shall be subject to the same laws as Navy personnel for purposes of temporary appointment or advancement in time of war or national emergency. Section 3061 of 33 U.S.C. provides that the President may, whenever in the judgment of the President a sufficient national emergency exists, transfer NOAA commissioned officers, ships, and stations to the military departments if the President deems it in the best interest of the country.

Members of the USPHS and NOAA Commissioned Corps are obligated to maintain physical fitness to ensure duty readiness in a similar manner to members of the Armed Forces. Members of these Commissioned Corps also enjoy certain benefits linked to their service.[714] As explained by the directors of the USPHS and NOAA Commissioned Corps in their joint comments, the Commissioned Corps are part of the eight Uniformed Services and may be assigned or detailed to the Armed Services. As such, according to the directors, members of the USPHS and NOAA Commissioned Corps ''must meet medical readiness standards consistent with the various military missions.'' [715] Thus, it is appropriate to permit the use and disclosure of PHI, without authorization, of members of the USPHS Commissioned Corps and the NOAA Commissioned Corps for the same purposes, and in a similar manner as the Privacy Rule currently permits with respect to the PHI of members of the Armed Forces.

Additionally, based on public comments, the Department believes that expanding the Armed Forces permission is likely to facilitate efficient care coordination and case management for members of the USPHS and NOAA Commissioned Corps, and thus help the respective Commissioned Corps ensure the health and safety of their officers. As explained by the Directors of the USPHS and NOAA Commissioned Corps, the health and safety of officers is crucial for ensuring that such officers can fulfill the mission of the Corps and protect the health and safety of the nation's population. Accordingly, we are finalizing the proposal with minor modifications to account for the organizational structure of the Department of Defense. The final regulatory text in paragraphs (k)(1), (k)(1)(i), (k)(1)(i)(A), and (k)(1)(ii) hews closely to the original regulatory text but substitutes the term ''Uniformed Services'' for the terms ''military'' and ''Armed Forces'' in certain instances and in others, substitutes ''command'' for ''military'' or ''military command.'' These modifications clarify that ''Uniformed Services'' refers to the personnel whose PHI may be used or disclosed under this permission, not to the departments, agencies, or components that oversee those personnel. The appropriate command authorities for purposes of 45 CFR 164.524(k)(1)(i) are those identified in the **Federal Register** notice required by that provision. Thus, this modification enshrines an explicit permission for covered entities to use and disclose the PHI of members of all Uniformed Services for the purposes specified in this provision. The final regulatory text is also consistent with the regulatory text suggested by USPHS and NOAA in their joint comments on the 2018 RFI, as explained in the 2021 Privacy Rule NPRM. The final rule does not modify the scope of the permission, nor does it change the requirement at 45 CFR 164.512(k)(1)(i) that the appropriate authority publish a notice in the **Federal Register** identifying the appropriate command authorities and the purposes for which PHI may be used or disclosed.

5. Responses to Public Comments

Comment: One commenter who expressed support for the proposal suggested that the Department define ''Uniformed Services.''

Response: At this time, the Department declines to define the term ''Uniformed Services.'' Instead, we look to 37 U.S.C. 101, which provides that the Uniformed Services consists of the six branches of the military plus the USPHS and NOAA Commissioned Corps. For purposes of 45 CFR 164.512(k)(1), Uniformed Services refers to the members whose PHI may be used or disclosed under this permission and does not refer to the departments, agencies, or components that oversee those members.

Comment: One commenter who expressed support for this proposal asserted that it would reduce barriers to care and enable the exchange of PHI for care coordination and case management for individuals whose PHI is subject to the permission, particularly when they seek care from military and non-military health care providers. Another commenter who expressed support for the proposal stated that it would reduce impediments to universal data exchange.

Response: The Department agrees that permitting covered entities to use and disclose the PHI of individuals who are Uniformed Services personnel for activities deemed necessary by the appropriate command authorities to assure the proper execution of the Uniformed Services mission will support the exchange of PHI for care coordination and case management. Accordingly, we are finalizing this proposal.

Comment: One commenter requested clarification on whether the proposed expansion of the permission to all Uniformed Services would include Armed Services recruitment activities. Another commenter expressed concern about the use or disclosure of genetic information for decision making related to an individual's ability to execute military missions.

Response: Consistent with the prior language at 45 CFR 164.512(k), this final rule continues to defer to appropriate command authorities to determine which uses and disclosures of PHI are deemed necessary to assure the proper execution of the mission. This final rule only expands the permission for use and disclosures of the PHI of members of the Armed Services to also include members of the USPHS and NOAA

[714] *See* 42 U.S.C. 213 and 33 U.S.C. 3071 (extending certain privileges granted to members of the Armed Forces to members of the USPHS and NOAA Commissioned Corps).

[715] Letter from Rear Admiral Joan Hunter, PHS Corps Director, Commissioned Corps Headquarters and Rear Admiral Michael J. Silah, NOAA Director, NOAA Corps to the Office for Civil Rights, U.S. Department of Health and Human Services (Feb. 11, 2019) (citing 42 U.S.C. 204a(a)(1), 33 U.S.C. 3073), *https://www.regulations.gov/comment/HHS-OCR-2018-0028-0965.*

Commissioned Corps, referred to collectively as ''Uniformed Services.''

J. Providing a Transition Period for Business Associate Agreements

1. Current Rule

The transition provisions for business associate contracts and other written arrangements (collectively, ''business associate agreements'') are found in 45 CFR 164.532(e). The Department's most recent revisions to this provision, made in 2013, allowed regulated entities to continue operating under existing business associate agreements for up to 1 year beyond the compliance date of the 2013 modifications to the HIPAA Rules.[716]

2. Proposed Rule

The Department did not specifically propose to modify the transition provisions at 45 CFR 164.532(e) as part of the 2021 Privacy Rule NPRM. However, as discussed above, we did solicit comments on the sufficiency of an 180-day compliance period.

3. Overview of Comments

While the Department did not specifically propose to provide regulated entities with additional time to modify business associate agreements, several commenters urged the Department to provide additional time for them to do so, citing the administrative burden and costs of implementing the revised business associate agreement provisions.

4. Final Rule

The Department recognizes that regulated entities may have existing business associate agreements that are not set to terminate or expire until after the compliance date, and we understand that a 6-month compliance period may not provide enough time to reopen and renegotiate all business associate agreements. Accordingly, we are modifying 45 CFR 164.532(e) to allow regulated entities to continue to operate under certain existing business associate agreements for up to 1 year beyond the effective date (*i.e.,* 6 months beyond the compliance date) for the revisions to the Privacy Rule made by this final rule.

The Department's authority to provide additional time for regulated entities to comply with certain provisions of the Privacy Rule is set forth in 45 CFR 160.104(c), which permits the Secretary to establish the compliance date for any modified standard or implementation specification, considering the extent of the modification and the time needed to comply with the modification. We provided a similar transition period for revising business agreements in the 2002 Privacy Rule[717] and 2013 Omnibus Rule[718] for similar reasons.

Specifically, the final rule modifies the transition provisions at 45 CFR 164.532(e) to allow regulated entities to continue to operate under certain existing business associate agreements for up to 1 year beyond the effective date of this final rule. The additional transition period is available to a regulated entity if, prior to the publication date of this final rule, the regulated entity has an existing contract or other written arrangement with a business associate or subcontractor that complies with the HIPAA Rules, and such contract or arrangement is not renewed or modified between the effective date and the compliance date of this final rule. These transition provisions allow regulated entities that have valid business associate agreements with business associates and subcontractors to continue to disclose PHI to the business associate or subcontractor, or to allow the business associate or subcontractor to continue to create, receive, maintain, or transmit PHI on behalf of the regulated entity, for up to 1 year beyond the effective date of this final rule, regardless of whether the business associate agreement meets the applicable requirements of this final rule. The Department will deem such business associate agreements compliant with the modifications to the Privacy Rule until the earlier of: (1) the regulated entity either renews or modifies the business associate agreement following the compliance date of this final rule; or (2) the date that is 1 year after the effective date.

Business associate agreements that renew automatically without any change in terms or other action by the parties (also known as ''evergreen contracts'') are eligible for the extension, and they will continue to be deemed compliant with the final rule, as described above, when they automatically roll over. These transition provisions apply only to written contracts or other written arrangements, and not to verbal contracts or other arrangements.

These transition provisions apply only to the requirement to amend business associate agreements; they do not affect any other compliance obligations under the HIPAA Rules. For example, beginning on the compliance date of this rule, a business associate that responds to requests for individual access on behalf of a covered entity must respond to such requests as soon as practicable, but not later than 15 calendar days after receiving a request, even if the business associate agreement has not yet been amended to reflect the modifications to the Privacy Rule.

5. Responses to Public Comments

Comment: A few commenters requested that the Department provide additional time for regulated entities to revise business associate agreements affected by the revised Privacy Rule.

Response: We agree with commenters that regulated entities may require additional time to update and renegotiate their business associate agreements. The Department is aware that many regulated entities have existing business associate agreements that do not terminate or expire until after the compliance date, and that a 240-day compliance period may be insufficient for regulated entities with many business associate agreements to come into compliance, while also implementing the other modifications finalized in this rule. To reduce this administrative burden, we are revising 45 CFR 164.532(e) to provide regulated entities with a 1-year transition period during which certain existing business associate agreements may remain in effect beyond the compliance date of this final rule.

K. Other Technical and Conforming Changes

In addition to the substantive modifications described above, this final rule implements several technical or conforming changes that are non-substantive in nature.

To improve readability and clarity, this final rule replaces semicolons with periods at the end of paragraphs in: (1) the definition of ''health care operations''; (2) 45 CFR 164.502(a)(2); (3) 45 CFR 164.524(a)(1); (4) 45 CFR 164.524(a)(3); and (5) 45 CFR 164.524(d)(3). Additionally, clarifying phrases were added before the colon: (1) in paragraph (6) of the definition of health care operations, the phrase ''any of the following''; (2) 45 CFR 164.502(a)(2) adds the phrase ''in each of the following circumstances''; and (3) Section 164.524(a)(1) adds the phrase ''either of the following.'' Section 164.524(a)(2) adds ''any of'' before ''the following circumstances'' and changes the period to a colon after ''circumstances.'' Section 164.524(a)(3) adds ''any of'' before ''the following circumstances.'' Section 164.524(d)(3) adds ''either of'' before ''the following circumstances.'' Additionally, 45 CFR 164.524(c)(2)(iv) adds a comma before ''or may.'' These technical changes do

[716] *See* 78 FR 5566, 5602–03 (Jan. 25, 2013).

[717] 67 FR 53182, 53247–51 (Aug. 14, 2002).

[718] 78 FR 5566, 5602–03 (Jan. 25, 2013).

not modify the substance of the relevant provisions.

Section 164.512(d)(3) contains a minor spelling error. This final rule replaces ''Nothwithstanding'' with ''Notwithstanding.''

Section 164.512(k)(1)(ii) currently uses the acronym ''DVA'' for the U.S. Department of Veterans Affairs. This final rule replaces the acronym ''DVA'' with ''VA,'' consistent with the U.S. Department of Veterans Affairs' use of VA.[719]

Additionally, we are finalizing a technical correction for the citation to the National Security Act of 1947 in 45 CFR 164.512(k)(2). Periodically, the Office of the Law Revision Counsel, which maintains and publishes the United States Code (U.S.C.) (a codification of the general and permanent laws of the United States organized into titles based on subject matter) may recodify statutes in the U.S.C. In 2013, the codified version of the National Security Act in chapter 15 of title 50 was recodified in the U.S.C.[720] In accordance with the current citation, this final rule modifies 45 CFR 164.512(k)(2) to change the citation for the National Security Act from 50 U.S.C. 401, *et seq.* to 50 U.S.C. 3001, *et seq.*

For consistency and clarity, in the NPP provisions we are modifying ''sponsor of the plan'' to ''plan sponsor'' at 45 CFR 164.520(b)(1)(iii)(B).[721]

Finally, we use the terms ''the'' and ''an'' before the term ''individual'' throughout 45 CFR 164.524. Generally, we use the term ''an'' at the beginning of a provision, while ''the'' refers back to the original individual referenced in the provision. This final rule makes such changes for clarity to change the term ''the'' to ''an'' before the term ''individual'' in 45 CFR 164.524(c)(1), 164.524(c)(2)(i), 164.524(c)(2)(iv)(A), 164.524(c)(3), 164.524(c)(4), and 164.524(e). In 45 CFR 164.524(c)(1) we changed the term ''them'' to ''an individual.''

V. Regulatory Impact Analysis

The Department has examined the impact of the final rule as required by Executive Order (E.O.) 12866 on Regulatory Planning and Review,[722] E.O. 13563 on Improving Regulation and Regulatory Review,[723] E.O. 13132 on Federalism,[724] E.O. 13175 on Consultation and Coordination with Indian Tribal Governments,[725] E.O. 14192 on Unleashing Prosperity Through Deregulation,[726] the Congressional Review Act (CRA),[727] the Unfunded Mandates Reform Act of 1995 (UMRA),[728] the Regulatory Flexibility Act (RFA),[729] E.O. 13272 on Proper Consideration of Small Entities in Agency Rulemaking,[730] the Assessment of Federal Regulation and Policies on Families,[731] and the Paperwork Reduction Act of 1995 (PRA).[732]

A. E.O. 12866 and E.O. 13563 and Related Executive Orders on Regulatory Review

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits.

This final rule is deregulatory. The Department has estimated that the effects of the requirements for covered entities[733] will result in new costs of $783.98 million within 12 months of implementing the final rule, in 2025 dollars. The Department estimates that these first-year costs will be offset by recurring cost savings of $798.13 million, followed by net savings of $702.75 million annually in years two through five, resulting in overall undiscounted net cost savings of $2,825.15 million over 5 years. The Department estimates that this final rule will generate $0.54 billion in net annualized savings at a 7 percent discount rate over a perpetual time horizon, in 2025 dollars.

The Department estimates that the private sector will bear approximately 60 percent of the costs, with state and Federal health plans bearing the remaining 40 percent of the costs. All of the cost savings experienced from the first year through subsequent years will benefit covered entities. Because of the economic effects, this rule is an economically significant regulatory action within the meaning of section 3(f)(1) of E.O. 12866. Accordingly, the Office of Management and Budget (OMB) has reviewed this rule. Because the rule has an annual effect on the economy of $100,000,000 or more, it is also a major rule, as defined by the CRA.[734] The Department presents a detailed analysis below.

1. Summary of Costs and Benefits

The Department estimates that the regulatory changes described in the preamble will result in quantified costs of approximately $1 billion and numerous and substantial deregulatory benefits in the form of quantified cost savings of approximately $4 billion. Additionally, the Department believes the modifications in this final rule will result in numerous unquantified benefits, including all of the following:

- Improved health outcomes because of better care coordination and case management.
- Greater understanding by individuals of their rights and the privacy practices of covered entities.
- Enhanced access to care.
- Quicker, more convenient access to protected health information (PHI) by individuals.
- Fewer disputes about access fees because of increased transparency about such fees.
- Expanded adoption and utilization of certified health information technology (health IT).
- Improved employment conditions and opportunities for workforce members of covered entities and business associates[735] who are deaf, hard of hearing, or deaf-blind, or who have a speech disability.
- Streamlined compliance with non-discrimination laws that require accessibility for individuals with disabilities.

The Department has identified four general categories of quantified costs arising from these regulatory changes, which generally relate to activities by covered entities, particularly health care providers and health plans:

- Administrative activities (non-recurring and recurring).
- Revising or creating policies and procedures, the Notice of Privacy Practices (NPP), and an access fee schedule.

[719] ''July 21, 1930: Creation of the Veterans Administration,'' U.S. Department of Veterans Affairs (Nov. 12, 2021), *https://department.va.gov/history/featured-stories/va-created/.*

[720] ''Editorial Reclassification Title 50, United States Code,'' Office of the Law Revision Counsel, U.S. House of Representatives (last accessed Mar. 2, 2026), *https://uscode.house.gov/editorial reclassification/t50/index.html.*

[721] *See* Public Law 93–406, 88 stat. 835 (Sept. 2, 1974) (codified at 29 U.S.C. 1002) (definition of ''plan sponsor'' in Employee Retirement Income Security Act of 1974).

[722] 58 FR 51735 (Oct. 4, 1993).

[723] 76 FR 3821 (Jan. 21, 2011).

[724] 64 FR 43255 (Aug. 10, 1999).

[725] 65 FR 67249 (Nov. 9, 2000).

[726] 90 FR 9065 (Feb. 6, 2025).

[727] Sec. 251 of Public Law 104–121, 110 Stat. 868 (Mar. 29, 1996) (codified at 5 U.S.C. 801–808).

[728] Public Law 104–4, 109 Stat. 48 (Mar. 22, 1995) (codified at 2 U.S.C. 1531–1538).

[729] Public Law 96–354, 94 Stat. 1164 (Sep. 19, 1980) (codified at 5 U.S.C. 601–612).

[730] 67 FR 53461 (Aug. 16, 2002).

[731] Sec. 654 of Public Law 105–277, 112 Stat. 2681–528 (Oct. 21, 1998) (codified at 5 U.S.C. 601 note).

[732] Public Law 104–13, 109 Stat. 163 (May 22, 1995).

[733] 45 CFR 160.103 (definition of ''Covered entity'').

[734] *See* 5 U.S.C. 804(2).

[735] *See* 45 CFR 160.103 (definition of ''Business associate'').

- Modifying training programs for workforce members.
- Non-recurring and recurring costs to provide individuals with a copy of the NPP, including individuals who are inmates.[736]

TABLE 1—ESTIMATED 5-YEAR COSTS AND COST-SAVINGS, UNDISCOUNTED, IN MILLIONS

	Amount
Costs	
Revise Training	$148.02
Revise Policies and Procedures, NPP, and Fee Schedule	$483.38
Administrative Activities	$502.41
Distribute NPP	$31.67
Total Costs	**$1,165.48**
Cost Savings	
Eliminate NPP Acknowledgment	$3,990.63
Total Cost Savings	**$3,990.63**
Net Total (negative = savings)	**-$2,825.15**

Table 2 reports quantified costs and benefits over 5 years.

TABLE 2—ACCOUNTING TABLE OF ESTIMATED BENEFITS AND COSTS OF ALL CHANGES, IN MILLIONS (2025 DOLLARS)

Costs	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Undiscounted	$783.98	$95.37	$95.37	$95.37	$95.37	**$1,165.48**
3% Discount	$761.15	$89.90	$87.28	$84.74	$82.27	**$1,105.34**
7% Discount	$732.69	$83.30	$77.85	$72.76	$68.00	**$1,034.61**
Cost Savings	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Undiscounted	$798.13	$798.13	$798.13	$798.13	$798.13	**$3,990.63**
3% Discount	$774.88	$752.31	$730.40	$709.12	$688.47	**$3,655.18**
7% Discount	$745.91	$697.11	$651.51	$608.89	$569.05	**$3,272.47**
Net (undiscounted)						**Savings $2,825.15**

Table 3 reports the present value and annualized estimates of costs, cost savings, and net cost savings of this final rule covering a 5-year time horizon. Using a 7 percent discount rate, the Department estimates that this final rule will result in annualized costs of $252.33 million, annualized cost savings of $798.13 million, and annualized net cost savings of $545.79 million. Using a 3 percent discount rate, the Department estimates this final rule will result in annualized costs of $241.36 million, annualized cost savings of $798.13 million, and annualized net cost savings of $556.77 million.

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[736] 45 CFR 164.501 (definition of ''Inmate'').

TABLE 3—ACCOUNTING TABLE (2025 $ MILLIONS) FOR 5-YEAR PERIOD 2026-2030

Category	Primary estimate	Discount rate (%)
Costs, present value	$1,165.48	Undiscounted
Costs, present value	1,034.61	7
Costs, present value	1,105.34	3
Annualized Costs	233.10	Undiscounted
Annualized Costs	252.33	7
Annualized Costs	241.36	3
Cost Savings, present value	3,990.63	Undiscounted
Cost Savings, present value	3,272.47	7
Cost Savings, present value	3,655.18	3
Annualized Cost Savings	798.13	Undiscounted
Annualized Cost Savings	798.13	7
Annualized Cost Savings	798.13	3
Net Cost Savings, present value	2,825.15	Undiscounted
Net Cost Savings, present value	2,237.86	7
Net Cost Savings, present value	2,549.85	3
Annualized Net Cost Savings	565.03	Undiscounted
Annualized Net Cost Savings	545.79	7
Annualized Net Cost Savings	556.77	3
Transfers to Individuals, present value	7.35	Undiscounted
Transfers to Individuals, present value	6.03	7
Transfers to Individuals, present value	6.74	3
Annualized Transfers to Individuals	1.47	Undiscounted
Annualized Transfers to Individuals	1.47	7
Annualized Transfers to Individuals	1.47	3

The regulatory changes likely will result in important benefits that the Department is unable to fully quantify at this time. The resulting benefits are summarized in Table 4.

TABLE 4—NON-QUANTIFIED COSTS/BENEFITS FOR COVERED ENTITIES AND INDIVIDUALS

Regulatory Changes	Costs	Benefits
Modifying definition of health care operations and clarifying disclosures permitted to social services agencies for certain purposes	Potential increase in requests for disclosures for certain care coordination and case management purposes	Improved health outcomes because of better care coordination and case management
Modifying requirements for identity verification		Improved access for individuals to their PHI
Adding permission to disclose PHI to Telecommunications Relay Services (TRS) and excluding TRS providers from the definition of business associate		Improved employment conditions and opportunities for workforce members who are deaf, hard of hearing, or deaf-blind, or who have a speech disability; compliance with non-discrimination laws
Adding right for individuals to discuss covered entity's privacy practices, eliminating requirement to acknowledge receipt of NPP, modifying NPP content requirements, and requiring provision of NPP to incarcerated individuals		Greater understanding of individuals' rights and covered entities' privacy practices; enhanced trust in the health care system
Strengthening right of access (free access using an internet-based method, decreased wait times for access, and information about access fees)		Improved access to PHI for individuals—receiving PHI more quickly; fewer disputes about access fees; increased certainty about allowable fees; expanded ability to use health IT
Restricting the right of access to direct a covered entity to transmit PHI in an electronic health record to a person designated by the individual ("right of access to direct")	Increased burden on individuals to submit two forms—an access request and an authorization—when seeking to send a complete designated record set (electronic and non-electronic) to a person they designate	Improved clarity and certainty for covered entities about the scope of the right of access to direct

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In addition to quantified costs and cost savings, the Department estimates that there is likely a monetary transfer attributable to this final rule. The Department estimates that the adjustments to costs that can be charged to individuals for copies of PHI in an electronic health record on electronic media will result in an estimated annual monetary transfer from covered entities to individuals of $1.47 million.

2. Baseline Conditions

The cost-benefit analysis in this final rule adopts in part the cost-benefit analysis in the 2021 Proposed Modifications to the [Health Insurance Portability and Accountability Act of 1996 (HIPAA)] Privacy Rule To Support, and Remove Barriers to, Coordinated Care and Individual Engagement notice of proposed rulemaking (NPRM) (''2021

Privacy Rule NPRM'').[737] The Department has modified and updated its cost-benefit analysis for the following reasons:

- To account for the smaller subset of 2021 proposed changes that we are finalizing.
- To incorporate certain proposals to modify the Privacy Rule included in the 2022 NPRM to modify 42 CFR part 2 (''2022 Part 2 NPRM'').[738]
- To incorporate updated wage and industry data.

The Regulatory Impact Analysis (RIA) explains and describes changes from the analysis in the 2021 Privacy Rule NPRM below.

a. Analytic Assumptions

The Department relies on Bureau of Labor Statistics (BLS) 2025 wage data.[739] See Table 5. All calculations that use mean hourly wages include benefits and overhead by multiplying the mean hourly pay for an occupation by two.

TABLE 5—OCCUPATIONAL PAY RATES

Occupational code and title[a]	Benefit loaded hourly labor wage[b]
23-1011 Lawyers	$178.70
13-1151 Training and Development Specialists	72.64
29-2072 Medical Records Specialists	54.60
29-1141 Registered Nurses	97.52
15-1254 Web Developers	94.98
43-9061 Office Clerks, General	44.64
11-9111 Medical and Health Services Managers	135.54
29-0000 Healthcare Practitioners and Technical Occupations	104.52

[a] To update wage data from the 2021 Privacy Rule NPRM to 2025 data, the Department implements the following changes because of revisions to the BLS occupational categories: 1) Replaces "29-2098 Medical Dosimetrists, Medical Records Specialists, and Health Technologists and Technicians, All Other" with "29-2072 Medical Records Specialists;" 2) Replaces "15-1134 Web Developer and Digital Interface Designer" with "15-1254 Web Developers;" and 3) Replaces "43-4171 Receptionists and Information Clerks" with "43-9061 Office Clerks, General."

[b] To incorporate employee benefits, these figures represent a doubling of the BLS mean hourly wage.

b. Covered Entities

This final rule applies to covered entities.[740] The Department uses the most recent Census data (year 2022) and industry data about pharmacy establishments, and the same methodology adopted in the 2021 Privacy Rule NPRM, to calculate that there are 847,506 covered entities' business establishments. See Table 6.[741]

[737] 86 FR 6446 (Jan. 21, 2021).

[738] 87 FR 74216 (Dec. 2, 2022).

[739] ''Occupational Employment and Wage Statistics (OEWS) Tables,'' Bureau of Labor Statistics, U.S. Department of Labor (May 2025), *https://www.bls.gov/oes/tables.htm.*

[740] The term ''covered entity'' includes health plans, health care clearinghouses, and most health care providers. Only certain provisions of the Privacy Rule apply to clearinghouses in their role as covered entities. Certain other provisions apply to clearinghouses in their role as business associates of other covered entities. *See* 45 CFR 164.500(b) and (c). Because the provisions addressed in this rule generally do not apply directly to clearinghouses, the Department does not anticipate that they will experience an increase in costs from the changes made by this final rule.

[741] *See* ''2022 Statistics of U.S. Businesses (SUSB) Annual Data Tables by Establishment Industry,'' United States Census Bureau (Apr. 2025), *https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html.*

TABLE 6—COVERED ENTITIES

NAICS[a] code	Type of entity	Firms	Establishments
524114	Direct Health and Medical Insurance Carriers	1,071	6,220
524292	Third Party Administrators	431	1,347
622	Hospitals	3,136	7,713
44611	Pharmacies and Drug Stores	18,857	56,910
6211-6213	Office of Drs. & Other Professionals	431,216	542,844
6215	Medical and Diagnostic Laboratories	9,025	19,810
6214	Outpatient Care Centers	28,324	59,802
6219	Other Ambulatory Health Care Services	11,317	16,715
623	Nursing and Residential Care Facilities	43,215	95,137
6216	Home Health Care Services	28,198	39,117
532283	Home Health Equipment Rental	485	1,891
Total		**575,275**	**847,506**

[a] North American Industry Classification System (NAICS) codes are six-digit industry identifiers used by Federal agencies to classify businesses for economic data analysis.

According to 2022 Census data, there are 1,071 Direct Health and Medical Insurance Carrier firms among the 6,116 Insurance Carrier firms (NAICS Code 5241); health and medical insurance firms make up 17.5 percent of insurance firms. Also, according to Census data, there are a total of 2,467 Third Party Administration of Insurance and Pension Funds firms (NAICS code 524292) with 7,693 establishments.[742] The Department assumes that 17.5 percent of these firms and establishments serve health and medical insurance because, although the Census does not specify what percentage of Third Party Administration firms and establishments are related to health care, it is reasonable to apply the same proportion as for insurance firms and establishments. Thus, in Table 6, the Department computes that this rule affects 431 of these firms (17.5 percent of 2,467) and their 1,347 associated establishments (17.5 percent of 7,693).

There were 56,910 community pharmacies (Census reports 18,857 pharmacy and drug store firms) operating in the U.S. in 2022.[743]

While certain changes will affect some health care providers and health plans differently than they affect others, all affected covered entities will need to adopt or modify some policies and procedures and re-train some employees. Affected entities include Federal, state, local, tribal, and private sector providers of health care. Because this final rule primarily affects covered entities, the Department does not calculate separately the effects of estimated costs and cost savings on business associates. To the extent that covered entities engage business associates to perform activities affected by this final rule, the Department logically anticipates that any additional costs are borne by the covered entities through their contractual agreements with business associates.

c. Individuals Affected

The Department believes that a large proportion of the approximately 343 million individuals in the United States[744] will be affected by this final rule because most individuals, even individuals who do not have health insurance or do not visit a health care provider this year, have some contact with at least one covered entity in a given year. The primary effect of the final rule on individuals will result from the modifications to the right of access, which will affect the speed of access, the fees that may be charged for access, and notice of those fees. Individuals also will be affected by an increase in disclosures for care coordination and case management to third parties, such as social services agencies, community-based support organizations, and home and community-based service providers. Eliminating the requirement for a covered health care provider to make a good faith effort to obtain a signed acknowledgment of receipt of the NPP, and replacing it with the right of an individual to discuss a covered entity's NPP, will affect nearly all individuals who receive services from a health care provider.

Individuals who are inmates and receive health care from covered health care providers will be affected by their inclusion in the right of an individual to receive an NPP at their first visit with a new health care provider. The Department provides details of the calculated estimate of the costs of this modification in section V.A.3.a.iv. below.

An express regulatory permission for workforce members to disclose PHI to a TRS communications assistant will have the greatest effect on the estimated 170,000 individuals employed in the health care sector who are deaf, hard of hearing, or deaf-blind,[745] as well as sector employees who have a speech disability.

3. Estimated Costs, Cost Savings, and Transfers Arising From Finalized Changes

Below, the Department provides the basis for the estimated quantified costs

[742] Each business organization consists of one firm that has one or more establishments (*i.e.,* places of business).

[743] ''2022 NCPA Digest, sponsored by Cardinal Health,'' The National Community Pharmacists Association, p. 9, Table 5 (2022), *https://ncpa.org/sites/default/files/2022-09/2022-Digest.pdf.*

[744] ''U.S. and World Population Clock,'' United States Census Bureau (last accessed Aug. 17, 2026), *https://www.census.gov/popclock/.*

[745] *See* ''Building Pathways to Health Care Careers for the Deaf and Hard-of-Hearing Community, Final Report,'' Task Force on Health Care Careers for the Deaf and Hard-of-Hearing Community, p. 14, 79, Table 4 (Mar. 2012), *https://www.rit.edu/ntid/sites/rit.edu.ntid/files/deafhub/taskforcereport2012.pdf; see also* Christopher J. Moreland, et al., ''Deafness Among Physicians and Trainees: A National Survey,'' Academic Medicine (Feb. 2013), *https://academic.oup.com/academicmedicine/article-abstract/88/2/224/8351869?redirectedFrom=fulltext.*

and savings resulting from the modifications to the Privacy Rule. These estimated quantified costs and savings are based on assumptions formed from the experience of the Office for Civil Rights with enforcement of the Privacy Rule, anecdotal reports from stakeholders, and public comments on the 2021 Privacy Rule NPRM and the 2022 Part 2 NPRM.

For the total annual number of access requests received by covered entities, this analysis adopts certain estimates from a survey commissioned by a trade association that responded to the request for comments on the 2021 Privacy Rule NPRM's assumptions [746]— estimates that are much greater than those in the proposed rule. See Table 7. This survey relied on responses from a sample of nearly 60 percent of association members who received 25 percent of total annual requests for copies of PHI, according to the survey's authors.

TABLE 7—ESTIMATED NUMBER OF ANNUAL REQUESTS FOR COPIES OF PHI, BY RECIPIENT[a]

Recipient of PHI copies	Number of PHI requests
Individuals	4,802,000[b]
Health Care Providers and/or Health Plans	24,108,000[c]
Designated Persons other than Providers and/or Plans	15,386,000[d]
Total	**44,296,000**

a. The figures in the table are based on an estimated total of 98 million annual requests for copies of PHI and adopt percentages presented in the association-sponsored study, which excluded 54.8 percent of requests (or 53.70 million) as unrelated to the right of access or the right of access to direct.
b. 4.9 percent of 98 million.
c. 24.6 percent of 98 million.
d. 15.7 percent of 98 million. This figure is used as a proxy for requests pursuant to the right of access to direct.

In addition to an estimate of total annual requests for copies of PHI, the survey included detailed quantitative estimates for the type of recipient, type of sender (a covered entity or a release of information company on behalf of a covered entity), PHI format (*i.e.,* paper, electronic PHI (ePHI) in an EHR,[747] and ePHI not in an EHR), and average fee per request. These estimates are largely consistent with estimates provided by other commenters.[748]

The survey provided data on the proportion of requests to send PHI to third parties other than health plans and health care providers in three formats: paper (8.7 percent); in an EHR (84.4 percent); and non-EHR electronic (6.8 percent). The Department applied these percentages to the 15.39 million requests to direct PHI to a person designated by the individual other than providers and/or health plans (in Table 7 above) to determine that 84.4 percent of requests (nearly 13 million) are for ePHI in an electronic health record and 6.8 percent of the 15.39 million requests are for ePHI that is not in an electronic health record (1 million). We do not have data to estimate the proportion of requests made pursuant to the right of access to direct that are for ePHI in an electronic health record and involve sending the copies via a non-internet-based method.

a. Quantified Costs to Covered Entities

The Department quantifies four categories of estimated costs arising from this final rule:

- Administrative activities [749] (non-recurring and recurring).
- Revising or creating policies and procedures, the NPP, and an access fee schedule.
- Revising training programs for workforce members.
- Distributing the NPP.

The Department estimates costs and cost savings for most activities attributable to this final rule using the equation below: [750]

Labor costs = fully loaded hourly wage (in 2025 dollars) × time (in hours) to perform regulatory requirement × number of instances the regulatory requirement is performed each year

i. Administrative Activities

Table 8 quantifies the additional estimated administrative non-recurring costs that covered entities will incur in the first year of implementing changes in this final rule.[751] This table does not include the costs for implementing proposals to require covered entities to print (and sometimes send) individualized fee estimates and itemized lists of copying charges,[752] which were reported as capital costs in the 2021 Privacy Rule NPRM, because those proposals are not being finalized.

[746] The commenter's members are release of health information companies.

[747] For purposes of this final rule, we use the term ''EHR'' to refer to the commonly understood meaning of the term; *i.e.,* a system that stores electronic health information across different health care settings. We use the term ''electronic health record'' when referring to the term defined in the HITECH Act and this final rule. *See* 42 U.S.C. 17921(5) (definition of ''Electronic health record''); 45 CFR 164.501 (definition of ''Electronic health record'').

[748] These commenters provided quantitative data estimates on a more limited set of issues than the association-sponsored survey. The survey also specifies how its estimates correspond to the estimates in the 2021 Privacy Rule NPRM. (Other commenters typically did not.)

[749] As used in this RIA, this term primarily applies to activities related to changes in the right of access.

[750] The Department estimates limited non-labor costs (paper, toner, and envelope and stamps as needed) to: (i) make fee schedules available at the point of service and upon request; (ii) distribute NPPs to individuals who are inmates; and (iii) provide NPPs to health plan subscribers. These costs represent an insignificant proportion of total costs of the final rule: about 1.7 percent in the first year; and 0.02 percent in subsequent years.

[751] The Department increased the estimated time to post each document online from 10 minutes to 15 minutes to align with the estimate in the 2024 Privacy Rule for posting documents online.

[752] *See* 86 FR 6446, 6517, (Jan. 21, 2021), Table 12b; proposed 45 CFR 164.525.

TABLE 8—NON-RECURRING ADMINISTRATIVE ACTIVITIES COSTS (2025 MILLION DOLLARS)

One-time cost	Burden count	Multiplier	Total administrative costs (millions)
Post access fee schedule online	15 min. x Web Developer ($94.98) = $23.75.	Total covered entities (847,506)	$20.12
Post revised NPP online	15 min. x Web Developer ($94.98) = $23.75.	Total covered entities (847,506)	$20.12
Total One-Time Administrative Burden			**$40.25**[a]

[a] Discrepancies in the total result from rounding.

Table 9 quantifies the recurring labor and capital [753] costs that the Department anticipates covered entities will incur for administrative activities that are included in the final rule.[754] The multipliers for the first three rows in Table 9 contain data from or associated with the estimated number of access requests for PHI in Table 7. These multipliers are substantially higher than the corresponding multipliers in the 2021 Privacy Rule NPRM [755] and incorporate information from commenters and Department assumptions. We adopt the approach taken in the 2021 Privacy Rule NPRM of increasing estimated costs for providing access within a shorter period of time by 1 minute of labor per request; however, in this final rule we are applying this approach equally to requests made pursuant to the right of access to direct. While one commenter reported that responding to requests made pursuant to the right of access to direct takes approximately 10 times the labor hours that the Department estimates (3–5 minutes), another commenter stated that in most cases, patients and other health care providers receive requested PHI in a matter of minutes. Some release of information firms stated that they generally respond to requests for copies of PHI in fewer than 15 days, which is consistent with the requirement in the final rule to provide access ''as soon as practicable'' and ''no later than 15 days.'' Given the variability in commenters' responses, the Department believes the approach used to estimate the burden hours for providing copies of PHI pursuant to the right of access (*i.e.,* adding an incremental labor burden) is reasonable. However, we also recognize that there are burdens associated with the right of access to direct that we did not previously acknowledge and are allocating 3 minutes per request as a previously unacknowledged burden on covered entities for the right of access to direct. See section V.G of this analysis.

[753] *See* 90 FR 15792, 15893 (Apr. 15, 2025) for the basis of our capital costs estimates.

[754] The proposed cost items that are excluded from the final rule are: ''Providing good faith fee estimates upon request''; ''Providing itemized list of access and authorization fees upon request''; and ''Submitting access requests to providers & plans for individuals.'' *See* 86 FR 6446, 6516, (Jan. 21, 2021), Table 12a.

[755] 86 FR 6446, 6516 (Jan. 21, 2021), Table 12a.

TABLE 9—RECURRING ADMINISTRATIVE ACTIVITIES COSTS (2025 MILLION DOLLARS)

Recurring Costs	Burden Hours & Pay or Capital Cost	Multiplier	Total Annual Cost (Millions)
Access for individuals in less time—Search and retrieval	1 min. x Medical Records Specialists time ($54.60) = $0.91	4,802,000 access requests	$4.37
Sending copies of ePHI to persons other than covered entities pursuant to the right of access to direct in less time—Non-internet-based method	1 min. x Medical Records Specialists time ($54.60) = $0.91	91.3% of 15,386,000 access requests = 14,046,078[a]	$12.78
Sending copies of ePHI to health plans and providers pursuant to the right of access to direct in less time—Non-internet-based method	1 min. x Medical Records Specialists time ($54.60) = $0.91	25% of 24,108,000 access requests = 6,027,000	$5.48
Discussing privacy practices with individuals upon request	7 min. x Registered Nurses time ($97.52) = $11.38	1% of 613,000,000 1st time encounters = 6,130,000	$69.74
Making fee schedule available at the point of service and upon request	2-page document printed on 1 sheet of paper = $0.021	3 copies for each of 847,506 covered entities = 2,542,518	$0.05
Total Annual Recurring Administrative Costs			**$92.43**

[a] Discrepancies in the total result from rounding.

The total estimated first year costs (including costs that will be recurring) for administrative activities are approximately $132.68 million (Table 8 total and Table 9 total).

ii. Costs for Revising Policies and Procedures

Table 10 quantifies non-recurring costs for covered entities to revise their policies and procedures to comply with the modifications made by this final rule. The Department also includes revising the NPP in this category because the labor costs for all these activities are attributable to the same occupation, a lawyer.

TABLE 10—COSTS FOR REVISING POLICIES AND PROCEDURES (2025 MILLION DOLLARS)

Revising policies & procedures	Time (mins.)	Covered entities affected	Burden hours
Disclosures for Care Coordination & Disclosures to Social Services Agencies & Community-Based Organizations	50	847,506	706,255
Right of Access	70	847,506	988,757
NPP (Revision)	60	847,506	847,506
Disclosures for Uniformed Services & TRS	10	847,506	141,251
Identity Verification	30	5% of 847,506 = 42,375	21,188
Total Burden Hours			**2,704,957**
Total Costs	1 hour of Lawyer's time ($178.70) * 2,704,957		**$483.38 million**

As compared to the 2021 Privacy Rule NPRM,[756] the estimated time to revise policies and procedures related to care coordination is reduced from 75 to 50 minutes because the Department is not finalizing modifications to the minimum necessary standard. Additionally, the estimated time to revise policies and procedures related to the right of access is reduced from 180 to 70 minutes because only a portion of the proposed modifications are being finalized. Specifically, covered entities will not be required to create or revise policies and procedures for the following proposals that are not being adopted:

- A right to inspect copies of PHI in person during a health care visit.
- A right to request that a health care provider forward an access request to another provider or health plan.
- A requirement to provide an individualized estimate of fees for copies of PHI.
- A requirement to provide an itemized list of costs for requested copies of PHI.

Finally, because the Department is not finalizing proposals addressing disclosures of PHI to family and friends of individuals and disclosures of PHI to prevent harm, we no longer include the corresponding non-recurring labor costs to revise related disclosure policies and procedures. This results in a reduction in labor of 60 minutes per covered entity (limited to health care providers) compared to the proposed rule.

In all other aspects (remaining time estimates, 5 percent estimate regarding covered entities expected to simplify verification and revise policies and procedures), Table 10 reflects the estimates in the 2021 Privacy Rule NPRM for revising HIPAA policies and procedures.[757]

iii. Training Costs

Table 11 quantifies non-recurring costs for revising HIPAA training programs.

[756] 86 FR 6446, 6517 (Jan. 21, 2021), Table 13.

[757] *See, e.g.,* 86 FR 6446, 6517 (Jan. 21, 2021), Table 13.

TABLE 11—COSTS FOR REVISING HIPAA TRAINING PROGRAMS (2025 MILLION DOLLARS)

Training content to be revised	Time (mins.)	Covered entities affected	Burden hours
Disclosures for Care Coordination, Disclosures to Social Services Agencies & Community-Based Organizations	40	847,506	565,004
Right of Access	80	847,506	1,130,008
Disclosures for Uniformed Services & TRS	15	847,506	211,877
Right to Discuss NPP	5	847,506	70,626
Identity Verification	10	5% of 847,506 = 42,375	7,063
Total Time to Update Training Content			1,984,577
Total Costs	1 hour of Training Specialists time = $72.64 * 1,984,577		**$144.16 million**

The Department is reducing the estimated time for a training specialist to update a covered entity's HIPAA training program, as compared to the 2021 Privacy Rule NPRM, because we are finalizing only some of the corresponding proposals. Accordingly, we have removed 20 minutes of labor for revising the training on the minimum necessary standard and removed 70 minutes of labor for revising the training to reflect multiple proposals to modify the right of access. Training will not be required to address proposed modifications that are not being adopted, namely, the proposals to:

- Expand the right to inspect copies of PHI in person to include viewing and recording PHI in conjunction with a health care visit.
- Add a right to request that a health care provider forward an access request to another provider.
- Require that a covered entity provide an individualized estimate of fees for copies of PHI.
- Require a covered entity to provide an itemized list of costs for copies of PHI.

Finally, because the Department is not finalizing proposals addressing disclosures of PHI to family and friends of individuals or to prevent harm, the Department no longer includes the corresponding labor costs to revise related training.

For all other components of the cost analysis for training (*i.e.,* remaining time estimates, 5 percent estimate of covered entities expected to change ''verification of identity'' procedures), Table 11 reflects the estimates in the 2021 Privacy Rule NPRM.

The Department also estimates non-recurring costs that will be incurred in the first year for training medical records specialists to implement changes to the right of access procedures as follows. On average, for each of the 847,506 covered entities, a medical records specialist will spend 5 additional minutes in training on this set of changes. These 70,626 hours for training workforce members correspond to $3.86 million non-recurring costs in 2025 dollars, based on the hourly wage in Table 5.

In total, additional non-recurring training costs attributable to changes in the final rule are $148.02 million in 2025 dollars.

iv. Distributing the NPP

Providing the NPP to Individuals Who Are Inmates

This final rule removes paragraph (a)(4) from 45 CFR 164.520, which excepts inmates in correctional institutions from the right to receive a copy of the NPP and excepts correctional institutions that are covered entities from the obligation of providing it. The Department requested comments about this proposal and did not receive any that addressed quantified costs for implementing it, although one commenter asserted that the proposal would add to workflow without any benefit. The Department is finalizing a new right for individuals who are inmates to receive a copy of an NPP and including an estimate of the costs for covered health care providers to provide such copies in person. We understand that contractors that provide health care in prisons and jails generally serve two roles: (1) managing a provider network and (2) handling claims for payments. To the extent that the contractor is a single covered entity, only one NPP is required. Where the contractor's business arrangements rely on separate covered entities to perform different functions, a joint NPP likely would be sufficient.[758] Thus, the cost estimates include only one NPP per individual who receives health care while an inmate in a correctional institution.

The Department anticipates that individuals who are newly admitted to prisons and jails will receive a two-page double-sided printed copy of the NPP during their first health care encounter, as will individuals who are already incarcerated when the rule becomes effective, likely upon their next visit to a covered health care provider. The Department estimates that distributing each NPP costs $0.972: $0.042 in paper and toner[759] and $0.930 in labor costs.[760] This totals approximately $4 million in year one for distributing an NPP to individuals who are inmates[761] and $3 million annually for this modification in years two through five.

The Bureau of Justice Statistics (BJS) reported that in 2023, there were 472,000 new admissions to prisons and

[758] *See* 45 CFR 164.520(d) (allowing joint notice for organized health care arrangements).

[759] *See* 90 FR 15792, 15893 (Apr. 15, 2025).

[760] One minute and 15 seconds of an office clerk's time at $44.624/hour in 2025 dollars.

[761] The non-recurring portion of the estimated cost in the first year is $1,185,193.

7,627,000 new admissions to jails.[762] The BJS reported that there were 1,230,000 individuals in prison as of the last day of the previous year, and 663,100 inmates in jails as of the last day of the previous year.[763]

At the high end, the Department assumes that during the first year, each individual who is a new inmate has a health care visit with a covered health care provider, as do individuals who were inmates on the last day of the previous year. While theoretically possible, there are several reasons why this scenario is unlikely to happen and the number of distributed NPPs will be lower in practice, as explained further below.

In the first year, the Department estimates that at the high end, costs for these new activities will be $9,712,321,[764] while annual costs in years two through five will be $7,872,228.[765] These estimates include labor and costs of paper and printing the NPPs. This likely is an overestimate for at least three reasons. First, some of the health care provided to individuals who are inmates is paid for directly by correctional facilities employing staff in prison or jail health clinics, rather than through electronic transactions using standards adopted under HIPAA.[766] Thus, only a portion of health care is provided by health care providers who are subject to HIPAA. Second, jail admission statistics include repeat offenders. The same individual who is admitted to the same jail multiple times in a year would receive only one NPP when the correctional institution health care provider's records show the individual is not a new patient. Third, unlike prisons that house persons who are serving sentences of longer than 1 year, individuals who are admitted to jails often are there for short periods of time and have less opportunity to receive health care, or may not need health care during that time period.[767]

The Department's low-end estimate accounts for these circumstances as follows. First, a recent study reports that 90 percent of jails contracted with private companies to provide health care.[768] The Department calculates its low-end estimates by assuming that only 85 percent of jails contract with private companies (slightly fewer than 90 percent), which implies that only 85 percent of new and current jail inmates will receive an NPP.

There is limited public information about the use by Federal prisons of covered health care providers; however, we do know that Federal prisons both employ workforce members and engage private companies to provide health care.[769] For its low-end estimates, the Department assumes that 85 percent of prisoners [770] in state prisons receive health care from covered health care providers, while 0 percent of Federal prisoners do. BJS reports that state prisons account for approximately 91 percent of new admissions to prison and 88 percent of individuals who are imprisoned at the end of the reporting year.[771] We estimate that 77 percent of individuals who are new inmates have rights under the Privacy Rule because they receive health care from a covered health care provider (weighted average of 85 percent and 0 percent); 74 percent is the percentage (average of Federal and state) of individuals in prison at the end of the year who have such rights.

Second, according to a recent study, ''[i]n 2023, there were 7.6 million jail admissions, but 1 in 4 of these admissions was someone returning to jail for at least the second time that year.'' For its low-end estimates, the Department assumes that unique jail inmates are 75 percent of the 85 percent of new jail inmates who have rights under HIPAA.

Third, the BJS reports that the average number of days an individual spent in jail was 31.8 in 2023, a number that is likely skewed upward by relatively few (about 30 percent) convicted individuals serving their sentence in jail, while the majority (70 percent) of individuals in jail are there for much shorter times.[772]

The BJS does not report detailed information about the distribution of the length of jail stay statistics. A recent study using data from a sample of jails reports that the median length of stay was 4 days.[773] The Department assumes that only individuals who spend more than 1 month in jail will receive a medical examination (and an NPP). The figures presented above imply that the fraction of jailed individuals whose stay is shorter than 1 month is greater than 50 percent and likely closer to 100 percent than 75 percent (the midpoint between the two). For its low-end estimate, the Department adopts an estimate that 80 percent of jailed individuals' stay is shorter than 1 month, and thus further reduces the counts of jailed individuals by that proportion (after reducing it to account for individuals who are admitted to jail multiple times and health care providers that are not covered entities).

Thus, at the low end, the Department estimates that individuals who are inmates will receive 2,330,628 NPPs at a $2,265,370 cost during the first year. The non-recurring portion of the estimated cost in the first year is $966,892, which reflects that, as compared to the high-end estimate, only 74 percent of individuals in prison and 12.75 percent of individuals in jail (85 percent × 75 percent × 20 percent) contribute to costs.

The recurring portions of the low-end estimates, which equal the estimates for the second year onward, are 1,335,883 NPPs and $1,298,478 in costs. These figures reflect that, as compared to the high-end estimate, only 77 percent of individuals in prison and 12.75 percent of individuals in jail (85 percent × 75 percent × 20 percent) contribute to costs.

For its primary estimate, the Department uses data from the

[762] *See* ''Prisoners in 2023—Statistical Tables,'' Office of Justice Programs, Bureau of Justice Statistics, U.S. Department of Justice, NCJ 310197 (Sept. 2025), *https://bjs.ojp.gov/document/p23st.pdf;* ''Jail Inmates in 2023—Statistical Tables,'' U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, U.S. Department of Justice, NCJ 309965 (Apr. 2025), *https://bjs.ojp.gov/document/ji23st.pdf.* Figures rounded to thousands of admissions. Jail statistics for the 12-month period ending on June 30, 2023.

[763] *Id.*

[764] $0.972 × 9,992,100, which is the sum of 8,099,000 new admissions and 1,893,100 year-end individuals who are inmates. The non-recurring portion of this amount is $1,840,093 ($0.972 × 1,893,100). Discrepancies in totals result from rounding.

[765] $0.972 × 8,099,000. Discrepancies in totals result from rounding.

[766] *See* Sec. 262(a) of Public Law 104–191, 110 Stat. 2021, adding sec. 1173(a) (codified at 42 U.S.C. 1320d–2(a)(1); *see also* 45 CFR 162.1101 *et seq.* and 162.1601 *et seq.*

[767] BJS also reports that people admitted to local jails spent an average of 32 days in custody before release.

[768] Jessica Carda-Auten, et al., ''Jail Health Care in the Southeastern United States from Entry to Release,'' The Milbank Quarterly, Vol. 100, No. 3, pp. 722–760 (May 3, 2022), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9576246/.*

[769] *See* ''Medical Care,'' Federal Bureau of Prisons, *https://www.bop.gov/inmates/custody_and_care/medical_care.jsp* (last accessed Mar. 9, 2026) (stating that the Federal Bureau of Prisons operates seven medical referral centers providing advanced care); *see also* ''Health Services Division,'' Federal Bureau of Prisons, *https://www.bop.gov/about/agency/org_hsd.jsp* (last accessed Mar. 9, 2026) (stating that the Federal Bureau of Prisons has over 3,000 health care positions).

[770] Here ''prisoners'' refers to individuals who are incarcerated in state and Federal prisons, as distinct from those who are held in jails.

[771] *See* ''Prisoners in 2023—Statistical Tables,'' Office of Justice Programs, Bureau of Justice Statistics, U.S. Department of Justice, NCJ 310197 (Sept. 2025), *https://bjs.ojp.gov/document/p23st.pdf.*

[772] *See* Zhen Zeng, ''Jail Inmates 2023—Statistical Tables,'' Office of Justice Programs, Bureau of Justice Statistics, U.S. Department of Justice, NCJ 309965 (Apr. 2025), *https://bjs.ojp.gov/document/ji23st.pdf.*

[773] Leah Wang, ''Jailing the homeless: New data shed light on unhoused people in local jails,'' Prison Policy Initiative Briefing (Feb. 11, 2025), *https://www.prisonpolicy.org/blog/2025/02/11/jail_unhoused_bookings/.*

Connecticut Department of Correction on individuals in jail to determine whether costs are likely closer to the low-end estimate.[774] The analysis shows that about 15 percent of new admissions to jail in any given year are for repeat offenders, which is closer to the 25 percent used in the low estimate than the 0 percent in the high estimate. The analysis shows that, when considering only the longest stay in jail for repeat offenders, about 50 percent of unique newly admitted individuals stay for 1 month or longer, which is closer to the 20 percent used in the low estimate than the 100 percent in the high estimate.

Thus, the Department's primary estimate is a weighted average of the low-end (75 percent) and high-end (25 percent) estimates. Based on the Department's primary estimate, individuals who are inmates will receive 4,245,996 NPPs at a $4,127,108 cost during the first year,[775] and 3,026,662 NPPs at a $2,941,915 cost in years two through five.

Providing the NPP to Health Plan Subscribers

The Department does not anticipate any new costs for covered health care providers associated with distribution of the revised NPP other than posting it on their websites (if they have one) because they have an ongoing obligation to provide the NPP to first-time patients that is already accounted for in cost estimates for the HIPAA Rules. Health plans that post their NPP online will incur minimal costs by posting the updated NPP and then including it in the next annual mailing to subscribers. Health plans that do not provide an annual mailing will incur the additional costs (capital and labor expenses) for mailing the revised NPP off-cycle.

Health plans that do not provide an annual mailing will potentially incur an additional $12,990,000 in capital expenses[776] for an off-cycle mailing of the revised NPP. The Department estimates that health plans will mail the NPP to an estimated 10 percent of the 150 million health plan subscribers who receive a mailed, paper copy of the NPP, as well as the labor expense for an office clerk at the rate shown in Table 5 to complete the mailing at a mailing rate of 240 NPPs per hour (15 seconds or 0.25 minutes per NPP), for $2,790,000 [= 62,500 hours × $44.64].

Total Costs of Distributing the NPP

The total costs of distributing the NPP to individuals who are inmates and to health plan subscribers are $19,907,108 in the first year and $2,941,915 in years two through five. These expenses include labor and capital costs.

v. Eliminating the NPP Acknowledgment

The final rule eliminates the requirement for covered health care providers who have a direct treatment relationship with an individual to make a good faith effort to obtain an acknowledgment from the individual that they received a copy of the NPP (or document the provider's efforts to obtain such acknowledgment) and adopts the estimated cost savings for approximately 613 million first time visits with health care providers annually.[777] As proposed in the 2021 Privacy Rule NPRM, the Department estimates a burden reduction because of the regulatory modifications in the amount of 1 minute and 45 seconds of labor at the hourly wage rate of an office clerk. One minute and 15 seconds of labor is retained for the act of providing a copy of the NPP. The final rule also replaces the wage rate of a general health occupations worker (used to calculate estimated costs for this requirement in the 2024 Privacy Rule) with that of a clerical worker.[778]

vi. Total Quantified Cost Savings

Table 12 summarizes the quantification of cost savings for covered entities and reports their value in 2025 dollars. This table eliminates the projected cost savings from creating an exception to the minimum necessary standard in 45 CFR 164.502(b).[779]

TABLE 12—RECURRING BENEFITS (LABOR COST SAVINGS, 2025 MILLION DOLLARS)

Cost item	Burden count	Multiplier	Savings (millions)
Eliminating NPP Acknowledgment	1 minute and 45 seconds (0.0292 hours) of Office Clerk, General time x $44.64 = $1.302	613,000,000 first-time encounters	$798.13
Total Annual Cost Savings			**$798.13**
Total Cumulative Cost Savings (5 years, undiscounted)			**$3,990.60**

[774] *See* ''Accused Pre-Trial Inmates in Correctional Facilities,'' State of Connecticut, Department of Corrections (2017–2025 data) (last accessed Mar. 9, 2026), *https://data.ct.gov/Public-Safety/Accused-Pre-Trial-Inmates-in-Correctional-Faciliti/b674-jy6w/about_data*.

[775] The non-recurring portion of the estimated cost in the first year is $1,185,193.

[776] *See* 90 FR 15792, 15893 (Apr. 15, 2025) for the basis of our capital cost estimates. We assume a 2-page, double-sided NPP to cost $.042 in paper and toner, an envelope to cost $0.044, and for the metered postage to cost $0.78 (as of Aug. 17, 2026). Accordingly, each NPP costs approximately $0.866, which is a high estimate given the availability of bulk postage rates for large volume mailings.

[777] 78 FR 5566, 5675 (Jan. 25, 2013).

[778] We are not adopting the proposal in the 2021 Privacy Rule NPRM to replace a general health occupations worker with a receptionist. *See* 86 FR 6446, 6514 (Jan. 21, 2021).

[779] *See* 86 FR 6446, 6515, (Jan. 21, 2021), Table 10.

b. Comparison of Quantified Costs and Benefits

The tables below present the Department's summary of estimated first year (Table 13) and ongoing (Table 14) quantified costs and cost savings.

TABLE 13— FIRST-YEAR ESTIMATED COSTS/COST SAVINGS (2025 MILLION DOLLARS)

Cost item	Costs	Savings
Revise Training	$148.02	
Revise Policies & Procedures	$483.38	
Administrative Costs	$132.68	
Distribute NPP	$19.91	
Eliminate NPP Acknowledgment		($798.13)
TOTAL	**$783.98**	**($798.13)**
NET SAVINGS/COST		**($14.15)**

TABLE 14—RECURRING ESTIMATED ANNUAL COSTS/COSTS SAVINGS (2025 MILLION DOLLARS)

Cost item	Costs	Set-off amount (savings)
Access & Administrative Costs	$92.43	
Distribute NPP	$2.94	
Eliminating NPP Acknowledgment		($798.13)
TOTAL	**$95.37**	**($798.13)**
NET SAVINGS/COST		**($702.75)**

c. Estimated Transfers From Modifications to Access Fees

As described below, the Department has revised estimates of monetary transfers resulting from changes to access fees by relying in part on quantitative data from a trade association that provided comments on the assumptions in the 2021 Privacy Rule NPRM.

Comment: One commenter submitted the results of a voluntary survey of members that it sponsored. The survey addressed the financial effects of the proposed rule, particularly modifications to the right of access to direct and allowable fees for the right of access to direct. According to the commenter, the results were based on data from responding members, who the commenter estimated were responsible for processing approximately 25 percent of the total number of requests for PHI annually. By extrapolating from the responses, the commenter then estimated the total number of requests for copies of PHI to be approximately 100 million annually. Other public comments on the 2021 Privacy Rule NPRM included estimates in the same order of magnitude—some as high as 200 million.

The total number of annual requests for copies of PHI represented in the survey included both requests made pursuant to the right of access and requests for disclosures based on authorizations, copies provided in all formats (electronic or not), and copies provided directly by health care providers and those provided by release of information companies on behalf of health care providers. According to the survey, the proposed changes would apply to only approximately 45 percent of requests (those made pursuant to the right of access). The percentages in the survey were consistent with estimates submitted in other public comments.[780]

The survey categorized the number of requests annually by type of person receiving the requested PHI (*i.e.,* individuals, health care providers or health plans, persons other than health care providers and health plans). It assumed that requests from health care providers or health plans were for treatment, care coordination, or payment and excluded those requests from the right of access category. The survey also categorized requests for copies of PHI by format (*i.e.,* ePHI in an electronic health record, ePHI not in an electronic health record, paper copies of PHI). According to the survey, almost 90 percent of all requests were for electronic copies of PHI in an electronic health record, and that percentage was increasing over time, while the other two formats were becoming increasingly rare. The percentages in the survey were consistent with percentage estimates provided by other commenters.[781]

Response: Based on public comments, the Department extrapolates the size of

[780] The survey reported that individuals, health care providers or health plans, and persons other than health care providers and health plans accounted for 11, 54, and 35 percent of requests, respectively. Another release of information company reported that disclosures to facilitate patient care accounted for 50 percent of the requests directed to one of its health care provider clients. An individual commenter asserted that 60–70 percent of requests received by his employer (a release of information company) were from health care providers requesting the transfer of PHI to facilitate care for individuals; another commenter reported that 50 percent of requests annually were to facilitate patient care.

[781] *Id.* Additionally, a commenter reported that fewer than 1 percent of requests were for paper records.

the total number of requests for copies of PHI from the figures provided in the survey described above and estimates a range between 78 and 171 million requests annually.[782] In addition to being consistent with other commenters' estimates, the Department believes that the survey correctly recognized that requests made pursuant to the right of access represent only about 45 percent of total requests for copies of PHI made annually, and thus the modifications made to fee limitations by this final rule cannot and do not apply to the majority of total requests for PHI.

Reducing the Expenses That Can Be Included in Calculated Access Fees for Providing Individuals With Copies of PHI in an Electronic Health Record on Electronic Media

The final rule prohibits a covered entity from charging an individual for the costs of electronic media and postage when providing access by mailing copies of PHI in an electronic health record on electronic media. The Department estimates that the costs of electronic media may range from $1 for a CD to $4 for a USB drive and the postage may range from $1 to $3, resulting in a range of estimated increased costs to covered entities of $2 to $7 per request of this type, or an average estimated increase of $4.50.

Based on the survey described above, the Department estimates that about 6.8 percent of the 4,802,000 copies of PHI that individuals receive annually will be subject to the fee limitations for sending copies on electronic media (or 326,863).[783] Thus, the Department estimates a total reduction in access fees paid by individuals of $1,470,883 because of this change. At the same time, these are payments that previously were revenue for covered entities (or their business associates), and thus may be considered a monetary transfer from covered entities to individuals, as reflected in Table 15.

Summary Results of the Department's Estimated Transfers Due to Fee Adjustments

The Department summarizes in Table 15 the estimated annual recurring monetary transfers that parties will experience because of changes in regulation.

TABLE 15—ESTIMATED ANNUAL TRANSFERS (2025 MILLION DOLLARS)

Monetary Change	Amount of monetary transfer (transferors)	Amount of monetary gain (transferees)
Decreased fees for providing electronic copies of PHI in an electronic health record on electronic media to individuals	$1.47 (covered entities, primarily providers)	$1.47 (individuals)

The Department estimates that individuals will benefit from an annual monetary transfer of $1.47 million from covered entities or their business associates as result of reductions in allowable fees for providing copies of PHI to individuals.

d. Costs Borne by the Department

The Department expects to incur costs related to disseminating information about the regulatory changes to covered entities, including health care providers and health plans. However, we expect that many of these costs will be included in the costs for the ongoing dissemination of guidance and other explanatory materials that the Department provides on the HIPAA Rules. The Department also expects to incur costs to enforce the final rule; however, these costs will be absorbed into the baseline budget for the ongoing enforcement of the Privacy Rule. The covered entities that are operated by the Department will be affected by the regulatory changes in a similar manner to other covered entities, and the Department has factored those costs into the estimates above.

e. Qualitative Analysis of Non-Quantified Benefits

The Department confirms the 2021 Privacy Rule NPRM's analysis of non-quantified benefits for the proposals that are being adopted in this final rule.

f. Uncertainty Analysis for Estimated Costs and Cost Savings

Below, the Department quantifies ranges for costs and cost savings for key compliance burdens. We perform an uncertainty analysis for each of the main drivers of costs and cost savings, reporting low, mid, and high values for each category, and for the final rule as a whole, to capture the range of potential outcomes.

In summary, the Department estimates that total costs of implementation over a 5-year period range from a low of approximately $0.63 billion to a high of approximately $4.93 billion and that the cost savings over that same 5-year period range from approximately $1.14 billion to approximately $6.65 billion.

[782] The annual number of access requests, as extrapolated from information provided by several commenters, varied from 171 million requests per year to 139 million, 136 million, and 78 million. The number of right of access requests annually as reported in the survey was approximately 20 times higher than the number estimated by the Department in the 2021 Privacy Rule NPRM (86 FR 6446, 6506 (Jan. 21, 2021), Table 6). The Department recognizes that larger studies provide stronger and more reliable results; a 25 percent sample relative to total number of requests for PHI (such as provided in the survey) is large by statistical standards.

[783] The survey reported that about 6.8 percent of access requests under the right of access to direct were for electronic records contained in systems that predate EHR systems. The Department believes it is reasonable to apply this same percentage to estimate that 6.8 percent of the 4,802,000 copies of PHI individuals receive annually will be subject to the proposed fee limitations for sending copies on electronic media (or 326,863). (The survey also reported that 8.7 percent of access requests under the right of access to direct were for paper records, and 84.4 percent were for electronic records in an EHR. Because of rounding, the three percentages sum to 99.9 percent (6.8+8.7+84.4=99.9 percent). The Department applied a mathematical correction to these percentages for accuracy.)

TABLE 16—RANGE OF TOTAL COSTS OVER 5 YEARS, 2025 DOLLARS[a]

Cost item	Low	Mid	High
Training	$130,056,576	$148,015,793	$166,746,240
Policies & Procedures	$376,939,119	$483,375,753	$904,434,863
Access & Administrative Tasks	$102,964,668	$502,411,896	$3,798,535,593
Distribute NPP	$23,239,281	$31,674,769	$56,981,233
TOTAL COSTS	**$633,199,644**	**$1,165,478,212**	**$4,926,697,929**

[a] Discrepancies in totals result from rounding.

TABLE 17—RANGE OF TOTAL COSTS SAVINGS OVER 5 YEARS, 2025 DOLLARS

Cost savings item	Low	Mid	High
Eliminating NPP Acknowledgment	$1,140,180,000	$3,990,630,000	$6,651,050,000
TOTAL COST SAVINGS	**$1,140,180,000**	**$3,990,630,000**	**$6,651,050,000**

The Department calculates these ranges adopting a methodology that is as close as possible as the uncertainty analysis in the 2021 Privacy Rule NPRM, as detailed below.

i. Cost Estimates

Updated Training Content

The 2021 Privacy Rule NPRM's uncertainty analysis for revising training content focused solely on the 150 minutes that each covered entity would spend on changes related to the right of access,[784] including allowable fees,[785] and established an uncertainty range between 120 minutes (2 hours) at the low end (80 percent of 150 minutes) and 180 minutes (3 hours) on the high end (120 percent of 150 minutes).

This final rule adopts the same approach by setting a range above and below the 80 minute estimate in Table 11, second row, between 64 minutes at the low end (80 percent of 80 minutes) and 96 minutes at the high end (120 percent of 80 minutes). This results in a low estimate of 904,006 total annual burden hours for all covered entities at a non-recurring cost of $65,667,025 and a high estimate of 1,356,010 burden hours at a non-recurring cost of $98,500,537 for updating the right of access portions of the training program. Overall, the total non-recurring cost for updating training content is $144,159,641, with a range between $127,742,884 and $160,576,397 in a low-end and high-end scenario, respectively.

Time Spent in Training

In this final rule, the Department revises downward the estimated additional time a medical records specialist will spend in training from 7 minutes to 5 minutes because proposed changes to the allowable fees for the right of access to direct are not addressed in this final rule.[786] The Department adopts the range that it applied in the 2021 Privacy Rule NPRM (minus 2 minutes or plus 3 minutes), and applies it to the revised 5-minute base estimate, resulting in a low of 3 minutes to a high of 8 minutes. Accordingly, the non-recurring burden hours for additional training of medical records specialists is 70,626 and ranges between 42,375 and 113,001 burden hours ($3.86 million base cost ranges between $2.31 and $6.17 million) for a low-end or high-end scenario, respectively.

Training, Overall

Overall (updating training content plus time spent in training), the estimated training burden ranges from a low of $130,056,576 (and 1,800,950 burden hours) to a high of $166,746,240 (and 2,323,579 burden hours), with a base estimate (the mid-range) of $148,015,793 (and 2,055,203 burden hours).

Updated Policies and Procedures

The 2021 Privacy Rule NPRM used a range for cost burden from $542,791,420 to $1,302,384,017 (78.0 percent and 187.1 percent relative to a base estimate of $696,059,017). For consistency, this analysis applies 78.0 percent and 187.1 percent to the base estimate of $483,375,753 in 2025 dollars, which yields a range between $376,939,119 and $904,434,863.

Access and Administrative Tasks—Recurring Costs Unless Specified

Post an Access Fee Schedule and a Revised NPP Online

As compared to the 2021 Privacy Rule NPRM, the Department increased the time to post each document online from 10 to 15 minutes for consistency with the estimate for posting documents online that was adopted in the 2024 Privacy Rule.

The Department adjusts the range used in the 2021 Privacy Rule NPRM for this non-recurring burden to a low of 8 minutes and a high of 20 minutes for each of the documents posted online. Thus, the total annual burden hours in Table 8 are 423,753 at a cost of $40,248,060 million, with a range from 226,002 to 565,004, and costs range from $21,465,632 at the low end to $53,664,080 at the high end.

Unreimbursed Costs of Providing Access (Search And Retrieval in Less Time)

To account for the additional costs to perform search and retrieval of PHI in less time, the Department applies a range of 0.5 minutes below the base estimate of 1 minute (at the low end) and 2.5 minutes above the base estimate of 1 minute (at the high end).[787] The Department applies these values to the number of copies of PHI sent to individuals in Table 9. Thus, the total estimated burden hours are 80,033 with a range from a low of 40,017 hours to a high of 200,083 hours. Annual

[784] In other words, the Department's estimate in Table 14 of the time required to make other revisions to training content did not vary across a low, middle, and high end. 86 FR 6446, 6517 (Jan. 21, 2021), Table 14.

[785] *Id.* at Table 14, second row.

[786] *See* 86 FR 6446, 6518 (Jan. 21, 2021), Table 14b.

[787] This is the same range applied in the 2021 Privacy Rule NPRM.

estimated cost in 2025 dollars is $4,369,820 with a range from a low of $2,184,910 to a high of $10,924,485 (see the first row of Table 9 for base estimate methodology).

Transmit Electronic Copies of PHI in an Electronic Health Record to Designated Persons Through Non-Internet-Based Method

The Department uses this range above and below the base estimate of 1 minute for the costs attributable to transmitting electronic copies of PHI in an electronic health record to persons designated by individuals: 0.5 minutes at the low end and 2.5 minutes at the high end. We apply these values to our estimate of copies of ePHI not in an EHR sent to designated persons via non-internet-based methods. Accordingly, the total estimated burden hours are 234,101 with a range from a low of 117,051 hours to a high of 585,253. The annual estimated cost in 2025 dollars is $12,781,931 with a range from a low of $6,390,966 to a high of $31,954,828 (see the second row of Table 9 for details of base estimate methodology).

Transmit ePHI to Health Plans and Providers Through Non-Internet-Based Method

The Department uses this range above and below the base estimate of 1 minute for these costs: 0.5 minutes at the low end and 2.5 minutes at the high end. We apply these values to our estimate of copies of ePHI not in an EHR sent to designated persons via non-internet-based methods. Accordingly, the total estimated burden hours are 100,450 with a range from a low of 50,225 hours to a high of 251,125. The annual estimated cost in 2025 dollars is $5,484,570 with a range from a low of $2,742,285 to a high of $13,711,425 (see the third row of Table 9 for details of base estimate methodology).

Discussing Privacy Practices

For these costs, the Department applies a range above and below the base estimate of 7 minutes for each of 6,130,000 health care encounters (1 percent of 613,000,000 total new health care encounters per year) for a total of 715,617 burden hours and an estimated cost of $69,743,053. The range is computed as follows: at the low end, a registered nurse spends 5 minutes for each of 613,000 health care encounters (0.1 percent of 613,000,000 total new health care encounters per year); at the high end, a health care manager spends 10 minutes for each of 30,650,000 health care encounters (5 percent of total new health care encounters per year).[788]

Thus, total estimated burden hours range from 51,083 at the low end to 5,108,333 at the high end. Estimated costs range from $4,981,647 at the low end to $692,383,500 at the high end (see the fourth row of Table 9 for details of base estimate methodology). Over time, it is likely that more covered health care providers will choose to employ technologies such as super intelligence as an option for individuals to obtain answers to their questions about the NPP. As a result of increased efficiencies from a technology-assisted approach, the burden hours and associated costs of the right to discuss may decrease; however, we are unable to predict the magnitude or velocity of this decrease.

NPP to Individuals Who Are Inmates

The Department's base estimate ($15,894,769 over 5 years), and low-end and high-end estimates ($7,459,281 and $41,201,233, respectively) have been discussed in detail above.

ii. Cost Savings Estimates

Removing NPP Acknowledgment Requirement

The Department adopts a range of cost savings from a low of 30 seconds to a high of 2 minutes and 55 seconds for each NPP that is provided to a new patient with whom the health care provider has a direct treatment relationship (respectively 166.7 percent and 28.6 percent relative to the mid-range value of 105 seconds in Table 12).[789]

On an annual basis for all covered entities, cost savings from removing the requirement to obtain a written acknowledgment of receipt of the NPP range from a total savings of 5,108,331 burden hours and $228,036,000 in cost savings at the low end to 29,798,611 burden hours and $1,330,210,000 in cost savings at the high end (respectively 28.6 percent and 166.7 percent relative to mid-range annual values of 17,879,167 burden hours and $798,126,000 in estimated cost savings).

4. Consideration of Regulatory Alternatives

The Department carefully considered several alternatives to issuing this final rule, including the option of not pursuing any regulatory changes, but rejected that approach for several reasons. First, the regulatory changes that we are finalizing will further the Administration's goal of reducing regulatory burden on individuals and the regulated community and promoting care coordination. Second, many commenters on the 2021 Privacy Rule NPRM believed that the Privacy Rule could be improved and offered comments that expressed support for some of the ideas suggested in the NPRM that are now finalized. Revising the Privacy Rule will clarify covered entities' obligations and flexibilities, improve individuals' access to their PHI, and improve care coordination and case management overall.

Table 18 reports estimated costs, benefits (*i.e.,* cost savings), and monetary transfers of finalizing the 2021 Privacy Rule NPRM as published and compares them to the corresponding values in this final rule. The costs, benefits, and transfers in the right-hand column (NPRM column) are an update of the estimates presented in the NPRM that match the assumptions in this final rule.

[788] *Id.*

[789] *Id.*

TABLE 18—COMPARISON OF FINAL RULE AND NPRM ESTIMATED 5-YEAR COSTS, COST-SAVINGS, AND TRANSFERS, UNDISCOUNTED, IN MILLIONS

	Final Rule	NPRM
Costs		
Revise Training	$148.02	$281.04
Revise Policies and Procedures, NPP, and Fee Schedule	$483.38	$974.23
Administrative Activities	$502.41	$569.33
Distribute NPP	$31.67	
Provide Individualized Fee Estimates and Itemized List of Copy Charges		$0.87
Total Costs	**$1,165.48**	**$1,825.47**
Cost Savings		
Eliminate NPP Acknowledgment	$3,990.63	$3,990.63
Clarifying Minimum Necessary		$2,297.42
Total Cost Savings	**$3,990.63**	**$6,288.05**
Net Total (negative = savings)	**-$2,825.15**	**-$4,462.58**
Transfers To Individuals	**$7.35**	**$7.35**

In addition to the proposals in the 2021 Privacy Rule NPRM that the Department declines to finalize at this time, the Department considered several other regulatory alternatives.

Scope of Health-Related Information of an Individual

The Department considered adopting a definition of the term ''electronic health record'' in which the scope of the ''health-related information of an individual'' description within the definition would cover the same scope of information as PHI as defined in the Privacy Rule at 45 CFR 160.103. Such an approach would have, by definition, excluded the subset of individually identifiable health information that is expressly excluded from the definition of PHI.[790]

However, the Department is adopting a definition of electronic health record for the specific purpose of clarifying how the Privacy Rule aligns with the statutory right of access to direct as set forth in section 13405(e) of the Health Information Technology for Economic and Clinical Health (HITECH) Act.[791] Section 164.524 limits the right of access to PHI about the individual in a designated record set. Because the HITECH Act added the right of an individual to direct a covered entity to transmit an electronic copy of their PHI in an electronic health record to a person designated by the individual as a component of the right of access at 45 CFR 164.524, the right of access to direct also is necessarily limited to PHI about the individual in a designated record set. Therefore, the Department believes that it is unnecessary to limit the information included in an electronic health record. Additionally, the Department believes that it is more appropriate to address the limitations of the right of access to direct within the applicable standard.

Further Reduce Timeliness Requirements for Responding to Requests Made Pursuant to 45 CFR 164.524

In the 2021 Privacy Rule NPRM, the Department requested comment on the ability of covered entities to respond to a request for access in under 15 days, and in this final rule considered requiring a shorter response time for requests to obtain electronic copies of PHI or a subset of PHI, including where such requests are made pursuant to the right of access to direct. In this alternative scenario, as in the final rule, covered entities would be required to respond to access requests ''as soon as practicable'' and ''no later than'' a certain number of days. The Department believes that it is possible for covered entities using health IT to provide access to at least electronic copies of ePHI in fewer than 15 days. In fact, as discussed with respect to recurring costs for providing access within a shorter time and Table 9 in section A.3.a.i of the RIA, the Department believes that some portion of covered entities already are providing individuals with access in fewer than 15 days. Adopting such an approach would have been consistent with opinions expressed by some commenters. However, the Department believes that we do not have sufficient information to determine whether this is true for all PHI or only a subset of such. Thus, we believe that this issue would be more appropriately addressed through additional notice and comment rulemaking. Accordingly, we intend to issue an NPRM in the future to address and obtain public comment on this issue.

Table 19 reports cost estimates to shorten access response time from 30 days to 3 days for all requests for electronic copies of PHI maintained electronically pursuant to 45 CFR 164.524. These estimates rely on the

[790] *See* 45 CFR 160.103 (definition of ''Protected health information'').

[791] 42 U.S.C. 17935(e).

methodology in Table 9, which projects that reducing the required response time by at least 15 days (from no more than 30 days to as soon as practicable but no more than 15 days) will cost $22.64 million (sum of costs in first three rows) annually. These costs are extrapolated proportionally: the Department estimates that reducing the required response time by an additional 12 days would add 80 percent of a minute (12/15 = 80 percent) or 48 seconds to the 1 minute in Table 9.

TABLE 19—ESTIMATED RECURRING ADMINISTRATIVE COSTS (2025 MILLION DOLLARS), RESPONSES WITHIN 3 DAYS

Recurring Costs	Burden Hours & Pay	Multiplier	Total Annual Administrative Cost (Millions)
Access for Individuals — Search and retrieval in less time.	1 min. and 48 sec. x Medical Records Specialists time ($54.60) = $1.64	91.3% of 4,802,000 access requests = 4,383,808[a]	$7.18
Sending copies of ePHI to third parties other than covered entities in less time—Non-internet-based method.	1 min. and 48 sec. x Medical Records Specialists time ($54.60) = $1.64	91.3% of 15,386,000 access requests = 14,046,[078b]	$23.01
Sending copies of ePHI to health plans and providers under the right of access in less time—Non-internet-based method.	1 min. and 48 sec. x Medical Records Specialists time ($54.60) = $1.64	25.0% of 24,108,000 access requests = 6,027,000	$9.87
Total Annual Recurring Administrative Costs			**$40.06**

[a] Discrepancies in total result from rounding.

Prohibition on Conditioning Provision of PHI Through a Personal Health Application (''personal health app'') on a Written Agreement

The Department considered adding a provision that would expressly prohibit covered entities from conditioning an individual's ability to access electronic copies of their PHI using a personal health app upon a separate writing, such as a user agreement or signature. The Department did not finalize such a provision because we believe that such prohibition is unnecessary. By modifying 45 CFR 164.524(c)(2)(ii), we clarify that when the individual requests an electronic copy of their PHI through a secure, standards-based Application Programming Interface (API) via a personal health app and the requested PHI is readily producible in such form and format, a covered provider must provide the requested access. This modification, coupled with the new prohibition against the imposition of unreasonable measures that impede an individual's access when a less burdensome measure is available and practicable for the entity, serves the same purpose as the considered prohibition.

The Department acknowledges the comments that express concerns about the security of personal health apps and the liability that could attach to a covered entity for failing to comply with HIPAA security provisions. Commenters also expressed concerns about the limitations of the Department's authority with respect to personal health apps and other persons that are not covered entities or business associates of covered entities.

The Department believes that individuals have a right of access to their own PHI subject only to the exceptions in the Privacy Rule.[792] While the Security Rule obligates covered entities, including health care providers, to ensure the confidentiality, integrity, and availability of any ePHI they transmit, covered entities also have an obligation to comply with the right of access without unduly or unnecessarily encumbering the right. Under the right of access, an individual may request a covered entity to transmit their ePHI to a personal health app in an unsecure manner or through an unsecure channel because the Security Rule addresses the level of risk to the security of the PHI on the covered entity's electronic information systems in responding to requests for access.[793] It does not

[792] *See* 45 CFR 164.524(a)(1).

[793] *See* ''Do individuals have the right under HIPAA to have copies of their PHI transferred or transmitted to them in the manner they request, even if the requested mode of transfer or transmission is unsecure?,'' Office for Civil Rights, U.S. Department of Health and Human Services, HIPAA FAQ #2060 (June 24, 2016), *https://www.hhs.gov/hipaa/for-professionals/faq/2060/do-*

Continued

address the level of privacy or security risks to the PHI once it has left the covered entity's electronic information systems.[794] For example, as discussed elsewhere in this final rule and consistent with the information blocking regulations, an individual may request that their unencrypted ePHI be transmitted to an app in an unsecure manner or through an unsecure channel. In such circumstances, the covered entity may consider informing the individual of the potential risks involved when the individual makes the request.[795]

Limiting Readily Producible Electronic Form And Format to That Required By Federal Law

The Department considered finalizing a provision deeming PHI readily producible to an individual who requests access to PHI in a particular electronic form and format based on Federal law only, and not state law. If adopted, to the extent that a state law requires the provision of ePHI in a particular form or format, such a requirement under state law would not automatically result in the ePHI being considered readily producible under the Privacy Rule right of access provisions. The Department determined that such an approach would cause confusion for covered entities and individuals, particularly for covered entities that operate in multiple states. Accordingly, we are not adopting this approach. The facts and circumstances of a covered entity's actions would be considered in any investigation into an individual's complaint alleging a violation of the right of access requirements. This includes circumstances where a state law requires a covered entity to provide PHI in a particular form and format requested by an individual, electronic or otherwise, and the covered entity declines to provide PHI to individuals in that form and format.

Issue Interim Guidance To Clarify That a Business Associate Agreement Is Not Required To Disclose PHI to TRS Providers

The Department considered issuing interim guidance to clarify that a business associate agreement is not required to disclose PHI to TRS providers. The Department has a longstanding FAQ that states that pursuant to 45 CFR 164.510(b), PHI can be shared during a telephone communication using a TRS provider because the individual will have an opportunity to agree or object to disclosures of PHI to the communication assistant.[796] For example, when the individual initiates the call through the TRS, it is reasonable for a covered health care provider to infer from these circumstances that the individual has identified the communication assistant as involved in the individual's care, and that the individual does not object to the disclosure.[797] The Department declined to issue such interim guidance because we believed that soliciting public comment on this issue via informal rulemaking would be helpful, even if not legally necessary.[798]

B. E.O. 14192

Section 4(a) of E.O. 14192 [799] stipulates that for regulations that increase incremental costs, the Department must identify offsetting regulations and provide the agency's best approximation of the total costs or savings associated with each new or repealed regulation. Section 3(c) requires any new costs associated with new regulations to be offset by the elimination of existing costs associated with at least 10 prior regulations, to the extent permitted by law.

Table 2 above shows that this is a deregulatory rule: cost savings exceed corresponding costs in each year (including the first, despite most costs being incurred only in the first year) and over 5 years at any discount rate. The Department calculates that this final rule generates $0.54 billion in net annualized savings at a 7 percent discount rate over a perpetual time horizon, in 2025 dollars.

TABLE 20—EO 14192 SUMMARY TABLE (2025 MILLION DOLLARS OVER AN INFINITE TIME HORIZON)[a]

Item	Primary Estimate (7%)
Present Value of Costs	$1,637,535,460
Present Value of Cost Savings	9,307,265,133
Present Value of Net Costs	-7,669,729,673
Annualized Costs	114,627,482
Annualized Cost Savings	651,508,559
Annualized Net Costs	-536,881,077

a. Showing values as of January 1, 2024, as is required when the first year of costs and cost savings is the year starting January 1, 2027. *See* "Accounting Methods under Executive Order 14192," Office of Information and Regulatory Affairs, Office of Management and Budget (last accessed Aug. 21, 2026), https://www.reginfo.gov/public/pdf/eo14192/Accounting_Methods_under_EO_14192.pdf.

individuals-have-the-right-under-hipaa-to-have/index.html.

[794] *See* 45 CFR 164.524(a)(1), (c)(2)(ii), and (c)(3)(ii).

[795] *See* 85 FR 25642, 25814 (May 1, 2020) (discussing how a covered entity that also meets the definition of an "actor" at 45 CFR 171.102 may provide individuals with such information).

[796] "When a covered entity, such as a doctor, uses a certified Telecommunications Relay Service to contact patients with hearing or speech impairments, is the Relay Service a business associate of the doctor?," *supra* note 364.

[797] *Id.; see also* 45 CFR 164.510(b)(2)(iii).

[798] 5 U.S.C. 553(c) (stating that interested persons must be given an opportunity to "participate in the rulemaking through submission of written data, views, or arguments").

[799] 90 FR 9065 (Feb. 6, 2025).

C. Regulatory Flexibility Act

The Department has examined the economic implications of this final rule as required by the RFA.[800] The Department generally considers a final rule to have significant economic impact on a substantial number of small covered entities if it generates a change in revenues of 3 percent or more for at least 5 percent of small covered entities.[801]

We published an initial assessment of the potential economic implications of the 2021 Privacy Rule NPRM in Section C., RFA, and a factual basis for certifying that the proposed rule would not result in a significant negative impact on a substantial number of small entities. We received no public comments on the small entity analysis or proposed certification under the RFA. We received several comments about the reduced burden resulting from the removal of the requirement for direct treatment providers to make a good faith effort to obtain an acknowledgment of receipt of the NPP and the addition of the permission for disclosures to certain third parties for individual-level care coordination and case management activities that constitute treatment or health care operations. We also received several comments that the number of simultaneous changes needed to update policies and procedures during the coronavirus disease 2019 public health emergency would be overly burdensome for small entities, particularly sole provider practices, such that more time and additional guidance from the Department would be needed to comply. In response to these comments and input from other Federal agencies, we have reconsidered certain aspects of the RFA analysis, including the scope of effects that may be relevant to certification. In this revised analysis, we include a comparison of the average costs by firms with employees (across all firm sizes) and the average yearly revenue of the smallest firms in each industry category that is potentially affected by this final rule. Generally, this approach likely would overestimate any economic effect on small entities because we also expect that the costs would be roughly proportional to entity size. For example, the cost to revise policies and procedures and revise training (representing more than 80 percent of costs in the first year, see Table 13) increases significantly as revenue increases because we assume that only larger businesses will incur expenses for lawyers' time for the revisions and training experts' time to revise training materials. We do not anticipate that small businesses with less than $100,000 in annual revenue will pay for tailor-made revisions to policies and training programs. Instead, we expect that they will adapt resource materials or tools offered by professional and trade associations and free government resources, such as the model NPP, in a manner suitable to their business. Even with these assumptions, we do not identify a significant economic impact on a substantial number of small entities in the smallest revenue categories. These findings also are generalizable to small entities in larger revenue categories (*e.g.,* firms with annual revenues between $100,000 and $500,000), which will have a lower cost-to-revenue ratio than the cost-to-revenue for the smallest entities. The ratio will be lower because the average costs are the same for smaller entities within the category as they are for the larger entities, but the actual revenue increases for the larger entities. This final regulatory flexibility analysis explains the factual basis for certifying the final rule under the RFA.

In addition to the statistical analysis that follows, the Department believes that the smallest of the small entities will be affected most directly by the final rule's reduced time period for responding to access requests because such entities generally do not have dedicated workforce members (or a business associate) to respond to requests for PHI. However, based on their size, we believe that such entities will receive few requests for access even if the cost per request is larger, and thus, will experience a negligible effect (lower than the effect estimated in this section) because the effect of the change is proportional to entity size. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. The Act defines ''small entities'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, and (3) a small government jurisdiction of less than 50,000 population. Because 90 percent or more of all health care firms meet the definition of small entities,[802] the Department generally treats all health care providers as small entities for purposes of performing a regulatory flexibility analysis. The SBA size standard for health care providers ranges between $9 million and $47 million in annual receipts, depending upon the type of entity.[803]

With respect to health insurers (NAICS code 524114), the SBA size standard is a maximum of $47 million in annual receipts, and for third party administrators (NAICS code 524292) it is $45.5 million.[804] While some insurers are classified as nonprofit, they may be dominant in their market. For example, many Blue Cross/Blue Shield insurers are organized as nonprofit entities; yet, they dominate the health insurance market in the states where they are licensed.

Table 21 provides an estimated count of affected small entities that have employees—which represent about 97 percent of all covered entities that are employer firms and affected by the final rule, but generate only 15.7 percent of total revenues).

[800] 5 U.S.C. 601–612.

[801] *See* 81 FR 31463 (May 18, 2016); *see also* 87 FR 47906 (Aug. 4, 2022).

[802] Specifically, of the 575,275 firms that are covered entities, an estimated 556,246 are small entities. ''2022 Statistics of U.S. Businesses (SUSB) Annual Data Tables by Establishment Industry,'' *supra* note 741, shows that 96.6 percent of the Health Care and Social Assistance (NAICS Sector 62) firms in Table 6 are small by SBA size standards, and the establishments owned by these small firms account for 73.8 percent of the Sector 62 establishments listed in Table 6. In addition, some large firms/establishments may be nonprofit organizations, thereby increasing the percentage of entities who are either small or nonprofit.

[803] *See* ''Small Business Size Standards by NAICS Industry,'' U.S. Small Business Administration (Mar. 17, 2023), 13 CFR 121.201 The $9 million SBA size standard applies to dentists and chiropractors, among others; the $47 million SBA size standard applies to hospitals.

[804] *Id.*

TABLE 21—ESTIMATED COUNTS OF SMALL COVERED ENTITIES

NAICS code	Type of entity	Firms	SBA small size threshold ($ million)	Small firms as % of all firms[a]	Small firms[b]	Small firm share of industry revenues
524114	Direct Health and Medical Insurance Carriers	1,071	$47.0	74.4%	797	0.1%
524292	Third Party Administrators	431	$45.5	89.3%	385	2.3%
622	Hospitals	3,136	$47.0	41.2%	1,292	1.5%
44611	Pharmacies and Drug Stores	18,857	$37.5	97.8%	18,442	21.2%
6211-6213	Office of Drs. & Other Professionals	431,216	$9.0 - $16.0	98.2%	423,454	42.3%
6215	Medical and Diagnostic Laboratories	9,025	$19.0 - $41.5	91.6%	8,267	22.1%
6214	Outpatient Care Centers	28,324	$19.0 - $47.0	90.4%	25,605	21.1%
6219	Other Ambulatory Health Care Services	11,317	$20.5 - $40.0	95.3%	10,785	22.9%
623	Nursing and Residential Care Facilities	43,215	$16.0 - $34.0	92.2%	39,844	42.4%
6216	Home Health Care Services	28,198	$19.0	95.5%	26,929	31.6%
532283	Home Health Equipment Rental	485	$41.0	91.9%	446	18.6%
Total		**575,275**		**96.6%**	**556,246**	**15.7%**

[a] Estimated using Census SUSB data by revenue size classes. *See* "2022 Statistics of U.S. Businesses (SUSB) Annual Data Tables by Establishment Industry," *supra* note 741.
[b] *Id.*

Table 22 demonstrates that more than 5 percent of small covered entities that are employer firms in each relevant NAICS category have annual revenues below $100,000 [805] with the exception of Pharmacies and Drug Stores (NAICS 446111).[806] Thus, the analysis relies on data for this set of firms to evaluate whether the final rule has an estimated effect of more than 3 percent on covered entity firms with employees.

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[805] This is the small revenue size class in Census' public SUSB dataset.

[806] The next revenue size class groups firms with at least $100,000 in annual revenues but below $500,000. For NAICS 446111, this revenue size class accounts for 9.4 percent of the total 18.4 thousand small covered entities (the average annual revenue in this class is $292,526).

TABLE 22—ESTIMATED COUNTS OF SMALL COVERED ENTITIES IN THE SMALLEST REVENUE SIZE CLASS

NAICS code	Type of entity	Firms with annual revenue below $100,000 (2022 dollars)[a]	Firms with annual revenue below $100,000 (2022 dollars) as % of total small firms[b]	Average annual revenue (2025 dollars)[c]	3% of average annual revenue (2025 dollars)[d]	Estimated first year cost per firm[e]	Estimated annualized (at 7%) cost per firm[f]
524114	Direct Health and Medical Insurance Carriers	157	19.7%	$58,022	$1,741	$925	$298
524292	Third Party Administrators	43	11.1%	$56,292	$1,689	$933	$300
622	Hospitals	68	5.0%	$51,988	$1,560	$925	$298
44611	Pharmacies and Drug Stores	560	3.0%	$55,681	$1,670	$927	$298
6211-6213	Office of Drs. & Other Professionals	55,947	13.2%	$57,801	$1,734	$926	$298
6215	Medical and Diagnostic Laboratories	1,097	13.1%	$54,741	$1,642	$925	$298
6214	Outpatient Care Centers	3,384	13.0%	$54,755	$1,643	$928	$299
6219	Other Ambulatory Health Care Services	1,357	12.6%	$51,822	$1,555	$925	$298
623	Nursing and Residential Care Facilities	4,449	10.8%	$48,773	$1,463	$927	$298
6216	Home Health Care Services	6,361	23.6%	$40,023	$1,201	$926	$298
532283	Home Health Equipment Rental	33	7.4%	$56,063	$1,682	$925	$298
Total		**73,217**	**13.2%**			**$926**	**$298**

[a] Estimated using Census SUSB data by revenue size classes. *See* "2022 Statistics of U.S. Businesses (SUSB) Annual Data Tables by Establishment Industry," *supra* note 741. 2022 is the most recent data available.
[b] *Id.*
[c] Average in 2022 dollars inflated using 2022-2025 GDP deflator (+9.279 percent).
[d] *Id.*
[e] First year cost per firm = (cost /establishment) * (establishments / firm).
[f] Annualized cost per firm (discounted at 7 percent) = (cost /establishment) * (establishments / firm).

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Table 2 provides the data to explain that, before accounting for cost savings, the average estimated cost per covered entity establishment [807] is $925 in the first year ($783.98 million divided by 847,506) and $113 in the following years ($95.37 million divided by 847,506), or $298 in annualized cost at a 7 percent discount rate. After multiplying the costs per establishment by establishments per firm within the SUSB categories, the average cost per small firm increases slightly in the first year (from $925 to $926, see Table 22) and remains unchanged at $298 (because of rounding) in annualized terms (at 7 percent discount rate). More than 5 percent of the small covered entities listed under the NAICS codes in Table 6 are one-establishment firms with annual revenues below $100,000, so the analysis must determine how the effects of the quantified costs on one-establishment firms compare to their revenues. Only small firms whose revenues are below $30,833 [=$925/0.03] could experience an effect exceeding 3 percent in the first year, and none of the small firms with employees are affected to that extent. On an annualized basis, only small firms with annualized revenues below $9,933 [=$298/0.03] could experience an effect exceeding 3 percent.

The Department acknowledges that there may be very small firms—namely 1.5 million firms without employees [808]—with revenues below $30,833; however, a number of these firms are not covered entities because they do not engage in covered electronic transactions. For example, many established solo practitioners rely on private pay patients. As another example, very small providers who accept Medicare are not subject to electronic claims filing requirements.[809] We have relied on the principle of scalability throughout the rule, and expect that small entities will adopt less expensive and less complex privacy measures that comply with the rule than the measures adopted by large entities. For the lowest-revenue nonemployer firms that are covered entities, we believe that they will comply with the regulation by adapting resource materials or tools offered by professional and trade associations and free government resources, such as the model NPP, as suitable to their business. These considerations, combined with the analysis of employer firms, support the Department's conclusion that the final rule does not generate a change in revenues of more than 3 percent for at least 5 percent of small covered entities on an annualized basis for any of the relevant NAICS.

The data in Table 2 is used to calculate cost savings that already exceed costs in the first year—the average annual cost saving per covered entity is $17—and more substantially so in the following years after non-recurring costs are no longer incurred—the average annual cost savings per covered entity is $829 in year two and onward. The Department acknowledges that the cost savings vary based on the number of health care encounters, which means that the average cost savings figure may overestimate the cost savings of the smallest of the small business firms. However, because small businesses represent 96.6 percent of covered entities, the average (small) covered entity will experience net savings each year.

The Department also recognizes that even when cost savings have an economically significant effect—as it is the case for this final rule—net cost savings do not necessarily imply certification. However, the average (small) covered entity with employees will experience net savings each year, and, as explained above, we believe nonemployer firms will not incur net costs above the 3 percent of annual revenue; thus, the effects on the average small business would support certification in this instance. Accordingly, available data allow the Department to carry out sufficiently high-quality fact-based analysis (as shown above) to support certification. Thus, the Secretary certifies that this final rule will not negatively affect a substantial number of small entities.

D. Unfunded Mandates Reform Act

Section 202(a) of the UMRA requires the Department to prepare a written statement, including an assessment of anticipated costs and benefits, before issuing ''any rule that includes any Federal mandate that may result in the expenditure by state, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any one year.'' [810] In 2025 dollars, that threshold is $193 million.[811] The Department does not anticipate that this final rule will have an effect only on state, local, or Tribal governments, in the aggregate that exceed this threshold; however, it may impose mandates on the private sector that will exceed this threshold in the first year of its effective date. Thus, we have prepared an analysis of the costs and benefits of the final rule.

E. E.O. 13132—Federalism

E.O. 13132 establishes certain requirements that an agency must meet when it promulgates a final rule (and preceding proposed rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. The Department does not believe that this rulemaking will have any implications for federalism.

The federalism implications of the Privacy Rules were assessed as required by E.O. 13132. That assessment was published as part of the preambles to the final rules in 2000,[812] 2003,[813] and 2013.[814] Regarding preemption, the preamble to the 2013 Privacy Rule explains that the HIPAA statute dictates the relationship between state law and Privacy Rule requirements, and therefore the Rule's preemption provisions do not raise federalism issues. The HITECH Act provides that HIPAA's preemption provisions also apply to the HITECH Act.[815]

The Department anticipates that the most significant direct costs on state and local governments will be the cost for state and local government-operated covered entities to revise policies and procedures, including drafting, printing, and distributing NPPs for individuals with first-time health encounters, which will include the cost of mailing these notices for state health plans, such as Medicaid. The RIA above addresses these costs in detail.

In considering the principles in and requirements of E.O. 13132, the

[807] Firms and establishments represent different levels of aggregation. A firm can have one or more establishments, with larger firms (by employees, or by revenues) typically having multiple establishments and small firms typically having one establishment. The Department estimated costs using number of establishments to account for larger firms having higher costs. The per-establishment cost is an estimate of the cost for a small, one-establishment firm. Thus, for the analysis in this section, the Department's estimated cost per covered entity establishment is the Department's estimate of costs for a small covered entity firm.

[808] *See* U.S. Census Bureau, Nonemployer Statistics (NES), 2022, *https://www.census.gov/programs-surveys/nonemployer-statistics.html.* The Department uses 2022 data or consistency with SUSB data in Table 6.

[809] *See* 42 CFR 424.32.

[810] Public Law 104–4, 109 Stat. 64 (Mar. 22, 1995) (codified at 2 U.S.C. 1532).

[811] Aaron Kearsley, ''HHS Standard Values for Regulatory Analysis, 2026,'' Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Mar. 10, 2026), *https://aspe.hhs.gov/reports/standard-ria-values.*

[812] 65 FR 82462, 82797–98 (Dec. 28, 2000).

[813] 68 FR 8334, 8373 (Feb. 20, 2003).

[814] 78 FR 5566, 5686 (Jan. 25, 2013).

[815] *See* Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111–5, 123 Stat. 226, sec. 13421(a) (Feb. 17, 2009) (codified at 42 U.S.C. 201 note).

Department has determined that these modifications to the Privacy Rule will not significantly affect the rights, roles, and responsibilities of the states.

F. Assessment of Federal Regulation and Policies on Families

Section 654 of the Treasury and General Government Appropriations Act of 1999 requires Federal departments and agencies to determine whether a policy or regulation could negatively affect family well-being.[816] If the determination is affirmative, then the Department or agency must prepare an impact assessment to address criteria specified in the law. The Department does not anticipate negative effects on family well-being from this regulation.

G. Paperwork Reduction Act of 1995

The PRA [817] requires the Department to submit to the OMB for review and approval any reporting or record-keeping requirements inherent in a proposed or final rule, and to publish such proposed requirements for public comment. To fairly evaluate whether an information collection should be approved by the OMB, section 3506(c)(2)(A) of the PRA requires that the Department solicit comment on all of the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency.
- The accuracy of the agency's estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The PRA requires consideration of the time, effort, and financial resources necessary to meet the information collection requirements referenced in this section.

In this RIA, the Department is revising certain information collection requirements associated with this final rule after consideration of the comments on the 2021 Privacy Rule NPRM and comments on the 2022 Part 2 NPRM that addressed certain proposed modifications to the Privacy Rule and, as such, is revising the information collection last prepared in 2024 and approved under OMB control #0945–0003. The revised information collection describes all new and adjusted information collection requirements for covered entities pursuant to the implementing regulation for HIPAA at 45 CFR parts 160 and 164, the HIPAA Privacy, Security, Breach Notification, and Enforcement Rules (''HIPAA Rules'').

The estimated annual labor burden presented by the regulatory modifications in the first year of implementation, including nonrecurring and recurring burdens, is 6,464,621 burden hours at a cost of $770,757,757, and $95,194,170 of estimated annual recurring labor costs in years two through five. The estimated annual capital costs burden presented by the regulatory modifications in the first year of implementation, including nonrecurring and recurring burdens, is $13,221,725 and $180,513 recurring capital costs in years two through five. Estimated annual costs savings of $798,126,000 reduce annual burdens, resulting in first year net cost savings of $14,146,519; net annual cost savings are $702,751,317 in years two through five.

The overall total burden for respondents to comply with the information collection requirements of all of the HIPAA Rules, including nonrecurring and recurring burdens presented by program changes, previously unrecognized burdens, and reduced burdens resulting from a court decision, is 984,129,331 burden hours at a labor cost of $121,661,926,211, plus $148,540,234 in capital costs, for a total estimated annual burden of $121,810,466,445 in the first year following the effective date of the final rule. Details describing the burden analysis for the proposals associated with this RIA are presented below and explained further in the Information Collection Request (ICR) associated with this final rule.

Explanation of Estimated Annualized Burden Hours

Below is a summary of the significant program changes and adjustments made since the ICR was approved in 2024. Because the ICR addresses regulatory burdens associated with the full suite of HIPAA Rules, the changes and adjustments include updated data and estimates for some provisions of the HIPAA Rules that are not affected by this final rule. These program changes and adjustments form the bases for the burden estimates presented in the ICR associated with this RIA.

Adjusted Estimated Annual Burdens of Compliance

- Increasing the number of covered entities (*i.e.,* respondents) from 774,331 to 847,506 based on program change.
- Increasing the multiplier for the annual number of individual access requests for copies of PHI requiring labor (through non-internet-based method) from 615,000 to 4,802,000 based on program change.
- Adding a previously unrecognized recurring labor burden of 18 hours per covered entity for determinations of the minimum necessary PHI for treatment, payment, and health care operations.
- Adding a previously unrecognized recurring burden of 3 minutes per request pursuant to the right of access to direct by separately enumerating requests to direct copies to a person other than a health care provider or health plan and requests to direct copies to a health care provider or health plan as follows:
  - Adding an estimate of 6,027,000 annual requests under the right of access to direct for copies of ePHI sent to health care providers and health plans based on program change, resulting in 301,350 burden hours.
  - Adding an estimate of 14,046,078 annual requests under the right of access to direct for copies of ePHI sent to persons designated by the individual other than health care providers and health plans based on program change, resulting in 702,304 burden hours.
- Updating capital costs for sheets of paper, toner for printing, envelopes, and postage using the values in this final rule.
- Removing a nonrecurring burden of 1 hour for updating each of 350,000 business associate agreements that applied to changes in the first year of implementing the 2024 Privacy Rule that has already passed.

Reductions in Burden Resulting From Program Change

This final rule decreases the estimated hourly burden for disseminating the NPP and obtaining an acknowledgment of receipt pursuant to 45 CFR 164.520, from 3 minutes to 1 minute and 15 seconds as a result of program change.

New Burdens From Program Changes

In addition to burden reductions and updated data, the Department added new estimated burdens as a result of program changes in the final rule:

- A burden of 1 minute and 15 seconds for each of 4,245,996 NPPs that will be disseminated to individuals who are inmates within the first year of compliance with the final rule, and an

[816] *See* Public Law 105–277, div. A, sec. 101(h), 112 Stat. 2681, 2681–480, 2681–528 (Oct. 21, 1998), as amended by Public Law 108–271, sec. 8(b), 118 Stat. 814 (July 7, 2004) (codified at 5 U.S.C. 601 note).

[817] Public Law 104–13, 109 Stat. 163 (May 22, 1995) (codified at 44 U.S.C. 3501–3521).

annual burden of 1 minute and 15 seconds for each of 3,026,662 NPPs that will be disseminated to individuals who are inmates in years two through five.

- A nonrecurring burden of 60 minutes per covered entity to update the required content of its NPP.
- A nonrecurring burden of 15 minutes per covered entity for posting an updated NPP online pursuant to 45 CFR 164.520.
- A nonrecurring burden of 15 minutes per covered entity for posting a fee schedule for copies of PHI online pursuant to 45 CFR 164.525.
- A nonrecurring burden of 30 minutes for 5 percent of covered entities to update policies and procedures related to identity verification pursuant to 45 CFR 164.530 and 2 hours and 10 minutes for all covered entities to update the remainder of updated policies and procedures under 45 CFR 164.530 (excluding updating NPP content, listed separately above).
- A nonrecurring burden of 10 minutes for 5 percent of covered entities to update HIPAA training related to changes in identity verification procedures pursuant to 45 CFR 164.530 and 2 hours and 20 minutes for all covered entities to update training for the remainder of updated policies and procedures.
- A nonrecurring burden of 5 minutes for a medical records specialist who is a workforce member of each covered entity to receive additional training on changes to the right of access.
- A nonrecurring burden for mailing an updated NPP to a percentage of health plan subscribers at a rate of 240 notices per hour pursuant to 45 CFR 164.520.
- An increase in the recurring burden for each of an estimated 4,802,000 individual access requests by 1 minute for covered entities to account for providing access within a shorter time pursuant to 45 CFR 164.524.
- A recurring burden of 1 minute for each of an estimated 14,046,078 requests pursuant to the right of access to direct that are for sending copies to a designated person other than a health care provider or health plan though a non-internet-based method within a shorter time period pursuant to 45 CFR 164.524.
- A recurring burden of 1 minute for each of an estimated 6,027,000 requests pursuant to the right of access to direct that are for sending copies to a health care provider or health plan through a non-internet-based method within a shorter time period pursuant to 45 CFR 164.524.
- A recurring burden of 7 minutes for each of an estimated 6,130,000 requests by individuals to discuss the NPP pursuant to 45 CFR 164.520.

Reductions in Burden Resulting From Court Decision

The court in *Carmen Purl* v. *U.S. Department of Health & Human Services,*[818] vacated the attestation requirement introduced in the 2024 Privacy Rule at 45 CFR 164.509, which had added an estimated 235,125 recurring burden hours. To reflect the effects of the court's decision the ICR will show the following burden reductions:

- Removing entirely a burden of 5 minutes per request for certain copies of PHI for workforce members to determine whether an attestation is required for disclosure pursuant to 45 CFR 164.509.
- Removing entirely a burden of 1 hour per request for legal review of certain requests identified by workforce members as potentially pertaining to the lawfulness of reproductive health care pursuant to 45 CFR 164.509.
- Removing entirely a burden of 3 hours per request for a percentage of requests requiring legal review that might require additional manager review pursuant to 45 CFR 164.509.

List of Subjects

45 CFR Part 160

Administrative practice and procedure, Computer technology, Electronic information system, Electronic transactions, Employer benefit plan, Health, Health care, Health facilities, Health insurance, Health professions, Health records, Hospitals, Investigations, Medicaid, Medical research, Medicare, Penalties, Preemption, Privacy, Public health, Reporting and recordkeeping requirements, Security.

45 CFR Part 164

Administrative practice and procedure, Computer technology, Electronic information system, Electronic transactions, Employer benefit plan, Health, Health care, Health facilities, Health insurance, Health professions, Health records, Hospitals, Medicaid, Medical research, Medicare, Privacy, Public health, Reporting and recordkeeping requirements, Security.

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter C, parts 160 and 164 as set forth below:

[818] *Purl,* 87, F. Supp. 3d 284.

PART 160—GENERAL ADMINISTRATIVE REQUIREMENTS

■ 1. The authority citation for part 160 is revised to read as follows:

Authority: 42 U.S.C. 1302(a); 42 U.S.C. 1320d–1320d–9; sec. 264, Pub. L. 104–191, 110 Stat. 2033–2034 (42 U.S.C. 1320d–2 (note)); 5 U.S.C. 552; secs. 13400–13424, Pub. L. 111–5, 123 Stat. 258–279 (42 U.S.C. 17921, 17931–17954); and sec. 1104 of Pub. L. 111–148, 124 Stat. 146–154.

■ 2. Amend § 160.103 by adding a new paragraph (4)(v) to the definition of ''Business associate'' to read as follows:

§ 160.103 Definitions.

* * * * *

Business associate * * *

(4) * * *

(v) A provider of telecommunications relay services, as defined in 47 U.S.C. 225(a)(3), with respect to enabling communications through services regulated under 47 CFR part 64.

* * * * *

PART 164—SECURITY AND PRIVACY

■ 3. The authority citation for part 164 is revised to read as follows:

Authority: 42 U.S.C. 1302(a); 42 U.S.C. 1320d–1320d–9; sec. 264 of Pub. L. 104–191, 110 Stat. 2033–2034 (42 U.S.C. 1320d–2 (note)); and secs. 13400–13424, Pub. L. 111–5, 123 Stat. 258–279 (42 U.S.C. 17921, 17931–17954).

■ 4. Amend § 164.501 by:

■ a. Adding in alphabetical order a definition for ''Electronic health record'';

■ b. Revising and republishing the definition of ''Health care operations''; and

■ c. Adding in alphabetical order a definition for ''Personal health application''.

The additions and revision read as follows:

§ 164.501 Definitions.

* * * * *

Electronic health record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. Such clinicians shall include, but are not limited to, health care providers that have direct or indirect treatment relationships with individuals as defined at § 164.501, such as physicians, nurses, pharmacists, and other allied health professionals. For purposes of this definition, ''health-related information on an individual'' covers the same scope of information as the term *individually identifiable health*

information as defined at § 160.103 of this subchapter.

* * * * *

Health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs; protocol development; case management and care coordination; contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities.

(3) Except as prohibited under § 164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable.

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

(6) Business management and general administrative activities of the entity, including, but not limited to, any of the following:

(i) Management activities relating to implementation of and compliance with the requirements of this subchapter.

(ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.

(iii) Resolution of internal grievances.

(iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity.

(v) Consistent with the applicable requirements of § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

* * * * *

Personal health application means an electronic application used by an individual to access health information about that individual, which can be drawn from multiple sources, provided that all of the following conditions apply:

(1) Such information is managed, shared, and controlled by or primarily for the individual.

(2) Such information is not managed, shared, or controlled in any of the following manners:

(i) By or primarily for a covered entity.

(ii) Primarily for another person.

* * * * *

■ 5. Amend § 164.502 by:
■ a. Revising paragraph (a)(2);
■ b. Revising paragraph (a)(4)(ii);
■ c. Redesignating paragraphs (a)(5)(ii)(B)(*2*)(*vii*) and (a)(5)(ii)(B)(*2*)(*viii*) as (a)(5)(ii)(B)(*2*)(*viii*) and (a)(5)(ii)(B)(*2*)(*ix*), respectively; and
■ d. Adding paragraph (a)(5)(ii)(B)(*2*)(*vii*).

The revisions and addition read as follows:

§ 164.502 Uses and disclosures of protected health information: General Rules.

(a) * * *

(2) *Covered entities: Required disclosures.* A covered entity is required to disclose protected health information in each of the following circumstances:

(i) To an individual, when requested under, and required by, § 164.524 or § 164.528.

(ii) To a person designated by the individual, when requested under, and required by, § 164.524.

(iii) When required by the Secretary under subpart C of part 160 of this subchapter to investigate or determine the covered entity's compliance with this subchapter.

* * * * *

(4) * * *

(ii) To the covered entity or, when specified in the written contract or other written arrangement with a business associate required by § 164.502(e)(2), to the individual or the individual's designee, as necessary to satisfy a covered entity's obligations with respect to § 164.524(c)(2)(ii) or § 164.524(d)(1).

(5) * * *

(ii) * * *

(B) * * *

(*2*) * * *

(*vii*) To a person designated by an individual, when requested under § 164.524;

* * * * *

■ 6. Amend § 164.506, by adding new paragraph (c)(6) to read as follows:

§ 164.506 Uses and disclosures to carry out treatment, payment, or health care operations.

* * * * *

(c) * * *

(6) A covered entity may disclose an individual's protected health information to a social services agency, community-based organization, home and community based services provider, or similar third party that provides health or human services to specific individuals, for individual-level care coordination and case management activities (whether such activities constitute treatment or health care operations as those terms are defined in § 164.501) with respect to that individual.

* * * * *

■ 7. Amend § 164.512 by:
■ a. Revising paragraph (d)(3);
■ b. Revising the heading for paragraph (k)(1);
■ c. Revising and republishing paragraphs (k)(1)(i) and (ii);
■ d. Revising paragraph (k)(2); and
■ e. Adding paragraph (m).

The revisions and addition read as follows:

§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

* * * * *

(d) * * *

(3) *Joint activities or investigations.* Notwithstanding paragraph (d)(2) of this section, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity

for purposes of paragraph (d) of this section.

* * * * *

(k) * * *

(1) *Uniformed Services and veterans activities*—(i) *Uniformed Services personnel.* A covered entity may use and disclose the protected health information of individuals who are Uniformed Services personnel for activities deemed necessary by appropriate command authorities to assure the proper execution of the applicable Uniformed Service's mission, if the appropriate command authority has published by notice in the **Federal Register** all of the following information:

(A) Appropriate command authorities.

(B) The purposes for which the protected health information may be used or disclosed.

(ii) *Separation or discharge from Uniformed Service.* A covered entity that is a component of the Departments of Defense, Homeland Security, Commerce, or Health and Human Services may disclose to the Department of Veterans Affairs (VA) the protected health information of an individual who is a member of the Uniformed Service upon the separation or discharge of the individual from Uniformed Service for the purpose of a determination by the VA of the individual's eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs.

* * * * *

(2) *National security and intelligence activities.* A covered entity may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 3001, *et seq.*) and implementing authority (*e.g.,* Executive Order 12333).

* * * * *

(m) *Standard: Disclosures to Telecommunications Relay Services.* (1) A covered entity may disclose protected health information to a Telecommunications Relay Service Communications Assistant, as defined at 47 CFR 64.601(a)(12), as necessary to conduct covered functions.

(2) Notwithstanding § 164.502(a)(3), a business associate may disclose protected health information to a Telecommunications Relay Service Communications Assistant, as defined at 47 CFR 64.601(a)(12), as necessary to conduct covered functions for or on behalf of a covered entity.

* * * * *

■ 8. Amend § 164.514 by adding paragraph (h)(2)(v).

§ 164.514 Other requirements relating to uses and disclosures of protected health information.

* * * * *

(h) * * *

(2) * * *

(v) *Exercise of individual rights.* A covered entity may not impose unreasonable verification measures on an individual that would impede the individual from exercising a right under this part. An unreasonable measure is one that causes an individual to expend unnecessary effort or resources when a less burdensome verification measure is practicable for the covered entity. Practicability considerations include a covered entity's technical capabilities, its obligations to protect the privacy of protected health information under § 164.530(c) and the security of electronic protected health information under § 164.306, and the costs of implementing measures that are more convenient for individuals.

■ 9. Amend § 164.520 by:

■ a. Revising paragraph (a)(1);

■ b. Removing paragraph (a)(4);

■ c. Revising paragraphs (b)(1)(i), (b)(1)(iii)(B), (b)(1)(iv)(C), (b)(1)(iv)(E), and (b)(1)(iv)(F);

■ d. Adding paragraph (b)(1)(iv)(G);

■ e. Revising paragraph (b)(1)(vii);

■ f. Adding paragraph (b)(2)(iii);

■ g. Removing paragraph (c)(2)(ii);

■ h. Redesignating paragraphs (c)(2)(iii) and (iv) as paragraphs (c)(2)(ii) and (iii), respectively;

■ i. Revising paragraph (c)(3)(iii); and

■ j. Revising paragraph (e).

The revisions and additions read as follows:

§ 164.520 Notice of privacy practices for protected health information.

(a) *Standard: Notice of privacy practices*—(1) *Right to notice.* Except as provided by paragraph (a)(3) of this section, an individual has a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to protected health information.

* * * * *

(b) * * *

(1) * * *

(i) *Header.* The notice must contain the following statement as a header or otherwise prominently displayed:

NOTICE OF PRIVACY PRACTICES OF [NAME OF COVERED ENTITY, AFFILIATED COVERED ENTITIES, OR ORGANIZED HEALTH CARE ARRANGEMENT, AS APPLICABLE]

THIS NOTICE DESCRIBES:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION.
- HOW TO EXERCISE YOUR RIGHT TO GET COPIES OF YOUR RECORDS AT LIMITED COST OR, IN SOME CASES, FREE OF CHARGE.
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION, INCLUDING YOUR RIGHT TO INSPECT OR GET COPIES OF YOUR RECORDS UNDER HIPAA.
- YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH [ENTER NAME, TITLE, OR OFFICE] AT [PHONE AND EMAIL] IF YOU HAVE ANY QUESTIONS.

* * * * *

(iii) * * *

(B) In accordance with § 164.504(f), the group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the plan sponsor;

(iv) * * *

(C) The right of access to inspect and obtain a copy of protected health information at limited cost or, in some cases, free of charge; and the right of access to direct a covered entity to transmit an electronic copy of protected health information in an electronic health record to a person designated by the individual, as provided by § 164.524;

* * * * *

(E) The right to receive an accounting of disclosures of protected health information as provided by § 164.528;

(F) The right of an individual, including an individual who has agreed to receive the notice electronically in accordance with paragraph (c)(3) of this section, to obtain a paper copy of the notice from the covered entity upon request; and

(G) The right to discuss the notice with a designated contact person or office identified by the covered entity pursuant to § 164.520(b)(1)(vii).

* * * * *

(vii) *Contact.* The notice must contain the name or title, telephone number, and email address for a designated person or office responsible for providing further information and answering questions about the covered entity's privacy practices, as required by § 164.530(a)(1)(ii).

* * * * *

(2) * * *

(iii) A covered entity may provide in its notice information about how an individual who seeks to direct a copy of protected health information to another person, when the request does not meet the conditions of § 164.524(d), can instead obtain a copy of protected health information directly under § 164.524(a)-(c) and (e) and send the copy to the person themselves, or request the covered entity to send a copy of protected health information to the person using a valid authorization under § 164.508.

* * * * *

(c) * * *

(2) * * *

(ii) If the covered health care provider maintains a physical service delivery site:

(A) Have the notice available at the service delivery site for individuals to request to take with them; and

(B) Post the notice in a clear and prominent location where it is reasonable to expect individuals seeking service from the covered health care provider to be able to read the notice; and

(iii) Whenever the notice is revised, make the notice available upon request on or after the effective date of the revision and promptly comply with the requirements of paragraph (c)(2)(ii) of this section, if applicable.

(3) * * *

(iii) For purposes of paragraph (c)(2)(i) of this section, if the first service delivery to an individual is delivered electronically, the covered health care provider must provide electronic notice automatically and contemporaneously in response to the individual's first request for service.

* * * * *

(e) *Implementation specifications: Documentation.* A covered entity must document compliance with the notice requirements, as required by § 164.530(j), by retaining copies of the notices issued by the covered entity.

* * * * *

■ 10. Revise and republish § 164.524 to read as follows:

§ 164.524 Access of individuals to protected health information.

(a) *Standard: Access to protected health information*—(1) *Right of access.* Except as otherwise provided in paragraphs (a)(2) or (3) of this section, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, except for either of the following:

(i) Psychotherapy notes.

(ii) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

(2) *Unreviewable grounds for denial.* A covered entity may deny an individual access without providing the individual an opportunity for review, in any of the following circumstances:

(i) The protected health information is excepted from the right of access by paragraph (a)(1) of this section.

(ii) A covered entity that is a correctional institution or a covered health care provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of protected health information, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate.

(iii) An individual's access to protected health information created or obtained by a covered health care provider in the course of research that includes treatment may be temporarily suspended for as long as the research is in progress, provided that the individual has agreed to the denial of access when consenting to participate in the research that includes treatment, and the covered health care provider has informed the individual that the right of access will be reinstated upon completion of the research.

(iv) An individual's access to protected health information that is contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law.

(v) An individual's access may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

(3) *Reviewable grounds for denial.* A covered entity may deny an individual access provided that the individual is given a right to have such denials reviewed, as required by paragraph (e)(4) of this section, in any of the following circumstances:

(i) A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.

(ii) The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.

(iii) The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

(4) *Review of a denial of access.* If access is denied on a ground permitted under paragraph (a)(3) of this section, the individual has the right to have the denial reviewed by a licensed health care professional who is designated by the covered entity to act as a reviewing official and who did not participate in the original decision to deny. The covered entity must provide or deny access in accordance with the determination of the reviewing official under paragraph (e)(4) of this section.

(b) *Implementation specifications: Requests for access and timely action*—

(1) *Individual's request for access.*

(i) The covered entity must permit an individual to request access to inspect or to obtain a copy of the protected health information about the individual that is maintained in a designated record set.

(ii) The covered entity may require individuals to make requests for access in writing, provided that it informs individuals of such a requirement. For purposes of this paragraph, in writing means that the request itself serves as documentation of the individual's exercise of the right of access, including when the request is submitted electronically or on paper.

(iii) The covered entity may not impose measures on individuals making requests for access that impede an individual from obtaining access when there is a measure for making such requests that is less burdensome for the individual and practicable for the entity.

(2) *Timely action by the covered entity.*

(i) Except as provided in paragraph (b)(2)(ii) of this section, the covered entity must act on a request for access as soon as practicable, but no later than 15 calendar days after receipt of the request, and the following conditions must be met:

(A) If the covered entity grants the request, in whole or in part, it must inform the individual of the acceptance

of the request and provide the access requested, in accordance with paragraph (c) of this section.

(B) If the covered entity denies the request, in whole or in part, it must provide the individual with a written denial, in accordance with paragraph (e)(2) of this section.

(ii) If the covered entity is unable to take an action required by paragraph (b)(2)(i)(A) or (B) of this section within the time required by paragraph (b)(2)(i) of this section, as applicable, the covered entity may extend the time for such actions by no more than 30 calendar days, provided that:

(A) The covered entity, within the time limit set by paragraph (b)(2)(i) of this section, as applicable, provides the individual with a written statement of the reasons for the delay and the date by which the covered entity will complete its action on the request; and

(B) The covered entity may have only one such extension of time for action on a request for access.

(iii) Where another federal or state law requires a covered entity to provide an individual with access to the protected health information requested in less than 15 calendar days, that shorter time period is deemed practicable for purposes of paragraph (b)(2)(i) of this section.

(c) *Implementation specifications: Provision of access.* If the covered entity provides an individual with access, in whole or in part, to protected health information, the covered entity must comply with the following requirements.

(1) *Providing the access requested.* The covered entity must provide the access requested by an individual, including inspection or obtaining a copy, or both, of the protected health information about the individual in designated record sets. If the same protected health information that is the subject of a request for access is maintained in more than one designated record set or at more than one location, the covered entity need only produce the protected health information once in response to a request for access.

(2) *Form of access requested.* (i) The covered entity must provide an individual with access to the protected health information in the form and format requested by the individual, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by the covered entity and the individual.

(ii) Notwithstanding paragraph (c)(2)(i) of this section, if the protected health information that is the subject of a request for access is maintained in one or more designated record sets electronically and if the individual requests an electronic copy of such information, the covered entity must provide the individual with access to the protected health information in the electronic form and format requested by the individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by the covered entity and the individual.

(iii) Where another federal or state law applicable to the covered entity requires the provision of access in a particular electronic form and format, the protected health information is deemed readily producible in such form and format for purposes of paragraphs (c)(2)(i) and (ii) of this section.

(iv)(A) The covered entity may provide an individual with a summary of the protected health information requested, in lieu of providing access to the protected health information, or may provide an explanation of the protected health information to which access has been provided, if:

(*1*) The individual agrees in advance to such a summary or explanation; and

(*2*) The individual agrees in advance to the fees imposed, if any, by the covered entity for such summary or explanation.

(B) The covered entity must inform an individual to whom it offers to provide a summary in lieu of a copy of protected health information that the individual retains the right to obtain a copy of the requested protected health information if the individual does not agree to receive such summary. This requirement does not apply if a covered entity is offering to provide a summary in lieu of a copy of protected health information because the covered entity is denying an individual's request for a copy; however, the covered entity still must follow the denial procedures under § 164.524(e).

(3) *Time and manner of access.* The covered entity must provide the access as requested by an individual in a timely manner as required by paragraph (b)(2) of this section, including arranging with the individual for a convenient time and place to inspect or obtain a copy of the protected health information, or at the individual's request, mailing or electronically transmitting the copy of the protected health information to the individual, including by email, or to or through the individual's personal health application, if a copy is readily producible to or through such application. The covered entity may discuss with an individual the scope, format, and other aspects of the individual's request for access as necessary to facilitate the timely provision of access; however, such discussion shall not extend the time allowed for the covered entity to provide access.

(4) *Fees.* (i) If an individual requests a copy of the protected health information or agrees to a summary or explanation of such information, the covered entity may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:

(A) Labor for copying the protected health information requested by the individual, whether in non-electronic (*e.g.,* paper, film) or electronic form;

(B) Supplies for creating a non-electronic copy;

(C) Postage, when the individual has requested that a non-electronic copy, or the summary or explanation, be mailed; and

(D) Labor of preparing an explanation or summary of the protected health information, if agreed to by the individual as required by paragraph (c)(2)(iv) of this section.

(ii) A covered entity may not impose a fee in either of the following circumstances:

(A) An individual inspects the protected health information about the individual, as described at (a)(1) of this section.

(B) An individual accesses electronic protected health information maintained by or on behalf of the covered entity using an internet-based method, such as a personal health application.

(d) *Standard: Directing an electronic copy of certain protected health information to a person designated by the individual*—(1) *Right of access to direct.* Subject to the limitations of paragraph (a)(1) of this section, and except as otherwise provided in paragraphs (d)(2) and (3) of this section, an individual has the right of access to direct a covered entity to transmit an electronic copy of protected health information about the individual (''right of access to direct'') in an electronic health record to a person designated by the individual.

(2) *Unreviewable grounds for denial.* A covered entity may deny an individual's request to exercise the right of access to direct a covered entity to transmit an electronic copy of protected health information in an electronic health record directly to a person designated by an individual under paragraph (d)(1) of this section, without providing an opportunity for review, in the following circumstances:

(i) The protected health information is excepted from the right of access to

direct by paragraph (d)(1) of this section.

(ii) A covered entity that is a correctional institution or a covered health care provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to exercise of the right of access to direct, if transmitting such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate.

(iii) An individual's ability to exercise of the right of access to direct may be temporarily suspended by a covered entity in the course of research that includes treatment for as long as the research is in progress, provided that the individual has agreed to the denial of access when consenting to participate in the research that includes treatment, and the covered entity has informed the individual that the right of access to direct will be reinstated upon completion of the research.

(iv) An individual's request to exercise the right of access to direct may be denied if the protected health information is contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, and if the denial of access under the Privacy Act would meet the requirements of that law.

(v) An individual's request to exercise the right of access to direct may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and providing the copy to the person designated by the individual would be reasonably likely to reveal the source of the information.

(3) *Reviewable grounds for denial of a request to exercise the right of access to direct.* A covered entity may deny an individual's request to exercise the right of access to direct under paragraph (d)(1) of this section, provided that the individual is given a right to have such denials reviewed, as required by paragraph (e)(4) of this section, in either of the following circumstances:

(i) A licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the individual or another person.

(ii) The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.

(4) *Implementation specification: Summary or explanation prepared by covered entity.* (i) The covered entity may transmit, to a person designated by an individual pursuant to the right of access to direct, a summary of requested protected health information in an electronic health record, in lieu of transmitting a copy of the protected health information, or may transmit an explanation of the requested protected health information in an electronic health record in addition to such protected health information, if all of the following conditions apply:

(A) The individual agrees in advance to such a summary or explanation.

(B) The individual agrees in advance to the fees imposed, if any, by the covered entity for such summary or explanation.

(ii) The covered entity must inform an individual with respect to whose protected health information it offers to transmit a summary to a person designated by the individual in lieu of a copy of protected health information that the individual retains the right of access to direct an electronic copy of the requested protected health information in an electronic health record if the individual does not agree to direct such summary. This requirement does not apply if a covered entity is offering to provide a summary in lieu of a copy of protected health information because the covered entity is denying an individual's request to exercise the right of access to direct; however, the covered entity still must follow the denial procedures under § 164.524(e).

(5) *Implementation specification: Requests for access and timely action.* (i) *Individual's request for access.* The covered entity must permit an individual to exercise the right of access to direct where the request is clear, conspicuous, and specific. The covered entity may require individuals to make requests for such access in writing, provided that it informs individuals of such a requirement. For purposes of this paragraph, in writing means that the request itself serves as documentation of the individual's exercise of the right of access to direct, including when the request is submitted electronically or on paper.

(ii) *Timely action by the covered entity.* (A) Except as provided in paragraph (d)(5)(ii)(B) of this section, the covered entity is required to provide an electronic copy requested under paragraph (d)(1) of this section as soon as practicable, but no later than 15 calendar days after receipt of an individual's request, and the following conditions must be met:

(*1*) If the covered entity grants the request, in whole or in part, it must inform the individual of the acceptance of the request and provide the access requested, in accordance with paragraph (d) of this section.

(*2*) If the covered entity denies the individual's request to exercise the right of access to direct, in whole or in part, it must provide the individual with a written denial, in accordance with paragraph (e)(2) of this section.

(B) If the covered entity is unable to take an action required by paragraph (d)(5)(ii)(A)(*1*) or (*2*) of this section within the time required by paragraph (d)(5)(ii)(A) of this section, as applicable, the covered entity may extend the time for such actions by no more than 30 calendar days, provided that:

(*1*) The covered entity, within the time limit set by paragraph (d)(5)(ii)(A) of this section, as applicable, provides the individual with a written statement of the reasons for the delay and the date by which the covered entity will complete its action on the individual's request to exercise the right of access to direct; and

(*2*) The covered entity may have only one such extension of time for action on the individual's request to exercise the right of access to direct.

(C) Where another federal or state law requires a covered entity to provide an individual with an electronic copy of the protected health information in an electronic health record in less than 15 calendar days, that shorter time period is deemed practicable for purposes of paragraph (d)(5)(ii)(A) of this section.

(e) *Implementation specifications: Denial of access.* If a covered entity denies an individual's right of access, in whole or in part, to protected health information pursuant to paragraph (a) or (d) of this section, the covered entity must comply with the following requirements.

(1) *Making other information accessible.* The covered entity must, to the extent possible, give the individual, or a person designated by the individual, access to any other protected health information requested pursuant to paragraph (a) or (d) of this section, after excluding the protected health information as to which the covered entity has a ground to deny access.

(2) *Denial.* The covered entity must provide a timely, written denial to the individual. The denial must be in plain language and contain all of the following:

(i) The basis for the denial.

(ii) If applicable, a statement of the individual's right of review under paragraph (e)(4) of this section, including a description of how the individual may exercise such right.

(iii) A description of how the individual may complain to the covered entity pursuant to the complaint procedures in § 164.530(d) or to the Secretary pursuant to the procedures in § 160.306 of this subchapter. The description must include the name, or title, and telephone number of the contact person or office designated in § 164.530(a)(1)(ii).

(3) *Other responsibility.* If the covered entity (or its business associate on the covered entity's behalf) does not maintain the protected health information that is the subject of the individual's request for access, and the covered entity knows where the requested protected health information is maintained, the covered entity must inform the individual where to direct the request for access.

(4) *Right to review of denial.* If the individual requests a review of a denial on a ground permitted under paragraphs (a)(3) or (d)(3) of this section, the covered entity must designate a licensed health care professional who was not directly involved in the denial to review the decision to deny access. The covered entity must promptly refer a request for review to such designated reviewing official. The designated reviewing official must determine, within a reasonable period of time, whether or not to deny the access requested based on the standards in paragraph (a)(3) or (d)(3) of this section. The covered entity must promptly provide written notice to the individual of the determination of the designated reviewing official and take other action as required by this section to carry out the designated reviewing official's determination.

(f) *Implementation specification: Documentation.* A covered entity must document all of the following and retain the documentation as required by § 164.530(j):

(1) The designated record sets that are subject to the right of access under paragraph (a) of this section.

(2) The electronic health records that are subject to the right of access to direct under paragraph (d) of this section.

(3) The titles of the persons or offices responsible for receiving and processing requests for access made pursuant to paragraphs (a) and (d) of this section.

* * * * *

■ 11. Add § 164.525 to subpart E to read as follows:

§ 164.525 Notice of access and authorization fees.

If a covered entity imposes fees for copies of protected health information requested under this subpart, the covered entity must post a fee schedule on its website, if it has one, and make the fee schedule available to individuals at the point of service and upon request. The fee schedule must specify all of the following:

(a) All types of access to protected health information available free of charge.

(b) Standard fees for all of the following copies, where the covered entity generally charges for such copies:

(1) Copies of protected health information provided under § 164.524(a) and § 164.524(d), with respect to all available electronic and non-electronic forms and formats for such copies.

(2) Copies of protected health information disclosed pursuant to the individual's valid authorization under § 164.508, with respect to all available forms and formats for such copies.

■ 12. Amend § 164.532 by revising paragraph (e) to read as follows:

§ 164.532 Transition provisions.

* * * * *

(e) *Implementation specification: Deemed compliance*—(1) *Qualification.* Notwithstanding other sections of this part, a covered entity, or business associate with respect to a subcontractor, is deemed to be in compliance with the documentation and contract requirements of §§ 164.308(b), 164.314(a), 164.502(e), and 164.504(e), with respect to a particular business associate relationship, for the time period set forth in paragraph (e)(2) of this section, if:

(i) Prior to November 19, 2026, such covered entity, or business associate with respect to a subcontractor, has entered into and is operating pursuant to a written contract or other written arrangement with the business associate that complies with the applicable provisions of § 164.314(a) or § 164.504(e) that were in effect on such date; and

(ii) The contract or other arrangement is not renewed or modified from January 19, 2027, until July 19, 2027.

(2) *Limited deemed compliance period.* A prior contract or other arrangement that meets the qualification requirements in paragraph (e) of this section shall be deemed compliant until the earlier of:

(i) The date such contract or other arrangement is renewed or modified on or after July 19, 2027; or

(ii) January 18, 2028.

(3) *Covered entity responsibilities.* Nothing in this section shall alter the requirements of a covered entity to comply with part 160, subpart C of this subchapter and §§ 164.524, 164.526, 164.528, and 164.530(f) with respect to protected health information held by a business associate.

* * * * *

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

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Part IV

Department of Commerce

Bureau of Industry and Security

15 CFR Parts 732, 734, 740, et al.
Addressing Remote Access to Advanced Semiconductors; Interim Final Rule

DEPARTMENT OF COMMERCE

Bureau of Industry and Security

15 CFR Parts 732, 734, 740, 742, 743, 744, 748, 762, 772, and 774

[Docket No. 261116–0005]

RIN 0694–AK50

Addressing Remote Access to Advanced Semiconductors

AGENCY: Bureau of Industry and Security, Department of Commerce.

ACTION: Interim final rule.

SUMMARY: In this interim final rule (IFR), the Department of Commerce is establishing new rules to prevent certain foreign actors from leveraging advanced computing power based on U.S. technology to threaten U.S. national security and foreign policy interests. First, this rule establishes new restrictions which will apply for exports, reexports, or transfers (in-country) to overseas data centers that remotely supply significant volumes of compute to companies headquartered in Country Group D:5 or Macau. These restrictions will undermine the ability of companies headquartered in countries of concern from using U.S. advanced Super Intelligence (SI) semiconductors to train advanced SI models. Data centers, foreign foundries, and chip exporters are required to perform robust due diligence on their customers, including any direct or indirect ownership or control by persons in Country Group D:5 or Macau, as part of complying with this new control. The license requirement will not apply to commercial recommender systems, such as those used by online retailers or social media companies, as these functions do not pose the same national security threat. Second, in addition to the current license requirements for advanced semiconductors, a license will be required to export, reexport, or transfer (in-country) advanced semiconductors to Indonesia, Malaysia, Singapore, Thailand, or Brazil (and any additional country designated by the Secretary of Commerce, in consultation with the Secretary of State or the Assistant to the President for National Security Affairs)—countries which present a higher-than-normal risk of diversion. The license requirement for these five countries will not apply to semiconductors destined to companies headquartered in, or whose ultimate parent company is headquartered in, the United States, provided certain reporting requirements are met. Commerce will be actively monitoring for countries that tolerate evasion of this IFR and will consider a range of consequences for such countries, such as import restrictions, new license requirements on advanced semiconductor exports, downgrading the country's status in the U.S. export control regime, and Entity List designations and temporary export prohibitions for foreign persons involved in such activities. Third, this IFR amends the presumptions which front-end chips fabricators and chip packagers face when exporting advanced-node logic chips. These amendments reduce the number of pathways to overcome the presumptions for chip designers located in destinations which face a license requirement for SI chips. This change gives the U.S. government critical oversight over companies headquartered in certain countries that seek to leverage advanced semiconductor production capabilities in third countries. Finally, the IFR formally rescinds the regulations implementing the Biden-era AI Diffusion Rule. The AI Diffusion Rule has never been enforced. The regulatory changes in this rule formalize the rescission of the AI Diffusion Rule, which the Department of Commerce Bureau of Industry and Security (BIS) announced in May 2025.

DATES:

Effective date: This rule is effective November 19, 2026.

Comment due date: Comments on the revisions and additions in this rule must be received by BIS no later than January 19, 2027.

ADDRESSES: Comments on this rule may be submitted to the Federal rulemaking portal (*www.regulations.gov*). The *regulations.gov* ID for this rule is: BIS–2026–0628. Please refer to RIN 0694–AK50 in all comments.

All filers using the portal should use the name of the person or entity submitting the comments as the name of their files, in accordance with the instructions below. Anyone submitting business confidential information should clearly identify the business confidential portion at the time of submission, file a statement justifying nondisclosure and referring to the specific legal authority claimed, and provide a non-confidential version of the submission.

For comments submitted electronically containing business confidential information, the file name of the business confidential version should begin with the characters ''BC.'' Any page containing business confidential information must be clearly marked ''BUSINESS CONFIDENTIAL'' on the top of that page. The corresponding non-confidential version of those comments must be clearly marked ''PUBLIC.'' The file name of the non-confidential version should begin with the character ''P.'' Any submissions with file names that do not begin with either a ''BC'' or a ''P'' will be assumed to be public and will be made publicly available through *https://www.regulations.gov.* Commenters submitting business confidential information are encouraged to scan a hard copy of the non-confidential version to create an image of the file, rather than submitting a digital copy with redactions applied, to avoid inadvertent redaction errors which could enable the public to read business confidential information.

FOR FURTHER INFORMATION CONTACT:

For general questions, contact Timothy Mooney, Director, Regulatory Policy Division, Office of Exporter Services, Bureau of Industry and Security, U.S. Department of Commerce at 202–482–2440 or by email: *RPD2@bis.doc.gov*.

For technical information, contact Patrick McCartney, Director, AI, Computers, and Telecommunications Division, Bureau of Industry and Security, U.S. Department of Commerce at 202–482–0707 or by email: *patrick.mccartney@bis.doc.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

In this IFR, BIS is amending the EAR (15 CFR parts 730–774) to establish new controls to ensure that computing power, based on U.S. technology located in foreign data centers, is not used in a manner contrary to U.S. national security or foreign policy interests. This IFR accomplishes this by:

- Adding an end-use control requiring a license for exports, reexports, or transfers (in-country) of advanced SI [1] items when there is ''knowledge'' the items are destined for use in data centers, wherever located, that will provide direct or indirect access to a significant volume of computing power to or for an entity headquartered in, or whose ultimate parent company is headquartered in, Macau or destination specified in Country Group D:5. License applications will be reviewed on a case-by-case basis. These changes are contained in new § 744.24(a)(1). In addition, if subsequent to the original

[1] Pursuant to Executive Order 14434, *Inaugurating the Era of Super Intelligence,* the terms ''Super Intelligence'' and ''SI'' is used in place of ''Artificial Intelligence'' or ''AI''.

export of advanced SI semiconductors to an overseas data center, that data center starts providing, directly or indirectly, significant volumes of compute to companies headquartered, or with an ultimate parent headquartered, in Macau or Country Group D:5, the owner, operator of the overseas data center, or other party making the transfer will be required to obtain a license. Any data center providing significant volume of compute power to companies headquartered, or with an ultimate parent headquartered, in Macau or Country Group D:5 prior to the publication date of this rule that wishes to continue providing these services must obtain a license with 90 days of the effective date of this IFR or face future export restrictions. However, the license requirement will not apply to 'commercial recommender systems,' such as those used by online retailers and social media companies, as these functions do not pose the same national security threat.

This new control is a logical extension of existing controls. At present, a license is required to export, reexport, or transfer (in-country) advanced SI semiconductors for entities headquartered in, or whose ultimate parent company is headquartered in, Country Group D:5 or Macau. Through this rule, BIS is imposing restrictions that will undermine those entities' ability to access significant volumes of advanced SI semiconductors remotely, including through connected cloud computing.

- Adding a destination-based license requirement for advanced SI items for destinations for which there is an unacceptable risk of diversion—which for the purposes of this IFR are Indonesia, Malaysia, Singapore, Brazil, and Thailand. See amendments to § 742.6(a)(6)(iii)(A)(*1*).
- Rescinding the worldwide Regional Stability (RS) license requirement and other regulatory changes implemented by the AI Diffusion rule, ''Framework for Artificial Intelligence Diffusion'' published January 15, 2025 (90 FR 4544) (''AI Diffusion Rule'').

By making these changes, this IFR prevents the use of certain SI items in data centers and at a computing power level that can be used for training or running of advanced SI models. Access to such computing power can be used to train and run advanced SI models capable of supporting military- and intelligence-related activities that could threaten U.S. national security or foreign policy interests, *e.g.,* using advanced SI for developing more effective weapons of mass destruction and advanced conventional weapons, coordinated cyber-espionage and targeted cyber-disruption, algorithmic theft, and weaponized disinformation.

Specifically, BIS is enhancing and streamlining the licensing policy on items controlled under Export Control Classifications Numbers (ECCNs) 3A090 and 4A090 and the corresponding .z items by using a combination of more focused and effective destination-based controls and enhanced end-use controls. This IFR amends the EAR to reflect a revision to the license review policy for these items in parts 742 (Regional stability) and 744 (Control Policy: End-User and End-Use Based) to simplify the licensing process for SI integrated circuits (ICs) and other SI-related items. The changes promulgated in this IFR follow extensive U.S. government consideration of the impact of these controls on U.S. national security and foreign policy interests.

II. License Requirements and Review Policy

Changes to § 742.6 Regional Stability

This IFR revises § 742.6 to impose new license requirements and licensing policies for advance computing items identified in paragraph (a)(6)(iii)(A).

First, under § 742.6(a)(6)(iii)(A)(*1*), a license is required for exports, reexports, or transfers (in-country) to or within Indonesia, Malaysia, Singapore, Brazil, and Thailand. As noted in section I of this preamble, these countries are being added in response to concerns that advanced computing items subject to EAR licensing requirements are being diverted to entities and countries of concern without authorization. See section III of this preamble for a discussion of those controls.

The license requirements for items described in § 742.6(a)(6)(iii)(A)(*1*) do not apply to exports, reexports, and transfers (in-country) to an ultimate consignee or end user headquartered in, or whose ultimate parent company is headquartered in, the United States, provided the reporting requirements of new § 743.10, described in section VI of this preamble, are met by the exporter, reexporter, or transferor. This is explained under new Note 1 to paragraph (a)(6)(iii)(A)(*1*) of § 742.6.

Second, under § 742.6(a)(6)(iii)(A)(*2*), this IFR amends the worldwide licensing requirement to require a license for exports, reexports, or transfers (in-country) to or within destinations specified in Country Groups D:1, D:4, and D:5, excluding destinations specified in Country Groups A:5 or A:6, as well as the United Arab Emirates—to the extent a license would otherwise be required by the final rule ''Enhanced Favorable Treatment for the United Arab Emirates Under the Export Administration Regulations'' (91 FR 43034, July 14, 2026).

For the license requirements under paragraph (a)(6)(iii)(A)(*1*) of § 742.6, applications for exports, reexports, and transfers (in-country) will be reviewed on a case-by-case basis to determine whether the transaction is contrary to the national security or foreign policy interests of the United States, as described under § 742.6(b)(10)(iii)(A)(*1*). Pursuant to § 742.6(b)(10)(iii)(A)(*1*), destinations will be evaluated on the effectiveness of their export control regimes and their coordination with BIS on the enforcement of export controls.

III. End-Use Restrictions

A. Changes to Part 744—Control Policy: End-User and End-Use Based

This IFR adds new § 744.24 Restrictions on exports, reexports, and transfers (in-country) of certain advanced computing items for use in data centers for end-uses and destinations of concern. Section 744.24 provides, in addition to the license requirements set forth elsewhere in the EAR, a prohibition on exports, reexports, or transfers (in-county) of advanced SI items without a license if, at the time of export, reexport, or transfer (in-country), you have ''knowledge'' that the item will be or is intended to be used in a data center end-use that is prohibited under paragraphs (a)(1) of § 744.24.

You may not knowingly export, reexport, or transfer (in-county) items specified in paragraph (a) of § 744.24 for use in a data center to or within any destination worldwide that will provide access to more than 12,000,000 ''aggregate TPP'' (either at one data center or through 'linked data centers' (including digitally-linked infrastructure, not just physically-linked infrastructure) to companies headquartered in, or whose ultimate parent company is headquartered in, Macau or a destination specified in Country Group D:5 in supplement no. 1 to part 740 of the EAR. 'Linked data centers' are data centers that use networking infrastructure that links two or more separate data centers together to allow physical and virtual facilities to share resources, balance workloads, and replicate data as a unified whole. This prohibition is described under § 744.24(a)(1) and the definition is provided in § 744.24(d). The term ''for an entity'' as used in this § 744.24(a)(1)

applies to instances in which there is ''knowledge'' that a data center is providing remote access to a non-D:5 customer that is in turn training SI models for, or participating in the training of SI models for, or providing SI models to a D:5 company. This control will cut off additional potential diversion pathways and evasion efforts.

These controls are necessary because providing computer power access at this level or greater will allow for training or running of advanced SI models; the Secretary of Commerce has determined that it could pose a national security and foreign policy threat to the United States when such computing power access will be provided to or for companies headquartered, or whose ultimate parent company is headquartered in, Macau or a destination specified in Country Group D:5—unless the computing power is exclusively used for commercial recommender systems. Access to advanced computing power presents significant national security and foreign policy concerns, primarily by enabling foreign countries or other entities of concern to accelerate the development of weapons of mass destruction (WMD), execute sophisticated zero-day cyberattacks on critical infrastructure, and disrupt global military balances of power—unless the computing power is exclusively used for commercial recommender systems.

Consistent with the national security and foreign policy concerns outlined in this IFR, BIS is imposing a notification and authorization requirement for subsequent changes in end-use. This requirement, provided in new paragraph (e) of § 744.24, and described in more detail further in this section, is triggered if there is a change in end-use of the items described in paragraph (a)(1) of § 744.24. In the event of such a change, a BIS authorization may be required. Relatedly, Note 1 to paragraph (a)(1) of § 744.24 provides that the prohibition applies regardless of whether the person in possession of the EAR item was a party to the transaction to the original export, reexport, or transfer (in-country), *i.e.,* the original shipment of the items to the data center. Because this EAR end-use control under § 744.24(a)(1) applies to any subsequent reexport or transfer (in-country), including changing from a non-prohibited end-use to a prohibited end-use, it is important that parties in possession of these items are aware of the need to review § 744.24(a)(1) for any subsequent reexport or transfer (in-country).

The prohibition described in paragraph (a)(1) applies regardless of whether a U.S.-origin item specified under paragraph (a) of § 744.24 has been incorporated or commingled into or with a foreign-made item. Reexporters and transferors may not rely on the *de minimis* provisions for incorporating or commingling U.S.-origin items specified under paragraph (a) of § 744.24 into foreign-made items where there is ''knowledge'' at any point in the chain from the development, production, or use of the foreign-made item that the U.S.-origin item will be used in this prohibited end-use under paragraph (a)(1) of § 744.24. This prohibition under § 744.24 is described under Note 2 to paragraph (a)(1).

Note 3 to paragraph (a)(1) describes due diligence expectations imposed on ''U.S. persons'' and foreign data centers to ensure compliance with these controls. Foreign data centers will be expected to perform robust due diligence on their customers to identify direct or indirect ownership or control by Country Group D:5 or Macau persons. This diligence will ensure that companies cannot circumvent new controls through corporate restructurings or spinoffs.

This IFR adds an ''is informed'' process under paragraph (a)(2) of § 744.24 to impose an additional prohibition on persons informed by BIS that a license is required for the export, reexport, or transfer (in-country) of specified items to certain persons or destinations, because there is an unacceptable risk of use in, or diversion to, the activities specified in paragraph (a)(1) of § 744.24. Notifications made under paragraph (a)(2) that there is an unacceptable risk of use in, or diversion to an end use specified in § 744.24 may be made either individually by specific notice or through amendment to the EAR.

As described under § 744.24(b), no license exceptions may overcome the prohibition described in paragraph (a)(2) of § 744.24, except when noted by BIS. The prohibitions under § 744.24 do not apply when the computing power access is being provided exclusively for a 'commercial recommender system' under the (b)(2) exception provided the reporting requirements described therein are followed.

Applications for licenses required by § 744.24 will be reviewed on a case-by-case basis as described under § 744.24(c).

This IFR adds paragraph (d) to define for purposes of § 744.24 the terms: 'linked data centers'; and 'commercial recommender system':

For purposes of § 744.24, 'linked data center' means a data center that uses networking infrastructure that links two or more separate data centers together that allows physical and virtual facilities to share resources, balance workloads, and replicate data as a unified whole. This includes digitally-linked infrastructure, not just physically-linked infrastructure.

For purposes of § 744.24, 'commercial recommender system' means a Super Intelligence (SI) tool exclusively designed and exclusively used to rank, filter, or suggest commercial products, services, or content to users based on user behavior, transaction history, or item attributes. This term does not include any SI system designed or used to generate novel text, image, audio, video, software, or other content in response to user inputs, or any system that incorporates such model, regardless of whether the system also performs recommendation functions.

This IFR adds paragraph (e) to impose a notification and authorization requirement for subsequent changes in end-use. New paragraph (e) specifies that for any export, reexport, or transfer made on or after November 19, 2026 without a license, *i.e.,* because the exporter, reexporter, or transferor had no ''knowledge'' that the item is for a prohibited end-use under this section and no other EAR license requirement applies, the exporter, reexporter, or transferor must inform the recipient that BIS authorization is required if the item will be transferred in-country; and that the recipient must follow the know-your-customer guidance in supplement no. 3 Part 732 of the EAR. The notification also must specify that the transferor, *e.g.,* the data center operator, must obtain authorization for this change in end-use. Changes in end-use from a non-prohibited end-use to a prohibited end-use under paragraphs (a)(1) are considered a ''transfer (in-country)'' for purposes of paragraphs (a)(1) or (2) and require an EAR authorization under § 744.24.

B. Conforming Change to 744.23 for Removal of Worldwide License Requirement in This IFR

This IFR, as described under section II of this preamble, removes the worldwide license requirement from former § 742.6(a)(6)(iii)(A). As a conforming change, this IFR makes revisions to the advanced computing items end-use control under § 744.23(a)(3) to ensure that a license will continue to be required for exports, reexports, and transfers (in-country) of these advanced computing items when such items are destined for entities headquartered in, or whose ultimate parent company is headquartered in, Country Group D:5 or Macau.

Specifically, this IFR revises § 744.23 ''Supercomputer,'' ''advanced-node integrated circuits,'' and semiconductor manufacturing equipment end-use controls under paragraph (a)(3)(i)(A) to specify that this end-use control for advanced computing items includes all advanced computing items (*e.g.,* those specified in ECCNs 3A090 (except for 3A090.c), 4A090, and related .z paragraph items). Prior to this IFR, there was an enforced license requirement under § 742.6(a)(6)(iii)(A) of the EAR that applied to all destinations outside of the United States for these advanced computing items when such items are destined to entities headquartered in, or whose ultimate parent company is headquartered in, Country Group D:5 or Macau. *See* the May 31, 2026, ''Guidance Regarding Enforcement of License Requirements for Advanced Computing Items for Entities Headquartered in Country Group D:5 and Macau'' on the BIS website at *http://www.bis.gov.* With the removal of the worldwide license requirement this IFR makes a required conforming change to return the license requirement for these advanced computing items to § 744.23(a)(3)(i)(A).

For § 744.23(a)(3)(i)(A), BIS has received inquiries regarding the meaning of the phrase ''for an entity'' that is headquartered in, or whose ultimate parent company is headquartered in, either Macau or a destination specified in Country Group D:5. As stated in BIS's October 2023 Advanced Computing/Supercomputing (''AC/S'') IFR (88 FR 73458) this control was intended to ensure that the national security and foreign policy objectives of the October 7, 2022 IFR and the AC/S IFR are not undermined by Macau, the People's Republic of China (PRC), or other Country Group D:5 headquartered entities setting up cloud servers or data centers in other countries to allow these entities of concern to continue to train their SI models in ways that would be contrary to U.S. national security and foreign policy interests. This end-use control thus is not, and has never been limited only to exports, reexports, and transfers (in-country) destined to such entities of concern as ultimate consignees or end users, but extends to exports, reexports, or transfers (in-country) *on behalf of* these entities of concern, *e.g.,* if an entity of concern was the purchaser in the transaction (directly or indirectly) or was the exclusive or primary (greater than 50 percent of total compute) remote end user of the data center computing capacity. Exporters, reexporters, and transferors are encouraged to examine both end-use controls in § 744.23(a)(3) and in new § 744.24 to the extent their transactions involve exports, reexports, or transfers to data centers outside of the United States where there is knowledge that a company headquartered in, or whose ultimate parent is headquartered in, Macau or D:5 will be an intended remote end user. Any entities in violation of this requirement should submit a voluntary self-disclosure (see Section 764.5 of the EAR). Bona fide operators of data centers who are otherwise engaged in activities consistent with the EAR and were providing remote access used for 'commercial recommender systems' (as defined in the new § 744.24(d)(1)) may continue providing these services for 90 days, but must obtain a license following expiration of this period to continue these services. Finally, § 744.23(a)(3)(i)(C) is added to create a license requirement for ''applicable advanced node integrated circuits'' that are subject to the EAR, specified in 3A090.a, designed by a company that is neither an approved IC designer (specified in supplement no. 6 to part 740) or an authorized IC designer (as described in Note 1 to 3A090.a), and exported, exported from abroad, reexported, or transferred (in-country) by a ''front end fabricator'' or ''OSAT'' to or within any destination. This addition ensures that a license requirement continues to apply to ''front end fabricators'' and ''OSATs'' creating advanced ICs for non-approved, non-authorized IC designers wherever located. Additionally, the presumption created in Note 1 to 3A090.a continues to apply but can be overcome by the ''front end fabricator'' or ''OSAT'' if they follow the due diligence steps specified in that note. BIS notes that the inclusion of the phrase ''exported from aboard'' in this new paragraph is simply descriptive and not intended to indicate that the activity of exporting from destinations other than the United States is not captured in provisions of the EAR where that phrase is omitted.

IV. Rescinded Provisions of the AI Diffusion Rule

A. Revoking Model Weights Controls

This IFR revokes the controls on model weights published in the AI Diffusion Rule. BIS has determined that a more effective approach to address national security and foreign policy concerns that arise from the transfer of model weights is through the use of specified destination-based or end-use license requirements. Accordingly, ECCN 4E091 is removed from the CCL in supplement no. 1 to part 774. This IFR also makes the necessary conforming changes to other parts of the EAR to remove references to ECCN 4E091 and model weights by: (1) removing Red Flag 28 in supplement no. 3 to part 732; (2) removing the AI Model weights Foreign Direct Product (FDP) rule in § 734.9; (3) removing reference to 4E091 from § 740.2; (4) removing the RS license requirement text that applies to AI model weights in § 742.6; (5) removing 748.3(f); and (6) removing the definition of ''Model Weights'' in § 772.1.

B. Removing Country Tiers, Data Center VEUs, and Related Regulatory Language

This IFR revokes the tiers of countries created in the AI Diffusion Rule and the final rule for ''Expansion of Validated End User Authorization: Data Center Validated End User Authorization,'' 89 FR 80080 (Oct. 2, 2024), which were implemented through License Exception Artificial Intelligence Authorization (AIA) in § 740.27, supplement no. 5 to part 740, the Data Center Validated End-Users (VEU) Authorization in § 748.15 and supplement no. 8 to part 748 (including reverting the reference to General VEU Authorization to use VEU Authorization wherever the term is used).

Specifically, this IFR removes License Exception AIA from the EAR by: (1) removing reference to this license exception in § 740.2; (2) reserving § 740.27 for future use; (3) removing supplement no. 5 to part 740; and (4) removing AIA from ECCNs in supplement no. 1 to part 774 when listed in the list-based license exceptions section. This IFR removes the Data Center VEU Authorization from § 748.15, supplement no. 8 to part 748, and supplement no. 10 to part 748. This IFR also makes conforming changes to the license review policy in § 742.6 to remove references to supplement no. 5 to part 740.

C. Conforming Changes Due to the Recission of the AI Diffusion Rule

(1) Removing License Exceptions AIA from § 740.2 Restrictions on all License Exceptions;

(2) Removing License Exceptions Artificial Intelligence Authorization (AIA) (§ 740.27) and License Exception Low Processing Performance (LPP) (§ 740.29) from the EAR;

(3) Removing references to the revoked License Exceptions AIA and LPP (formerly in § 740.27 and § 740.29) and adding the notification and authorization requirements in the new § 744.24 in § 762.2 Records to be retained; and

(4) Removing references to the revoked License Exceptions AIA, and LPP (formerly in § 740.27 and § 740.29) from the CCL.

D. Foreign-Direct Product Rules

BIS is retaining the worldwide destination scope of the advanced computing foreign direct product (FDP) rule in § 734.9(h)(2)(i) if there is ''knowledge'' that a foreign-produced item is destined worldwide or will be incorporated into any ''part,'' ''component,'' ''computer,'' or ''equipment'' not designated EAR99 to any location worldwide. Retention of this provision ensures the prohibitions of relevant controls are not otherwise limited.

Though BIS is not making any changes to § 734.9(h), BIS notes that the agency has received questions about the application of that paragraph. Consistent with the robust controls implemented in this IFR, BIS notes that provision's expansive application. If a foreign-produced product is subject to the EAR pursuant to § 734.9(h), BIS retains jurisdiction of that item after its incorporation into another foreign-produced item, as provided by the text of § 734.9(h)(2)(i). For example, if an ECCN 3A090 IC is incorporated into a foreign-produced ''part,'' ''component,'' ''computer,'' or ''equipment'' (such as a GPU board or server), BIS continues to have jurisdiction over the IC and license requirements may apply to the export, reexport, or transfer (in-country) of the IC (and by extension, the server). Generally, BIS does not retain jurisdiction over items after incorporation into other items, absent the applicability of the EAR's *de minimis* provisions. But in this context, specifically, in the relevant ECCN entries (ECCN 4A090 and those ECCNs with a .z paragraph), the CCL notes that such items only meet the specifications for those ECCNs if they contain an ECCN 3A090 IC. Thus, even third parties who only receive a 4A090 item are on notice that such items contain an ECCN 3A090 IC. Furthermore, the retention of BIS's jurisdiction under § 734.9(h) after incorporation is reflected by past BIS guidance to inform parties in the supply chain of the applicability of the FDP rule, including the Model Certification for Purposes of the FDP Rule of supplement no. 1 to part 734 of the EAR.

In addition, consistent with the removal of ECCN 4E091, this IFR removes the AI Model weights FDP rule in § 734.9(l).

E. License Exception Advanced Compute Manufacturing ACM

BIS is retaining License Exception ACM under § 740.28 due to the benefits this license exception plays in supporting the supply chains of export, reexports, and transfers (in-country) of advanced SI items destined to ultimate end users outside of Macau or destinations in Country Group D:5.

V. Amendments to the Presumptions Faced by Front-End Fabricators and OSAT Companies

This IFR also changes the presumptions faced by front-end fabricators and OSAT companies defined in Note 1 to 3A090.a. Specifically, paragraphs b. and c. of Note 1 to 3A090.a are amended to remove eligibility to overcome the presumption in Note 1 to 3A090.a for an integrated circuit designer located in or having an ultimate parent headquartered in a destination specified in Country Groups D;1, D:4, or D:5 of supplement no. 1 to part 740 of the EAR or in paragraph (a)(6)(iii)(A)(1) of § 742.6. Such companies which are not Authorized or Approved IC designers and face a presumption that their IC is 3A090.a for all ''applicable advanced logic integrated circuits''. This addresses potential diversion pathways of advanced ICs.

VI. Conforming Changes

In addition to the changes described in Sections II and III, this IFR makes conforming changes to the EAR due to the changes described in this preamble.

A. Revisions to Part 743

For a transaction to be excluded from the license requirements of § 742.6(a)(6)(iii)(*1*), the exporter, reexporter, or transferor must comply with the reporting requirement introduced by this IFR in new § 743.10 Reporting Requirements to Qualify for Exclusion from Certain Regional Stability Requirements. The reporting requirement mitigates the risk that transactions excluded from this license requirement will be used or diverted contrary to the EAR by allowing the U.S. Government to monitor the items being exported, reexported, or transferred (in-country).

New § 743.10 describes in paragraph (b) the information to be included in the report; in paragraph (c), where to submit the report; in paragraph (d), the timeframe as to when reporting is required; and in paragraph (e), contacts for general information or questions about this report.

B. Addition to Part 772

In addition to removing the definition for ''model weights'' described in section IV.A. of this preamble, this IFR adds a definition to § 772.1 for ''Aggregate TPP'' to describe the sum TPP of a group of ICs or commodities.

C. Revisions to the CCL

Due to the revisions to the RS reason for control under § 742.6 made in this IFR, conforming revisions are made to ECCNs: 3A001, 3A090, 3D001, 3E001, 4A003, 4A004, 4A005, 4A090, 4D001, 4D090, 4E001, 5A002, 5A992, 5A004, 5D002, 5E002, 5E992, and 5D992. For these ECCNs, the reason for control table is revised by removing references to items paragraphs 3A090.a and .b, 4A090.a and .b, and the corresponding .z paragraphs. Additionally, the reference to the worldwide RS license requirement in the control tables is revised with a new reference that a license is required to or within any destination specified in § 742.6(a)(6)(iii)(A) of the EAR.

Savings Clause

For the changes being made in this IFR, shipments of items removed from eligibility for a License Exception or export, reexport, or transfer (in-country) without a license (NLR) as a result of this regulatory action that were en route aboard a carrier to a port of export, reexport, or transfer (in-country), on November 19, 2026, pursuant to actual orders for export, reexport, or transfer (in-country) to or within a foreign destination, may proceed to that destination under the previous eligibility for a License Exception or export, reexport, or transfer (in-country) without a license (NLR), provided the export, reexport, or transfer (in-country) is completed no later than on December 21, 2026.

Export Control Reform Act of 2018

On August 13, 2018, the President signed into law the John S. McCain National Defense Authorization Act for Fiscal Year 2019, which included the Export Control Reform Act of 2018 (ECRA), 50 U.S.C. 4801–4852. ECRA, as amended, provides the legal basis for BIS's principal authorities and serves as the authority under which BIS issues this IFR. In particular, and as noted elsewhere, Section 1753 of ECRA (50 U.S.C. 4812) authorizes the regulation of exports, reexports, and transfers (in-country) of items subject to U.S. jurisdiction. Further, Section 1754(a)(1)–(16) of ECRA (50 U.S.C. 4813(a)(1)–(16)) authorizes, *inter alia,* the establishment of a list of controlled items; the prohibition of unauthorized

exports, reexports, and transfers (in-country); the requirement of licenses or other authorizations for exports, reexports, and transfers (in-country) of controlled items; apprising the public of changes in policy, regulations, and procedures; and any other action necessary to carry out ECRA that is not otherwise prohibited by law. Pursuant to Section 1762(a) of ECRA (50 U.S.C. 4821(a)), these changes can be imposed in an IFR without prior notice and comment.

Rulemaking Requirements

1. BIS has examined the impact of this rule as required by Executive Orders (E.O.) 12866 and 13563, which direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (*e.g.,* potential economic, environmental, public, health, and safety effects, distributive impacts, and equity). Pursuant to E.O. 12866, this rule has been determined to be not significant. This rule is exempt from the requirements of E.O. 14192 because it is being issued with respect to a national security function of the United States, per section 5(a) of E.O. 14192.

2. Notwithstanding any other provision of 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 of 1995 (44 U.S.C. 3501 *et seq.*) (PRA), unless that collection of information displays a currently valid Office of Management and Budget (OMB) Control Number. This rule involves the following OMB-approved collections under control numbers 0694–0088, ''Multi-Purpose Application;'' 0694–0096, ''Five Year Records Retention Period;'' 0694–0096, ''Advance Computing Items License Requirement Exclusion Submissions and Forms;'' and 0607–0152, ''Automated Export System (AES) Program.''

For OMB control number 0694–0088, *Simple Network Application Process and Multipurpose Application Form.* BIS expects an annual increase of approximately 100 licenses for an increase in burden in 50 burden hours per year for this collection with an estimated cost increase of $1,900. BIS believes that this increase in burden falls within the already approved amounts for this existing collection.

Changes impacting OMB control numbers 0694–0096, and 0607–0152 *Five Year Records Retention Period* and *Automated Export System (AES) Program,* respectively, are not expected to result in a change in burden hours.

With this rule, BIS has requested emergency approval of revisions of an existing collection of information OMB Control Number 0694–0137, ''License Exceptions and Other Authorizations. BIS expects a net annual increase of approximately 970 submissions for an increase in burden of 440 burden hours for this collection with an estimated cost increase of $16,720, which takes into account the increase of reporting required under new § 743.10 and the reduction of recordkeeping and reporting eliminated with the removal of License Exceptions Artificial Intelligence Authorization (AIA) (§ 740.27) and License Exception Low Processing Performance (LPP) (§ 740.29) from the EAR. BIS expects the burden hours for this collection to fall within the already approved amounts for this existing collection. Upon approval of these emergency revisions, BIS will publish a separate 60 day notice requesting comment.

BIS invites comments as part of this rulemaking on if these collections of information are necessary and whether they will have practical utility; whether our estimate of the public burden of this collection of information is accurate and based on valid assumptions and methodology; and ways to enhance the quality, utility, and clarity of the information to be collected. Current information regarding all of these collections of information—including all background materials—can be found at *https://www.reginfo.gov/public/do/PRAMain* by using the search function to enter either the title of the collection or the OMB Control Number.

3. This rule does not contain policies with federalism implications as that term is defined in Executive Order 13132.

4. Pursuant to section 1762 of the Export Control Reform Act of 2018, this action is exempt from the Administrative Procedure Act (5 U.S.C. 553) requirements for notice of proposed rulemaking, opportunity for public participation, and delay in effective date.

5. Because a notice of proposed rulemaking and an opportunity for public comment are not required to be given for this rule by 5 U.S.C. 553, or by any other law, the analytical requirements of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.,* are not applicable. Accordingly, no regulatory flexibility analysis is required and none has been prepared.

List of Subjects

15 CFR Parts 732 and 740

Administrative practice and procedure, Exports, Reporting and recordkeeping requirements.

15 CFR Part 734

Administrative practice and procedure, Exports, Inventions and patents, Research, Science and technology.

15 CFR Part 742

Exports, Terrorism.

15 CFR Part 743

Administrative practice and procedure, Reporting and recordkeeping requirements.

15 CFR Part 744

Exports, Reporting and recordkeeping requirements, Terrorism.

15 CFR Part 748

Administrative practice and procedure, Exports, Reporting and recordkeeping requirements, Terrorism.

15 CFR Part 762

Administrative practice and procedure, Business and industry, Confidential business information, Exports, Reporting and recordkeeping requirements.

15 CFR Part 772

Exports.

15 CFR Part 774

Exports, Reporting and recordkeeping requirements.

For the reasons stated in the preamble, BIS amends 15 CFR parts 732, 734, 740, 742, 743, 744, 748, 762, 772, and 774 as follows:

PART 732—STEPS FOR USING THE EAR

■ 1. The authority citation for part 732 is revised to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 1701 *et seq.;* E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228.

Supplement No. 3 to Part 732 [Amended]

■ 2. Amend supplement no. 3 to part 732 by removing and reserving paragraph 28 under ''Red Flags.''

PART 734—SCOPE OF THE EXPORT ADMINISTRATION REGULATIONS

■ 3a. The authority citation for part 734 continues to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.;* E.O.

12938, 59 FR 59099, 3 CFR, 1994 Comp., p. 950; E.O. 13020, 61 FR 54079, 3 CFR, 1996 Comp., p. 219; E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228; E.O. E.O. 13637, 78 FR 16129, 3 CFR, 2014 Comp., p. 223; Notice of November 7, 2024, 89 FR 88867 (November 8, 2024).

§ 734.9 [Amended]

■ 3b. Amend § 734.9 by removing paragraph (l).

PART 740—LICENSE EXCEPTIONS

■ 4. The authority citation for part 740 continues to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 1701 *et seq.;* 22 U.S.C. 7201 *et seq.;* E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228.

■ 5. Amend § 740.2 by revising paragraph (a)(9)(ii) to read as follows:

§ 740.2 Restrictions on all License Exceptions.

* * * * *

(a) * * *

(9) * * *

(ii) The item is identified in paragraph (a)(9)(ii)(A) or (B) of this section, is being exported, reexported, or transferred (in-country) to or within a destination specified in § 742.6(a)(6)(iii)(A), excluding the United Arab Emirates, or to an entity headquartered in or whose ultimate parent company is headquartered in, Macau or a destination specified in Country Group D:5, wherever located, and the license exception is other than: TMP, restricted to eligibility under the provisions of § 740.9(a)(6); NAC/ACA, under the provisions of § 740.8; RPL, under the provisions of § 740.10; GOV, restricted to eligibility under the provisions of § 740.11(b); TSU under the provisions of § 740.13(a) and (c); HBM under the provisions of § 740.25; or ACM under the provisions of § 740.28. Items restricted to eligibility only for the foregoing license exceptions are:

(A) Controlled under ECCNs 3A090, 4A090, or associated software and technology in 3D001, 3E001, 4D090, and 4E001;

(B) An integrated circuit, ''electronic assembly'' or ''component'' or related software or technology specified in ECCNs 3A001.z.4; 3D001 (for ''software'' for commodities controlled by 3A001.z.4, 3A090); 3E001 (for ''technology'' for commodities controlled by 3A001.z.4); 4A003.z; 4A004.z; 4A005.z; 4D001 (for ''software'' for commodities controlled by 4A003.z, 4A004.z, and 4A005.z); and 4E001 (for ''technology'' for commodities controlled by 4A003.z, 4A004.z, 4A005.z); 5A002.z; 5A004.z; 5A992.z; 5D002.z; 5D992.z; 5E002 (for ''technology'' for commodities controlled by 5A002.z or 5A004.z); ''software'' specified by 5D002 (for 5A002.z or 5A004.z commodities)); 5E992 (for ''technology'' for commodities controlled by 5A992.z or ''software'' controlled by 5D992.z).

Note 1 to paragraph (a)(9)(ii): *ECCN 3A090.c requires a license for exports, reexports, and transfers (in-country) to or within Macau or destinations specified in Country Group D:5, but is still included within the scope of this paragraph because it generally shares the same EAR license exception eligibility as other 3A090 commodities, except for NAC/ACA, under the provisions of § 740.8, for which ECCN 3A090.c is not eligible. An export, reexport, or transfer (in-country) of an ECCN 3A090.c commodity to a destination specified in Country Groups D:1 or D:4 that is not specified in Country Group D:5, may be made under the No License Required (NLR) designation, provided no part 744 or 746 license requirements are applicable.*

* * * * *

§ 740.27 [Removed and Reserved]

■ 6. Remove and reserve § 740.27.

§ 740.29 [Removed and Reserved]

■ 7. Remove and reserve § 740.29.

Supplement No. 5 to Part 740 [Removed and Reserved]

■ 8. Remove and reserve supplement no. 5 to part 740.

PART 742—CONTROL POLICY—CCL BASED CONTROLS

■ 9. The authority citation for part 742 continues to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.;* 22 U.S.C. 3201 *et seq.;* 42 U.S.C. 2139a; 22 U.S.C. 7201 *et seq.;* 22 U.S.C. 7210; Sec. 1503, Pub. L. 108–11, 117 Stat. 559; E.O. 12058, 43 FR 20947, 3 CFR, 1978 Comp., p. 179; E.O. 12851, 58 FR 33181, 3 CFR, 1993 Comp., p. 608; E.O. 12938, 59 FR 59099, 3 CFR, 1994 Comp., p. 950; E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228; E.O. 13222, 66 FR 44025, 3 CFR, 2001 Comp., p. 783; Presidential Determination 2003–23, 68 FR 26459, 3 CFR, 2004 Comp., p. 320.

■ 10. Section 742.6 is amended by:
■ a. Revising paragraph (a)(6)(iii)(A);
■ b. Adding paragraphs (a)(6)(iii)(A)(*1*) and (*2*);
■ c. Removing and reserving paragraph (a)(6)(iii)(B);
■ d. Removing paragraph (a)(13);
■ e. Revising paragraphs (b)(10)(iii)(A)(*1*), and (b)(10)(iii)(A)(*2*);
■ f. Removing and reserving paragraph (b)(10)(iii)(B); and
■ g. Removing paragraphs (b)(10)(iii)(C) and (b)(14).

The revisions to read as follows:

§ 742.6 Regional stability.

(a) * * *

(6) * * *

(iii) * * *

(A) A license is required for items specified in ECCNs 3A001.z; 3A090 (except for 3A090.c); 3D001 (for ''software'' for commodities controlled by 3A001.z, 3A090 (except for 3A090.c)); 3E001 (for ''technology'' for commodities controlled by 3A001.z, 3A090 (except for 3A090.c)); 4A003.z; 4A004.z; 4A005.z; 4A090; 4D001 (for ''software'' for commodities controlled by 4A003.z, 4A004.z, and 4A005.z); 4D090 (for ''software'' for commodities controlled by 4A090); 4E001 (for ''technology'' for commodities controlled by 4A003.z, 4A004.z, 4A005.z, 4A090 or ''software'' specified by 4D001 (for 4A003.z, 4A004.z, and 4A005.z), 4D090 (for ''software'' for commodities controlled by 4A090)); 5A002.z; 5A004.z; 5A992.z; 5D002.z; 5D992.z; 5E002 (for ''technology'' for commodities controlled by 5A002.z or 5A004.z or ''software'' specified by 5D002 (for 5A002.z or 5A004.z commodities)); or 5E992 (for ''technology'' for commodities controlled by 5A992.z or ''software'' controlled by 5D992.z) for exports, reexports, and transfers (in-country) to or within the destinations specified under paragraphs (a)(6)(iii)(A)(*1*)–(*2*).

(*1*) Indonesia, Malaysia, Singapore, Brazil, and Thailand.

Note 1 to paragraph (a)(6)(iii)(A)(1): *The license requirements in this paragraph (a)(6)(iii)(A)(1) do not apply to exports, reexports, and transfers (in-country) to an ultimate consignee or end user headquartered in, or whose ultimate parent company is headquartered in, the United States, provided the exporter, reexporter, or transferor follows the reporting requirements in § 743.10 Reporting Requirements to Qualify for Exclusion from Certain Regional Stability License Requirements.*

(*2*) A destination in Country Groups D:1, D:4, or D:5 (excluding destinations also specified in Country Groups A:5 or A:6) or the United Arab Emirates, except that a license is not required when the ultimate consignee and all end users are approved entities in the United Arab Emirates listed in supplement no. 8 to part 740 and specified as approved to receive the items covered by this paragraph.

(B) [Reserved]

* * * * *

(iii) * * *

(A) * * *

(*1*) License review policy for paragraph (a)(6)(iii)(A)(*1*). Applications for exports, reexports, and transfers (in-country) will be reviewed on a case-by-case basis to determine whether the transaction is contrary to the national security or foreign policy interests of the United States, to include the effectiveness of a destination's export control regimes and coordination with BIS on the enforcement of export controls.

(*2*) Policy for Country Groups D:1, D:4, D:5 and the United Arab Emirates. There is a case-by-case license review policy for license applications for

exports of commodities with a TPP (as defined in Technical Note 2 to 3A090.a and 3A090.b) less than 21,000, and a 'total DRAM bandwidth' (as defined in the notes to paragraph (dd)(1) in supplement no. 2 to part 748) less than 6,500 GB/s, when destined to end-users located in China or Macau, provided the applicant provides the additional information described in supplement no. 2 to part 748 under paragraph (dd). All other applications for exports, reexports, or transfers (in-country) to or within Country Group D:5 and Macau or for an entity headquartered or with an ultimate parent headquartered in Country Group D:5 or Macau will be reviewed under a presumption of denial. All other applications to or within destinations specified in Country Groups D:1 and D:4 (excluding any destinations also specified in Country Groups A:5 or A:6) and the United Arab Emirates will be reviewed under a presumption of approval. If the license application meets the criteria of more than one licensing policy, then this licensing policy and its requirements will be applied.

(B) [RESERVED]

* * * * *

PART 743—SPECIAL REPORTING AND NOTIFICATION

■ 11. The authority citation for part 743 is revised to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.;* E.O. 13637, 78 FR 16129, 3 CFR, 2014 Comp., p. 223; 78 FR 16129.

■ 12. Add § 743.10 to read as follows:

§ 743.10 Reporting requirements to qualify for exclusion from certain regional stability license requirements.

(a) *Scope.* This section describes reporting which is required to qualify for an exclusion from the Regional Stability license requirement under § 742.6(a)(6)(iii)(A)(*1*). Pursuant to Note 1 to paragraph (a)(6)(iii)(A)(*1*), the license requirements in § 742.6(a)(6)(iii)(A)(*1*) do not apply to exports, reexports, and transfers (in-country) to an ultimate consignee or end user headquartered in, or whose ultimate parent company is headquartered in, the United States, provided the exporter, reexporter, or transferor follows the reporting requirements of this section.

(b) *Information to be included in the reports.* The following information specified under paragraph (b)(1) through (4) of this section must be included in each report to BIS.

(1) Information on each of the parties, as described in § 748.5, involved in the transaction as well as the ultimate parent(s) of the ultimate consignee and end user, including:

(i) Name;

(ii) Physical address;

(iii) Mailing address (if different from physical address);

(iv) Phone number;

(v) Information in paragraphs (b)(1)(i) through (iv) for all parent company headquarters and specifying which company is the ultimate parent; and

(vi) The role(s) each party is playing in the transaction (*i.e.,* exporter, reexporter, transferor, end-user, ultimate consignee, or ultimate parent of the ultimate consignee or end-user).

(2) The ultimate destination of the commodities being exported, reexported or transferred (in-country) and any ''end-users'' of the commodity which are not the ultimate consignee.

(3) Information for each product being exported, exported from abroad, reexported, or transferred (in-country) including:

(i) ECCN, including the item's paragraph-level classification; *e.g.,* 3A090.a;

(ii) Product name and SKU;

(iii) Total processing performance (TPP) of the product (see the Technical Notes to ECCN 3A090); and

(iv) Quantity of each product.

(4) Date of export, reexport, or transfer (in-country) for each commodity described in paragraph (b)(3).

(c) *Where to submit reports required under this section.* Notifications to BIS under this section must be submitted to BIS using the following URL: *https://www.bis.gov/ai/exclusionnotesubmission.*

(d) *Monthly reporting requirement.* You must submit monthly reports regarding any transactions subject to the provisions of this section. The report shall cover any exports, reexports, or transfers (in-country) that qualify for an exclusion from the Regional Stability license requirement pursuant to Note 1 to § 742.6(a)(6)(iii)(A)(*1*) on or after November 19, 2026. Reports regarding any export, reexport, or transfer (in-country) subject to the provisions of this section are due no later than the first business day of the month following the transaction.

(e) *Contacts.* General information or questions about these reports can be directed to the Office of National Security Controls, tel. (202) 482–0092, or email: *EAR.Reports@bis.doc.gov.*

PART 744—CONTROL POLICY: END-USER AND END-USE BASED

■ 13. The authority citation for part 744 continues to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.;* 22 U.S.C. 3201 *et seq.;* 42 U.S.C. 2139a; 22 U.S.C. 7201 *et seq.;* 22 U.S.C. 7210; E.O. 12058, 43 FR 20947, 3 CFR, 1978 Comp., p. 179; E.O. 12851, 58 FR 33181, 3 CFR, 1993 Comp., p. 608; E.O. 12938, 59 FR 59099, 3 CFR, 1994 Comp., p. 950; E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228; E.O. 13099, 63 FR 45167, 3 CFR, 1998 Comp., p. 208; E.O. 13222, 66 FR 44025, 3 CFR, 2001 Comp., p. 783; E.O. 13224, 66 FR 49079, 3 CFR, 2001 Comp., p. 786.

■ 14. Amend § 744.1 by adding a sentence at the end of paragraph (a)(1) to read as follows:

§ 744.1 General provisions.

(a) * * *

(1) * * * Section 744.24 sets forth restrictions on exports, reexports, and transfers (in-country) for an item that will be or is intended to be used in a data center for end users and destinations of concern.

* * * * *

■ 15. Revise § 744.23(a)(3)(i) to read as follows:

§ 744.23 ''Supercomputer,'' ''advanced-node integrated circuits,'' and semiconductor manufacturing equipment end use controls.

(a)

* * * * *

(3) * * * (i)(A) Any item subject to the EAR and specified in ECCN 3A001.z; 3A090 (except for 3A090.c); 4A003.z; 4A004.z; 4A005.z; 4A090; 5A002.z; 5A004.z; 5A992.z, 5D002.z; 5D992.z destined to any destination other than those specified in Country Groups D:1, D:4, or D:5 (excluding any destination also specified in Country Groups A:5 or A:6) for an entity that is headquartered in, or whose ultimate parent company is headquartered in, either Macau or a destination specified in Country Group D:5 (*e.g.,* a PRC-headquartered cloud or data server provider located outside of Country Groups D:1, D:4, or D:5 (excluding any destination also specified in Country Groups A:5 or A:6)).

(B) Any item subject to the EAR and specified in ECCN 3A090.c destined to any destination other than Macau or those specified in Country Group D:5, for an entity that is headquartered in, or whose ultimate parent company is headquartered in, either Macau or a destination specified in Country Group D:5.

(C) An ''applicable advanced logic integrated circuit'' that is subject to the EAR, specified in 3A090.a, designed by a company that is neither an approved IC designer (specified in supplement no. 6 to part 740) nor an authorized IC designer (as described in Note 1 to

3A090.a), and exported, exported from abroad, reexported, or transferred (in-country) by a ''front end fabricator'' or ''OSAT'' to or within any destination.

* * * * *

■ 16. Add § 744.24 to read as follows:

§ 744.24 Restrictions on exports, reexports, and transfers (in-country) of certain advanced computing items for use in data centers for end-uses and destinations of concern.

(a) *General prohibition*—(1) *Prohibition on exports, reexports, or transfers (in-country) for certain advanced computing items for use in data centers for end uses of concern.* In addition to the license requirements set forth elsewhere in the EAR, you may not export, reexport, or transfer (in-county) items specified in ECCNs 3A001.z; 3A090 (except for 3A090.c); 3D001 (for ''software'' for commodities controlled by 3A001.z, 3A090 (except for 3A090.c)); 3E001 (for ''technology'' for commodities controlled by 3A001.z, 3A090 (except for 3A090.c)); 4A003.z; 4A004.z; 4A005.z; 4A090; 4D001 (for ''software'' for commodities controlled by 4A003.z, 4A004.z, and 4A005.z); 4D090 (for ''software'' for commodities controlled by 4A090); 4E001 (for ''technology'' for commodities controlled by 4A003.z, 4A004.z, 4A005.z, 4A090 or ''software'' specified by 4D001 (for 4A003.z, 4A004.z, and 4A005.z), 4D090 (for ''software'' for commodities controlled by 4A090)); 5A002.z; 5A004.z; 5A992.z; 5D002.z; 5D992.z; 5E002 (for ''technology'' for commodities controlled by 5A002.z or 5A004.z or ''software'' specified by 5D002 (for 5A002.z or 5A004.z commodities)); or 5E992 (for ''technology'' for commodities controlled by 5A992.z or ''software'' controlled by 5D992.z) without a license if you have ''knowledge'' at the time of the export, reexport, or transfer (in-country) that the item is destined to a data center to or within any destination worldwide that is providing or will provide access to more than 12,000,000 ''aggregate TPP'' either at one data center or through 'linked data centers' to or for companies headquartered in, or whose ultimate parent company is headquartered in, Macau or a destination specified in Country Group D:5 in supplement no. 1 to part 740 of the EAR.

Note 1 to paragraph (a)(1): *The prohibitions pursuant to paragraph (a)(1) apply regardless of whether the person in possession of the EAR item was a party to the transaction to the original export, reexport, or transfer (in-country) (see § 748.5).*

Note 2 to paragraph (a)(1): *The prohibitions pursuant to paragraph (a)(1) apply regardless of whether a U.S.-origin item specified under paragraph (a) of this section has been incorporated or commingled into or with a foreign-made item. Reexporters and transferors may not rely on the de minimis provisions for incorporating or commingling U.S.-origin items specified under paragraph (a) into foreign-made items where there is ''knowledge'' at any point in the chain from the ''development'', ''production'', or ''use'' of the foreign-made item that incorporates or commingles a U.S.-origin item will be used in a prohibited end-use under paragraph (a)(1) of this section.*

Note 3 to paragraph (a)(1): *To satisfy the requirement that you do not have ''knowledge'' for purposes of this paragraph, you will be expected to obtain and be able to provide sufficient information from the foreign data center regarding that data center's ''know your customer'' due diligence checks. Such diligence checks will include diligence on whether any data center customers are subject to direct or indirect ownership or control by persons located in, headquartered in, or whose ultimate parent is headquartered in, Macau or a destination specified in Country Group D:5. A foreign data center declining or being unable to provide information sufficient to verify compliance with this end use control shall be considered a red flag that presumptively provides you with ''knowledge'' unless you are able to resolve that red flag before proceeding with the transaction.*

(2) *Additional prohibition on persons informed by BIS.* BIS may inform persons, either individually by specific notice or through amendment to the EAR, that a license is required for the export, reexport, or transfer (in-country) of specified items to certain persons or destinations, because there is an unacceptable risk of use in, or diversion to, the activities specified in paragraph (a)(1) of this section. Specific notice is to be given only by, or at the direction of the Secretary of Commerce or the Under Secretary of Commerce for Industry and Security. When such notice is provided orally, it will be followed by a written notice within two working days signed by the Secretary of Commerce or the Under Secretary of Commerce for Industry and Security. However, the absence of any such notification does not excuse persons from compliance with the license requirements of paragraphs (a)(1) of this section. The Secretary of State or the Assistant to the President for National Security Affairs may notify the Secretary of Commerce that a certain destination is at high risk of use in, or diversion to, the activities specified in paragraph (a)(1) of this section. Within 10 days of receipt of such notice, the Secretary of Commerce shall, if he deems it appropriate, inform persons, either individually by specific notice or through amendment to the EAR, that a license is required for the export, reexport, or transfer (in-country) of specific items to that destination.

(b) *Exceptions.* (1) No license exceptions may overcome the prohibition described in paragraph (a) of this section, except as noted by BIS when a destination is designated under paragraphs (3) of this section.

(2) The prohibitions under this section do not apply when the computing power access is only being provided for a 'commercial recommender system' and you submit the following information to *https://www.bis.gov/ai/exclusionnote submission,* which will be shared with the End User Review Committee.

(i) The name of the company headquartered in, or whose ultimate parent company is headquartered in, Macau or a destination specified in Country Group D:5 in supplement no. 1 to part 740 of the EAR.

(ii) The sum of the total processing performance (TPP, as defined in the Technical Notes to ECCN 3A090) of all of the ICs or commodities specified in paragraph (a)(1) provided to or for the company specified in (b)(2)(i).

(iii) The due diligence performed to ensure the computing power access is exclusively being provided for a 'commercial recommender system.' (3) Any data center providing significant volume of compute power to companies headquartered, or with an ultimate parent headquartered, in Macau or Country Group D:5 prior to the publication date of this rule that wishes to continue providing these services must obtain a license with 90 days of the effective date of this IFR or face future export restrictions.

(c) *License review policy.* Applications for licenses required by this section will be reviewed on a case-by-case basis.

(d) *Definitions.* For purposes of this section, the following definitions are applicable:

(1) *Commercial recommender system.* A commercial recommender system means a Super Intelligence (SI) tool exclusively designed and exclusively used to rank, filter, or suggest commercial products, services, or content to users based on user behavior, transaction history, or item attributes. This term does not include any SI system designed or used to generate novel text, image, audio, video, software, or other content in response to user inputs, or any system that incorporates such model, regardless of whether the system also performs recommendation functions.

(2) *Linked data center.* For purposes of this section, a 'linked data center' means a data center that uses networking infrastructure that links two or more separate data centers together, through digitally-linked or physically-linked infrastructure, that allows physical and virtual facilities to share resources, balance workloads, and replicate data as a unified whole. 'Linked data center' includes digitally-linked infrastructure, not just physically-linked infrastructure.

(e) *Notification and authorization requirement for subsequent changes in end-use.* For any export, reexport, or transfer made on or after November 19, 2026 without authorization, *i.e.,* because the exporter, reexporter, or transferor had no ''knowledge'' that the item is for a prohibited end-use under this section and no other EAR license requirement applies, the exporter, reexporter, or transferor must inform the recipient that a BIS authorization is required if the item or items will be used at a data center to provide access to more than 12,000,000 ''aggregate TPP'' either at one data center or through 'linked data centers' to or for companies headquartered in, or whose ultimate parent company is headquartered in, Macau or a destination specified in Country Group D:5 in supplement no. 1 to part 740 of the EAR. The notification from the exporter, reexporter, or transferor must also specify that the transferor, *e.g.,* the data center operator, must obtain authorization for this change in end-use. The notification from the exporter, reexporter, and transferor must also specify that the transferor must follow the know-your-customer guidance in supplement no. 3 Part 732 of the EAR.

PART 748—APPLICATIONS (CLASSIFICATION, ADVISORY, AND LICENSE) AND DOCUMENTATION

■ 17. The authority citation for part 748 continues to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.;* E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228.

§ 748.3 [Amended]

■ 18. Amend § 748.3 by removing paragraph (f).

■ 19. Amend § 748.15 by:

■ a. Revising the introductory text and paragraphs (a)(1);

■ b. Removing and reserving paragraph (b)(2);

■ c. Revising paragraph (c)(1);

■ d. Removing and reserving paragraphs (c)(2) and (d)(2);

■ e. Revising paragraphs (e) and (f)(1)(i);

■ f. Removing and reserving paragraph (f)(1)(ii); and

■ g. Revising paragraphs (f)(1)(iii) and (f)(1)(iv), (f)(2), (g), (h), and (i).

The revisions read as follows:

§ 748.15 Authorization Validated End-User (VEU).

VEU Authorization permits the export, reexport, and transfer (in-country) to validated end-users of any eligible items that will be used in a specific eligible destination. Reexports by a VEU require separate authorization. Validated end-users are those who have been previously approved by BIS pursuant to the requirements of this section. To be eligible for authorization VEU, exporters, reexporters, and validated end-user applicants must adhere to the conditions and restrictions set forth in paragraphs (a) through (f) of this section. If a request for VEU authorization for a particular end-user is not granted, no new license requirement is triggered. In addition, such a result does not render the end-user ineligible for license approvals from BIS.

(a)(1) *Eligible end users for VEU Authorization.* The only end users to whom eligible items may be exported, reexported, or transferred (in-country) under a VEU Authorization are those validated end users identified in supplement no. 7 to part 748, according to the provisions in this section and those set forth in supplement nos. 8 and 9 to this part that have been granted VEU status by the End-User Review Committee (ERC) according to the process set forth in supplement no. 9 to this part.

(2) *Requests for authorizations.* To apply for a VEU Authorization, requests for authorization must be submitted in the form of an advisory opinion request, as described in § 748.3(c), and must include a list of items (items for purposes of authorization VEU include commodities, software, and technology, except as excluded by paragraph (c) of this section), identified by ECCN, that exporters, reexporters, or transferors intend to export, reexport, or transfer (in-country) to an eligible end user, once approved. To ensure a thorough review, requests for VEU authorization must include the information described in supplement no. 8 to this part. Requests for authorization will be accepted from exporters, reexporters, transferors, or end-users. Submit the request to: The Office of Exporter Services, Bureau of Industry and Security, U.S. Department of Commerce, 14th Street and Pennsylvania Avenue NW, Room 2099B, Washington, DC 20230. Mark the package ''Request for ''General'' Authorization Validated End-User.''

* * * * *

(c) * * *

(1) Items controlled under the EAR for missile technology (MT) and crime control (CC) reasons may not be exported or reexported under a VEU Authorization.

* * * * *

(e) *Certification and recordkeeping.* Prior to an initial export, reexport, or transfer (in-country) to a validated end-user under a VEU Authorization, exporters, reexporters, and transferors must obtain certifications from the validated end-user regarding end-use and compliance with VEU requirements. Such certifications must include the contents set forth in supplement no. 8 to this part. Certifications and all records relating to VEU must be retained by exporters, reexporters, or transferors in accordance with the recordkeeping requirements set forth in part 762 of the EAR.

(f) *Reporting and review requirements*—(1) *Reports*—(i) *Reexport Information Required for VEU authorization.* Reexporters or transferors who make use of a VEU Authorization are required to submit annual reports to BIS. For VEU authorization, reexporters and transferors must include, for each validated end user to whom the exporter, reexporter, or transferor exported, reexported, or transferred (in-country) eligible items:

(A) The name and address of each validated end-user to whom eligible items were exported, reexported or transferred (in-country);

(B) The eligible destination to which the items were exported or reexported;

(C) The quantity of such items;

(D) The value of such items; and

(E) The ECCN(s) of such items.

(ii) [Reserved]

(iii) *Deadlines.* For reexporters or transferors making use of VEU Authorization, reports are due by February 15 of each year, and must cover the period from January 1 through December 31 of the prior year.

(iv) *Addresses.* Reports must be sent to: Office of Exporter Services, Bureau of Industry and Security, U.S. Department of Commerce, 14th Street and Constitution Avenue NW, Room 2099B, Washington, DC 20230. Mark the package ''General Authorization Validated End-User Report.''

(2) *Reviews.* Records related to activities covered by VEU Authorizations that are maintained by exporters, reexporters, transferors, and VEU authorizations will be reviewed on a periodic basis. Upon request by BIS,

exporters, reexporters, transferors, and validated end-users must allow review of records, including on-site reviews covering the information set forth in paragraphs (e) and (f)(1) of this section.

(g) *Notification requirement.* Exporters, reexporters, and transferors shipping under VEU Authorization are required to provide the VEUs to which they are shipping notice of the shipment. Such notification must be conveyed to the VEU in writing and must include a list of the VEU-authorized contents of the shipment and a list of the ECCNs under which the VEU-authorized items in the shipment are classified, as well as a statement that the items are being, will be, or were shipped pursuant to relevant VEU Authorization. Notification of the export, reexport, or transfer (in-country) to the VEU must be made within a timeframe agreed to in writing by the VEU and the person exporting, reexporting or transferring (in-country). The VEU and the person exporting, reexporting, or transferring (in-country) must agree to the notification timeframe prior to the initial shipment under the VEU Authorizations. Depending on the agreement between the VEU and the person exporting, reexporting, or transferring (in-country), a notification may be for individual shipments or for multiple shipments. Exporters, reexporters, transferors, and VEUs are required to maintain the notifications they send or receive in accordance with their recordkeeping requirements.

(h) *Termination of Conditions on a VEU Authorization.* VEUs that are subject to item-specific conditions and have received items subject to such conditions under General VEU Authorization are no longer bound by the conditions associated with the items if the items no longer require a license for export, reexport, or transfer (in-country) to or within the PRC or India, as applicable, or become eligible for shipment under a license exception to the destination. Items that become eligible for a license exception are subject to the terms and conditions of the applicable license exception and the restrictions in § 740.2 of the EAR. Items that become eligible for export, reexport, or transfer (in-country) without a license and that remain subject to the EAR may only be exported, reexported, transferred (in-country), or disposed of in accordance with the requirements of the EAR. Termination of VEU conditions does not relieve a validated end-user of its responsibility for violations that occurred prior to the availability of a license exception or prior to the removal of license requirements.

(i) *Records.* Records of items that were shipped under VEU Authorization prior to the removal of a license requirement or the availability of a license exception remain subject to the review requirements of paragraph (f)(2) of this section on and after the date that the license requirement was removed or the license exception became applicable.

Supplement No. 2 to Part 748 [Amended]

■ 20. Amend supplement no. 2 to part 748 by removing paragraphs (c)(3) and (c)(4).

■ 21. Amend supplement no. 8 to part 748 by:

■ a. Revising the heading of paragraph A; and

■ b. Removing and reserving paragraph B.

The revised heading reads as follows:

Supplement No. 8 to Part 748—Information Required in Requests for VEU Authorization

* * * * *

A. Required Information for Validated End-User Authorization Requests

* * * * *

Supplement No. 10 to Part 748 [Removed]

■ 22. Remove supplement no. 10 to part 748.

PART 762—RECORDKEEPING

■ 23. The authority citation for part 762 continues to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.*

■ 24. Amend § 762.2 by:

■ a. Removing and reserving paragraph (58); and

■ b. Revising paragraph (b)(60).

The revisions to read as follows:

§ 762.2 Records to be retained.

* * * * *

(b) * * *

(58) [Reserved]

* * * * *

(60) § 744.24, Restrictions on exports, reexports, and transfers (in-country) of certain advanced computing items for use in data centers for end users and destinations of concern.

* * * * *

PART 772—DEFINITIONS OF TERMS

■ 25. The authority citation for part 772 continues to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.*

■ 26. Amend § 772.1 by:

■ a. Adding the definition in alphabetical order for ''Aggregate TPP''; and

■ b. Removing the definition for ''Model Weights.''

§ 772.1 Definitions of terms as used in the Export Administration Regulations (EAR).

* * * * *

Aggregate TPP. When referring to a group of integrated circuits (ICs) or commodities (*e.g.,* in a license application or other authorization), the ''aggregate TPP'' of the ICs or commodities is the sum of the total processing performance (TPP), as defined in the Technical Notes to ECCN 3A090, of all of the ICs or commodities specified in ECCNs 3A001.z; 3A090 (except for 3A090.c); 4A003.z; 4A004.z; 4A005.z; 4A090; 5A002.z; 5A004.z; 5A992.z in the group.

* * * * *

PART 774—THE COMMERCE CONTROL LIST

■ 27. The authority citation for part 774 continues to read as follows:

Authority: 50 U.S.C. 4801–4852; 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.;* 10 U.S.C. 8720; 10 U.S.C. 8730(e); 22 U.S.C. 287c, 22 U.S.C. 3201 *et seq.;* 22 U.S.C. 6004; 42 U.S.C. 2139a; 15 U.S.C. 1824; 50 U.S.C. 4305; 22 U.S.C. 7201 *et seq.;* 22 U.S.C. 7210; E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228; E.O. 13222, 66 FR 44025, 3 CFR, 2001 Comp., p. 783.2.

■ 28. Amend supplement no. 1 to part 774 by:

■ a. Revising ECCNs 3A001, 3A090, 3D001, 3E001, 4A003, 4A004, 4A005, 4A090, 4D001, 4D090, 4E001;

■ b. Removing ECCN 4E091; and

■ c. Revising ECCNs 5A002, 5A992, 5A004, 5D002, 5D992, 5E002, and 5E992.

The revisions to read as follows:

Supplement No. 1 to Part 774—The Commerce Control List

* * * * *

3A001 Electronic items as follows (see List of Items Controlled).

Reason for Control: NS, RS, MT, NP, AT

Control(s)	Country chart (see Supp. No. 1 to part 738)
NS applies to ''Monolithic Microwave Integrated Circuit'' (''MMIC'') amplifiers in 3A001.b.2 and discrete microwave transistors in 3A001.b.3, except those 3A001.b.2 and b.3 items being exported or reexported for use in civil telecommunications applications.	NS Column 1.
NS applies to entire entry	NS Column 2.
RS applies ''Monolithic Microwave Integrated Circuit'' (''MMIC'') amplifiers in 3A001.b.2 and discrete microwave transistors in 3A001.b.3, except those 3A001.b.2 and b.3 items being exported or reexported for use in civil telecommunications applications.	RS Column 1.
RS applies to 3A001.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to 3A001.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
MT applies to 3A001.a.1.a when usable in ''missiles''; and to 3A001.a.5.a when ''designed or modified'' for military use, hermetically sealed and rated for operation in the temperature range from below −54 °C to above +125 °C; and 3A001.z.2.	MT Column 1.
NP applies to pulse discharge capacitors in 3A001.e.2 and superconducting solenoidal electromagnets in 3A001.e.3 that meet or exceed the technical parameters in 3A201.a and 3A201.b, respectively; and 3A001.z.3.	NP Column 1.
AT applies to entire entry	AT Column 1.

Reporting Requirements: See § 743.1 of the EAR for reporting requirements for exports under 3A001.b.2 or b.3 under License Exceptions, and Validated End-User authorizations.

License Requirements: See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: N/A for MT, NP; N/A for ''Monolithic Microwave Integrated Circuit'' (''MMIC'') amplifiers in 3A001.b.2, discrete microwave transistors in 3A001.b.3, except those that are being exported or reexported for use in civil telecommunications applications; N/A for and 3A001.z.

Yes for:

$1500: 3A001.c.

$3000: 3A001.b.1, b.2 (exported or reexported for use in civil telecommunications applications), b.3 (exported or reexported for use in civil telecommunications applications), b.9, .d, .e, .f, and .g.

$5000: 3A001.a (except a.1.a and a.5.a when controlled for MT), b.4 to b.7, and b.12.

GBS: Yes for 3A001.a.1.b, a.2 to a.14 (except .a.5.a when controlled for MT), b.2 (exported or reexported for use in civil telecommunications applications), b.8 (except for ''vacuum electronic devices'' exceeding 18 GHz), b.9., b.10, .g, .h, .i, and z.1.b (exported or reexported for use in civil telecommunications applications).

NAC/ACA: Yes, for 3A001.z.

ACM: Yes for 3A001.z

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 3A001.z.*

Special Conditions for STA

STA: License Exception STA may not be used to ship any item in 3A001.b.2 or b.3, except those that are being exported or reexported for use in civil telecommunications applications, or 3A001.z to any of the destinations listed in Country Group A:5 or A:6 (See Supplement No. 1 to part 740 of the EAR).

List of Items Controlled

Related Controls: (1) See Category XV of the USML for certain ''space-qualified'' electronics and Category XI of the USML for certain ASICs, 'transmit/receive modules,' 'transmit modules,' or 'MMICs' ''subject to the ITAR.'' (2) See also 3A090, 3A101, 3A201, 3A611, 3A901 for cryogenic CMOS integrated circuits and parametric signal amplifiers or quantum limited amplifiers not controlled by 3A001, 3A991, and 9A515.

Related Definitions: 'Microcircuit' means a device in which a number of passive or active elements are considered as indivisibly associated on or within a continuous structure to perform the function of a circuit. For the purposes of integrated circuits in 3A001.a.1, 5×10^3 Gy(Si) = 5×10^5 Rads (Si); 5×10^6 Gy (Si)/s = 5×10^8 Rads (Si)/s.

Items:

a. General purpose integrated circuits, as follows:

Note 1: *Integrated circuits include the following types:*

—''*Monolithic integrated circuits*'';

—''*Hybrid integrated circuits*'';

—''*Multichip integrated circuits*'';

—''*Film type integrated circuits*'', *including silicon-on-sapphire integrated circuits;*

—''*Optical integrated circuits*'';

—''*Three dimensional integrated circuits*'';

—''*Monolithic Microwave Integrated Circuits*'' (''*MMICs*'').

a.1. Integrated circuits designed or rated as radiation hardened to withstand any of the following:

a.1.a. A total dose of 5×10^3 Gy (Si), or higher;

a.1.b. A dose rate upset of 5×10^6 Gy (Si)/s, or higher; *or*

a.1.c. A fluence (integrated flux) of neutrons (1 MeV equivalent) of 5×10^{13} n/cm^2 or higher on silicon, or its equivalent for other materials;

Note: *3A001.a.1.c does not apply to Metal Insulator Semiconductors (MIS).*

a.2. ''Microprocessor microcircuits,'' ''microcomputer microcircuits,'' microcontroller microcircuits, storage integrated circuits manufactured from a compound semiconductor, analog-to-digital converters, integrated circuits that contain analog-to-digital converters and store or process the digitized data, digital-to-analog converters, electro-optical or ''optical integrated circuits'' designed for ''signal processing'', field programmable logic devices, custom integrated circuits for which either the function is unknown or the control status of the equipment in which the integrated circuit will be used in unknown, Fast Fourier Transform (FFT) processors, Static Random-Access Memories (SRAMs), or 'non-volatile memories,' having any of the following:

Technical Note: *For the purposes of 3A001.a.2, 'non-volatile memories' are memories with data retention over a period of time after a power shutdown.*

a.2.a. Rated for operation at an ambient temperature above 398 K (+125 °C);

a.2.b. Rated for operation at an ambient temperature below 218 K (−55 °C); *or*

a.2.c. Rated for operation over the entire ambient temperature range from 218 K (−55 °C) to 398 K (+125 °C);

N.B.: For cryogenic CMOS integrated circuits not specified by 3A001.a.2, see 3A901.a.

Note: *3A001.a.2 does not apply to integrated circuits designed for civil automobile or railway train applications.*

a.3. ''Microprocessor microcircuits'', ''microcomputer microcircuits'' and microcontroller microcircuits, manufactured from a compound semiconductor and operating at a clock frequency exceeding 40 MHz;

Note: *3A001.a.3 includes digital signal processors, digital array processors and digital coprocessors.*

a.4. [Reserved]

a.5. Analog-to-Digital Converter (ADC) and Digital-to-Analog Converter (DAC) integrated circuits, as follows:

a.5.a. ADCs having any of the following:

a.5.a.1. A resolution of 8 bit or more, but less than 10 bit, with a ''sample rate'' greater than 1.3 Giga Samples Per Second (GSPS);

a.5.a.2. A resolution of 10 bit or more, but less than 12 bit, with a ''sample rate'' greater than 600 Mega Samples Per Second (MSPS);

a.5.a.3. A resolution of 12 bit or more, but less than 14 bit, with a ''sample rate'' greater than 400 MSPS;

a.5.a.4. A resolution of 14 bit or more, but less than 16 bit, with a ''sample rate'' greater than 250 MSPS; *or*

a.5.a.5. A resolution of 16 bit or more with a ''sample rate'' greater than 65 MSPS;

N.B.: For integrated circuits that contain analog-to-digital converters and store or process the digitized data see 3A001.a.14.

Technical Notes: *For the purposes of 3A001.a.5.a:*

1. A resolution of n bit corresponds to a quantization of 2^n levels.

2. The resolution of the ADC is the number of bits of the digital output that represents the measured analog input. Effective Number of Bits (ENOB) is not used to determine the resolution of the ADC.

3. For ''multiple channel ADCs'', the ''sample rate'' is not aggregated and the ''sample rate'' is the maximum rate of any single channel.

4. For ''interleaved ADCs'' or for ''multiple channel ADCs'' that are specified to have an interleaved mode of operation, the ''sample rates'' are aggregated and the ''sample rate'' is the maximum combined total rate of all of the interleaved channels.

a.5.b. Digital-to-Analog Converters (DAC) having any of the following:

a.5.b.1. A resolution of 10-bit or more but less than 12-bit, with an 'adjusted update rate' of exceeding 3,500 MSPS; *or*

a.5.b.2. A resolution of 12-bit or more and having any of the following:

a.5.b.2.a. An 'adjusted update rate' exceeding 1,250 MSPS but not exceeding 3,500 MSPS, and having any of the following:

a.5.b.2.a.1. A settling time less than 9 ns to arrive at or within 0.024% of full scale from a full scale step; *or*

a.5.b.2.a.2. A 'Spurious Free Dynamic Range' (SFDR) greater than 68 dBc (carrier) when synthesizing a full scale analog signal of 100 MHz or the highest full scale analog signal frequency specified below 100 MHz; *or*

a.5.b.2.b. An 'adjusted update rate' exceeding 3,500 MSPS;

Technical Notes: *For the purposes of 3A001.a.5.b:*

1. 'Spurious Free Dynamic Range' (SFDR) is defined as the ratio of the RMS value of the carrier frequency (maximum signal component) at the input of the DAC to the RMS value of the next largest noise or harmonic distortion component at its output.

2. SFDR is determined directly from the specification table or from the characterization plots of SFDR versus frequency.

3. A signal is defined to be full scale when its amplitude is greater than −3 dBfs (full scale).

4. 'Adjusted update rate' for DACs is:

a. For conventional (non-interpolating) DACs, the 'adjusted update rate' is the rate at which the digital signal is converted to an analog signal and the output analog values are changed by the DAC. For DACs where the interpolation mode may be bypassed (interpolation factor of one), the DAC should be considered as a conventional (non-interpolating) DAC.

b. For interpolating DACs (oversampling DACs), the 'adjusted update rate' is defined as the DAC update rate divided by the smallest interpolating factor. For interpolating DACs, the 'adjusted update rate' may be referred to by different terms including:

- *input data rate*
- *input word rate*
- *input sample rate*
- *maximum total input bus rate*
- *maximum DAC clock rate for DAC clock input*

a.6. Electro-optical and ''optical integrated circuits'', designed for ''signal processing'' and having all of the following:

a.6.a. One or more than one internal ''laser'' diode;

a.6.b. One or more than one internal light detecting element; *and*

a.6.c. Optical waveguides;

a.7. 'Field programmable logic devices' having any of the following:

a.7.a. A maximum number of single-ended digital input/outputs of greater than 700; *or*

a.7.b. An 'aggregate one-way peak serial transceiver data rate' of 500 Gb/s or greater;

Note: *3A001.a.7 includes:*

—Complex Programmable Logic Devices (CPLDs);

—Field Programmable Gate Arrays (FPGAs);

—Field Programmable Logic Arrays (FPLAs);

—Field Programmable Interconnects (FPICs).

N.B.: For integrated circuits having field programmable logic devices that are combined with an analog-to-digital converter, see 3A001.a.14.

Technical Notes: *For the purposes of 3A001.a.7:*

1. Maximum number of digital input/outputs in 3A001.a.7.a is also referred to as maximum user input/outputs or maximum available input/outputs, whether the integrated circuit is packaged or bare die.

2. 'Aggregate one-way peak serial transceiver data rate' is the product of the peak serial one-way transceiver data rate times the number of transceivers on the FPGA.

a.8. [Reserved]

a.9. [Reserved]

a.10. Custom integrated circuits for which the function is unknown, or the control status of the equipment in which the integrated circuits will be used is unknown to the manufacturer, having any of the following:

a.10.a. More than 1,500 terminals;

a.10.b. A typical ''basic gate propagation delay time'' of less than 0.02 ns; *or*

a.10.c. An operating frequency exceeding 3 GHz;

a.11. Digital integrated circuits, other than those described in 3A001.a.3 to 3A001.a.10 and 3A001.a.12, based upon any compound semiconductor and having any of the following:

a.11.a. An equivalent gate count of more than 3,000 (2 input gates); *or*

a.11.b. A toggle frequency exceeding 1.2 GHz;

a.12. Fast Fourier Transform (FFT) processors having a rated execution time for an N-point complex FFT of less than ($N \log_2 N$)/20,480 ms, where N is the number of points;

Technical Note: *For the purposes of 3A001.a.12, when N is equal to 1,024 points, the formula in 3A001.a.12 gives an execution time of 500* μ*s.*

a.13. Direct Digital Synthesizer (DDS) integrated circuits having any of the following:

a.13.a. A Digital-to-Analog Converter (DAC) clock frequency of 3.5 GHz or more and a DAC resolution of 10 bit or more, but less than 12 bit; *or*

a.13.b. A DAC clock frequency of 1.25 GHz or more and a DAC resolution of 12 bit or more;

Technical Note:

For the purposes of 3A001.a.13, the DAC clock frequency may be specified as the master clock frequency or the input clock frequency.

a.14. Integrated circuits that perform or are programmable to perform all of the following:

a.14.a. Analog-to-digital conversions meeting any of the following:

a.14.a.1. A resolution of 8 bit or more, but less than 10 bit, with a ''sample rate'' greater than 1.3 Giga Samples Per Second (GSPS);

a.14.a.2. A resolution of 10 bit or more, but less than 12 bit, with a ''sample rate'' greater than 1.0 GSPS;

a.14.a.3. A resolution of 12 bit or more, but less than 14 bit, with a ''sample rate'' greater than 1.0 GSPS;

a.14.a.4. A resolution of 14 bit or more, but less than 16 bit, with a ''sample rate'' greater than 400 Mega Samples Per Second (MSPS); *or*

a.14.a.5. A resolution of 16 bit or more with a ''sample rate'' greater than 180 MSPS; *and*

a.14.b. Any of the following:

a.14.b.1. Storage of digitized data; *or*

a.14.b.2. Processing of digitized data;

N.B.: 1: For analog-to-digital converter integrated circuits see 3A001.a.5.a.

N.B.: 2: For field programmable logic devices see 3A001.a.7.

Technical Notes: *For the purposes of 3A001.a.14:*

1. A resolution of n bit corresponds to a quantization of 2^n levels.

2. The resolution of the ADC is the number of bits of the digital output of the ADC that represents the measured analog input. Effective Number of Bits (ENOB) is not used to determine the resolution of the ADC.

3. For integrated circuits with non-interleaving ''multiple channel ADCs'', the ''sample rate'' is not aggregated and the ''sample rate'' is the maximum rate of any single channel.

4. For integrated circuits with ''interleaved ADCs'' or with ''multiple channel ADCs'' that are specified to have an interleaved mode of operation, the ''sample rates'' are aggregated and the ''sample rate'' is the maximum combined total rate of all of the interleaved channels.

b. Microwave or millimeter wave items, as follows:

Technical Note: *For the purposes of 3A001.b, the parameter peak saturated power output may also be referred to on product data sheets as output power, saturated power output, maximum power output, peak power output, or peak envelope power output.*

N.B.: For parametric signal amplifiers or Quantum-limited amplifiers (QLAs) not specified by 3A001.b, see ECCN 3A901.b.

b.1. ''Vacuum electronic devices'' and cathodes, as follows:

Note 1: *3A001.b.1 does not control ''vacuum electronic devices'' designed or rated for operation in any frequency band and having all of the following:*

a. Does not exceed 31.8 GHz; and

b. Is ''allocated by the ITU'' for radio-communications services, but not for radio-determination.

Note 2: *3A001.b.1 does not control non-''space-qualified'' ''vacuum electronic devices'' having all the following:*

a. An average output power equal to or less than 50 W; and

b. Designed or rated for operation in any frequency band and having all of the following:

1. Exceeds 31.8 GHz but does not exceed 43.5 GHz; and

2. Is ''allocated by the ITU'' for radio-communications services, but not for radio-determination.

b.1.a. Traveling-wave ''vacuum electronic devices,'' pulsed or continuous wave, as follows:

b.1.a.1. Devices operating at frequencies exceeding 31.8 GHz;

b.1.a.2. Devices having a cathode heater with a turn on time to rated RF power of less than 3 seconds;

b.1.a.3. Coupled cavity devices, or derivatives thereof, with a ''fractional bandwidth'' of more than 7% or a peak power exceeding 2.5 kW;

b.1.a.4. Devices based on helix, folded waveguide, or serpentine waveguide circuits, or derivatives thereof, having any of the following:

b.1.a.4.a. An ''instantaneous bandwidth'' of more than one octave, and average power (expressed in kW) times frequency (expressed in GHz) of more than 0.5;

b.1.a.4.b. An ''instantaneous bandwidth'' of one octave or less, and average power (expressed in kW) times frequency (expressed in GHz) of more than 1;

b.1.a.4.c. Being ''space-qualified''; *or*

b.1.a.4.d. Having a gridded electron gun;

b.1.a.5. Devices with a ''fractional bandwidth'' greater than or equal to 10%, with any of the following:

b.1.a.5.a. An annular electron beam;

b.1.a.5.b. A non-axisymmetric electron beam; *or*

b.1.a.5.c. Multiple electron beams;

b.1.b. Crossed-field amplifier ''vacuum electronic devices'' with a gain of more than 17 dB;

b.1.c. Thermionic cathodes, designed for ''vacuum electronic devices,'' producing an emission current density at rated operating conditions exceeding 5 A/cm^2 or a pulsed (non-continuous) current density at rated operating conditions exceeding 10 A/cm^2;

b.1.d. ''Vacuum electronic devices'' with the capability to operate in a 'dual mode.'

Technical Note: *For the purposes of 3A001.b.1.d, 'dual mode' means the ''vacuum electronic device'' beam current can be intentionally changed between continuous-wave and pulsed mode operation by use of a grid and produces a peak pulse output power greater than the continuous-wave output power.*

b.2. ''Monolithic Microwave Integrated Circuit'' (''MMIC'') amplifiers that any of the following:

N.B.: For ''MMIC'' amplifiers that have an integrated phase shifter see 3A001.b.12.

b.2.a. Rated for operation at frequencies exceeding 2.7 GHz up to and including 6.8 GHz with a ''fractional bandwidth'' greater than 15%, and having any of the following:

b.2.a.1. A peak saturated power output greater than 75 W (48.75 dBm) at any frequency exceeding 2.7 GHz up to and including 2.9 GHz;

b.2.a.2. A peak saturated power output greater than 55 W (47.4 dBm) at any frequency exceeding 2.9 GHz up to and including 3.2 GHz;

b.2.a.3. A peak saturated power output greater than 40 W (46 dBm) at any frequency exceeding 3.2 GHz up to and including 3.7 GHz; *or*

b.2.a.4. A peak saturated power output greater than 20 W (43 dBm) at any frequency exceeding 3.7 GHz up to and including 6.8 GHz;

b.2.b. Rated for operation at frequencies exceeding 6.8 GHz up to and including 16 GHz with a ''fractional bandwidth'' greater than 10%, and having any of the following:

b.2.b.1. A peak saturated power output greater than 10 W (40 dBm) at any frequency exceeding 6.8 GHz up to and including 8.5 GHz; *or*

b.2.b.2. A peak saturated power output greater than 5 W (37 dBm) at any frequency exceeding 8.5 GHz up to and including 16 GHz;

b.2.c. Rated for operation with a peak saturated power output greater than 3 W (34.77 dBm) at any frequency exceeding 16 GHz up to and including 31.8 GHz, and with a ''fractional bandwidth'' of greater than 10%;

b.2.d. Rated for operation with a peak saturated power output greater than 0.1 nW (−70 dBm) at any frequency exceeding 31.8 GHz up to and including 37 GHz;

b.2.e. Rated for operation with a peak saturated power output greater than 1 W (30 dBm) at any frequency exceeding 37 GHz up to and including 43.5 GHz, and with a ''fractional bandwidth'' of greater than 10%;

b.2.f. Rated for operation with a peak saturated power output greater than 31.62 mW (15 dBm) at any frequency exceeding 43.5 GHz up to and including 75 GHz, and with a ''fractional bandwidth'' of greater than 10%;

b.2.g. Rated for operation with a peak saturated power output greater than 10 mW (10 dBm) at any frequency exceeding 75 GHz up to and including 90 GHz, and with a ''fractional bandwidth'' of greater than 5%; *or*

b.2.h. Rated for operation with a peak saturated power output greater than 0.1 nW (−70 dBm) at any frequency exceeding 90 GHz;

Note 1: *[Reserved]*

Note 2: *The control status of the ''MMIC'' whose rated operating frequency includes frequencies listed in more than one frequency range, as defined by 3A001.b.2.a through 3A001.b.2.h, is determined by the lowest peak saturated power output control threshold.*

Note 3: *Notes 1 and 2 following the Category 3 heading for product group A. Systems, Equipment, and Components mean that 3A001.b.2 does not control ''MMICs'' if they are ''specially designed'' for other applications, e.g., telecommunications, radar, automobiles.*

b.3. Discrete microwave transistors that are any of the following:

b.3.a. Rated for operation at frequencies exceeding 2.7 GHz up to and including 6.8 GHz and having any of the following:

b.3.a.1. A peak saturated power output greater than 400 W (56 dBm) at any frequency exceeding 2.7 GHz up to and including 2.9 GHz;

b.3.a.2. A peak saturated power output greater than 205 W (53.12 dBm) at any frequency exceeding 2.9 GHz up to and including 3.2 GHz;

b.3.a.3. A peak saturated power output greater than 115 W (50.61 dBm) at any frequency exceeding 3.2 GHz up to and including 3.7 GHz; *or*

b.3.a.4. A peak saturated power output greater than 60 W (47.78 dBm) at any frequency exceeding 3.7 GHz up to and including 6.8 GHz;

b.3.b. Rated for operation at frequencies exceeding 6.8 GHz up to and including 31.8 GHz and having any of the following:

b.3.b.1. A peak saturated power output greater than 50 W (47 dBm) at any frequency exceeding 6.8 GHz up to and including 8.5 GHz;

b.3.b.2. A peak saturated power output greater than 15 W (41.76 dBm) at any frequency exceeding 8.5 GHz up to and including 12 GHz;

b.3.b.3. A peak saturated power output greater than 40 W (46 dBm) at any frequency exceeding 12 GHz up to and including 16 GHz; *or*

b.3.b.4. A peak saturated power output greater than 7 W (38.45 dBm) at any frequency exceeding 16 GHz up to and including 31.8 GHz;

b.3.c. Rated for operation with a peak saturated power output greater than 0.5 W (27 dBm) at any frequency exceeding 31.8 GHz up to and including 37 GHz;

b.3.d. Rated for operation with a peak saturated power output greater than 1 W (30 dBm) at any frequency exceeding 37 GHz up to and including 43.5 GHz;

b.3.e. Rated for operation with a peak saturated power output greater than 0.1 nW (−70 dBm) at any frequency exceeding 43.5 GHz; *or*

b.3.f. Other than those specified by 3A001.b.3.a to 3A001.b.3.e and rated for operation with a peak saturated power output greater than 5 W (37.0 dBm) at all frequencies exceeding 8.5 GHz up to and including 31.8 GHz;

Note 1: *The control status of a transistor in 3A001.b.3.a through 3A001.b.3.e, whose rated operating frequency includes frequencies listed in more than one frequency range, as defined by 3A001.b.3.a through 3A001.b.3.e, is determined by the lowest peak saturated power output control threshold.*

Note 2: *3A001.b.3 includes bare dice, dice mounted on carriers, or dice mounted in packages. Some discrete transistors may also be referred to as power amplifiers, but the status of these discrete transistors is determined by 3A001.b.3.*

b.4. Microwave solid state amplifiers and microwave assemblies/modules containing microwave solid state amplifiers, that are any of the following:

b.4.a. Rated for operation at frequencies exceeding 2.7 GHz up to and including 6.8 GHz with a ''fractional bandwidth'' greater than 15%, and having any of the following:

b.4.a.1. A peak saturated power output greater than 500 W (57 dBm) at any frequency exceeding 2.7 GHz up to and including 2.9 GHz;

b.4.a.2. A peak saturated power output greater than 270 W (54.3 dBm) at any frequency exceeding 2.9 GHz up to and including 3.2 GHz;

b.4.a.3. A peak saturated power output greater than 200 W (53 dBm) at any frequency exceeding 3.2 GHz up to and including 3.7 GHz; *or*

b.4.a.4. A peak saturated power output greater than 90 W (49.54 dBm) at any frequency exceeding 3.7 GHz up to and including 6.8 GHz;

b.4.b. Rated for operation at frequencies exceeding 6.8 GHz up to and including 31.8 GHz with a ''fractional bandwidth'' greater than 10%, and having any of the following:

b.4.b.1. A peak saturated power output greater than 70 W (48.45 dBm) at any frequency exceeding 6.8 GHz up to and including 8.5 GHz;

b.4.b.2. A peak saturated power output greater than 50 W (47 dBm) at any frequency exceeding 8.5 GHz up to and including 12 GHz;

b.4.b.3. A peak saturated power output greater than 30 W (44.77 dBm) at any frequency exceeding 12 GHz up to and including 16 GHz; *or*

b.4.b.4. A peak saturated power output greater than 20 W (43 dBm) at any frequency exceeding 16 GHz up to and including 31.8 GHz;

b.4.c. Rated for operation with a peak saturated power output greater than 0.5 W (27 dBm) at any frequency exceeding 31.8 GHz up to and including 37 GHz;

b.4.d. Rated for operation with a peak saturated power output greater than 2 W (33 dBm) at any frequency exceeding 37 GHz up to and including 43.5 GHz, and with a ''fractional bandwidth'' of greater than 10%;

b.4.e. Rated for operation at frequencies exceeding 43.5 GHz and having any of the following:

b.4.e.1. A peak saturated power output greater than 0.2 W (23 dBm) at any frequency exceeding 43.5 GHz up to and including 75 GHz, and with a ''fractional bandwidth'' of greater than 10%;

b.4.e.2. A peak saturated power output greater than 20 mW (13 dBm) at any frequency exceeding 75 GHz up to and including 90 GHz, and with a ''fractional bandwidth'' of greater than 5%; *or*

b.4.e.3. A peak saturated power output greater than 0.1 nW (−70 dBm) at any frequency exceeding 90 GHz; *or*

b.4.f. [Reserved]

N.B.:

1. For ''MMIC'' amplifiers see 3A001.b.2.

2. For 'transmit/receive modules' and 'transmit modules' see 3A001.b.12.

3. For converters and harmonic mixers, designed to extend the operating or frequency range of signal analyzers, signal generators, network analyzers or microwave test receivers, see 3A001.b.7.

Note 1: *[Reserved]*

Note 2: *The control status of an item whose rated operating frequency includes frequencies listed in more than one frequency range, as defined by 3A001.b.4.a through 3A001.b.4.e, is determined by the lowest peak saturated power output control threshold.*

b.5. Electronically or magnetically tunable band-pass or band-stop filters, having more than 5 tunable resonators capable of tuning across a 1.5:1 frequency band (f_{max}/f_{min}) in less than 10 ms and having any of the following:

b.5.a. A band-pass bandwidth of more than 0.5% of center frequency; *or*

b.5.b. A band-stop bandwidth of less than 0.5% of center frequency;

b.6. [Reserved]

b.7. Converters and harmonic mixers, that are any of the following:

b.7.a. Designed to extend the frequency range of ''signal analyzers'' beyond 90 GHz;

b.7.b. Designed to extend the operating range of signal generators as follows:

b.7.b.1. Beyond 90 GHz;

b.7.b.2. To an output power greater than 100 mW (20 dBm) anywhere within the frequency range exceeding 43.5 GHz but not exceeding 90 GHz;

b.7.c. Designed to extend the operating range of network analyzers as follows:

b.7.c.1. Beyond 110 GHz;

b.7.c.2. To an output power greater than 31.62 mW (15 dBm) anywhere within the frequency range exceeding 43.5 GHz but not exceeding 90 GHz;

b.7.c.3. To an output power greater than 1 mW (0 dBm) anywhere within the frequency range exceeding 90 GHz but not exceeding 110 GHz; *or*

b.7.d. Designed to extend the frequency range of microwave test receivers beyond 110 GHz;

b.8. Microwave power amplifiers containing ''vacuum electronic devices'' controlled by 3A001.b.1 and having all of the following:

b.8.a. Operating frequencies above 3 GHz;

b.8.b. An average output power to mass ratio exceeding 80 W/kg; *and*

b.8.c. A volume of less than 400 cm^3;

Note: *3A001.b.8 does not control equipment designed or rated for operation in any frequency band which is ''allocated by the ITU'' for radio-communications services, but not for radio-determination.*

b.9. Microwave Power Modules (MPM) consisting of, at least, a traveling-wave ''vacuum electronic device,'' a ''Monolithic Microwave Integrated Circuit'' (''MMIC'') and an integrated electronic power conditioner and having all of the following:

b.9.a. A 'turn-on time' from off to fully operational in less than 10 seconds;

b.9.b. A volume less than the maximum rated power in Watts multiplied by 10 cm^3/W; *and*

b.9.c. An ''instantaneous bandwidth'' greater than 1 octave ($f_{max} > 2f_{min}$) and having any of the following:

b.9.c.1. For frequencies equal to or less than 18 GHz, an RF output power greater than 100 W; *or*

b.9.c.2. A frequency greater than 18 GHz;

Technical Notes: *For the purposes of 3A001.b.9:*

1. To calculate the volume in 3A001.b.9.b, the following example is provided: for a maximum rated power of 20 W, the volume would be: 20 W × 10 cm^3/W = 200 cm^3.

2. The 'turn-on time' in 3A001.b.9.a refers to the time from fully-off to fully operational, i.e., it includes the warm-up time of the MPM.

b.10. Oscillators or oscillator assemblies, specified to operate with a single sideband (SSB) phase noise, in dBc/Hz, less (better) than $-(126 + 20\log_{10}F - 20\log_{10}f)$ anywhere within the range of 10 Hz ≤ F ≤ 10 kHz;

Technical Note: *For the purposes of 3A001.b.10, F is the offset from the operating frequency in Hz and f is the operating frequency in MHz.*

b.11. 'Frequency synthesizer' ''electronic assemblies'' having a ''frequency switching time'' as specified by any of the following:

b.11.a. Less than 143 ps;

b.11.b. Less than 100 µs for any frequency change exceeding 2.2 GHz within the synthesized frequency range exceeding 4.8 GHz but not exceeding 31.8 GHz;

b.11.c. [Reserved]

b.11.d. Less than 500 µs for any frequency change exceeding 550 MHz within the synthesized frequency range exceeding 31.8 GHz but not exceeding 37 GHz;

b.11.e. Less than 100 µs for any frequency change exceeding 2.2 GHz within the synthesized frequency range exceeding 37 GHz but not exceeding 75 GHz;

b.11.f. Less than 100 µs for any frequency change exceeding 5.0 GHz within the synthesized frequency range exceeding 75 GHz but not exceeding 90 GHz; *or*

b.11.g. Less than 1 ms within the synthesized frequency range exceeding 90 GHz;

Technical Note: *For the purposes of 3A001.b.11, a 'frequency synthesizer' is any kind of frequency source, regardless of the actual technique used, providing a*

multiplicity of simultaneous or alternative output frequencies, from one or more outputs, controlled by, derived from or disciplined by a lesser number of standard (or master) frequencies.

N.B.: For general purpose ''signal analyzers'', signal generators, network analyzers and microwave test receivers, see 3A002.c, 3A002.d, 3A002.e and 3A002.f, respectively.

b.12. 'Transmit/receive module,' 'transmit/receive MMIC,' 'transmit modules,' and 'transmit MMICs,' rated for operation at frequencies above 2.7 GHz and having all of the following:

b.12.a. A peak saturated power output (in watts), P_{sat}, greater than 505.62 divided by the maximum operating frequency (in GHz) squared [P_{sat}>505.62 W*GHz^2/f_{GHz}^2] for any channel;

b.12.b. A ''fractional bandwidth'' of 5% or greater for any channel;

b.12.c. Any planar side with length d (in cm) equal to or less than 15 divided by the lowest operating frequency in GHz [d ≤ 15cm*GHz*N/f_{GHz}] where N is the number of transmit or transmit/receive channels; *and*

b.12.d. An electronically variable phase shifter per channel;

Technical Notes: *For the purposes of 3A001.b.12:*

1. A 'transmit/receive module' is a multifunction ''electronic assembly'' that provides bi-directional amplitude and phase control for transmission and reception of signals.

2. A 'transmit module' is an ''electronic assembly'' that provides amplitude and phase control for transmission of signals.

3. A 'transmit/receive MMIC' is a multifunction ''MMIC'' that provides bi-directional amplitude and phase control for transmission and reception of signals.

4. A 'transmit MMIC' is a ''MMIC'' that provides amplitude and phase control for transmission of signals.

*5. 2.7 GHz should be used as the lowest operating frequency (f_{GHz}) in the formula in 3A001.b.12.c for transmit/receive or transmit modules that have a rated operation range extending downward to 2.7 GHz and below [d≤15cm*GHz*N/2.7 GHz].*

6. 3A001.b.12 applies to 'transmit/receive modules' or 'transmit modules' with or without a heat sink. The value of d in 3A001.b.12.c does not include any portion of the 'transmit/receive module' or 'transmit module' that functions as a heat sink.

7. 'Transmit/receive modules' or 'transmit modules,' 'transmit/receive MMICs' or 'transmit MMICs' may or may not have N integrated radiating antenna elements where N is the number of transmit or transmit/receive channels.

c. Acoustic wave devices as follows and ''specially designed'' ''components'' therefor:

c.1. Surface acoustic wave and surface skimming (shallow bulk) acoustic wave devices, having any of the following:

c.1.a. A carrier frequency exceeding 6 GHz;

c.1.b. A carrier frequency exceeding 1 GHz, but not exceeding 6 GHz and having any of the following:

c.1.b.1. A 'frequency side-lobe rejection' exceeding 65 dB;

c.1.b.2. A product of the maximum delay time and the bandwidth (time in μs and bandwidth in MHz) of more than 100;

c.1.b.3. A bandwidth greater than 250 MHz; *or*

c.1.b.4. A dispersive delay of more than 10 μs; *or*

c.1.c. A carrier frequency of 1 GHz or less and having any of the following:

c.1.c.1. A product of the maximum delay time and the bandwidth (time in μs and bandwidth in MHz) of more than 100;

c.1.c.2. A dispersive delay of more than 10 μs; *or*

c.1.c.3. A 'frequency side-lobe rejection' exceeding 65 dB and a bandwidth greater than 100 MHz;

Technical Note: *For the purposes of 3A001.c.1, 'frequency side-lobe rejection' is the maximum rejection value specified in data sheet.*

c.2. Bulk (volume) acoustic wave devices that permit the direct processing of signals at frequencies exceeding 6 GHz;

c.3. Acoustic-optic ''signal processing'' devices employing interaction between acoustic waves (bulk wave or surface wave) and light waves that permit the direct processing of signals or images, including spectral analysis, correlation or convolution;

Note: *3A001.c does not control acoustic wave devices that are limited to a single band pass, low pass, high pass or notch filtering, or resonating function.*

d. Electronic devices and circuits containing ''components,'' manufactured from ''superconductive'' materials, ''specially designed'' for operation at temperatures below the ''critical temperature'' of at least one of the ''superconductive'' constituents and having any of the following:

d.1. Current switching for digital circuits using ''superconductive'' gates with a product of delay time per gate (in seconds) and power dissipation per gate (in watts) of less than 10^{-14} J; *or*

d.2. Frequency selection at all frequencies using resonant circuits with Q-values exceeding 10,000;

e. High energy devices as follows:

e.1. 'Cells' as follows:

e.1.a 'Primary cells' having any of the following at 20 °C:

e.1.a.1. 'Energy density' exceeding 550 Wh/kg and a 'continuous power density' exceeding 50 W/kg; *or*

e.1.a.2. 'Energy density' exceeding 50 Wh/kg and a 'continuous power density' exceeding 350 W/kg;

e.1.b. 'Secondary cells' having an 'energy density' exceeding 350 Wh/kg at 20 °C;

Technical Notes:

1. For the purposes of 3A001.e.1, 'energy density' (Wh/kg) is calculated from the nominal voltage multiplied by the nominal capacity in ampere-hours (Ah) divided by the mass in kilograms. If the nominal capacity is not stated, energy density is calculated from the nominal voltage squared then multiplied by the discharge duration in hours divided by the discharge load in Ohms and the mass in kilograms.

2. For the purposes of 3A001.e.1, a 'cell' is defined as an electrochemical device, which has positive and negative electrodes, an electrolyte, and is a source of electrical energy. It is the basic building block of a battery.

3. For the purposes of 3A001.e.1.a, a 'primary cell' is a 'cell' that is not designed to be charged by any other source.

4. For the purposes of 3A001.e.1.b, a 'secondary cell' is a 'cell' that is designed to be charged by an external electrical source.

5. For the purposes of 3A001.e.1.a, 'continuous power density' (W/kg) is calculated from the nominal voltage multiplied by the specified maximum continuous discharge current in ampere (A) divided by the mass in kilograms. 'Continuous power density' is also referred to as specific power.

Note: *3A001.e does not control batteries, including single-cell batteries.*

e.2. High energy storage capacitors as follows:

e.2.a. Capacitors with a repetition rate of less than 10 Hz (single shot capacitors) and having all of the following:

e.2.a.1. A voltage rating equal to or more than 5 kV;

e.2.a.2. An energy density equal to or more than 250 J/kg; *and*

e.2.a.3. A total energy equal to or more than 25 kJ;

e.2.b. Capacitors with a repetition rate of 10 Hz or more (repetition rated capacitors) and having all of the following:

e.2.b.1. A voltage rating equal to or more than 5 kV;

e.2.b.2. An energy density equal to or more than 50 J/kg;

e.2.b.3. A total energy equal to or more than 100 J; *and*

e.2.b.4. A charge/discharge cycle life equal to or more than 10,000;

e.3. ''Superconductive'' electromagnets and solenoids, ''specially designed'' to be fully charged or discharged in less than one second and having all of the following:

Note: *3A001.e.3 does not control ''superconductive'' electromagnets or solenoids ''specially designed'' for Magnetic Resonance Imaging (MRI) medical equipment.*

e.3.a. Energy delivered during the discharge exceeding 10 kJ in the first second;

e.3.b. Inner diameter of the current carrying windings of more than 250 mm; *and*

e.3.c. Rated for a magnetic induction of more than 8 T or ''overall current density'' in the winding of more than 300 A/mm^2;

e.4. Solar cells, cell-interconnect-coverglass (CIC) assemblies, solar panels, and solar arrays, which are ''space-qualified,'' having a minimum average efficiency exceeding 20% at an operating temperature of 301 K (28 °C) under simulated 'AM0' illumination with an irradiance of 1,367 Watts per square meter (W/m^2);

Technical Note: *For the purposes of 3A001.e.4, 'AM0', or 'Air Mass Zero', refers to the spectral irradiance of sun light in the earth's outer atmosphere when the distance between the earth and sun is one astronomical unit (AU).*

f. Rotary input type absolute position encoders having an ''accuracy'' equal to or less (better) than 1.0 second of arc and ''specially designed'' encoder rings, discs or scales therefor;

g. Solid-state pulsed power switching thyristor devices and 'thyristor modules',

using either electrically, optically, or electron radiation controlled switch methods and having any of the following:

g.1. A maximum turn-on current rate of rise (di/dt) greater than 30,000 A/µs and off-state voltage greater than 1,100 V; *or*

g.2. A maximum turn-on current rate of rise (di/dt) greater than 2,000 A/µs and having all of the following:

g.2.a. An off-state peak voltage equal to or greater than 3,000 V; *and*

g.2.b. A peak (surge) current equal to or greater than 3,000 A;

Note 1: *3A001.g. includes:*

—Silicon Controlled Rectifiers (SCRs)
—Electrical Triggering Thyristors (ETTs)
—Light Triggering Thyristors (LTTs)
—Integrated Gate Commutated Thyristors (IGCTs)
—Gate Turn-off Thyristors (GTOs)
—MOS Controlled Thyristors (MCTs)
—Solidtrons

Note 2: *3A001.g does not control thyristor devices and 'thyristor modules' incorporated into equipment designed for civil railway or ''civil aircraft'' applications.*

Technical Note: *For the purposes of 3A001.g, a 'thyristor module' contains one or more thyristor devices.*

h. Solid-state power semiconductor switches, diodes, or 'modules', having all of the following:

h.1. Rated for a maximum operating junction temperature greater than 488 K (215 °C);

h.2. Repetitive peak off-state voltage (blocking voltage) exceeding 300 V; *and*

h.3. Continuous current greater than 1 A.

Technical Note: *For the purposes of 3A001.h, 'modules' contain one or more solid-state power semiconductor switches or diodes.*

Note 1: *Repetitive peak off-state voltage in 3A001.h includes drain to source voltage, collector to emitter voltage, repetitive peak reverse voltage and peak repetitive off-state blocking voltage.*

Note 2: *3A001.h includes:*

—Junction Field Effect Transistors (JFETs)
—Vertical Junction Field Effect Transistors (VJFETs)
—Metal Oxide Semiconductor Field Effect Transistors (MOSFETs)
—Double Diffused Metal Oxide Semiconductor Field Effect Transistor (DMOSFET)
—Insulated Gate Bipolar Transistor (IGBT)
—High Electron Mobility Transistors (HEMTs)
—Bipolar Junction Transistors (BJTs)
—Thyristors and Silicon Controlled Rectifiers (SCRs)
—Gate Turn-Off Thyristors (GTOs)
—Emitter Turn-Off Thyristors (ETOs)
—PiN Diodes
—Schottky Diodes

Note 3: *3A001.h does not apply to switches, diodes, or 'modules', incorporated into equipment designed for civil automobile, civil railway, or ''civil aircraft'' applications.*

i. Intensity, amplitude, or phase electro-optic modulators, designed for analog signals and having any of the following:

i.1. A maximum operating frequency of more than 10 GHz but less than 20 GHz, an optical insertion loss equal to or less than 3 dB and having any of the following:

i.1.a. A 'half-wave voltage' ('Vπ') less than 2.7 V when measured at a frequency of 1 GHz or below; *or*

i.1.b. A 'Vπ' of less than 4 V when measured at a frequency of more than 1 GHz; *or*

i.2. A maximum operating frequency equal to or greater than 20 GHz, an optical insertion loss equal to or less than 3 dB and having any of the following:

i.2.a. A 'Vπ' less than 3.3 V when measured at a frequency of 1 GHz or below; *or*

i.2.b. A 'Vπ' less than 5 V when measured at a frequency of more than 1 GHz.

Note: *3A001.i includes electro-optic modulators having optical input and output connectors (e.g., fiber-optic pigtails).*

Technical Note: *For the purposes of 3A001.i, a 'half-wave voltage' ('Vπ') is the applied voltage necessary to make a phase change of 180 degrees in the wavelength of light propagating through the optical modulator.*

j. through y. [Reserved]

z. Any commodity described in 3A001 that meets or exceeds the performance parameters in 3A090, as follows:

z.1.a ''Monolithic Microwave Integrated Circuit'' (''MMIC'') amplifiers described in 3A001.b.2 and discrete microwave transistors in 3A001.b.3 that also meet or exceed the performance parameters in ECCN 3A090.a, except those 3A001.b.2 and b.3 items being exported or reexported for use in civil telecommunications applications;

z.1.b ''Monolithic Microwave Integrated Circuit'' (''MMIC'') amplifiers described in 3A001.b.2 and discrete microwave transistors in 3A001.b.3 that also meet or exceed the performance parameters in ECCN 3A090.b, except those 3A001.b.2 and b.3 items being exported or reexported for use in civil telecommunications applications;

z.2.a Commodities that are described in 3A001.a.1.a when usable in ''missiles'' that also meet or exceed the performance parameters in ECCN 3A090.a; and to 3A001.a.5.a when ''designed or modified'' for military use, hermetically sealed and rated for operation in the temperature range from below −54 °C to above +125 °C and that also meet or exceed the performance parameters in ECCN 3A090.a;

z.2.b Commodities that are described in 3A001.a.1.a when usable in ''missiles'' that also meet or exceed the performance parameters in ECCN 3A090.b; and to 3A001.a.5.a when ''designed or modified'' for military use, hermetically sealed and rated for operation in the temperature range from below −54 °C to above +125 °C and that also meet or exceed the performance parameters in ECCN 3A090.b;

z.3.a. Pulse discharge capacitors described in 3A001.e.2 and superconducting solenoidal electromagnets in 3A001.e.3 that meet or exceed the technical parameters in 3A201.a and 3A201.b, respectively and that also meet or exceed the performance parameters in ECCN 3A090.a;

z.3.b Pulse discharge capacitors described in 3A001.e.2 and superconducting solenoidal electromagnets in 3A001.e.3 that meet or exceed the technical parameters in 3A201.a and 3A201.b, respectively and that also meet or exceed the performance parameters in ECCN 3A090.b;

z.4.a. All other commodities specified in this ECCN that meet or exceed the performance parameters of ECCN 3A090.a; or

z.4.b All other commodities specified in this ECCN that meet or exceed the performance parameters of ECCN 3A090.b.

* * * * *

3A090 Integrated circuits as follows (see List of Items Controlled).

License Requirements

Reason for Control: RS, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
RS applies to entire entry, except for 3A090.c	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to entire entry, except 3A090.c	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
RS applies to 3A090.c	To or within Macau or a destination specified in Country Group D:5 of supplement no. 1 to part 740 of the EAR. See § 742.6(a)(6)(i)(B) of the EAR.
AT applies to entire entry	AT Column 1.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: N/A

GBS: N/A

NAC/ACA: Yes, for 3A090.a, if the item is not designed or marketed for use in datacenters and has a 'total processing performance' of 4800 or more; yes, for 3A090.b, if the item is designed or marketed for use in datacenters. N/A for 3A090.c.

HBM: Yes, for 3A090.c. See § 740.25 of the EAR.

ACM: Yes

List of Items Controlled

Related Controls: (1) See ECCNs 3D001, 3E001, 5D002.z, and 5D992.z for associated technology and software controls. (2) See ECCNs 3A001.z, 5A002.z, 5A004.z, and 5A992.z.
Related Definitions: N/A
Items:

a. Integrated circuits having one or more digital processing units having either of the following:

a.1. A 'total processing performance' of 4800 or more; *or*

a.2. A 'total processing performance' of 1600 or more and a 'performance density' of 5.92 or more.

Note 1 to 3A090.a: *When a ''front-end fabricator'' or ''OSAT'' company is seeking to export, reexport, or transfer (in-country) an ''applicable advanced logic integrated circuit,'' there is a presumption that the item is 3A090.a and designed or marketed for datacenters. If the ''front-end fabricator'' or ''OSAT'' company cannot overcome this presumption, then it must comply with all license requirements applicable to items specified in 3A090.a. However, this presumption does not apply to any entity other than the ''front-end fabricator'' or ''OSAT'' company. A ''front-end fabricator'' or ''OSAT'' company can overcome this presumption in any of the following three ways outlined in paragraphs a. through c. of this Note 1.*

a. If the designer of the ''applicable advanced logic integrated circuit'' is an approved or authorized integrated circuit designer, then a datasheet or other attestation of the 'total processing performance' and the 'performance density' from the approved or authorized integrated circuit designer indicating that the IC is not specified in 3A090.a will overcome the presumption for the ''front-end fabricator'' or ''OSAT'' company that the IC is specified in ECCN 3A090.a.

(1) Approved integrated circuit designers are listed in supplement no. 6 to this part of the EAR;

(2) Prior to December 31, 2026, authorized integrated circuit designers include all integrated circuit designers:

(i) Headquartered in Taiwan or a destination specified in Country Group A:1 or A:5, that are neither located in nor have an ultimate parent headquartered in Macau or a destination specified in Country Group D:5 of supplement no. 1 to part 740 of the EAR; and

(ii) That have agreed to submit applicable information described in § 743.9(b) to the ''front-end fabricator,'' which the ''front-end fabricator'' must then report to BIS.

(3) After December 31, 2026, authorized integrated circuit designers include any integrated circuit designer that both meets the criteria specified in subparagraph (2) and has submitted an application to become an approved integrated circuit designer. However, any company deemed an authorized IC designer after December 31, 2026, will cease to be an authorized IC designer 180 days after the submission of its application to become an approved IC designer.

b. If the integrated circuit designer is neither located in nor has an ultimate parent headquartered in a destination specified in Country Groups D:1, D:4, or D:5 of supplement no. 1 to part 740 of the EAR or in paragraph (a)(6)(iii)(A)(1) of § 742.6, and if the integrated circuit die is packaged by the ''front-end fabricator'' at a location outside of Macau or a destination specified in Country Group D:5 in supplement no. 1 to part 740, then the attestation of the ''front-end fabricator'' that (a) the ''aggregated approximated transistor count'' of the final packaged IC is below 30 billion transistors, or (b) the final packaged IC does not contain high-bandwidth memory and that the ''aggregated approximated transistor count'' of the final packaged IC is below (i) 35 billion transistors for any exports, reexports, or transfers (in-country) completed in 2027; or (ii) 40 billion transistors for any exports, reexports, or transfers (in-country) completed in 2029 or thereafter, then this overcomes the presumption by the ''front-end fabricator'' or ''OSAT'' company that the IC is specified in ECCN 3A090.a.

c. If the integrated circuit designer is neither located in nor have an ultimate parent headquartered in a destination specified in Country Groups D;1, D:4, or D:5 of supplement no. 1 to part 740 of the EAR or in paragraph (a)(6)(iii)(A)(1) of § 742.6, and if the integrated circuit is packaged by an approved ''OSAT'' company listed in supplement no. 7 to part 740 of the EAR, then the attestation of the approved ''OSAT'' company that (a) the ''aggregated approximated transistor count'' of the final packaged IC is below 30 billion transistors, or (b) the final packaged IC does not contain high-bandwidth memory and that the ''aggregated approximated transistor count'' of the final packaged IC is below (i) 35 billion transistors for any exports, reexports, or transfers (in-country) completed in 2027; or (ii) 40 billion transistors for any exports, reexports, or transfers (in-country) completed in 2029 or thereafter, then this overcomes the presumption by the ''front-end fabricator'' or ''OSAT'' company that the IC is specified in ECCN 3A090.a.

d. It is not sufficient for the ''front-end fabricator'' or ''OSAT'' company to confirm the ECCN by relying on the attestation of the end user or other party to the transaction, except under one of the three ways enumerated in paragraphs a. through c. of this note. In the absence of an attestation of the 'total processing performance' and the 'performance density' by an approved integrated circuit designer listed in supplement no. 6 to part 740 of the EAR, the ''front-end fabricator'' or ''OSAT'' company must presume that any logic integrated circuit produced using the ''16/14 nanometer node'' or below, or using a non-planar transistor architecture and destined for a commodity with an (a) ''aggregated approximated transistor count'' of the final packaged IC is below 30 billion transistors, or (b) the final packaged IC does not contain high-bandwidth memory and that the ''aggregated approximated transistor count'' of the final packaged IC is below (i) 35 billion transistors for any exports, reexports, or transfers (in-country) completed in 2027; or (ii) 40 billion transistors for any exports, reexports, or transfers (in-country) completed in 2029 or thereafter, or where the ''aggregated approximated transistor count,'' of the final, packaged integrated circuit cannot be confirmed by the ''front-end fabricator,'' or an approved ''OSAT'' company listed in supplement no. 7 to part 740 of the EAR, is specified in ECCN 3A090.a and designed or marketed for a datacenter.

Technical Note 1 to 3A090.a: *The 'approximated transistor count' of a die is the 'transistor density' of the die multiplied by the area of the die measured in square millimeters. The 'transistor density' of the die is the number of transistors that can be fabricated per square millimeter for the process node used to manufacture the die. To calculate the number of 'approximated transistor count' of a die, a ''front end fabricator'' or ''OSAT'' company has two options. First, the ''front end fabricator'' or ''OSAT'' company may take the transistor density of the process node used to manufacture the die and multiply this density by the area of the die. This number may be significantly higher than the true transistor count, but if the result is below the relevant transistor threshold, then the ''front end fabricator'' or ''OSAT'' company can be confident that the die in question will not exceed that threshold. Second, to adjudicate edge cases, the ''front end fabricator'' or ''OSAT'' company may use standard design verification tools to estimate the number of (both active and passive) transistors on the die using the GDS file.*

b. Integrated circuits having one or more digital processing units having either of the following:

b.1. A 'total processing performance' of 2400 or more and less than 4800 and a 'performance density' of 1.6 or more and less than 5.92, or

b.2. A 'total processing performance' of 1600 or more and a 'performance density' of 3.2 or more and less than 5.92.

Note 2 to 3A090.a and 3A090.b: *3A090.a and 3A090.b do not apply to items that are not designed or marketed for use in datacenters and do not have a 'total processing performance' of 4800 or more. For 3A090.a and 3A090.b items that are not designed or marketed for use in datacenters and that have a 'total processing performance' of 4800 or more, see license exceptions NAC and ACA.*

Note 3 to 3A090.a and 3A090.b: *Integrated circuits specified by 3A090 include graphical processing units (GPUs), tensor processing units (TPUs), neural processors, in-memory processors, vision processors, text processors, co-processors/accelerators, adaptive processors, field-programmable logic devices (FPLDs), and application-specific integrated circuits (ASICs). Examples of integrated circuits are in the Note to 3A001.a.*

Note 4 to 3A090.a and 3A090.b: *For integrated circuits that are excluded from ECCN 3A090 under Note 2 or 3 to 3A090, those ICs are also not applicable for classifications made under ECCNs 3A001.z, 4A003.z, 4A004.z, 4A005.z, 4A090, 5A002.z, 5A004.z, 5A992.z, 5D002.z, or 5D992.z because those other CCL classifications are based on the incorporation of an integrated*

circuit that meets the control parameters under ECCN 3A090 or otherwise meets or exceeds the control parameters or ECCNs 3A090 or 4A090. The performance parameters under ECCN 3A090.c are not used for determining whether an item is classified in a .z ECCN. See the Related Controls paragraphs of ECCNs 3A001.z, 4A003.z, 4A004.z, 4A005.z, 4A090, 5A002.z, 5A004.z, 5A992.z, 5D002.z, or 5D992.z.

Technical Note 2 to 3A090.a and 3A090.b:

1. 'Total processing performance' ('TPP') is 2 × 'MacTOPS' × 'bit length of the operation', aggregated over all processing units on the integrated circuit.

a. For purposes of 3A090, 'MacTOPS' is the theoretical peak number of Tera (10^{12}) operations per second for multiply-accumulate computation (D = A × B + C).

b. The 2 in the 'TPP' formula is based on industry convention of counting one multiply-accumulate computation, D = A × B + C, as 2 operations for purpose of datasheets. Therefore, 2 × MacTOPS may correspond to the reported TOPS or FLOPS on a datasheet.

c. For purposes of 3A090, 'bit length of the operation' for a multiply-accumulate computation is the largest bit-length of the inputs to the multiply operation.

d. Aggregate the TPPs for each processing unit on the integrated circuit to arrive at a total. 'TPP' = TPP1 + TPP2 + ... + TPPn (where n is the number or processing units on the integrated circuit).

2. The rate of 'MacTOPS' is to be calculated at its maximum value theoretically possible. The rate of 'MacTOPS' is assumed to be the highest value the manufacturer claims in a manual or brochure for the integrated circuit. For example, the 'TPP' threshold of 4800 can be met with 600 tera integer operations (or 2 × 300 'MacTOPS') at 8 bits or 300 tera FLOPS (or 2 × 150 'MacTOPS') at 16 bits. If the integrated circuit is designed for MAC computation with multiple bit lengths that achieve different 'TPP' values, the highest 'TPP' value should be evaluated against parameters in 3A090.

3. For integrated circuits specified by 3A090 that provide processing of both sparse and dense matrices, the 'TPP' values are the values for processing of dense matrices (e.g., without sparsity).

4. 'Performance density' is 'TPP' divided by 'applicable die area'. For purposes of 3A090, 'applicable die area' is measured in millimeters squared and includes all die area of logic dies manufactured with a process node that uses a non-planar transistor architecture.

c. High bandwidth memory (HBM) having a 'memory bandwidth density' greater than 2 gigabytes per second per square millimeter.

Technical Note 1 to 3A090.c: *'Memory bandwidth density' is the memory bandwidth measured in gigabytes per second divided by the area of the package or stack measured in square millimeters. In the case where a stack is contained in a package, use the memory bandwidth of the packaged device and the area of the package. High bandwidth memory (HBM) includes dynamic random access memory integrated circuits, regardless of whether they conform to the JEDEC standards for high bandwidth memory (HBM), provided they have a 'memory bandwidth density' greater than 2 gigabytes per second per square millimeter. This control does not cover co-packaged integrated circuits with both HBM and logic integrated circuit where the dominant function of the co-packaged integrated circuit is processing. It does include HBM permanently affixed to a logic integrated circuit designed as a control interface and incorporating a physical layer (PHY) function.*

* * * * *

3D001 ''Software'' ''specially designed'' for the ''development'' or ''production'' of commodities controlled by 3A001.b to 3A002.h, 3A090, or 3B (except 3B001.a.4, c, d, f.1, f.5, k to n, p.2, p.4, r, 3B002.c, 3B903, 3B904, 3B991, 3B992, 3B993, or 3B994).

License Requirements

Reason for Control: NS, RS, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
NS applies to ''software'' for equipment controlled by 3B001.q	Worldwide control. *See § 742.4(a)(5) and (b)(10) of the EAR.*
RS applies to ''software'' for equipment controlled by 3B001.q	Worldwide control. *See § 742.6(a)(10) and (b)(11) of the EAR.*
NS applies to ''software'' for commodities controlled by 3A001.b to 3A001.h, 3A001.z, and 3B (except as specified in the heading).	NS Column 1.
RS applies to ''software'' for commodities controlled by 3A001.z and 3A090 (except for 3A090.c).	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to ''software'' for commodities controlled by 3A001.z and 3A090 (except for 3A090.c).	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
RS applies to ''software'' for commodities controlled by 3A090.c	To or within Macau or a destination specified in Country Group D:5 of supplement no. 1 to part 740 of the EAR. *See* § 742.6(a)(6)(i) of the EAR.
AT applies to entire entry	AT Column 1.

Reporting Requirements

See § 743.1 of the EAR for reporting requirements for exports under License Exceptions, and Validated End-User authorizations.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: Yes, except for ''software'' ''specially designed'' for the ''development'' or ''production'' of Traveling Wave Tube Amplifiers described in 3A001.b.8 having operating frequencies exceeding 18 GHz; or commodities specified in 3A090.

ACM: Yes for ''software'' for commodities controlled by 3A001.z or 3A090

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 3D001 ''software'' for commodities controlled by 3A001.z and 3A090.*

IEC: Yes, for ''software'' for equipment controlled by 3B001.q, see § 740.2(a)(22) and § 740.24 of the EAR.

Special Conditions for STA

STA: License Exception STA may not be used to ship or transmit ''software'' ''specially designed'' for the ''development'' or ''production'' of equipment specified by 3A090.a or 3B001.q to any of the destinations listed in Country Group A:5 or A:6 (See Supplement No.1 to part 740 of the EAR); and 3A090.b or 3A002.g.1 to any of the destinations listed in Country Group A:6.

List of Items Controlled

Related Controls: N/A
Related Definitions: N/A
Items: The list of items controlled is contained in the ECCN heading.

* * * * *

3E001 ''Technology'' according to the General Technology Note for the ''development'' or ''production'' of commodities controlled by 3A (except 3A069, 3A901, 3A904, 3A980, 3A981, 3A991, 3A992, or 3A999), 3B (except 3B001.a.4, c, d, f.1, f.5, k to n, p.2, p.4, r, 3B002.c, 3B903, 3B904, 3B991, 3B992, 3B993, or 3B994) or 3C (except 3C907, 3C908, 3C909, or 3C992).

License Requirements

Reason for Control: NS, MT, NP, RS, AT

Control(s)	Country chart (see Supp. No. 1 to part 738)
NS applies to ''technology'' for commodities controlled by 3A001, 3A002, 3A003, 3B001 (except as noted in the heading), 3B002 (except 3B002.c), or 3C001 to 3C006.	NS Column 1.
MT applies to ''technology'' for commodities controlled by 3A001 or 3A101 for MT Reasons.	MT Column 1.
NP applies to ''technology'' for commodities controlled by 3A001, 3A201, or 3A225 to 3A234 for NP reasons.	NP Column 1.
RS applies to ''technology'' for commodities controlled in 3A090, when exported from Macau or a destination specified in Country Group D:5.	Worldwide (see § 742.6(a)(6)(ii)).
RS applies to ''technology'' for commodities controlled by 3A001.z, 3A090 (except for 3A090.c).	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to ''technology'' for commodities controlled by 3A001.z, 3A090 (except for 3A090.c).	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
RS applies to ''technology'' for commodities controlled by 3A090.c	To or within Macau or a destination specified in Country Group D:5 of supplement no. 1 to part 740 of the EAR. See § 742.6(a)(6)(i)(B) of the EAR.
RS applies to ''technology'' for commodities controlled by 3A001.a.15 or b.13, 3A004, 3B003, 3C007, 3C008, or 3C009.	RS Column 2.
AT applies to entire entry	AT Column 1.

License Requirements Note: *See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.*

Reporting Requirements

See § 743.1 of the EAR for reporting requirements for exports under License Exceptions and Validated End-User authorizations.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: Yes, except N/A for MT, and ''technology'' for the ''development'' or ''production'' of: (a) vacuum electronic device amplifiers described in 3A001.b.8, having operating frequencies exceeding 19 GHz; (b) solar cells, coverglass-interconnect-cells or covered-interconnect-cells (CIC) ''assemblies,'' solar arrays and/or solar panels described in 3A001.e.4; (c) ''Monolithic Microwave Integrated Circuit'' (''MMIC'') amplifiers in 3A001.b.2; (d) discrete microwave transistors in 3A001.b.3; and (e) commodities described in 3A090.

ACM: Yes for ''technology'' for commodities controlled by 3A001.z or 3A090.

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 3E001 ''technology'' for commodities controlled by 3A001.z, 3A090.*

IEC: Yes, for ''technology'' for equipment controlled by 3B001.q, see § 740.2(a)(22) and § 740.24 of the EAR.

Special Conditions for Strategic Trade Authorization (STA)

STA: License Exception STA may not be used to ship or transmit ''technology'' according to the General Technology Note for the ''development'' or ''production'' of equipment specified by ECCNs 3A002.g.1 or 3B001.a.2 to any of the destinations listed in Country Group A:6 (see supplement no.1 to part 740 of the EAR). License Exception STA may not be used to ship or transmit ''technology'' according to the General Technology Note for the ''development'' or ''production'' of components specified by ECCN 3A001.b.2, b.3, commodities specified in 3A090, to any of the destinations listed in Country Group A:5 or A:6 (see supplement no. 1 to part 740 of the EAR).

List of Items Controlled

Related Controls: (1) ''Technology'' according to the General Technology Note for the ''development'' or ''production'' of certain ''space-qualified'' atomic frequency standards described in Category XV(e)(9), MMICs described in Category XV(e)(14), and oscillators described in Category XV(e)(15) of the USML are ''subject to the ITAR'' (see 22 CFR parts 120 through 130). See also ECCNs 3E101, 3E201 and 9E515. (2) ''Technology'' for ''development'' or ''production'' of ''Microwave Monolithic Integrated Circuits'' (''MMIC'') amplifiers in 3A001.b.2 is controlled in this ECCN 3E001; 5E001.d refers only to that additional ''technology'' ''required'' for telecommunications.

Related Definition: N/A.

Items: The list of items controlled is contained in the ECCN heading.

Note 1: *3E001 does not control ''technology'' for equipment or ''components'' controlled by 3A003.*

Note 2: *3E001 does not control ''technology'' for integrated circuits controlled by 3A001.a.3 to a.14 or z, having all of the following:*

(a) Using ''technology'' at or above 0.130 µm; and

(b) Incorporating multi-layer structures with three or fewer metal layers.

* * * * *

4A003 Digital computers'', ''electronic assemblies'', and related equipment therefor, as follows (see List of Items Controlled) and ''specially designed'' ''components'' therefor.

License Requirements

Reason for Control: NS, RS, CC, AT

Control(s)	Country chart (see Supp. No. 1 to part 738)
NS applies to 4A003.b, .c, and .z.1	NS Column 1.
NS applies to 4A003.g and z.2	NS Column 2.
RS applies to 4A003.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to 4A003.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
CC applies to ''digital computers'' for computerized finger-print equipment.	CC Column 1.

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
AT applies to entire entry (refer to 4A994 for controls on ''digital computers'' with an APP >0.0128 but ≤70 WT).	AT Column 1.

Note: *For all destinations, except those countries in Country Group E:1 or E:2 of Supplement No. 1 to part 740 of the EAR, no license is required (NLR) for computers with an ''Adjusted Peak Performance'' (''APP'') not exceeding 70 Weighted TeraFLOPS (WT) and for ''electronic assemblies'' described in 4A003.c that are not capable of exceeding an ''Adjusted Peak Performance'' (''APP'') exceeding 70 Weighted TeraFLOPS (WT) in aggregation, except certain transfers as set forth in § 746.3 (Iraq).*

Reporting Requirements

Special Post Shipment Verification reporting and recordkeeping requirements for exports of computers to destinations in Computer Tier 3 may be found in § 743.2 of the EAR.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: $5000; N/A for 4A003.b, c, and z.
GBS: Yes, for 4A003.g and ''specially designed'' ''parts'' and ''components'' therefor, exported separately or as part of a system.
APP: Yes, for computers controlled by 4A003.b, and ''electronic assemblies'' controlled by 4A003.c, to the exclusion of other technical parameters. See § 740.7 of the EAR.
NAC/ACA: Yes, for 4A003.z.
ACM: Yes for 4A003.z

Note to List Based License Exceptions:
See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 4A003.z.

List of Items Controlled

Related Controls: See also ECCNs 4A090, 4A994 and 4A980.
Related Definitions: N/A
Items:

Note 1: *4A003 includes the following:*

—'3Vector processors' (as defined in Note 7 of the ''Technical Note on ''Adjusted Peak Performance'' (''APP'')'');
—Array processors;
—Digital signal processors;
—Logic processors;
—Equipment designed for ''image enhancement.''

Note 2: *The control status of the ''digital computers'' and related equipment described in 4A003 is determined by the control status of other equipment or systems provided:*

a. The ''digital computers'' or related equipment are essential for the operation of the other equipment or systems;

b. The ''digital computers'' or related equipment are not a ''principal element'' of the other equipment or systems; and

N.B. 1: The control status of ''signal processing'' or ''image enhancement'' equipment ''specially designed'' for other equipment with functions limited to those required for the other equipment is determined by the control status of the other equipment even if it exceeds the ''principal element'' criterion.

N.B. 2: For the control status of ''digital computers'' or related equipment for telecommunications equipment, see Category 5, Part 1 (Telecommunications).

c. The ''technology'' for the ''digital computers'' and related equipment is determined by 4E.

a. [Reserved]

b. ''Digital computers'' having an ''Adjusted Peak Performance'' (''APP'') exceeding 70 Weighted TeraFLOPS (WT);

c. ''Electronic assemblies'' ''specially designed'' or modified to be capable of enhancing performance by aggregation of processors so that the ''APP'' of the aggregation exceeds the limit in 4A003.b.;

Note 1: *4A003.c applies only to ''electronic assemblies'' and programmable interconnections not exceeding the limit in 4A003.b when shipped as unintegrated ''electronic assemblies.''*

Note 2: *4A003.c does not control ''electronic assemblies'' ''specially designed'' for a product or family of products whose maximum configuration does not exceed the limit of 4A003.b.*

d. to f. [Reserved]

N.B.: For ''electronic assemblies,'' modules or equipment, performing analog-to-digital conversions, see 3A002.h.

g. Equipment ''specially designed'' for aggregating the performance of ''digital computers'' by providing external interconnections which allow communications at unidirectional data rates exceeding 2.0 Gbyte/s per link.

Note: *4A003.g does not control internal interconnection equipment (e.g., backplanes, buses) passive interconnection equipment, ''network access controllers'' or ''communication channel controllers''.*

h. through y. [Reserved]

z. Commodities specified in this ECCN 4A003 that also meet or exceed the performance parameters in 4A090.

z.1.a. Commodities specified in 4A003.b or .c that also meet or exceed the performance parameters in ECCN 4A090.a;

z.1.b Commodities specified in 4A003.b or .c that also meet or exceed the performance parameters in ECCN 4A090.b;

z.2.a. Commodities specified in 4A003.g that also meet or exceed the performance parameters in ECCN 4A090a; or

z.2.b Commodities specified in 4A003.g that also meet or exceed the performance parameters in ECCN 4A090.b.

* * * * *

4A004 Computers as follows (see List of Items Controlled) and ''specially designed'' related equipment, ''electronic assemblies'' and ''components'' therefor.

License Requirements

Reason for Control: NS, RS, AT

Control(s)	Country chart *(see Supp. No. 1 to part 738)*
NS applies to entire entry	NS Column 2.
RS applies to 4A004.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to 4A004.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: $5000, N/A for 4A004.z
GBS: N/A
NAC/ACA: Yes, for 4A004.z.
ACM: Yes for 4A004.z

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 4A004.z.*

List of Items Controlled

Related Controls: See also ECCN 4A090.
Related Definitions: N/A
Items:

a. 'Systolic array computers';
b. 'Neural computers';
c. 'Optical computers'.

Technical Notes:

1. For the purposes of 4A004.a, 'systolic array computers' are computers where the flow and modification of the data is

dynamically controllable at the logic gate level by the user.

2. For the purposes of 4A004.b, 'neural computers' are computational devices designed or modified to mimic the behavior of a neuron or a collection of neurons, i.e., computational devices which are distinguished by their hardware capability to modulate the weights and numbers of the interconnections of a multiplicity of computational components based on previous data.

3. For the purposes of 4A004.c, 'optical computers' are computers designed or modified to use light to represent data and whose computational logic elements are based on directly coupled optical devices.

d. through y. [Reserved]

z.1. Commodities that are described in 4A004 and that also meet or exceed the performance parameters in 4A090.a; or

z.2 Commodities that are described in 4A004 and that also meet or exceed the performance parameters in 4A090.b.

* * * * *

4A005 Systems,'' ''equipment,'' and ''components'' therefor, ''specially designed'' or modified for the generation, command and control, or delivery of ''intrusion software'' (see List of Items Controlled).

License Requirements

Reason for Control: NS, RS, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
NS applies to entire entry	NS Column 1.
RS applies to items controlled by 4A005.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to items controlled by 4A005.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.

Reporting Requirements

See § 743.1 of the EAR for reporting requirements for exports under License Exceptions, and Validated End-User authorizations.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: N/A
GBS: N/A
APP: N/A
ACE: Yes, except to Country Group E:1 or E:2. See § 740.22 of the EAR for eligibility criteria.
NAC/ACA: Yes, for 4A005.z.
ACM: Yes for 4A005.z

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 4A005.z.*

Special Conditions for STA

STA: License Exception STA may not be used to ship items specified by ECCN 4A005.

List of Items Controlled

Related Controls: (1) Defense articles described in USML Category XI(b), and software directly related to a defense article, are ''subject to the ITAR'' (see 22 CFR parts 120 through 130). (2) See also ECCN 4A090.
Related Definitions: N/A
Items: The list of items controlled is contained in the ECCN heading, except for the commodities controlled under 4A005.z.

a. through y. [Reserved]

z.1. Commodities that are specified in 4A005 that also meet or exceed the performance parameters in 4A090.a.

z.2 Commodities that are specified in 4A005 that also meet or exceed the performance parameters in 4A090.b.

* * * * *

4A090 Computers as follows (see List of Items Controlled) and related equipment, ''electronic assemblies,'' and ''components'' therefor.

License Requirements

Reason for Control: RS, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
RS applies to 4A090	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to 4A090	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: N/A
GBS: N/A
NAC/ACA: Yes
ACM: Yes

List of Items Controlled

Related Controls: (1) For associated ''software'' for commodities in this ECCN, see 4D090, 5D002.z, and 5D992.z and for associated ''technology'' for commodities in this ECCN, see 4E001. (2) Also ECCNs 4A003.z, 4A004.z, 4A005.z, 5A002.z, 5A004.z, and 5A992.z.
Related Definitions: N/A
Items:

a. Computers, ''electronic assemblies,'' and ''components'' containing integrated circuits, any of which meets or exceeds the limits in 3A090.a.

b. Computers, ''electronic assemblies,'' and ''components'' containing integrated circuits, any of which meets or exceeds the limits in 3A090.b.

Technical Note: *For purposes of 4A090.a and .b, computers include ''digital computers,'' ''hybrid computers,'' and analog computers.*

* * * * *

4D001 ''Software'' as follows (see List of Items Controlled).

License Requirements

Reason for Control: NS, RS, CC, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
NS applies to entire entry	NS Column 1.

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
RS applies to ''software'' for commodities controlled by 4A003.z, 4A004.z, and 4A005.z.	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to ''software'' for commodities controlled by 4A003.z, 4A004.z, and 4A005.z.	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
CC applies to ''software'' for computerized finger-print equipment controlled by 4A003 for CC reasons.	CC Column 1.
AT applies to entire entry	AT Column 1.

Reporting Requirements

See § 743.1 of the EAR for reporting requirements for exports under License Exceptions, and Validated End-User authorizations.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: Yes, except for ''software'' for the following:

(1) The ''development'' or ''production'' of commodities with an ''Adjusted Peak Performance'' (''APP'') exceeding 29 WT;

(2) The ''development'' or ''production'' of commodities controlled by 4A005 or ''software'' controlled by 4D004; or

(3) Commodities controlled by 4A003.z, 4A004.z, and 4A005.z

APP: Yes to specific countries (see § 740.7 of the EAR for eligibility criteria).

ACE: Yes for 4D001.a (for the ''development'', ''production'' or ''use'' of equipment or ''software'' specified in ECCN 4A005 or 4D004), except to Country Group E:1 or E:2. See § 740.22 of the EAR for eligibility criteria.

ACM: Yes for ''software'' for commodities controlled by 4A003.z, 4A004.z, 4A005.z

Note: *See § 740.2(a)(9)(ii) for license exception restrictions for ''software'' for commodities controlled by 4A003.z, 4A004.z, and 4A005.z.*

Special Conditions for STA

STA: License Exception STA may not be used to ship or transmit ''software'' ''specially designed'' or modified for the ''development'' or ''production'' of equipment specified by ECCN 4A001.a.2 or for the ''development'' or ''production'' of ''digital computers'' having an 'Adjusted Peak Performance' ('APP') exceeding 29 Weighted TeraFLOPS (WT) to any of the destinations listed in Country Group A:6 (See Supplement No. 1 to part 740 of the EAR); may not be used to ship or transmit ''software'' specified in 4D001.a ''specially designed'' for the ''development'' or ''production'' of equipment specified by ECCN 4A005; and may not be used to ship or transmit ''software'' for commodities controlled by 4A003.z.1.a, z.2.a, 4A004.z.1, and 4A005.z.1 to any of the destinations listed in Country Group A:5 or A:6.

List of Items Controlled

Related Controls: N/A

Related Definitions: N/A

Items:

a. ''Software'' ''specially designed'' or modified for the ''development'' or ''production'', of equipment or ''software'' controlled by 4A001, 4A003, 4A004, 4A005 or 4D (except 4D090, 4D906, 4D980, 4D993 or 4D994).

b. ''Software'', other than that controlled by 4D001.a, ''specially designed'' or modified for the ''development'' or ''production'' of equipment as follows:

b.1. ''Digital computers'' having an ''Adjusted Peak Performance'' (''APP'') exceeding 24 Weighted TeraFLOPS (WT);

b.2. ''Electronic assemblies'' ''specially designed'' or modified for enhancing performance by aggregation of processors so that the ''APP'' of the aggregation exceeds the limit in 4D001.b.1.

* * * * *

4D090 ''Software'' ''specially designed'' or modified for the ''development'' or ''production,'' of computers and related equipment, ''electronic assemblies,'' and ''components'' therefor specified in ECCN 4A090.

License Requirements

Reason for Control: RS, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
RS applies to ''software'' for commodities controlled by 4A090	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to ''software'' for commodities controlled by 4A090	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: N/A

ACM: Yes

List of Items Controlled

Related Controls: For associated ''technology'' for software in this ECCN, see 4E001.

Related Definitions: N/A

Items: The list of items controlled is contained in the ECCN heading.

* * * * *

4E001 ''Technology'' as follows (see List of Items Controlled)

License Requirements

Reason for Control: NS, MT, RS, CC, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
NS applies to entire entry, except for ''technology'' for 4A090 or ''software'' specified by 4D090.	NS Column 1.
MT applies to ''technology'' for items controlled by 4A001.a and 4A101 for MT reasons.	MT Column 1.
RS applies to ''technology'' for commodities controlled by 4A003.z, 4A004.z, 4A005.z, 4A090 or ''software'' specified by 4D001 (for 4A003.z, 4A004.z and 4A005.z), or 4D090.	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.

Control(s)	Country chart (see Supp. No. 1 to part 738)
RS applies to ''technology'' for commodities controlled by 4A003.z, 4A004.z, 4A005.z, 4A090 or ''software'' specified by 4D001 (for 4A003.z, 4A004.z, and 4A005.z), or 4D090.	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
CC applies to ''technology'' for computerized finger-print equipment controlled by 4A003 for CC reasons.	CC Column 1.
AT applies to entire entry	AT Column 1.

Reporting Requirements

See § 743.1 of the EAR for reporting requirements for exports under License Exceptions, and Validated End-User authorizations.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: Yes, except for the following:

(1) ''Technology'' for the ''development'' or ''production'' of commodities with an ''Adjusted Peak Performance'' (''APP'') exceeding 70 WT or for the ''development'' or ''production'' of commodities controlled by 4A005 or ''software'' controlled by 4D004;

(2) ''Technology'' for the ''development'' of ''intrusion software''; or

(3) ''Technology'' for commodities controlled by 4A003.z, 4A004.z, 4A005.z, 4A090 or ''software'' specified by 4D001 (for 4A003.z, 4A004.z, and 4A005.z), or 4D090

APP: Yes, to specific countries (see § 740.7 of the EAR for eligibility criteria).

ACE: Yes for 4E001.a (for the ''development'', ''production'' or ''use'' of equipment or ''software'' specified in ECCN 4A005 or 4D004); and for 4E001.c, except to Country Group E:1 or E:2. See § 740.22 of the EAR for eligibility criteria.

ACM: Yes for ''technology'' for commodities controlled by 4A003.z, 4A004.z, 4A005.z, 4A090 or ''software'' specified by 4D001 (for 4A003.z, 4A004.z and 4A005.z), or 4D090.

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for technology for .z paragraphs under ECCNs 4A003, 4A004, 4A005 or 4A090, or ''software'' specified by 4D001 (for 4A003.z, 4A004.z, 4A005.z, and 4A090).*

Special Conditions for STA

STA: License Exception STA may not be used to ship or transmit ''technology'' according to the General Technology Note for the ''development'' or ''production'' of any of the following equipment or ''software'': a. Equipment specified by ECCN 4A001.a.2; b. ''Digital computers'' having an 'Adjusted Peak Performance' ('APP') exceeding 70 Weighted TeraFLOPS (WT); c. ''software'' specified in the License Exception STA paragraph found in the License Exception section of ECCN 4D001; or ''technology'' for commodities controlled by 4A003.z.1.b, z.2.b, 4A004.z.2, 4A005.z.2, 4A090.b or ''software'' specified by 4D001 (for 4A003.z.1.b, z.2.b, 4A004.z.2, and 4A005.z.2), or 4D090.b to any of the destinations listed in Country Group A:6 (See Supplement No. 1 to part 740 of the EAR). License Exception STA may not be used to ship or transmit ''technology'' for commodities controlled by 4A003.z.1.a, z.2.a, 4A004.z.1, 4A005.z.1, 4A090.a or ''software'' specified by 4D001 (for 4A003.z.1.a, z.2.a, 4A004.z.1 and 4A005.z.1), or 4D090.a to any of the destinations listed in Country Group A:5 or A:6 (See Supplement No. 1 to part 740 of the EAR).

List of Items Controlled

Related Controls: N/A

Related Definitions: N/A

Items:

a. ''Technology'' according to the General Technology Note, for the ''development'', ''production'', or ''use'' of equipment or ''software'' controlled by 4A (except 4A906, 4A980 or 4A994 and ''use'' of equipment controlled under 4A090) or 4D (except 4D906, 4D980, 4D993, 4D994 and ''use'' of software controlled under 4D090).

b. ''Technology'' according to the General Technology Note, other than that controlled by 4E001.a, for the ''development'' or ''production'' of equipment as follows:

b.1. ''Digital computers'' having an ''Adjusted Peak Performance'' (''APP'') exceeding 24 Weighted TeraFLOPS (WT);

b.2. ''Electronic assemblies'' ''specially designed'' or modified for enhancing performance by aggregation of processors so that the ''APP'' of the aggregation exceeds the limit in 4E001.b.1.

c. ''Technology'' for the ''development'' of ''intrusion software.''

Note 1: *4E001.a and .c do not apply to ''vulnerability disclosure'' or ''cyber incident response''.*

Note 2: *Note 1 does not diminish national authorities' rights to ascertain compliance with 4E001.a and .c.*

* * * * *

5A002 ''Information security'' systems, equipment and ''components,'' as follows (see List of Items Controlled).

License Requirements

Reason for Control: NS, RS, AT, EI

Control(s)	Country chart (see Supp. No. 1 to part 738)
NS applies to entire entry	NS Column 1.
RS applies to items controlled by 5A002.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to items controlled by 5A002.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.
EI applies to entire entry	Refer to § 742.15 of the EAR.

License Requirements Note: *See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.*

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: Yes: $500 for ''components,'' N/A for systems and equipment. N/A for 5A002.z.

GBS: N/A

ENC: Yes for certain EI controlled commodities, see § 740.17 of the EAR for eligibility.

NAC/ACA: Yes, for 5A002.z.1.b, z.2.b

ACM: Yes for 5A002.z

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 5A002.z.*

List of Items Controlled

Related Controls: (1) ECCN 5A002.a controls ''components'' providing the means or functions necessary for ''information security.'' All such ''components'' are presumptively ''specially designed'' and controlled by 5A002.a. (2) See USML Categories XI (including XI(b)) and XIII(b)

(including XIII(b)(2)) for controls on systems, equipment, and components described in 5A002.d or .e that are ''subject to the ITAR'' (see 22 CFR parts 120 through 130). (3) For ''satellite navigation system'' receiving equipment containing or employing decryption see 7A005, and for related decryption ''software'' and ''technology'' see 7D005 and 7E001. (4) Noting that items may be controlled elsewhere on the CCL, examples of items not controlled by ECCN 5A002.a.4 include the following: (a) An automobile where the only 'cryptography for data confidentiality' having a 'described security algorithm' is performed by a Category 5—Part 2 Note 3 eligible mobile telephone that is built into the car. In this case, secure phone communications support a non-primary function of the automobile but the mobile telephone (equipment), as a standalone item, is not controlled by ECCN 5A002 because it is excluded by the Cryptography Note (Note 3) (See ECCN 5A992.c). (b) An exercise bike with an embedded Category 5—Part 2 Note 3 eligible web browser, where the only controlled cryptography is performed by the web browser. In this case, secure web browsing supports a non-primary function of the exercise bike but the web browser (''software''), as a standalone item, is not controlled by ECCN 5D002 because it is excluded by the Cryptography Note (Note 3) (See ECCN 5D992.c). (5) After classification or self-classification in accordance with § 740.17(b) of the EAR, mass market encryption commodities that meet eligibility requirements are released from ''EI'' and ''NS'' controls. These commodities are designated 5A992.c. (6) See also ECCNs 3A090 and 4A090.

Related Definitions: N/A

Items:

a. Designed or modified to use 'cryptography for data confidentiality' having a 'described security algorithm', where that cryptographic capability is usable, has been activated, or can be activated by any means other than secure ''cryptographic activation'', as follows:

a.1. Items having ''information security'' as a primary function;

a.2. Digital communication or networking systems, equipment or components, not specified in paragraph 5A002.a.1;

a.3. Computers, other items having information storage or processing as a primary function, and components therefor, not specified in paragraphs 5A002.a.1 or .a.2;

N.B.: For operating systems see also 5D002.a.1 and .c.1.

a.4. Items, not specified in paragraphs 5A002.a.1 to a.3, where the 'cryptography for data confidentiality' having a 'described security algorithm' meets all of the following:

a.4.a. It supports a non-primary function of the item; *and*

a.4.b. It is performed by incorporated equipment or ''software'' that would, as a standalone item, be specified by ECCNs 5A002, 5A003, 5A004, 5B002 or 5D002.

N.B. to paragraph a.4: See Related Control Paragraph (4) of this ECCN 5A002 for examples of items not controlled by 5A002.a.4.

Technical Notes:

1. For the purposes of 5A002.a, 'cryptography for data confidentiality' means ''cryptography'' that employs digital techniques and performs any cryptographic function other than any of the following:

1.a. ''Authentication;''

1.b. Digital signature;

1.c. Data integrity;

1.d. Non-repudiation;

1.e. Digital rights management, including the execution of copy-protected ''software;''

1.f. Encryption or decryption in support of entertainment, mass commercial broadcasts or medical records management; or

1.g. Key management in support of any function described in paragraphs 1.a to 1.f of this Technical Note paragraph 1.

2. For the purposes of 5A002.a, 'described security algorithm' means any of the following:

2.a. A ''symmetric algorithm'' employing a key length in excess of 56 bits, not including parity bits;

2.b. An ''asymmetric algorithm'' where the security of the algorithm is based on any of the following:

2.b.1. Factorization of integers in excess of 512 bits (e.g., RSA);

2.b.2. Computation of discrete logarithms in a multiplicative group of a finite field of size greater than 512 bits (e.g., Diffie-Hellman over Z/pZ); or

2.b.3. Discrete logarithms in a group other than mentioned in paragraph 2.b.2 of this Technical Note in excess of 112 bits (e.g., Diffie-Hellman over an elliptic curve); or

2.c. An ''asymmetric algorithm'' where the security of the algorithm is based on any of the following:

2.c.1. Shortest vector or closest vector problems associated with lattices (e.g., NewHope, Frodo, NTRUEncrypt, Kyber, Titanium);

2.c.2. Finding isogenies between Supersingular elliptic curves (e.g., Supersingular Isogeny Key Encapsulation); or

2.c.3. Decoding random codes (e.g., McEliece, Niederreiter).

Technical Note: *An algorithm described by Technical Note 2.c. may be referred to as being post-quantum, quantum-safe or quantum-resistant.*

Note 1: *Details of items must be accessible and provided upon request, in order to establish any of the following:*

a. Whether the item meets the criteria of 5A002.a.1 to a.4; or

b. Whether the cryptographic capability for data confidentiality specified by 5A002.a is usable without ''cryptographic activation.''

Note 2: *5A002.a does not control any of the following items, or specially designed ''information security'' components therefor:*

a. Smart cards and smart card 'readers/writers' as follows:

a.1. A smart card or an electronically readable personal document (e.g., token coin, e-passport) that meets any of the following:

a.1.a. The cryptographic capability meets all of the following:

a.1.a.1. It is restricted for use in any of the following:

a.1.a.1.a. Equipment or systems, not described by 5A002.a.1 to a.4;

a.1.a.1.b. Equipment or systems, not using 'cryptography for data confidentiality' having a 'described security algorithm'; or

a.1.a.1.c. Equipment or systems, excluded from 5A002.a by entries b. to f. of this Note; and

a.1.a.2. It cannot be reprogrammed for any other use; or

a.1.b. Having all of the following:

a.1.b.1. It is specially designed and limited to allow protection of 'personal data' stored within;

a.1.b.2. Has been, or can only be, personalized for public or commercial transactions or individual identification; and

a.1.b.3. Where the cryptographic capability is not user-accessible;

Technical Note to paragraph a.1.b.1 of Note 2: *For the purposes of 5A002.a Note 2.a.1.b.1, 'personal data' includes any data specific to a particular person or entity, such as the amount of money stored and data necessary for ''authentication.''*

a.2. 'Readers/writers' specially designed or modified, and limited, for items specified by paragraph a.1 of this Note;

Technical Note to paragraph a.2 of Note 2: *For the purposes of 5A002.a Note 2.a.2, 'readers/writers' include equipment that communicates with smart cards or electronically readable documents through a network.*

b. Cryptographic equipment specially designed and limited for banking use or 'money transactions';

Technical Note to paragraph b. of Note 2: *For the purposes of 5A002.a Note 2.b, 'money transactions' in 5A002 Note 2 paragraph b. includes the collection and settlement of fares or credit functions.*

c. Portable or mobile radiotelephones for civil use (e.g., for use with commercial civil cellular radio communication systems) that are not capable of transmitting encrypted data directly to another radiotelephone or equipment (other than Radio Access Network (RAN) equipment), nor of passing encrypted data through RAN equipment (e.g., Radio Network Controller (RNC) or Base Station Controller (BSC));

d. Cordless telephone equipment not capable of end-to-end encryption where the maximum effective range of unboosted cordless operation (i.e., a single, unrelayed hop between terminal and home base station) is less than 400 meters according to the manufacturer's specifications;

e. Portable or mobile radiotelephones and similar client wireless devices for civil use, that implement only published or commercial cryptographic standards (except for anti-piracy functions, which may be non-published) and also meet the provisions of paragraphs a.2 to a.4 of the Cryptography Note (Note 3 in Category 5—Part 2), that have been customized for a specific civil industry application with features that do not affect the cryptographic functionality of these original non-customized devices;

f. Items, where the ''information security'' functionality is limited to wireless ''personal area network'' functionality implementing only published or commercial cryptographic standards;

g. Mobile telecommunications Radio Access Network (RAN) equipment designed

for civil use, which also meet the provisions of paragraphs a.2 to a.4 of the Cryptography Note (Note 3 in Category 5—Part 2), having an RF output power limited to 0.1W (20 dBm) or less, and supporting 16 or fewer concurrent users;

h. Routers, switches, gateways or relays, where the ''information security'' functionality is limited to the tasks of ''Operations, Administration or Maintenance'' (''OAM'') implementing only published or commercial cryptographic standards;

i. General purpose computing equipment or servers, where the ''information security'' functionality meets all of the following:

i.1. Uses only published or commercial cryptographic standards; and

i.2. Is any of the following:

i.2.a. Integral to a CPU that meets the provisions of Note 3 in Category 5—Part 2;

i.2.b. Integral to an operating system that is not specified by 5D002; or

i.2.c. Limited to ''OAM'' of the equipment; or

j. Items specially designed for a 'connected civil industry application', meeting all of the following:

j.1. Being any of the following:

j.1.a. A network-capable endpoint device meeting any of the following:

j.1.a.1. The ''information security'' functionality is limited to securing 'non-arbitrary data' or the tasks of ''Operations, Administration or Maintenance'' (''OAM''); or

j.1.a.2. The device is limited to a specific 'connected civil industry application'; or

j.1.b. Networking equipment meeting all of the following:

j.1.b.1. Being specially designed to communicate with the devices specified by paragraph j.1.a. above; and

j.1.b.2. The ''information security'' functionality is limited to supporting the 'connected civil industry application' of devices specified by paragraph j.1.a. above, or the tasks of ''OAM'' of this networking equipment or of other items specified by paragraph j. of this Note; and

j.2. Where the ''information security'' functionality implements only published or commercial cryptographic standards, and the cryptographic functionality cannot easily be changed by the user.

Technical Notes:

1. For the purposes of 5A002.a Note 2.j, 'connected civil industry application' means a network-connected consumer or civil industry application other than ''information security'', digital communication, general purpose networking or computing.

2. For the purposes of 5A002.a Note 2.j.1.a.1, 'non-arbitrary data' means sensor or metering data directly related to the stability, performance or physical measurement of a system (e.g., temperature, pressure, flow rate, mass, volume, voltage, physical location, etc.), that cannot be changed by the user of the device.

b. Being a 'cryptographic activation token';

Technical Note: *For the purposes of 5A002.b, a 'cryptographic activation token' is an item designed or modified for any of the following:*

1. Converting, by means of ''cryptographic activation'', an item not specified by Category 5—Part 2 into an item specified by 5A002.a or 5D002.c.1, and not released by the Cryptography Note (Note 3 in Category 5—Part 2); or

2. Enabling by means of ''cryptographic activation'', additional functionality specified by 5A002.a of an item already specified by Category 5—Part 2;

c. Designed or modified to use or perform ''quantum cryptography'';

Technical Note: *For the purposes of 5A002.c, ''quantum cryptography'' is also known as Quantum Key Distribution (QKD).*

d. Designed or modified to use cryptographic techniques to generate channelizing codes, scrambling codes or network identification codes, for systems using ultra-wideband modulation techniques and having any of the following:

d.1. A bandwidth exceeding 500 MHz; *or*

d.2. A ''fractional bandwidth'' of 20% or more;

e. Designed or modified to use cryptographic techniques to generate the spreading code for ''spread spectrum'' systems, not specified by 5A002.d, including the hopping code for ''frequency hopping'' systems.

f. through y. [Reserved]

z. Other commodities, as follows:

z.1.a. Commodities that are described in 5A002.a and that also meet or exceed the performance parameters in 3A090.a or 4A090.a;

z.1.b Commodities that are described in 5A002.a and that also meet or exceed the performance parameters in 3A090.b or 4A090.b;

z.2.a Commodities that are described in 5A002.b and that also meet or exceed the performance parameters in 3A090.a or 4A090.a;

z.2.b Commodities that are described in 5A002.b and that also meet or exceed the performance parameters in 3A090.b or 4A090.b;

z.3.a Commodities that are described in 5A002.c and that also meet or exceed the performance parameters in 3A090.a or 4A090.a;

z.3.b Commodities that are described in 5A002.c and that also meet or exceed the performance parameters in 3A090.b or 4A090.b;

z.4.a Commodities that are described in 5A002.d and that also meet or exceed the performance parameters in 3A090.a or 4A090.a;

z.4.b Commodities that are described in 5A002.d and that also meet or exceed the performance parameters in 3A090.b or 4A090.b;

z.5.a Commodities that are described in 5A002.e and that also meet or exceed the performance parameters in 3A090.a or 4A090.a; or

z.5.b Commodities that are described in 5A002.e and that also meet or exceed the performance parameters in 3A090.b or 4A090.b.

5A992 Equipment not controlled by 5A002 (see List of Items Controlled)

License Requirements

Reason for Control: RS, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
RS applies to items controlled by 5A992.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to items controlled by 5A992.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.

License Requirements Note: *See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.*

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: N/A

GBS: N/A

NAC/ACA: Yes, for 5A992.z.2; N/A for all other 5A992 commodities.

ACM: Yes for 5A992.z

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 5A992.z.*

List of Items Controlled

Related Controls: See also ECCNs 3A090 and 4A090.

Related Definitions: N/A

Items:

a. [Reserved]

b. [Reserved]

c. Commodities classified as mass market encryption commodities in accordance with § 740.17(b) of the EAR.

d. through y. [Reserved]

z.1. Commodities that are described in 5A992.c and that also meet or exceed the performance parameters in 3A090.a or 4A090.a; or

z.2 Commodities that are described in 5A992.c and that also meet or exceed the performance parameters in 3A090.b or 4A090.b.

* * * * *

5A004 ''Systems,'' ''equipment'' and ''components'' for defeating, weakening or bypassing ''information security,'' as follows (see List of Items Controlled).

License Requirements

Reason for Control: NS, RS, AT, EI

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
NS applies to entire entry	NS Column 1.
RS applies to items controlled by 5A004.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to items controlled by 5A004.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.
EI applies to entire entry	Refer to § 742.15 of the EAR.

License Requirements

See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

LVS: Yes: $500 for ''components''; N/A for 5A004.z. N/A for systems and equipment.
GBS: N/A
ENC: Yes for certain EI controlled commodities. See § 740.17 of the EAR for eligibility.
NAC/ACA: Yes, for 5A004.z.1.b, z.2.b
ACM: Yes for 5A004.z

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 5A004.z.*

List of Items Controlled

Related Controls: (1) ECCN 5A004.a controls ''components'' providing the means or functions necessary for ''information security.'' All such ''components'' are presumptively ''specially designed'' and controlled by 5A004.a. (2) See also ECCNs 3A090 and 4A090.

Related Definitions: N/A
Items:

a. Designed or modified to perform 'cryptanalytic functions.'

Note: *5A004.a includes systems or equipment, designed or modified to perform 'cryptanalytic functions' by means of reverse engineering.*

Technical Note: *For the purposes of 5A004.a, 'cryptanalytic functions' are functions designed to defeat cryptographic mechanisms in order to derive confidential variables or sensitive data, including clear text, passwords or cryptographic keys.*

b. Items, not specified by ECCNs 4A005 or 5A004.a, designed to perform all of the following:

b.1. 'Extract raw data' from a computing or communications device; *and*

b.2. Circumvent ''authentication'' or authorization controls of the device, in order to perform the function described in 5A004.b.1.

Technical Note: *For the purposes of 5A004.b.1, 'extract raw data' from a computing or communications device means to retrieve binary data from a storage medium, e.g., RAM, flash or hard disk, of the device without interpretation by the device's operating system or filesystem.*

Note 1: *5A004.b does not apply to systems or equipment specially designed for the ''development'' or ''production'' of a computing or communications device.*

Note 2: *5A004.b does not include:*

a. Debuggers, hypervisors;

b. Items limited to logical data extraction;

c. Data extraction items using chip-off or JTAG; or

d. Items specially designed and limited to jail-breaking or rooting.

c. through y. [Reserved]

z. Other commodities, as follows:

z.1.a Commodities that are described in 5A004.a and that also meet or exceed the performance parameters in 3A090.a or 4A090.a;

z.1.b Commodities that are described in 5A004.a and that also meet or exceed the performance parameters in 3A090.b or 4A090.b;

z.2.a Commodities that are described in 5A004.b and that also meet or exceed the performance parameters in 3A090.a or 4A090.a; or

z.2.b Commodities that are described in 5A004.b and that also meet or exceed the performance parameters in 3A090.b or 4A090.b.

* * * * *

5D002 ''Software'' as follows (see List of Items Controlled)

License Requirements

Reason for Control: NS, RS, AT, EI

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
NS applies to entire entry	NS Column 1.
RS applies to ''software'' controlled by 5D002.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to ''software'' controlled by 5D002.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.
EI applies to ''software'' in 5D002.a.1, a.3, .b, c.1 and c.3, for commodities or ''software'' controlled for EI reasons in ECCN 5A002, 5A004 or 5D002.	Refer to § 742.15 of the EAR. *Note: Encryption software is controlled because of its functional capacity, and not because of any informational value of such software; such software is not accorded the same treatment under the EAR as other ''software''; and for export licensing purposes, encryption software is treated under the EAR in the same manner as a commodity included in ECCN 5A002.*

License Requirements Note: *See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.*

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: N/A
ENC: Yes for certain EI controlled software. See § 740.17 of the EAR for eligibility.
NAC/ACA: Yes, for 5D002.z.
ACM: Yes for 5D002.z

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 5D002.z.*

List of Items Controlled

Related Controls: (1) After classification or self-classification in accordance with § 740.17(b) of the EAR, mass market encryption software that meets eligibility requirements is released from ''EI'' and ''NS'' controls. This software is designated as 5D992.c. (2) See also ECCNs 3D001 as it applies to ''software'' for commodities controlled by 3A001.z and 3A090, and 4D001 as it applies to ''software'' for commodities controlled by 4A003.z, 4A004.z, and 4A005.z.
Related Definitions: 5D002.a controls ''software'' designed or modified to use ''cryptography'' employing digital or analog techniques to ensure ''information security.''
Items:

a. ''Software'' ''specially designed'' or modified for the ''development,'' ''production'' or ''use'' of any of the following:

a.1. Equipment specified by 5A002 or ''software'' specified by 5D002.c.1;

a.2. Equipment specified by 5A003 or ''software'' specified by 5D002.c.2; *or*

a.3. Equipment or ''software'', as follows:

a.3.a. Equipment specified by 5A004.a or ''software'' specified by 5D002.c.3.a;

a.3.b. Equipment specified by 5A004.b or ''software'' specified by 5D002.c.3.b;

b. ''Software'' having the characteristics of a 'cryptographic activation token' specified by 5A002.b;

c. ''Software'' having the characteristics of, or performing or simulating the functions of, any of the following:

c.1. Equipment specified by 5A002.a, .c, .d or .e;

Note: *5D002.c.1 does not apply to ''software'' limited to the tasks of ''OAM'' implementing only published or commercial cryptographic standards.*

c.2. Equipment specified by 5A003; *or*

c.3. Equipment, as follows:

c.3.a. Equipment specified by 5A004.a;

c.3.b. Equipment specified by 5A004.b.

Note: *5D002.c.3.b does not apply to ''intrusion software''.*

d. [Reserved]

N.B.: See 5D002.b for items formerly specified in 5D002.d.

e. through y. [Reserved]

z. Other software, as follows:

z.1.a Software that is described in 5D002.a.1, and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a;

z.1.b Software that is described in 5D002.a.1, and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b;

z.2.a Software that is described in 5D002.a.2, and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a;

z.2.b Software that is described in 5D002.a.2, and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b;

z.3.a Software that is described in 5D002.a.3a, and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a;

z.3.b Software that is described in 5D002.a.3a, and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b;

z.4.a Software that is described in 5D002.a.3.b, and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a;

z.4.b Software that is described in 5D002.a.3.b, and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b;

z.5.a Software that is described in 5D002.b and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a;

z.5.b Software that is described in 5D002.b and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b;

z.6.a Software that is described in 5D002.c.1 and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a;

z.6.b Software that is described in 5D002.c.1 and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b;

z.7.a Software that is described in 5D002.c.2 and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a;

z.7.b Software that is described in 5D002.c.2 and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b;

z.8.a Software that is described in 5D002.c.3.a and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a;

z.8.b Software that is described in 5D002.c.3.a and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b;

z.9.a Software that is described in 5D002.c.3.b and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a; or

z.9.b Software that is described in 5D002.c.3.b and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b.

5D992 ''Information Security'' ''software,'' not controlled by 5D002, as follows (see List of Items Controlled)

License Requirements

Reason for Control: RS, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
RS applies to ''software'' controlled by 5D992.z	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to ''software'' controlled by 5D992.z	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.

License Requirements Note: *See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.*

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: N/A
NAC/ACA: Yes, for 5D992.z.
ACM: Yes for 5D992.z

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for ECCN 5D992.z.*

List of Items Controlled

Related Controls: (1) This entry does not control ''software'' designed or modified to protect against malicious computer damage, *e.g.,* viruses, where the use of ''cryptography'' is limited to authentication, digital signature and/or the decryption of data or files. (2) See also ECCNs 3D001 as it applies to ''software'' for commodities controlled by 3A001.z and 3A090, and 4D001 as it applies to

''software'' for commodities controlled by 4A003.z, 4A004.z, and 4A005.z.

Related Definitions: N/A

Items:

a. [Reserved]

b. [Reserved]

c. ''Software'' classified as mass market encryption software in accordance with § 740.17(b) of the EAR.

d. through y. [Reserved]

z.1 Other software that is described in 5D992 and that also meet or exceed the performance parameters in 3D001 for 3A090.a or 4D001 for 4A090.a; or

z.2 Other software that is described in 5D992 and that also meet or exceed the performance parameters in 3D001 for 3A090.b or 4D001 for 4A090.b.

* * * * *

5E002 ''Technology'' as follows (see List of Items Controlled)

License Requirements

Reason for Control: NS, RS, AT, EI

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
NS applies to entire entry	NS Column 1.
RS applies to ''technology'' for commodities controlled by 5A002.z or 5A004.z or ''software'' specified by 5D002 (for 5A002.z or 5A004.z commodities).	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to ''technology'' for commodities controlled by 5A002.z or 5A004.z or ''software'' specified by 5D002 (for 5A002.z or 5A004.z commodities).	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.
EI applies to ''technology'' in 5E002.a for commodities or ''software'' controlled for EI reasons in ECCNs 5A002, 5A004 or 5D002, and to ''technology'' in 5E002.b.	Refer to § 742.15 of the EAR.

License Requirements Notes:

(1) See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.

(2) When a person performs or provides technical assistance that incorporates, or otherwise draws upon, ''technology'' that was either obtained in the United States or is of U.S.-origin, then a release of the ''technology'' takes place. Such technical assistance, when rendered with the intent to aid in the ''development'' or ''production'' of encryption commodities or software that would be controlled for ''EI'' reasons under ECCN 5A002, 5A004 or 5D002, may require authorization under the EAR even if the underlying encryption algorithm to be implemented is from the public domain or is not of U.S.-origin.

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: N/A

ENC: Yes for certain EI controlled technology. See § 740.17 of the EAR for eligibility.

ACM: Yes for ''technology'' for commodities controlled by 5A002.z or 5A004.z or ''software'' specified by 5D002 (for 5A002.z or 5A004.z commodities.

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for technology for .z paragraphs under ECCNs 5A002, 5A004 or ''software'' specified by 5D002 (for 5A002.z or 5A004.z commodities).*

List of Items Controlled

Related Controls: See also 5E992. This entry does not control ''technology'' ''required'' for the ''use'' of equipment excluded from control under the Related Controls paragraph or the Technical Notes in ECCN 5A002 or ''technology'' related to equipment excluded from control under ECCN 5A002.

Related Definitions: N/A

Items:

a. ''Technology'' according to the General Technology Note for the ''development,'' ''production'' or ''use'' of equipment controlled by 5A002, 5A003, 5A004 or 5B002, or of ''software'' controlled by 5D002.a, z.1 through z.3, or 5D002.c, z.6 through z.8.

Note: *5E002.a does not apply to ''technology'' for items specified by 5A004.b, z.3 or z.4, 5D002.a.3.b, z.4, or 5D002.c.3.b.*

b. ''Technology'' having the characteristics of a 'cryptographic activation token' specified by 5A002.b, z.2.

Note: *5E002 includes ''information security'' technical data resulting from procedures carried out to evaluate or determine the implementation of functions, features or techniques specified in Category 5—Part 2.*

5E992 ''Information Security'' ''Technology'' according to the general Technology Note, not controlled by 5E002, as follows (see List of Items Controlled)

License Requirements

Reason for Control: RS, AT

Control(s)	*Country chart (see Supp. No. 1 to part 738)*
RS applies to ''technology'' for commodities controlled by 5A992.z or ''software'' controlled by 5D992.z.	To or within any destination specified in § 742.6(a)(6)(iii)(A)(*1*) of the EAR.
RS applies to ''technology'' for commodities controlled by 5A992.z or ''software'' controlled by 5D992.z.	To or within the United Arab Emirates or destinations specified in Country Groups D:1, D:4, and D:5 of supplement no. 1 to part 740 of the EAR, excluding any destination also specified in Country Groups A:5 or A:6.
AT applies to entire entry	AT Column 1.

License Requirements Note: *See § 744.17 of the EAR for additional license requirements for microprocessors having a processing speed of 5 GFLOPS or more and an arithmetic logic unit with an access width of 32 bit or more, including those incorporating ''information security'' functionality, and associated ''software'' and ''technology'' for the ''production'' or ''development'' of such microprocessors.*

List Based License Exceptions (See Part 740 for a Description of All License Exceptions)

TSR: N/A

NAC/ACA: N/A

ACM: Yes for ''technology'' for commodities controlled by 5A992.z or ''software'' controlled by 5D992.z.

Note: *See § 740.2(a)(9)(ii) of the EAR for license exception restrictions for technology for .z paragraphs under ''technology'' for commodities controlled by 5A992.z or ''software'' controlled by 5D992.z.*

List of Items Controlled

Related Controls: N/A
Related Definitions: N/A
Items:

a. [Reserved]

b. ''Technology'', n.e.s., for the ''use'' of mass market commodities controlled by 5A992 or mass market ''software'' controlled by 5D992.

* * * * *

Jeffrey I. Kessler,

Under Secretary for Industry and Security.

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17 CFR Parts 229, 232, 239, et al.
Executive Compensation Disclosure Reform; Proposed Rule

SECURITIES AND EXCHANGE COMMISSION

17 CFR Parts 229, 232, 239, 240, 249, and 274

[Release Nos. 33–11455; 34–106873; IC–36385; File No. S7–2026–39]

RIN 3235–AN60

Executive Compensation Disclosure Reform

AGENCY: Securities and Exchange Commission.

ACTION: Proposed rule.

SUMMARY: The Securities and Exchange Commission (''Commission'') is proposing amendments to its executive and director compensation disclosure rules to make the requirements more principles-based and to reduce compliance burdens for registrants, while maintaining the disclosure of material information to investors. The proposed amendments would focus the disclosures on the principal executive officer (''PEO'') and principal financial officer (''PFO''), streamline the tabular disclosure requirements, and simplify and rationalize various other aspects of the compensation disclosure rules, including the Compensation Discussion and Analysis (''CD&A''), pay ratio, pay-versus-performance, and perquisites disclosure requirements.

DATES: This release was published in the **Federal Register** on November 19, 2026. Comments should be submitted on or before January 19, 2027.

ADDRESSES: Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number S7–2026–39 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number S7–2026–39. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method of submission. The Commission will post all comments on the Commission's website (*https://www.sec.gov/rules-regulations/public-comments/s7-2026-39*). Do not include personally identifiable information in submissions; you should submit only information that you wish to make available publicly. The Commission may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection.

Studies, memoranda, or other substantive items may be added by the Commission or staff to the comment file during this rulemaking. A notification of the inclusion in the comment file of any such materials will be made available on the Commission's website. To ensure direct electronic receipt of such notifications, sign up through the ''Stay Connected'' option at *www.sec.gov* to receive notifications by email.

A summary of the proposal of not more than 100 words is posted on the Commission's website (*https://www.sec.gov/rules-regulations/2026/11/s7-2026-39*).

FOR FURTHER INFORMATION CONTACT: Dennis Hermreck, Special Counsel, and Amanda Ravitz, Senior Special Counsel, Office of Rulemaking, Division of Corporation Finance, at (202) 551–3430, U.S. Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549.

SUPPLEMENTARY INFORMATION: The Commission is proposing to amend the following rules, forms, and schedules:

Commission Reference		CFR Citation (17 CFR)
Regulation S-K[1]	Item 201	§ 229.201
	Item 402	§ 229.402
	Item 403	§ 229.403
	Item 404	§ 229.404
	Item 601	§ 229.601
	Item 1011	§ 229.1011
Regulation S-T[2]	Rule 405	§ 232.405
Securities Act of 1933 ("Securities Act")[3]	Form S-1	§ 239.11
	Form S-11	§ 239.18
	Form S-4	§ 239.25
Securities Exchange Act of 1934 ("Exchange Act")[4]	Rule 14a-6	§ 240.14a-6
	Rule 14a-21	§ 240.14a-21
	Schedule 14A	§ 240.14a-101
	Rule 14c-5	§ 240.14c-5
	Schedule 14C	§ 240.14c-101
	Form 20-F	§ 249.220f
	Form 40-F	§ 249.240f
	Form 8-K	§ 249.308
	Form 10-K	§ 249.310
Investment Company Act of 1940 ("Investment Company Act")[5]	Form N-CSR	§ 274.128
Securities Act and Investment Company Act	Form N-2	§§ 239.14 and 274.11a-1

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I. Introduction

We are proposing amendments to our executive and director compensation disclosure rules [6] to make the requirements more principles-based and the disclosures clearer, more concise, and less complex. In addition, the proposed amendments are intended to reduce compliance burdens for registrants [7] and maintain investor protection by focusing the disclosures on material information.

A. Regulatory History

Disclosure requirements regarding executive compensation were initially set forth in Item 14 of Schedule A to the Securities Act and section 12(b) of the Exchange Act, which list the type of information to be included in Securities Act and Exchange Act registration statements.[8] Beginning in the 1930s, the Commission began expanding on compensation disclosure requirements by promulgating its first executive compensation disclosure rules for registration and proxy statements.[9] Over time, the Commission has continued to modify its executive compensation disclosure requirements. At various times, the Commission has mandated tabular, narrative, or combinations of tabular and narrative disclosures.[10] The Commission has likewise expanded its disclosure requirements over time to require disclosure of various components of compensation. While it is undisputed that these requirements, and the resulting disclosures, have become increasingly complex and lengthy, it is less clear if the increased complexity and length have always provided investors with corresponding additional information that would be viewed by a reasonable investor as significant to the total mix of information made available.[11] Further, some commenters indicate that some rulemaking releases may underestimate the compliance burdens associated with the disclosure requirements for some registrants.[12]

The Commission's current executive compensation disclosure requirements,

[6] References to ''executive compensation'' throughout this release generally are meant to include both named executive officer and director compensation. Where relevant, such as in section II.L, we have made substantive distinctions between named executive officer and director compensation.

[7] We generally use the terms ''companies,'' ''registrants,'' and ''issuers'' interchangeably in this release. Unless explained in the text, the use of different terms in different places is not meant to connote a substantive difference.

[8] Item 14 of Schedule A to the Securities Act calls for disclosure of ''the remuneration, paid or estimated to be paid, by the issuer or its predecessor, directly or indirectly, during the past year and ensuing year to (a) the directors or persons performing similar functions, and (b) its officers and other persons, naming them wherever such remuneration exceeded $25,000 during any such year.'' Section 12(b) of the Exchange Act requires disclosure of ''the directors, officers, and underwriters, and each security holder of record holding more than 10 per centum of any class of any equity security of the issuer (other than an exempted security), their remuneration and their interests in the securities of, and their material contracts with, the issuer and any person directly or indirectly controlling or controlled by, or under direct or indirect common control with, the issuer.''

[9] *See, e.g.,* Release No. 34–1823 (Aug. 11, 1938) [3 FR 1991 (Aug. 13, 1938)].

[10] *See, e.g.,* Release No. 34–3347 (Dec. 18, 1942) [7 FR 10653 (Dec. 22, 1942)] (first introducing tabular executive compensation disclosure requirements); Release No. 34–4775 (Dec. 11, 1952) [17 FR 11431 (Dec. 18, 1952)] (expanding tabular disclosure for pensions and deferred remuneration); *Uniform and Integrated Reporting Requirements: Management Remuneration,* Release No. 33–6003 (Dec. 4, 1978) [43 FR 58181 (Dec. 12, 1978)] (expanding tabular disclosure to cover all forms of compensation); *Disclosure of Executive Compensation,* Release No. 33–6486 (Sept. 23, 1983) [48 FR 44467 (Sept. 29, 1983)] (''1983 Adopting Release'') (limiting tabular disclosure to cash compensation and adopting a mostly narrative approach).

[11] *See, e.g., TSC Indus.* v. *Northway, Inc.,* 426 U.S. 438 (1976).

[12] *See, e.g.,* letters from National Association of Manufacturers (Aug. 6, 2025) (''NAM–2''), available at *https://www.sec.gov/comments/4-855/4855-636727-1893534.pdf* (referring to a statement made by Roland Schustereder of ExxonMobil that ''it took his company 300 hours to prepare its initial 'pay versus performance' disclosure'' and stating that this number of hours was ''20 times more than the SEC estimated that disclosure would take.'').

which are contained in Item 402 of Regulation S–K, require an extensive combination of tabular and narrative disclosures, some of which are scaled for certain registrants.[13] In the context of the Commission's periodic reassessment of, and amendments to, its executive compensation disclosure requirements, current Item 402 is primarily the result of:

- A comprehensive revision of Item 402 adopted in 1992 (''1992 Amendments''); [14]
- A substantial expansion of Item 402 adopted in 2006 (''2006 Amendments''); [15] and
- A series of specialized additions to Item 402 adopted in response to Congressional mandates under the Dodd-Frank Wall Street Reform and Consumer Protection Act (''Dodd-Frank Act'') [16] regarding:
  - Disclosures related to shareholder approval of executive compensation and golden parachute compensation (''2011 Say-on-Pay Amendments''); [17]
  - Pay ratio disclosures (''2015 Pay Ratio Amendments''); [18]
  - Pay-versus-performance disclosures (''2022 Pay-versus-Performance Amendments''); [19] and
  - Disclosures of a registrant's actions to recover certain erroneously awarded compensation (''2022 Clawback Disclosure Amendments'' and, together with 2011 Say-on-Pay Amendments, 2015 Pay Ratio Amendments, and 2022 Pay-versus-Performance Amendments, ''Dodd-Frank Act Amendments'').[20]

The 1992 Amendments comprehensively overhauled the Commission's executive compensation disclosure requirements and mandated a series of detailed tabular disclosures. Among other things, the 1992 Amendments introduced the Summary Compensation Table [21] as the central point of focus of the executive compensation disclosures. The Summary Compensation Table aimed to provide an overview of executive compensation in a single location and set forth highly prescriptive presentation requirements that sought to increase consistency and comparability across years for each registrant and across registrants.

The 2006 Amendments built upon the 1992 Amendments by revising and expanding the required tabular disclosures and also adding substantial new narrative disclosure requirements. Among other changes to the required tabular disclosures, the 2006 Amendments notably added a ''total'' column to the Summary Compensation Table, requiring registrants to disclose a single dollar figure intended to represent total compensation for each named executive officer (''NEO'') for each covered fiscal year.[22] As the principal tabular disclosure vehicle under the current rule, the Summary Compensation Table attempts to present a comprehensive overview of an NEO's compensation, combining elements of compensation that have already been earned (such as salary) with elements that remain subject to contingencies (such as performance-based equity awards). As a result, some compensation reported in the Summary Compensation Table ultimately might not be earned at all, or might be earned at different levels depending on, for example, to what extent performance-based conditions are satisfied over the relevant performance period.

The 2006 Amendments also changed the narrative disclosure requirements, including introducing the CD&A. The CD&A was designed to be a principles-based overview of executive compensation in plain English and without boilerplate disclosures. The 2006 Amendments also provided an illustrative list of 15 example topics that may be material for discussion in the CD&A (depending on the registrant's particular facts and circumstances), as well as a number of topics that the CD&A is required to discuss.[23]

Subsequently, the Commission adopted the Dodd-Frank Act Amendments to implement the Dodd-Frank Act mandates related to Item 402. The Dodd-Frank Act added section 14A of the Exchange Act,[24] which requires registrants to (i) conduct non-binding, advisory shareholder votes to approve compensation of executives as disclosed pursuant to Item 402 (''say-on-pay'') and to determine the frequency of say-on-pay votes; and (ii) in connection with a meeting of shareholders to approve certain acquisitions, mergers, or similar transactions involving the registrant, to conduct a non-binding, advisory shareholder vote to approve agreements or understandings with any NEO of the registrant based on or relating to the transaction and related compensation. Section 14A of the Exchange Act also requires registrants to make specific golden parachute executive compensation disclosures, as implemented by the 2011 Say-on-Pay Amendments.[25] The Dodd-Frank Act also mandated the adoption of a rule requiring registrants to disclose the ratio between the annual total compensation of the principal executive officer and that of a median employee, as well as a rule requiring disclosure showing the relationship between executive pay and registrant performance.[26] The 2015 Pay Ratio Amendments adopted 17 CFR 229.402(u) (''Item 402(u)'') that requires registrants to disclose the ratio between the annual total compensation of the PEO and that of a median employee where the median employee is identified once every three years [27] from among all full-time and part-time,

[13] Item 402 of Regulation S–K was originally adopted in 1982. *See Adoption of Integrated Disclosure System,* Release No. 33–6383 (Mar. 3, 1982) [47 FR 11380–01 (Mar. 16, 1982)].

[14] *See Executive Compensation Disclosure,* Release No. 33–6962 (Oct. 16, 1992) [57 FR 48125 (Oct. 21, 1992)] (''1992 Adopting Release'').

[15] *See Executive Compensation and Related Person Disclosure,* Release No. 33–8732A (Aug. 29, 2006) [71 FR 53158 (Sept. 8, 2006)] (''2006 Adopting Release'').

[16] *See* Dodd-Frank Wall Street Reform and Consumer Protection Act, Public Law 111–203, 124 Stat. 1376 (2010).

[17] *See Shareholder Approval of Executive Compensation and Golden Parachute Compensation,* Release No. 33–9178 (Jan. 25, 2011) [76 FR 6010 (Feb. 2, 2011)] (''2011 Say-on-Pay Adopting Release'').

[18] *See Pay Ratio Disclosure,* Release No. 33–9877 (Aug. 5, 2015) [80 FR 50103 (Aug. 18, 2015)] (''2015 Pay Ratio Adopting Release'').

[19] *See Pay Versus Performance,* Release No. 34–95607 (Aug. 25, 2022) [87 FR 55134 (Sept. 8, 2022)] (''2022 Pay-versus-Performance Adopting Release'').

[20] *See Listing Standards for Recovery of Erroneously Awarded Compensation,* Release No. 33–11126 (Oct. 26, 2022) [87 FR 73076 (Nov. 28, 2022)] (''2022 Clawback Adopting Release'').

[21] *See* 17 CFR 229.402(c).

[22] Under the 2006 Amendments, the Summary Compensation Table also requires that registrants base the value of stock and option awards on their grant date fair value and provide more detailed disclosure about perquisites and pensions. *See* 17 CFR 229.402(c)(2)(v) through (vi).

[23] *See* 17 CFR 229.402(b)(1) and (2). The 2006 Amendments established six required topics, including: the objectives of the registrant's compensation programs; what the compensation program is designed to reward; each element of compensation; why the registrant chooses to pay each element; how the registrant determines the amount; and how each compensation element and the registrant's decisions regarding that element fit into the registrant's overall compensation objectives and affect decisions regard other elements. A seventh topic, which was added to the CD&A via the 2011 Say-on-Pay Amendments, requires registrants to disclose whether and, if so, how the registrant has considered the results of its most recent say-on-pay advisory vote in determining compensation policies and decisions and, if so, how that consideration has affected the registrant's executive compensation decisions and policies.

[24] *See* Public Law 111–203, 124 Stat. 1376, section 951 (2010); *see also* 17 CFR 240.14a–21(a) through (c) (Commission rules addressing shareholder approval of executive compensation, frequency of votes for approval of executive compensation, and golden parachute compensation).

[25] *See* 17 CFR 229.402(t) (''Item 402(t)'').

[26] *See* Public Law 111–203, 124 Stat. 1376, sec. 953(b) and 953(a) (2010).

[27] Under the current rule, the median employee determination must be made more frequently when circumstances change with respect to a registrant's employee population or employee compensation arrangements as determined by the registrant in accordance with its reasonable belief. *See* 17 CFR 229.402(u); Instruction 2 to 17 CFR 229.402(u).

seasonal, and temporary U.S. and non-U.S. workers.[28] The 2022 Pay-versus-Performance Amendments adopted 17 CFR 229.402(v) (''Item 402(v)'') that, among other things, requires registrants to disclose the value of a specialized measure of executive compensation and several specific financial performance measures. Item 402(v) requires registrants to annually conduct a detailed and complex set of calculations to arrive at the specialized measure of executive pay used exclusively in pay-versus-performance disclosures and to demonstrate the relationship between that specialized pay measure and the financial performance of the registrant.

Also, in accordance with the Dodd-Frank Act, in 2022, the Commission adopted 17 CFR 240.10D–1 (''Exchange Act Rule 10D–1''), which directed the national securities exchanges and associations that list securities to establish listing standards that require issuers to develop and implement a policy providing for the recovery, in the event of a required accounting restatement, of incentive-based compensation received by current or former executive officers where that compensation is based on the erroneously reported financial information.[29] In connection with these amendments, the Commission added 17 CFR 229.402(w) (''Item 402(w)'') to require (i) in the event of an accounting restatement that required recovery of erroneously awarded compensation pursuant to the registrant's compensation recovery policy, disclosure regarding the restatement, including, but not limited to, the dollar amount of the erroneously awarded compensation attributable to such restatement; or (ii) in the event of an accounting restatement that did *not* require recovery of erroneously awarded compensation, a brief explanation of why the application of the recovery policy resulted in such conclusion.[30] In addition, the Commission added check boxes to Form 10–K, Form 20–F, and Form 40–F which require listed issuers to indicate whether the financial statements included in the filing reflect the correction of an error to previously issued financial statements and, if so, whether any of those error corrections are restatements that required the registrant to analyze whether to recover erroneously awarded compensation in accordance with Exchange Act Rule 10D–1.[31]

B. Public Views on the Executive Compensation Disclosure Rules

We believe that executive compensation disclosures are relevant to, among other things: evaluating the overall relationship between the registrant and its NEOs; assessing the cost of NEO compensation to the registrant; identifying retention risk with respect to NEOs; gauging the strength of alignment between NEO compensation and registrant performance; and informing say-on-pay advisory votes [32] and other corporate governance matters.[33] We also recognize, however, that the Commission's executive compensation disclosure rules have become increasingly complex and burdensome over the years. In response to prior rulemakings and requests for comment, some representatives of market participants have expressed concerns to the Commission regarding various aspects of the current rule and the often lengthy disclosures produced by registrants under it.[34] The Commission has also received a number of rulemaking petitions regarding executive compensation disclosures since the 2006 Amendments.[35]

[28] *See* 17 CFR 229.402(u).

[29] *See* 2022 Clawback Adopting Release at 73078.

[30] *See id.* at 73107.

[31] *See id.* at 73108. The 2022 Clawback Adopting Release also amended Form N–CSR for certain investment companies, to include the same disclosure requirements called for by Item 402(w).

[32] Say-on-pay advisory votes are required by section 14A(a)(1) of the Exchange Act, which was added to the Exchange Act pursuant to the Dodd-Frank Act. *See* Public Law 111–203, 124 Stat. 1376, section 951 (2010). Section 14A(a)(1) of the Exchange Act requires that ''[n]ot less frequently than once every 3 years, a proxy or consent or authorization for an annual or other meeting of the shareholders for which the proxy solicitation rules of the Commission require compensation disclosure shall include a separate resolution subject to shareholder vote to approve the compensation of executives,'' as disclosed pursuant to Item 402 of Regulation S–K, or any successor to Item 402. The shareholder vote to approve executive compensation required by section 14A(a)(1) ''shall not be binding on the issuer or the board of directors of an issuer'' and emerging growth companies are exempt from the requirement to hold such say-on-pay votes. *See* 15 U.S.C. 78n–1(c) and (e)(2). As part of the Commission's effort to simplify and rationalize disclosure obligations for registrants, on May 19, 2026, the Commission proposed, among other things, to extend existing scaled disclosure and other accommodations to all non-accelerated filers, which under that proposal would include approximately 81% of current registrants, representing 6.5% of total market public float. *See Enhancement of Emerging Growth Company Accommodations and Simplification of Filer Status for Reporting Companies,* Release No. 33–11419 (May 19, 2026) [91 FR 30086 (May 21, 2026)] (''2026 Filer Status Proposing Release''). More specifically, the 2026 Filer Status Proposing Release, if adopted as proposed, would exempt these companies from holding say-on-pay advisory votes.

[33] *See, e.g.,* letters from Americans for Financial Reform Education Fund (Aug. 6, 2025) (''AFREF''), available at *https://www.sec.gov/comments/4-855/4855-636507-1892934.pdf* (suggesting comprehensive executive compensation disclosures are necessary for shareholders to determine whether boards of directors are representing their interests in negotiations with executives); Axcelis Technologies, Inc. (June 10, 2025) (''Axcelis''), available at *https://www.sec.gov/comments/4-855/4855-610947-1790534.pdf* (suggesting factual executive compensation disclosures allow investors to assess the effectiveness of boards of directors and compensation committees, provide a sound basis for say-on-pay votes, and inform executive compensation decision-making by helping companies understand where their compensation falls relative to peers); Baillie Gifford & Co. (June 30, 2025) (''Baillie Gifford''), available at *https://www.sec.gov/comments/4-855/4855-619127-1817494.pdf* (indicating that, as a long-term active manager, it relies on executive compensation disclosures to evaluate the alignment between pay outcomes, corporate culture, and long-term value creation for investors); Council of Institutional Investors (June 25, 2025) (''Council of Institutional Investors''), available at *https://www.sec.gov/comments/4-855/4855-616687-1809534.pdf* (suggesting that executive compensation is a top priority for institutional investors and that executive compensation disclosures better equip investors to monitor the effectiveness of boards of directors in exercising their critical responsibility of oversight of executive compensation).

[34] *See, e.g.,* letters from Center for Capital Markets Competitiveness, U.S. Chamber of Commerce (Oct. 27, 2016), available at *https://www.sec.gov/comments/s7-15-16/s71516-33.pdf* (indicating that ''[t]he complexity of the SEC's rules and interpretations, coupled with the technical nature of the broader subject of executive compensation, means that special expertise is often required to understand what CD&A requires a company to disclose'' and that ''[t]he length of CD&A alone—a 20-page narrative is not uncommon and it has been known to run on for over 40 pages at some companies—can obscure what is material'' and citing a survey that suggested ''[l]ess than half (38 percent) of institutional investors believe that information about executive compensation is clear and effectively disclosed in the corporate proxy''); Center on Executive Compensation (Nov. 1, 2016), available at *https://www.sec.gov/comments/s7-18-16/s71816-14.pdf* (indicating that ''extensive additions to executive compensation disclosures have occurred since 2007, and especially since the 2010 Dodd-Frank Act'' and urging ''the SEC to undertake a comprehensive re-examination of the current content, structure, and format of the executive compensation disclosure regime as soon as is feasible'').

[35] *See* Stuart J. Kaswell, *Petition for Rulemaking to Amend Instruction 7 to 17 CFR 229.402(d),* SEC File Number 4–772 (Apr. 21, 2021), available at *https://www.sec.gov/files/rules/petitions/2021/petn4-772.pdf* (requesting the Commission amend Instruction 7 to 17 CFR 229.402(d) ''to better inform investors as to whether issuer repurchases trigger higher payments to senior executives under performance-based compensation schemes''); Kenneth A. Bertsch & Jeffrey P. Mahoney, *Petition for Rulemaking Regarding Disclosures on the Use of Non-GAAP Financials in Proxy Statement CD&As,* SEC File Number 4–745 (Apr. 29, 2019) (''Non-GAAP Petition''), available at *https://www.sec.gov/files/rules/petitions/2019/petn4-745.pdf* (requesting the Commission, among other things, ''provide that all non-GAAP financial measures presented in the [CD&A] are subject to the requirements of Regulation G''); Ira T. Kay, *Petition for Rulemaking to Amend Item 402 to Revise the Current Summary Compensation Table to Better Depict the Compensation Earned for the Year by Named Executive Officers,* SEC File Number 4–585 (May 26, 2009) (''Summary Compensation Table Petition''), available at *https://www.sec.gov/files/rules/petitions/2009/petn4-585.pdf* (requesting the Commission ''reconsider the current Summary Compensation Table'' and take an alternative approach ''which focuses on depicting the *pay*

In light of these considerations and in order to facilitate review of these requirements, including how the Commission's rules can focus more on requiring disclosure likely to elicit material compensation information, the Commission held a roundtable discussion on the executive compensation disclosure rules on June 26, 2025 (''2025 Roundtable'').[36] The 2025 Roundtable consisted of three panel discussions that featured a wide range of market participants, including representatives of registrants, investors, law firms, executive compensation consultants, industry bodies, labor unions, and pension funds.[37] Interested parties were also invited to submit written comment letters in connection with the 2025 Roundtable.[38] Commenters representing a wide range of interested parties, including registrants, investors, executive compensation and corporate governance consultants, law firms, and public interest organizations submitted over 70 comment letters in response to the 2025 Roundtable.

During the 2025 Roundtable, representatives of registrants and their advisors generally emphasized the burdens associated with the current regulatory regime and queried the value of certain executive compensation disclosures to investors.[39] In particular, some panelists expressed concerns about elements of the Summary Compensation Table and the requirement to disclose a total compensation amount given the disparate nature of the various components of compensation required to be included in the table.[40] Several panelists also voiced concern about the burden of preparing, and the value to investors of, the disclosures required by the Dodd-Frank Act Amendments.[41]

Representatives of investors who participated in the 2025 Roundtable generally were more supportive of the current executive compensation disclosure rules than were registrants and their advisors,[42] but also expressed dissatisfaction with certain aspects of the rules and related market practices.[43] In that regard, as with the representatives of registrants and their advisors, these panelists generally acknowledged that the current disclosures often include unnecessary complexity and repetition.[44] Other representatives of investors suggested that the complexity of registrants' executive pay practices (rather than the requirements of the Commission's rules) may be driving the length and density of the disclosures.[45] In addition, some of these panelists noted it is difficult to follow an equity award through its lifecycle and recommended revising the disclosure requirements to make it easier for investors to do so.[46]

Many written comments in connection with the 2025 Roundtable also stated that the disclosures required by the current rules have become increasingly complex and lengthy.[47] By way of example, one commenter highlighted a recent estimate that the average CD&A in a company's proxy statement comprises 10,000 words or 15 pages.[48] Further, some commenters

realizable by an executive during the year''). The Commission has considered these petitions in connection with developing the proposed rules.

[36] *See SEC Roundtable on Executive Compensation Disclosure Requirements* (June 26, 2025), available at *https://www.sec.gov/newsroom/meetings-events/sec-roundtable-executive-compensation-disclosure-requirements.* The Commission's Investor Advisory Committee also held a panel discussion in March 2026 on public company disclosure reform and in March 2024 on the use of materiality as a disclosure standard. *See* Investor Advisory Committee Meeting Agenda (March 12, 2026), available at *https://www.sec.gov/about/advisory-committees/investor-advisory-committee/iac031226-agenda;* Investor Advisory Committee Meeting Agenda (March 7, 2024), available at *https://www.sec.gov/advocate/iac030724-agenda.* The Commission's Office of the Advocate for Small Business Capital Formation also held roundtable discussions in June 2025 on reassessing the framework for small public companies and on reexamining the IPO on-ramp. The transcripts of these roundtable discussions are available at *https://www.sec.gov/files/small-cap-policy-roundtable-transcript.pdf* and *https://www.sec.gov/files/ipo-roundtable-transcript.pdf.* In July 2026, the Office of the Advocate for Small Business Capital Formation and the Division of Corporation Finance held another roundtable on modernizing the IPO process and access to public capital. The transcript of this roundtable discussion is available at *https://www.sec.gov/files/OASB-CF-Rethinking-Rulebook-transc-508.pdf.*

[37] The transcript of the remarks made during the 2025 Roundtable is available at *https://www.sec.gov/files/sec-roundtable-executive-compensation-disclosure-requirements-2025-06-26-transcript.pdf* (''2025 Roundtable Transcript'').

[38] *See* Chairman Paul S. Atkins, *Statement on the Upcoming Executive Compensation Roundtable* (May 16, 2025), available at *https://www.sec.gov/newsroom/speeches-statements/statement-upcoming-executive-compensation-roundtable.* Comments letters submitted in connection with the 2025 Roundtable are available at *https://www.sec.gov/comments/4-855/4-855.htm.*

[39] *See, e.g.,* Michael Lennartz (Mastercard), 2025 Roundtable Transcript at 34:18–25 (suggesting ''[i]t requires a Herculean effort to produce all of the numbers that go into the tables''); Zachary Levine (Metropolitan Commercial Bank), 2025 Roundtable Transcript at 113:19–21 and 114:10–11 (suggesting ''there's . . . an immense administrative burden that is particularly challenging'' and ''[i]f you're not sure who the NEOs are, that's really impactful from a cost perspective''); *see also* Sarah Fortt (Ford Motor Company), 2025 Roundtable Transcript at 156: 9–24 and 181:13–23 (suggesting that the current disclosure requirements can distort board decision-making, require substantial registrant resources, and may produce disclosures that are confusing to and often unread by investors).

[40] *See* Ning Chiu (Davis Polk & Wardwell), 2025 Roundtable Transcript at 161:20–24 and 162:1–3; Ronald O. Mueller (Gibson Dunn), 2025 Roundtable Transcript at 163:13–25 and 164:1–4; Marc Treviño (Sullivan & Cromwell), 2025 Roundtable Transcript at 166:13–25.

[41] *See, e.g.,* Roland Schustereder (ExxonMobil), 2025 Roundtable Transcript at 116:1–3 (suggesting that while it took his company 300 hours to prepare its initial pay-versus-performance disclosures, shareholders have not asked any questions about them); *see also* Lennartz, 2025 Roundtable Transcript at 84:3–9 (questioning the utility of certain disclosures and noting that ''[n]o one has ever asked me once about the CEO pay ratio on the investor side, nor about the pay-versus-performance table'').

[42] *See* Brandon Rees (American Federation of Labor and Congress of Industrial Organizations), 2025 Roundtable Transcript at 103:6–7 (suggesting that ''[n]o investor is asking the SEC to reduce the amount of disclosure'').

[43] *See* Drew Hambly (California Public Employees' Retirement System), 2025 Roundtable Transcript at 152:2–15, 174:25 and 175:1–2 (commenting that ''we've learned how to use the regime we have, but it's a very cumbersome and inefficient regime to use'').

[44] *See* Hambly, 2025 Roundtable Transcript at 152:2–15, 174:25, and 175:1–2 (commenting that the disclosure includes unnecessary repetition with graphics and paragraphs repeated verbatim); Michael McCauley (State Board of Administration of Florida), 2025 Roundtable Transcript at 107:1–3 (commenting on inclusion of ''generic boilerplate legalese [that] is not really helping anybody'').

[45] *See* Rees, 2025 Roundtable Transcript at 102:12–15 (suggesting that ''the problem with executive compensation disclosure is not that investors are receiving too much information . . . [but rather] that the executive compensation plans are too elaborate''); *see also* Hambly, 2025 Roundtable Transcript at 152:16–22 (''There is nothing in the rules . . . that says we have to set up compensation programs that require a slide rule and an abacus to figure out [what] somebody is going to get paid.'').

[46] *See* Ola Peter Krohn Gjessing (Norges Bank Investment Management), 2025 Roundtable Transcript at 50:15 and 80:2–10 (commenting that ''[e]ven though we have all this disclosure . . . it is incredibly hard to follow one equity grant through its life[cycle]''); *see also* Terry Adamson (Infinite Equity), 2025 Roundtable Transcript at 175:17–25 and 176:1–11 (commenting that ''it would be really easy with a life cycle that reconciles, this is what was outstanding at the beginning of the year, this is anything new that was granted . . . this is what vested during the year, and this is what's outstanding at the end of the year, grant by grant by grant, all the way through'').

[47] *See, e.g.,* letters from McGuireWoods LLP and Brownstein Hyatt Farber Schreck, LLP (June 20, 2025) (''McGuireWoods & Brownstein''), available at *https://www.sec.gov/comments/4-855/4855-614907-1802694.pdf;* NEI Investments (June 26, 2025) (''NEI''), available at *https://www.sec.gov/comments/4-855/4855-617107-1810154.pdf;* NYSE Institute (June 25, 2025) (''NYSE''), available at *https://www.sec.gov/comments/4-855/4855-617127-1810194.pdf.* In contrast, other commenters expressed support for retaining, and even expanding, the current executive compensation disclosure requirements. *See, e.g.,* Form Letter A, available at *https://www.sec.gov/comments/4-855/4855-typea.htm* (stating support for ''keeping, and even expanding, the SEC's strong disclosure rules for executive compensation''); Form Letter B, available at *https://www.sec.gov/comments/4-855/4855-typeb.htm* (urging the Commission ''to maintain its executive compensation disclosure rules in their current form'').

[48] Letter from U.S. Chamber of Commerce, Center for Capital Markets Competitiveness (June 25, 2025) (''Chamber of Commerce''), available at *https://www.sec.gov/comments/4-855/4855-622607-1826714.pdf* (noting that for ''many companies,

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asserted that the complexity of the disclosures mandated by the executive compensation disclosure rules has led to, among other things, registrants failing to apply the rules in a consistent manner, relying on boilerplate disclosures, and providing a voluminous amount of information that is difficult for investors to digest.[49] Some commenters stated that the executive compensation disclosure rules have become so complicated that registrants increasingly have had to rely on third parties who have unique expertise, such as specialized executive compensation lawyers and consultants, to assist them with compliance.[50] Some commenters also stated that investors similarly rely on third parties, such as proxy advisory firms, to advise them on matters related to executive compensation disclosures due to their complicated nature.[51] Furthermore, one commenter cited a 2015 survey finding that only 38 percent of institutional investors found executive compensation disclosure ''clear and easy to understand.'' [52]

Commenters suggested a variety of solutions to help address some of these issues. Many of the proposed solutions involved simplifying the disclosure requirements [53] and adopting more principles-based requirements that allow registrants to provide executive compensation disclosures that are more tailored to how compensation decisions are actually made.[54] Several commenters similarly recommended allowing companies to have more flexibility regarding their executive compensation disclosures.[55]

II. Discussion of Proposed Amendments

We are proposing primarily principles-based amendments to Item 402 that are intended to provide investors with material information relevant to an assessment of the compensation of the registrant's NEOs and directors by requiring disclosures that we anticipate to be clearer, more concise, easier for investors to read and understand, and less burdensome for registrants to produce.[56] We continue to recognize that a registrant's design of executive compensation, including the level of pay (also known as the ''amount'' or ''quantum'' of pay or pay ''opportunity'') and its performance sensitivity, may be material. The proposed amendments aim to, among other things:

- Reduce compliance burdens and provide registrants with more flexibility to present their executive compensation disclosures in a way that is consistent with their compensation programs and goals and the intentions of their boards of directors and compensation committees; and
- Refocus the disclosures on the information material to investors and improve investors' ability to track equity awards through their lifecycle.

The proposed amendments also include disclosure accommodations for smaller reporting companies (''SRCs'') [57] and emerging growth companies (''EGCs'').[58] In the 2026 Filer Status Proposing Release, we proposed streamlining the filer statuses for reporting companies into two primary categories—large accelerated filers (''LAFs'') and non-accelerated filers (''NAFs'')—and eliminating the SRC filer status.[59] If those rules are adopted as proposed, we would extend any proposed Item 402 accommodations for SRCs and EGCs to all NAFs.

The following table provides a high-level, non-exhaustive summary of how certain topics covered under the current rule would be addressed under the proposed amendments.[60]

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CD&A may be significantly longer, covering dozens of pages[.]'').

[49] *See, e.g.,* letters from EOS at Federated Hermes Limited (June 24, 2025) (''EOS''), available at *https://www.sec.gov/comments/4-855/4855-616227-1808194.pdf;* McGuireWoods & Brownstein; NYSE.

[50] *See, e.g.,* letters from McGuireWoods & Brownstein; NEI; NYSE.

[51] *See, e.g.,* letters from Committee on Federal Regulation of Securities of the American Bar Association, Section of Business Law (Oct. 6, 2025) (''ABA''), available at *https://www.sec.gov/comments/4-855/4855-669587-2016034.pdf;* Equity Abacus (June 10, 2025) (''Equity Abacus''), available at *https://www.sec.gov/comments/4-855/4855-613027-1795414.pdf;* McGuireWoods & Brownstein; Society for Corporate Governance (Aug. 27, 2025) (''Society for Corporate Governance''), available at *https://www.sec.gov/comments/4-855/4855-644367-1928454.pdf.*

[52] Letter from Chamber of Commerce (footnote omitted).

[53] *See, e.g.,* letters from Baillie Gifford (recommending, among other things, that some information required by Item 402 be dropped or moved to footnotes and that CD&A ''return'' to a simpler presentation); Norges Bank Investment Management (July 25, 2025) (''Norges Bank''), available at *https://www.sec.gov/comments/4-855/4855-635367-1885195.pdf* (suggesting that there should be ''[s]impler disclosure when pay structure is straightforward'' and recommending, among other things, that the length of CD&A be reduced and performance-related disclosures that have little relevance to time-based awards be eliminated).

[54] *See, e.g.,* letters from ABA; Business Roundtable (Aug. 19, 2025) (''Business Roundtable''), available at *https://www.sec.gov/comments/4-855/4855-640487-1915734.pdf;* McGuireWoods & Brownstein; NYSE.

[55] *See, e.g.,* letters from ABA (noting that ''the fundamental value of a 'principles-based' CD&A is its flexibility''); Business Roundtable (urging ''a return to a disclosure regime that prioritizes clarity, materiality and flexibility''); EOS (encouraging a ''more flexible requirement for companies to reflect how the compensation committee considers the appropriateness of executive pay relative to their employees in its own way, rather than one relaying on a specific metric'').

[56] We are also proposing to make conforming changes to cross-references to the appropriate provisions of Item 402 in the following places: 17 CFR 229.201, 17 CFR 229.403, 17 CFR 229.404, 17 CFR 229.407, 17 CFR 229.601, 17 CFR 229.1011, 17 CFR 240.14a–6, 17 CFR 14a–21, 17 CFR 14a–101, 17 CFR 14c–5, and 17 CFR 14c–101.We are additionally making some non-substantive clarifying edits to these rules, such as by changing the word ''shall'' to ''must'' in 17 CFR 229.601 and revising how the numbering of Instructions is labeled in 17 CFR 240.14a–21.

[57] *See* 17 CFR 229.10(f)(1); 17 CFR 229.405; 17 CFR 240.12b–2.

[58] *See* 17 CFR 230.405; 17 CFR 240.12b–2.

[59] *See* 2026 Filer Status Proposing Release.

[60] Unless otherwise stated or the context otherwise requires, when this proposing release mentions the current rule or the proposed rule, we are referring to the rules that apply to registrants generally, rather than to the scaled rules that apply to SRCs and EGCs. For a discussion of the scaled rules, see section II.M below.

Current Rule	Proposed Rule Addressing Similar Topic	Section(s) Discussing Topic	Summary of Treatment of Topic under Proposed Rule as Compared to Current Rule
Item 402(a)(1) – Treatment of foreign private issuers	Item 402(a)(6)(iii) – Foreign private issuers	II.N	Largely retained. The proposed rule text largely tracks the current rule, with some streamlining.
Item 402(a)(2) – All compensation covered	Item 402(a)(1) – Objective	II.A	Substantially revised. The proposed rule text continues to require clear, concise, and understandable disclosure of NEO and director compensation, but adds that the objective of the disclosure is to provide investors with material information relevant to an assessment of that compensation.
Item 402(a)(3) – Persons covered	Item 402(a)(2) – Persons covered	II.B	Partially retained. The proposed rule text would limit the NEOs to only the PEO and PFO (for all registrants), and would eliminate existing coverage of: • The three most highly compensated executive officers other than the PEO and PFO; and • Up to two additional individuals for whom disclosure would have been provided but for the fact the individual was not serving as an executive officer at the end of the last completed fiscal year.
Item 402(a)(4) Information for full fiscal year	Item 402(a)(3) Information required	II.N	Largely retained. The proposed rule text largely tracks the current rule, with some streamlining.
Item 402(a)(5) – Omission of table or column	Item 402(a)(5)(ii) – Flexibility in the manner of tabular presentation	II.E.2	Retained with additions. The proposed rule text largely tracks the current rule with respect to the omission of a table or column and would also provide additional flexibilities in the manner of tabular presentation by expressly permitting the splitting of a single column into multiple columns (or a supplemental table).
Item 402(a)(6) – Definitions	Item 402(a)(7) – Definitions	II.N	Largely retained. The proposed rule text largely tracks the current rule, with some streamlining.
Item 402(b) – Compensation discussion and analysis	Item 402(e) – Compensation Discussion and Analysis	II.F; II.M	Partially retained. The proposed rule text would: • Require registrants to address three topics in the CD&A (as compared to seven topics under the current rule); • Eliminate the non-exhaustive list of 15 example topics that may be material for discussion, depending on the facts and circumstances; • Streamline the instructions to the CD&A; and • Continue to exempt both SRCs and EGCs from this requirement.
Item 402(c) – Summary compensation table	Item 402(b) – Earned Compensation Table; Item 402(c) – Granted Compensation Table	II.C.1; II.C.2	Substantially revised. The proposed rule text would, in effect, split the disclosure currently required by the Summary Compensation Table into two simpler tables: • The Earned Compensation Table would capture compensation earned during the fiscal years covered and would include the value realized on previous equity awards; and • The Granted Compensation Table would capture the primary compensation elements granted during the fiscal years covered (generally at their target value) and would reflect compensation inputs in a manner designed to be more consistent with the registrant's compensation intentions.

Current Rule	Proposed Rule Addressing Similar Topic	Section(s) Discussing Topic	Summary of Treatment of Topic under Proposed Rule as Compared to Current Rule
Item 402(d) – Grants of plan-based awards table	Item 402(c) – Granted Compensation Table; Item 402(d) – Status of Equity Awards Table	II.C.2; II.C.3	Partially retained. The proposed rule text would incorporate certain concepts currently used by the Grants of Plan-Based Awards Table into the Granted Compensation Table and Status of Equity Awards Table.
Item 402(e) – Narrative disclosure to summary compensation table and grants of plan-based awards table	Item 402(a)(5)(i) – Information necessary to an understanding of the tables	II.E.1	Substantially revised. The proposed rule would incorporate certain concepts used in current Item 402(e) into proposed Item 402(a)(5)(i).
Item 402(f) – Outstanding equity awards at fiscal year-end table	Item 402(d) – Status of Equity Awards Table	II.C.3	Substantially revised. The proposed rule text would establish a Status of Equity Awards Table to provide disclosure relating to equity awards that are currently addressed in the Outstanding Equity Awards at Fiscal Year-End Table and incorporate certain concepts currently used by the Grants of Plan-Based Awards Table.
Item 402(g) – Option exercises and stock vested table	Item 402(b) – Earned Compensation Table	II.C.1	Partially retained. The proposed rule text would incorporate certain concepts currently used by the Option Exercises and Stock Vested Table into the Earned Compensation Table.
Item 402(h) – Pension benefits table	N/A	II.O.1	Eliminated. The proposed rule text would eliminate the current Pension Benefits Table.
Item 402(i) – Nonqualified deferred compensation table	N/A	II.O.1	Eliminated. The proposed rule text would eliminate the current Nonqualified Deferred Compensation Table.
Item 402(j) Potential payments upon termination or change-in-control	Item 402(i) Potential payments upon termination or change-in-control	II.J; II.M	Substantially revised. The proposed rule text would eliminate the requirement to *quantify* potential payments and benefits in various termination or change-in-control scenarios, and limit the requirement to provide *qualitative* disclosures to the material terms of arrangements that provide for payments or benefits in connection with such scenarios. The proposed rule text would also apply the requirement to SRCs and EGCs in lieu of Item 402(q).
Item 402(k) – Compensation of directors	Item 402(k) – Compensation of directors	II.L	Partially retained. The proposed rule text would: • Eliminate the requirement for a prescribed tabular format for quantitative director compensation disclosures; • Limit quantified cash and equity disclosure to compensation earned during the last completed fiscal year (including cash earned and the value realized on previous equity awards) while eliminating the prescriptive requirement for pension-related compensation disclosure and nonqualified deferred compensation; and • Provide for a principles-based narrative requirement to describe the material aspects of the registrant's compensation of directors and other material compensation for the last completed fiscal year, without requiring disclosure of a prescriptive list of "other" items.

Current Rule	Proposed Rule Addressing Similar Topic	Section(s) Discussing Topic	Summary of Treatment of Topic under Proposed Rule as Compared to Current Rule
Item 402(l) through 402(r) – Smaller reporting companies and emerging growth companies	Item 402(a)(6)(i) and (ii) – Smaller reporting companies and emerging growth companies	II.M	Substantially revised. The proposed rule text would: • Address the treatment of SRCs and EGCs each in a single paragraph of proposed Item 402; • Continue to provide scaling and exemptions from Dodd-Frank Act provisions applicable to SRCs and EGCs; and • Eliminate multiple current paragraphs that repeat disclosure provisions specifically for SRCs and EGCs.
Item 402(s) – Narrative disclosure of registrant's compensation policies and practices as they relate to risk management	N/A	II.O.2	Eliminated. The proposed rule would eliminate for all registrants the disclosure requirements currently contained in Item 402(s).
Item 402(t) – Golden parachute compensation	Item 402(j) – Golden parachute compensation	II.K; II.M	Partially retained. The proposed rule text would consolidate several columns in the current Golden Parachute Compensation Table and streamline narrative disclosure requirements.
Item 402(u) – Pay ratio disclosure	Item 402(h) – Pay ratio disclosure	II.I; II.M	Partially retained. The proposed rule text would: • Limit the population of employees from which the median employee is identified to full-time workers employed in the United States (these workers, "U.S.-based employees"); • Use the proposed Granted Compensation Table, rather than the current Summary Compensation Table, to determine PEO and median employee compensation; and • Change the required frequency for identifying a new median employee from once every three years to once every five years.
Item 402(v) – Pay-versus-performance	Item 402(f) – Pay-versus-performance	II.G; II.M	Partially retained. The proposed rule text would: • Use the amount from the Total Compensation Earned column of the proposed Earned Compensation Table for "Compensation Actually Paid," instead of the current methodology; • Limit the disclosure period to three years for all registrants; • Limit required disclosure to PEO and PFO compensation; and • Limit required performance measure disclosure to only cumulative total shareholder return ("TSR").
Item 402(w) – Disclosure of registrant's action to recover erroneously awarded compensation	Item 402(g) – Disclosure of registrant's action to recover erroneously awarded compensation	II.H	Partially retained. The proposed rule text would: • Remove the requirement to explain, where applicable, why the registrant concluded that recovery of erroneously awarded compensation was not required; and • Remove from annual reports the cover page required check box disclosures regarding financial statement error corrections and related compensation recovery analysis.
Item 402(x) – Disclosure of the registrant's policies and practices related to the grant of certain equity awards close in time to the release of material nonpublic information	N/A	II.O.3	Eliminated. The proposed rule would eliminate the disclosure requirements currently contained in Item 402(x).

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A. Objective—Proposed Item 402(a)(1)

The executive compensation rules today provide detailed and prescriptive requirements for a registrant's executive and director compensation disclosures. We are proposing to revise this prescriptive approach in favor of a primarily principles-based approach toward executive compensation disclosure. To implement this approach, proposed Item 402(a)(1) would specify that the objective of Item 402 is to provide investors with material information relevant to an assessment of the compensation of the registrant's NEOs and directors.[61] Proposed Item 402(a)(1), consistent with current Item 402(a)(2), would continue to require clear, concise, and understandable disclosure of the compensation granted to, earned by, or paid to the NEOs and directors for all services rendered in all capacities to the registrant and its subsidiaries.[62] This proposed shift to a more principles-based approach would allow for fewer and less prescriptive rules relating to NEO and director compensation disclosure in Item 402 but would continue to focus on providing investors with the material information relevant to an assessment of such compensation.[63] In so doing, this

[61] As proposed, registrants would be required to provide ''material information'' in contrast to current Item 402(a)(2) which requires disclosure of ''all plan and non-plan compensation'' even if also called for by another requirement. *See* 17 CFR 229.402(a)(2).

[62] The current rule generally refers to compensation awarded to, earned by, or paid to the NEOs. *See, e.g.,* 17 CFR 229.402(a)(2); 17 CFR 229.402(a)(5); 17 CFR 229.402(b)(1). The proposed rule generally refers to compensation granted to, earned by, or paid to the NEOs. *See, e.g.,* proposed Item 402(a)(1); proposed Item 402(a)(5)(ii)(A). This proposed change from ''awarded'' to ''granted'' is not intended to connote a substantive change; rather, the change was made to provide for greater consistency under the proposed rule.

[63] For example, current 17 CFR 229.402(a)(2) provides that no amount reported as compensation for one fiscal year need be reported in the same manner as compensation for a subsequent fiscal year. While this statement would continue to be true, the more principles-based approach provided in proposed Item 402(a)(1) would simply call for

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approach could reduce compliance costs and permit registrants to tailor disclosure in a way that provides greater transparency in regard to the registrant's compensation practices and is easier for investors to read and understand.

As proposed, executive compensation disclosure under Item 402 would be focused on compensation earned, compensation granted, and the status of outstanding equity awards, all of which disclosure would be required in a set of three new executive compensation tables. The tables and the related disclosure would not include all of the existing detailed instructions and footnote requirements associated with current lengthy and burdensome executive compensation disclosures. Instead, proposed Item 402(a)(1) would specify that the objective of Item 402 is to provide investors with material information relevant to an assessment of the compensation of the registrant's NEOs and directors and would permit the registrant to provide any information not explicitly called for by proposed Item 402 that is relevant to this objective in any format the registrant determines to be appropriate, including in a supplemental table, in additional columns in an existing table, in footnotes to the tabular disclosures, or in supplemental narrative disclosures.[64] As discussed further in section II.E.1 below, proposed Item 402(a)(5)(i) also would require the registrant to disclose any material information necessary to an understanding of the information disclosed in the proposed Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table.

Request for Comment

1. Should Item 402(a)(1) be adopted as proposed? What modifications, if any, should be made to proposed Item 402(a)(1)?

2. Would registrants' Item 402 disclosures made in accordance with the principles-based approach in proposed Item 402(a)(1) continue to provide investors with material information with respect to a registrant's NEO and director compensation that they need to make informed investment and voting decisions?

3. Should proposed Item 402(a)(1) require or encourage a brief narrative summary or overview, consistent with a layered disclosure approach?[65] Other than a summary page, are there other approaches to layered disclosure that we should consider?

B. Persons Covered—Proposed Item 402(a)(2)

Under the current rule, the executive compensation disclosures under Item 402[66] generally are required to cover each of the following individuals (the ''named executive officers'' or ''NEOs''):

- All individuals serving as the registrant's PEO or acting in a similar capacity during the last completed fiscal year, regardless of compensation level;[67]
- All individuals serving as the registrant's PFO or acting in a similar capacity during the last completed fiscal year, regardless of compensation level;[68]
- The registrant's three most highly compensated executive officers other than the PEO and PFO who were serving as executive officers at the end of the last completed fiscal year;[69] and
- Up to two additional individuals for whom disclosure would have been provided but for the fact that the individual was not serving as an executive officer at the end of the last completed fiscal year.[70]

Under the current rule, SRCs' and EGCs' disclosures are permitted to cover a more limited set of NEOs as follows:

- All individuals serving as the registrant's PEO or acting in a similar capacity during the last completed fiscal year, regardless of compensation level;[71]
- The registrant's two most highly compensated executive officers other than the PEO who were serving as executive officers at the end of the last completed fiscal year;[72] and
- Up to two additional individuals for whom disclosure would have been provided but for the fact that the individual was not serving as an executive officer at the end of the last completed fiscal year.[73]

We are proposing to amend Item 402(a) to provide that, for all registrants, the NEOs would consist of all individuals who served as the PEO or PFO, or acted in a similar capacity, during the last completed fiscal year.[74] Accordingly, the proposed amendments would reduce the number of NEOs to two in most circumstances,[75] as compared to typically five or more for non-SRCs and non-EGCs (and typically three or more for SRCs and EGCs) under the current rule.[76] The proposed amendments also would make the identified NEOs more consistent across registrants, including SRCs and EGCs.[77]

The Commission has considered alternative approaches regarding the number and scope of the executive officers for whom disclosure is required and has adjusted the standard over the decades. For example, in the 1983 Adopting Release, the Commission noted that it had requested comment on a variety of potential standards (*e.g.,* individuals holding certain positions, individuals performing certain designated functions, a straight numerical approach based on levels of compensation) and that, at that time, the greatest number of commenters who responded had favored a straight numerical approach and, of those, the majority had favored five.[78] Accordingly, in 1983, the Commission required disclosures for the five most highly compensated executive officers (regardless of their specific positions). Subsequently, in the 1992 Adopting

clear, concise, and understandable disclosure without specifying that a registrant need not provide repetitive disclosure.

[64] *See* proposed Instruction to Item 402(a)(1).

[65] *See Business and Financial Disclosure Required by Regulation S–K,* Release No. 33–10064 (Apr. 13, 2016) [81 FR 23915 (Apr. 22, 2016)], at 24004 (discussing layered disclosure and noting that ''some investors may prefer a summary presentation while others may seek detailed data that they can analyze and compare across companies or industries.'').

[66] In addition, a registrant's disclosure obligations under Item 5.02(b), (e), and (f) of Form 8–K (17 CFR 249.308) are tied to its NEOs. *See infra* accompanying text at notes 566 through 568. The reduction in the number of NEOs under Item 402 would affect certain other disclosure requirements under Regulation S–K, including 17 CFR 229.403(b) and 17 CFR 229.404(a). *See infra* note 91.

[67] *See* 17 CFR 229.402(a)(3)(i).

[68] *See* 17 CFR 229.402(a)(3)(ii).

[69] *See* 17 CFR 229.402(a)(3)(iii). Under the current rule, executive officers (other than the PEO and PFO) whose total compensation does not exceed $100,000 are not covered by this prong of the NEO definition. *See* Instruction 1 to 17 CFR 229.402(a)(3).

[70] *See* 17 CFR 229.402(a)(3)(iv).

[71] *See* 17 CFR 229.402(m)(2)(i).

[72] *See* 17 CFR 229.402(m)(2)(ii). Under the current rule, executive officers (other than the PEO) whose total compensation does not exceed $100,000 are not covered by this prong of the NEO definition. *See* Instruction 1 to 17 CFR 229.402(m)(2).

[73] *See* 17 CFR 229.402(m)(2)(iii).

[74] In effect, the proposed amendments would largely retain the current wording with respect to PEOs and PFOs in 17 CFR 229.402(a)(3)(i) and (ii), but eliminate the current wording with respect to additional NEOs in 17 CFR 229.402(a)(3)(iii) and (iv).

[75] If the registrant had multiple individuals who served as PEO or PFO during the last completed fiscal year (including interim or acting PEOs or PFOs and situations where the registrant has dual PEOs or co-PEOs), then all such individuals would be NEOs for whom disclosure would be required.

[76] The proposed amendments to limit the NEOs to just the PEO and PFO would apply throughout most of Item 402, including to disclosures regarding golden parachute compensation pursuant to current 17 CFR 229.402(t), and the recovery of erroneously awarded compensation pursuant to current 17 CFR 229.402(w).

[77] See section II.M below for a discussion of the scaled disclosure accommodations that would be provided to SRCs and EGCs under the proposed rule.

[78] *See* 1983 Adopting Release at 44469.

Release, the Commission adjusted the approach to require disclosures for the chief executive officer (regardless of compensation level), along with the four other most highly compensated executive officers.[79] Finally, in the 2006 Adopting Release, the Commission adjusted the approach again to require disclosures for the PEO and PFO (regardless of compensation level), along with the three other most highly compensated executive officers.[80]

We are proposing to focus the executive compensation disclosures on the PEO and PFO because we believe that disclosures about the individuals holding those positions are most important for investors due to the crucial roles such individuals play in managing the registrant. The PEO is typically the most senior and prominent executive officer and generally takes the leading role in managing the registrant's business and the other executive officers, and in determining and executing on the registrant's corporate strategy, among other things. The PFO often makes strategic investment decisions[81] and has responsibility for the registrant's financial management and financial disclosure (including financial statements), and (together with the PEO) provides the certifications of the registrant's Commission filings required under the Sarbanes-Oxley Act of 2002.[82] Understanding the PEO's and PFO's monetary incentives is therefore likely to be material to an investor when evaluating the strategic direction of the registrant and the reliability of the registrant's financial disclosures and the soundness of its financial decisions.

We also are proposing to limit the required disclosures to those persons who served as the PEO or PFO in order to reduce the length and complexity of registrants' executive compensation disclosures, as well as the costs and burdens incurred by registrants in preparing such disclosures. We believe that detailed compensation disclosures for additional executive officers based solely on their compensation level, regardless of position, also may be less relevant to investors than disclosures regarding the PEO and PFO, given the central roles played by the PEO and PFO in managing the registrant.[83] Indeed, a number of the comment letters submitted in connection with the 2025 Roundtable indicated that the number of individuals covered under the current rule contributes to the complexity and burdens of the disclosures without commensurate benefits to investors.[84] Some commenters stated that, based on their surveys, registrants estimated they would be able to reduce the number of hours worked on preparing executive compensation disclosures by up to 50–60 percent if such disclosures were limited to the PEO and PFO.[85] Commenters suggested a wide range of approaches to the number and type of individuals who should be covered, including covering:

- Only the PEO (and any other executive officer who is also a director);[86]
- The PEO and PFO;[87]
- The PEO and two most highly compensated non-PEO executive officers;[88] and
- The PEO, PFO, and one additional highly compensated executive officer.[89]

In contrast, some commenters recommended that the Commission consider expanding the persons covered as NEOs.[90]

We recognize that there are reasons why compensation of other executive

[79] *See* 1992 Adopting Release at 48129.

[80] *See* 2006 Adopting Release at 53189.

[81] *See, e.g.,* Dave Magnani, *The CFO's Expanding Role: Why Finance Leaders Are Becoming the Next CEOs,* M&A Executive Search (Apr. 15, 2025), available at *https://maexecsearch.com/the-cfos-expanding-role-why-finance-leaders-are-becoming-the-next-ceos/.*

[82] *See* Public Law 107–204, 116 Stat. 745 section 302(a) (2002); *see also* 17 CFR 240.13a–14; 17 CFR 240.15d–14.

[83] If the proposed amendments are adopted, the registrant could elect to provide disclosures for additional persons beyond the PEO and PFO in the Earned Compensation Table, Granted Compensation Table, and the Status of Equity Awards Table, so long as the registrant provided disclosures responsive to the proposed tables in their entirety for each such additional person. In that case, as a result of such voluntary disclosure, any such additional person(s) would not be considered NEOs (*e.g.,* the registrant would not be required to provide disclosures for such additional person(s) under other parts of proposed Item 402, such as compensation discussion and analysis disclosures under proposed Item 402(e) or pay-versus-performance disclosures under proposed Item 402(f), or under other regulations, forms, or schedules that reference NEOs, such as Item 5.02 of Form 8–K). However, proposed Item 402(a)(5)(i), which requires the registrant to disclose any material information necessary to an understanding of the information disclosed in the Earned Compensation Table, Granted Compensation Table, and the Status of Equity Awards Table, would apply to the disclosures for any additional person(s).

[84] *See, e.g.,* letters from ABA (suggesting that the number of individuals required to be covered under the current rule contributes to the length and complexity of the required executive compensation disclosures and that ''with the exception of the PEO, the volume of detailed information presented . . . about the remaining NEOs is often immaterial to investors and, if anything, tends to obscure the information that they genuinely seek''); McGuireWoods & Brownstein (''[I]t is not uncommon to see companies with six, seven, or even eight covered executives due to departures and individuals serving in interim CEO/CFO roles. In our experience, this is far too many executives and investors do not care about executive compensation decisions beyond the CEO, CFO and top paid other executive officer.'').

[85] *See* letters from Center on Executive Compensation (July 31, 2025) (''CEC–2''), available at *https://www.sec.gov/comments/4-855/4855-635147-1884055.pdf* (''A recent Center survey of its SEC Working Group found that limiting disclosure to the CEO/CFO would reduce hours worked by 30–50% due to reduced data collection, narrative, table publication and auditing, cost of physical publication, cost of external and internal counsel cost and leadership time to review.''); Davis Polk & Wardwell LLP (July 31, 2025) (''Davis Polk''), available at *https://www.sec.gov/comments/4-855/4855-635027-1882894.pdf* (''In the Davis Polk Survey, multiple issuers noted that they would save approximately 50–60% of hours worked on preparing executive compensation disclosure by limiting it to the CEO and CFO.'').

[86] *See* letter from Sullivan & Cromwell LLP (Sept. 30, 2025) (''Sullivan & Cromwell''), available at *https://www.sec.gov/comments/4-855/4855-665527-1989614.pdf* (suggesting ''disclosure should be required only for the Chief Executive Officer and for any other officer serving on the board of directors'' and indicating that requiring disclosure for the PFO and the other three most highly compensated executive officers ''does not provide material information and needlessly contributes to the length and complexity of disclosure'').

[87] *See* letters from Business Roundtable; Davis Polk (indicating that ''disclosure of compensation information related to the CEO and CFO is what is material to investors'' and that ''investors almost never discuss any compensation disclosed other than CEO compensation during shareholder engagement''); National Association of Manufacturers (June 25, 2025) (''NAM–1''), available at *https://www.sec.gov/comments/4-855/4855-616827-1809754.pdf* (''Other securities laws, such as the Sarbanes-Oxley Act, impose explicit obligations on the CEO and CFO positions (which are present at every public company) but not on other senior executives. Unlike with the CEO and CFO, the titles and responsibilities of the three other highest-paid positions vary considerably by company depending on industry, so requiring issuers to disclose what the third- or fourth-highest highest-paid executive earns generates additional data that is not directly comparable or even relevant to most investors, who primarily focus on CEO pay.''); Society for Corporate Governance (indicating that ''approximately 84% of respondents to the Society's Survey would support limiting the NEOs for all executive compensation disclosure requirements to only the CEO and CFO'').

[88] *See* letter from ABA.

[89] *See* letters from Chamber of Commerce; Equity Methods, LLC (Aug. 12, 2025) (''Equity Methods-1''), available at *https://www.sec.gov/comments/4-855/4855-638467-1904274.pdf;* Infinite Equity (June 25, 2025) (''Infinite Equity-2''), available at *https://www.sec.gov/comments/4-855/4855-616287-1808254.pdf;* McGuireWoods & Brownstein.

[90] *See* letters from CFA Institute (Feb. 6, 2026) (''CFA Institute''), available at *https://www.sec.gov/comments/4-855/4855-701151-2201014.pdf* (suggesting that the Commission ''[a]ugment the covered persons for compensation disclosure to include executive management personnel besides just the CEO, CFO, and three other most highly compensated executive officers''); State Board of Administration of Florida (Aug. 21, 2025) (''State Board Florida''), available at *https://www.sec.gov/comments/4-855/4855-641487-1919034.pdf* (''Investors would benefit from expanded disclosure for top five hundred companies or those meeting certain revenue thresholds, potentially covering 7–10 executives including business unit leaders and succession candidates who may not be among the highest paid but hold significant operational influence.'').

officers may be of interest to some investors. For example, such disclosure may facilitate investors' ability to evaluate the effectiveness of the compensation committee, provide insight into the dynamics of a registrant's management team or its ability to retain executive employees, or provide timely information about the departure of, or material contracts, plans, or arrangements with, the executive officers for whom Item 5.02(b) and (e) Form 8–K disclosure would no longer be required. We believe, however, that the proposed amendments would appropriately focus compensation disclosures on the executive officers for whom those disclosures are most likely to be material to investors given the central roles played by the PEO and PFO in managing the registrant. Reducing the number of NEOs as proposed should reduce the length and complexity of executive compensation disclosures, thereby reducing burdens on registrants and potentially making the disclosures easier to read and understand for investors.[91] We believe that the proposed amendments also would reduce burdens on registrants by making it easier for registrants to determine the executive officers for which disclosures must be provided (*i.e.,* the PEO and PFO, based on their position).[92]

Request for Comment

4. Should registrants be required to provide executive compensation disclosures for any individuals beyond the PEO and PFO, or should we adopt the proposal to limit the NEOs to the PEO and PFO for all registrants? For example, should the highest paid executive officer other than the PEO and PFO be deemed an NEO, or should any executive officer who is also a director be deemed an NEO? Should registrants be required to include a third named executive officer but be allowed to determine who that named executive officer should be, based on the registrant's particular facts and circumstances? If disclosures for any individual or individuals beyond the PEO and PFO are appropriate, should the disclosures for the additional individual(s) cover the same information as for the PEO and PFO, or only a subset of such information? If disclosures for additional individual(s) are appropriate, should this be required for all registrants or only some registrants or for all registrants but only in specific circumstances (*e.g.,* only if an executive officer is more highly compensated than the PEO and PFO)? Would any such expansion in the individual(s) for whom disclosures would be required (beyond the proposal) result in increased burdens on registrants?

5. Alternatively, should we require executive compensation disclosures for only the PEO for some or all registrants? For example, should registrants that are not LAFs only have to provide disclosures with respect to the PEO? Why or why not? Do investors monitor or scrutinize compensation disclosures regarding a registrant's PEO (or any other senior executives) more than the disclosures regarding other NEOs?

6. How would limiting the scope of the required disclosures to the PEO and PFO, as proposed, reduce costs and burdens for registrants?

7. Would requiring only the PEO and PFO to be covered as NEOs, as proposed, result in the loss of material information for investors or otherwise affect investor protection under proposed Item 402? Would the proposed approach result in a loss of material information or otherwise affect investor protection in connection with disclosure requirements beyond proposed Item 402 itself (*e.g.,* under 17 CFR 229.403(b) (Security ownership of certain beneficial owners and management))? If so, should any supplementary or alternative disclosure requirements be added regarding additional individuals or executive officer compensation generally to address any potential loss of material information? Are there any other consequences of the proposed approach that have not been adequately addressed under the proposed amendments? If so, how should any such consequences be addressed?

C. Primary Tabular Disclosure Requirements

We believe that the current rule's use of tabular disclosure allows for the efficient presentation of executive compensation information and that the current rule's approach of combining tabular and narrative disclosures remains a useful framework. We are, however, proposing to revise the primary tabular disclosure requirements in an effort to make the presentation more streamlined and consolidated and easier to digest, while continuing to allow investors to evaluate the level and performance sensitivity of executive compensation. We are therefore proposing to consolidate and revise the main tabular disclosure requirements of Item 402 into three new tables titled as follows:

- The Earned Compensation Table;
- The Granted Compensation Table; and
- The Status of Equity Awards Table.[93]

The three new tables would replace the following four tables required under the current rule:[94]

- The Summary Compensation Table;
- The Grants of Plan-Based Awards Table;[95]
- The Outstanding Equity Awards at Fiscal Year-End Table;[96] and
- The Option Exercises and Stock Vested Table.[97]

The proposed three new tables are intended to retain material information currently required in the four eliminated tables but would seek to streamline and clarify the presentation.[98]

[91] The reduction in the number of NEOs under Item 402 would affect certain other disclosure requirements under Regulation S–K. Under 17 CFR 229.403(b), registrants are required to disclose certain information regarding the security ownership of management, including for each NEO as defined in Item 402, as well as for directors and executive officers of the registrant as a group. *See* 17 CFR 229.403(b). Accordingly, as proposed, the reduction in the number of NEOs would reduce the number of executives for whom disclosure of security ownership would be required on an individual basis under 17 CFR 229.403(b). However, disclosure of security ownership of directors and executive officers as a group would continue to be required. Under 17 CFR 229.404(a), registrants are required to disclose certain information regarding transactions with related persons, subject to certain exceptions, including where the compensation arising from a transaction is reported pursuant to Item 402. *See* Instruction 5.a to 17 CFR 229.404(a). Accordingly, as proposed, the reduction in the number of NEOs may reduce the number of situations where a registrant would be able to rely on an exception from the disclosure requirements under 17 CFR 229.404(a).

[92] Commission staff consulted informally with staff from the Department of the Treasury (''Treasury'') regarding the continued applicability of 26 U.S.C. 162(m), which prohibits deductions for compensation over $1 million that is paid to certain employees, to compensation paid to the three most highly compensated executive officers of a publicly held corporation other than the PEO and PFO, if the amendments are finalized as proposed. Staff from Treasury advised Commission staff that 26 U.S.C. 162(m) contains a provision indicating that its deduction disallowance rule applies to this category of employees without regard to whether their compensation is required to be reported. Thus, to the extent that the deduction limit in 26 U.S.C. 162(m) is implicated, registrants may have to calculate compensation of executive officers for that purpose.

[93] Under the proposed amendments, registrants that are not EGCs also would be required to provide tabular disclosures with respect to golden parachute compensation under certain circumstances. *See infra* section II.K.

[94] In addition, the proposed amendments would also eliminate the following two tables required under the current rule: the Pension Benefits Table and the Nonqualified Deferred Compensation Table. *See infra* section II.O.1.

[95] *See* 17 CFR 229.402(d).

[96] *See* 17 CFR 229.402(f).

[97] *See* 17 CFR 229.402(g).

[98] Proposed Item 402(a)(1) would specify that the objective of Item 402 is to provide investors with

Under the current rule, the Summary Compensation Table includes the following two types of compensation in one table, with the intent of providing disclosure of an NEO's total compensation:

- Compensation that has been *earned* during the fiscal year covered by the disclosure (such as salary and annual cash bonuses); and
- Compensation that has been *granted* during the fiscal year covered but that may not have been earned (such as performance-based equity awards, which ultimately might not be earned at all, or might be earned in different amounts depending on, for example, to what extent the applicable conditions are satisfied over a defined performance period, which is typically the next several years).

In effect, the proposed amendments would split the information required in the current Summary Compensation Table into two simpler tables—namely, the Earned Compensation Table and the Granted Compensation Table.[99]

The Earned Compensation Table would aim to capture compensation that was earned in the fiscal years covered. As proposed, the Earned Compensation Table is intended to reflect a comprehensive picture of all material compensation—including salary, non-equity awards (including cash bonuses), equity awards, retirement contributions, and perquisites and other miscellaneous compensation—earned in the fiscal years covered. With respect to equity awards in particular, as proposed, the Earned Compensation Table would deem stock awards to be earned once they have vested and option awards to be earned once they have been exercised.[100] Accordingly, the Earned Compensation Table would aim to communicate compensation outcomes, including the value ultimately earned on equity awards that were granted in prior years.

In turn, the Granted Compensation Table would aim to capture the primary elements of compensation granted to the NEO in the relevant fiscal year—specifically, salary, non-equity awards (including cash bonuses), and equity awards—typically at their target value.[101] As proposed, the Granted Compensation Table is intended to be similar to the concept of ''total direct compensation'' and related metrics that many registrants currently present as being reflective of the primary compensation intention of the registrant, its board of directors, and compensation committee. The Granted Compensation Table generally would reflect equity awards at the time of grant[102] and be based on target outcomes.[103] The Granted Compensation Table would thus aim to communicate the compensation opportunity granted to the NEO by the registrant for each covered fiscal year. In contrast to the Earned Compensation Table, the Granted Compensation Table would be limited to salary, non-equity awards, and equity awards (similar to the concept of ''total direct compensation'') and thus would not provide a comprehensive picture of compensation.

Finally, the Status of Equity Awards Table would aim to bridge the gap between the Granted Compensation Table and the Earned Compensation Table by tracking each equity award granted to the NEO from the first year it is introduced in the Granted Compensation Table until after the award has been reflected in the Earned Compensation Table as earned or otherwise has fully expired. As proposed, the Status of Equity Awards Table would be, in effect, a revised version of the current Outstanding Equity Awards at Fiscal Year-End Table that also would include certain concepts used in the current Grants of Plan-Based Awards Table.[104] The Status of Equity Awards Table is intended to make it easier for investors to track equity awards throughout their lifecycle by disclosing certain information regarding each equity award on an award-by-award basis, all in one consolidated location. At the same time, by limiting the disclosures to information that registrants should have readily available and by not requiring registrants to perform value recalculations each year, the proposed amendments would seek to reduce burdens on registrants.

We believe that, under the proposed principles-based approach, the three new tables and any accompanying narratives, when taken together, would provide investors with material information relevant to an assessment of the compensation of the registrant's NEOs and would clarify and streamline the reporting process and related disclosures.[105] We discuss each of the three new tables in more detail in the sections that follow.

1. Earned Compensation Table—Proposed Item 402(b)

The proposed Earned Compensation Table would seek to capture compensation that was earned in the fiscal years covered. The Earned Compensation Table would take the following form:

material information relevant to an assessment of the compensation of the registrant's NEOs and directors. *See supra* section II.A. Proposed Item 402(a)(5)(i) would require a registrant to disclose any material information necessary to an understanding of the information disclosed in the Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table. *See infra* section II.E.1. To the extent that information that would have been required to be disclosed in any of the eliminated tables constitutes such material information, proposed Item 402(a)(1) and proposed Item 402(a)(5)(i) would require this information to be disclosed under the proposed principles-based approach, but registrants would have additional flexibility as to how to provide such material information.

[99] Similar to the current Summary Compensation Table, the proposed Earned Compensation Table and Granted Compensation Table generally would cover the registrant's last three completed fiscal years. *See* 17 CFR 229.402(c)(1); proposed Item 402(b)(1); proposed Item 402(c)(1). Similar to the current rule, the proposed rule would require SRCs and EGCs to cover only the last two completed fiscal years. *See* 17 CFR 229.402(n); proposed Item 402(a)(6)(i) and (ii); *see also infra* section II.M.

[100] *See* proposed Item 402(b)(2)(v) and (vi).

[101] As proposed, salary would be reported in the Granted Compensation Table at the annualized dollar value of base salary as of the last day of the fiscal year covered and so salary in the Granted Compensation Table would reflect any salary raises that became effective by the end of the fiscal year. *See infra* section II.C.2.a. As proposed, equity awards would be reported in the Granted Compensation Table at grant date fair value computed in accordance with Financial Accounting Standards Board (''FASB'') Accounting Standards Codification (''ASC'') Topic 718, except that it would be assumed that the award's target outcome(s) will be achieved. *See infra* section II.C.2.c; proposed Instruction 3 to Item 402(c)(2)(v) and (vi).

[102] As proposed, while reporting an equity award in the fiscal year during which the award was granted would remain the default approach for the Granted Compensation Table, registrants would have the flexibility to report an equity award in the fiscal year immediately prior to the grant year under certain circumstances. *See infra* section II.C.2.c.

[103] For equity awards with multiple potential outcomes (*e.g.,* minimum, target, and maximum), the target outcome would be the achievement of the target outlined in the award at the 100% level. For equity awards that have a binary outcome (*i.e.,* awards that are either fully earned or not earned at all), the target outcome would be that the award criteria are met and the award is fully earned. *See infra* section II.C.2.c; proposed Instruction 3 to Item 402(c)(2)(v) and (vi).

[104] Under the current rule, the Grants of Plan-Based Awards Table covers equity awards and certain non-equity incentives (such as cash bonuses granted under an incentive plan). As proposed, the Status of Equity Awards Table would cover only equity awards.

[105] Under the principles-based approach set out in the proposed rule, registrants would be required to supplement the disclosure called for by the three new tables with any material information necessary to an understanding of such disclosure. *See infra* section II.E.1; proposed Item 402(a)(5)(i); *see also supra* section II.A; proposed Item 402(a)(1).

Earned Compensation Table							
Name and Position	**Year**	**Salary Earned ($)**	**Non-Equity Awards Earned ($)**	**Equity Awards**		**Miscellaneous Compensation Received ($)**	**Total Compensation Earned ($)**
				Stock Awards Vested ($)	**Option Awards Exercised ($)**		
(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g)*	*(h)*
[PEO]							
[PFO]							

The Earned Compensation Table would retain many concepts currently used in the Summary Compensation Table and Option Exercises and Stock Vested Table. We discuss the primary columns of the proposed table below.

a. Salary Earned Column—Proposed Item 402(b)(2)(iii)

Under the current rule, registrants are required to disclose in column (c) of the Summary Compensation Table (''Salary'') the dollar value of base salary (cash and non-cash) earned by the NEO during the fiscal year covered.[106] Under the proposed rule, the Salary Earned column of the Earned Compensation Table would, in a similar manner, report the dollar value of base salary (cash and non-cash) earned by the NEO during the fiscal year covered.[107] The proposed rule text with respect to the Salary Earned column would therefore largely track the current rule text for reporting salary in the Summary Compensation Table.

b. Non-Equity Awards Earned Column—Proposed Item 402(b)(2)(iv)

Under the current rule, registrants are required to disclose in column (d) of the Summary Compensation Table (''Bonus'') the dollar value of bonuses (cash and non-cash) earned by the NEO during the fiscal year covered.[108] Registrants are also required to disclose in column (g) of the Summary Compensation Table (''Non-equity incentive plan compensation'') the dollar value of all earnings for services performed during the fiscal year pursuant to awards under non-equity incentive plans and all earnings on any outstanding awards.[109]

Under the proposed rule, the Non-Equity Awards Earned column of the Earned Compensation Table would report the aggregate dollar value of non-equity awards (including annual cash bonuses, *ad hoc* cash bonuses, such as signing and retention bonuses, and non-equity incentive plan awards) earned by the NEO during the fiscal year covered and all earnings on any outstanding awards under non-equity incentive plans.[110] The proposed rule text with respect to the Non-Equity Awards Earned column would therefore largely track the current rule text for reporting bonuses and non-equity incentive plan awards, including earnings on such awards, in the Summary Compensation Table, except that it would consolidate all types of non-equity awards and earnings into one column.[111]

Several commenters suggested that column (d) of the Summary Compensation Table (''Bonus'') and column (g) of the Summary Compensation Table (''Non-equity incentive plan awards'') should be merged into one column.[112] Commenters indicated that these two columns should be merged because the current rule makes unnecessary distinctions between certain cash awards and yields redundant disclosures.[113] We believe the proposed Non-Equity Award Earned column, which effectively combines elements of the ''Bonus'' and ''Non-equity incentive plan awards'' columns of the current Summary Compensation Table, would address such concerns.

c. Stock Awards Vested Column—Proposed Item 402(b)(2)(v)

Under the current rule, registrants are required to disclose in column (e) of the Option Exercises and Stock Vested Table (''Value realized on vesting'') the aggregate dollar value realized upon vesting of stock, or upon the transfer of an award for value, during the last completed fiscal year.[114]

Under the proposed rule, the Stock Awards Vested column of the Earned Compensation Table would report the aggregate dollar value realized upon the vesting of stock [115] (computed by

[106] *See* 17 CFR 229.402(c)(2)(iii).

[107] *See* proposed Item 402(b)(2)(iii). Under the proposed rule, registrants would be required to include in the Salary Earned column of the Earned Compensation Table any amount of cash salary forgone at the election of an NEO under which stock, equity-based, or other forms of non-cash compensation instead have been received by the NEO. *See* proposed Instruction 1 to Item 402(b)(2)(iii) and (iv). This approach would be similar to what is currently required under the salary column of the Summary Compensation Table. *See* Instruction 2 to 17 CFR 229.402(c)(2)(iii) and (iv). In contrast to the current rule, but consistent with the principles-based approach discussed below, the proposed rule would not mandate footnote disclosure of the receipt of forms of non-cash compensation instead of salary. *See infra* section II.E.1; *see also supra* section II.A.

[108] *See* 17 CFR 229.402(c)(2)(iv).

[109] *See* 17 CFR 229.402(c)(2)(vii).

[110] *See* proposed Item 402(b)(2)(iv). Under the proposed rule, registrants would be required to include in the Non-Equity Awards Earned column of the Earned Compensation Table any amount of non-equity awards forgone at the election of an NEO under which stock, equity-based, or other forms of non-cash compensation instead have been received by the NEO. *See* proposed Instruction 1 to Item 402(b)(iii) and (iv). This approach would be similar to what is currently required under the bonus column of the Summary Compensation Table. *See* Instruction 2 to 17 CFR 229.402(c)(2)(iii) and (iv). In contrast to the current rule but consistent with the principles-based approach discussed below, the proposed rule would not mandate footnote disclosure of the receipt of forms of non-cash compensation instead of non-equity awards. *See infra* section II.E.1; *see also supra* section II.A.

[111] In contrast to the current rule, but consistent with the principles-based approach discussed below, the proposed rule would not mandate that all earnings on non-equity incentive plan compensation be separately identified and quantified in a footnote. *See infra* section II.E.1; Instruction 2 to 17 CFR 229.402(c)(2)(vii); *see also supra* section II.A. Under the proposed rule, however, a registrant could elect to split the Non-Equity Awards Earned column into multiple columns (for example, to show annual cash bonuses, *ad hoc* cash bonuses, and earnings under multi-year cash incentive plan awards separately) or provide a supplemental table or footnotes disaggregating the earnings reflected in the Non-Equity Awards Earned column. *See* proposed Item 402(a)(5)(ii); *infra* section II.E.2.

[112] *See* letters from ABA; McGuireWoods & Brownstein; Society for Corporate Governance.

[113] *See* letters from McGuireWoods & Brownstein (stating that existing disclosure rules distinguish between discretionary cash awards as ''Bonuses'' and formulaic cash awards as ''Non-Equity Incentive Plan Awards'', but that the ''average reader/individual uses the term bonus to refer to both types of arrangements''); Society for Corporate Governance (stating that having separate columns in the Summary Compensation Table for ''Bonus'' and ''Non-Equity Incentive Plan Compensation'' is redundant and that the ''overlap of information distorts the overall total compensation for a given NEO'').

[114] *See* 17 CFR 229.402(g)(2)(v).

[115] As defined in the proposed amendments, ''stock'' means instruments such as common stock, restricted stock, restricted stock units, phantom stock, phantom stock units, stock equivalent units, or any similar instruments that do not have option-like features. This definition is substantially

multiplying the number of shares of stock or units by the closing market price of the underlying shares or units on the vesting date), or upon the transfer of a stock award for value.[116] As proposed, the rule text with respect to the Stock Awards Vested column would therefore largely track the current rule [117] for reporting the value realized on the vesting of stock awards in the Option Exercises and Stock Vested Table.[118]

d. Option Awards Exercised Column—Proposed Item 402(b)(2)(vi)

Under the current rule, registrants are required to disclose in column (c) of the Option Exercises and Stock Vested Table (''Value realized on exercise'') the aggregate dollar value realized upon the exercise of options, or upon the transfer of an award for value.[119]

Under the proposed rule, the Option Awards Exercised column of the Earned Compensation Table would report the aggregate dollar value realized upon exercise of options (computed by multiplying (a) the total number of securities underlying the options by (b) the difference between the closing market price of the underlying securities on the exercise date and the exercise or base price of the options), or upon the transfer of an option award for value.[120] As proposed, the rule text with respect to the Option Awards Exercised column would therefore largely track the current rule for reporting the value realized on the exercise of option awards in the Option Exercises and Stock Vested Table.[121]

We believe that showing the value realized upon exercise of an option award may more fully reflect the economic value of the award than showing the intrinsic value of the award at vesting.[122] We also believe that showing the value realized upon exercise of an option award may be less burdensome for registrants as compared to an alternative that would require registrants to compute a fair value for the award at vesting.

e. Miscellaneous Compensation Received Column—Proposed Item 402(b)(2)(vii)

Under the current rule, registrants are required to disclose in column (i) of the Summary Compensation Table (''All other compensation'') all other compensation for the fiscal year that the registrant could not properly report in any other column of the Summary Compensation Table including, but not limited to, the following items:

- Perquisites and other personal benefits, or property, unless the aggregate amount of such compensation is less than $10,000; [123]
- All ''gross-ups'' or other amounts reimbursed during the fiscal year for the payment of taxes; [124]
- The compensation cost, if any, computed in accordance with FASB ASC Topic 718 for certain securities purchased at a discount from the registrant or its subsidiaries unless such discount is available generally, either to all security holders or to all salaried employees of the registrant; [125]
- The amount paid or accrued pursuant to a plan or arrangement in connection with any termination (*e.g.,* retirement, resignation, severance, or constructive termination) of the NEO's employment or a change in control of the registrant; [126]
- Registrant contributions or other allocations to vested and unvested defined contribution plans (such as plans established under section 401(k) [127] of the Internal Revenue Code of 1986 (''Internal Revenue Code'')); [128]
- The dollar value of any insurance premiums paid by, or on behalf of, the registrant with respect to life insurance for the benefit of the NEO; [129] and
- The dollar value of any dividends or other earnings on stock or option awards, when those amounts were not factored into the grant date fair value required to be reported in column (e) (''Stock awards'') or (f) (''Option awards'') of the Summary Compensation Table.[130]

Separately, under the current rule, registrants also are required to disclose in column (h) of the Summary Compensation Table (''Change in pension value and nonqualified deferred compensation earnings'') the sum of the following items:

- The aggregate change in the actuarial present value of the NEO's accumulated benefit under all defined benefit and actuarial pension plans (including supplemental plans) from the pension plan measurement date used for financial statement reporting purposes for the prior completed fiscal year to the pension plan measurement date used for financial statement reporting purposes for the covered year; [131] and
- Above-market or preferential earnings on compensation that is deferred on a basis that is not tax-qualified, including such earnings on

consistent with the current definition in 17 CFR 229.402(a)(6)(i).

[116] We are proposing to require the value realized upon vesting to be computed based on the closing market price on the vesting date so as to use the defined term ''closing market price'' consistently throughout the rule text. In the event that a stock award vests at a value other than the closing market price on the vesting date under the relevant contractual arrangements, registrants may explain the relevant facts in supplemental disclosures.

[117] In contrast to the current rule but consistent with the principles-based approach discussed below, the proposed rule would not mandate that registrants provide footnote disclosure, for any amount realized upon vesting for which receipt has been deferred, quantifying the amount and disclosing the terms of the deferral. *See infra* section II.E.1; Instruction to 17 CFR 229.402(g)(2); *see also supra* section II.A.

[118] *See* 17 CFR 229.402(g)(2)(v); Instruction to 17 CFR 229.402(g)(2). Accordingly, as proposed, the Stock Awards Vested column of the Earned Compensation Table would follow the approach taken to stock awards by the Option Exercises and Stock Vested Table rather than that taken by the Summary Compensation Table—*i.e.,* the Stock Awards Vested column would reflect the value realized on any stock awards that vested during the covered fiscal year (regardless of when the award was originally granted), rather than the grant date fair value of the stock awards that were originally granted during the covered fiscal year. Because the Earned Compensation Table aims to show compensation outcomes, we believe the approach taken for stock awards by the Summary Compensation Table is inapposite in this context. However, we are proposing to take an approach to stock awards similar to that taken by the Summary Compensation Table (with certain changes) in the context of the Granted Compensation Table. *See infra* section II.C.2.c.

[119] *See* 17 CFR 229.402(g)(2)(iii).

[120] We are proposing to require the value realized upon exercise to be computed based on the closing market price on the exercise date so as to use the defined term ''closing market price'' consistently throughout the rule text. In the event that an option award is exercised at a value other than the closing market price on the exercise date under the relevant contractual arrangements, registrants may explain the relevant facts in supplemental disclosures.

[121] *See* 17 CFR 229.402(g)(2)(iii); Instruction to 17 CFR 229.402(g)(2). Accordingly, as proposed, the Option Awards Exercised column of the Earned Compensation Table would follow the approach taken for option awards by the Option Exercises and Stock Vested Table rather than that taken by the Summary Compensation Table—*i.e.,* the Option Awards Exercised column would reflect the value realized on any option awards that were exercised during the covered fiscal year (regardless of when the award was originally granted), rather than the grant date fair value of the option awards that were originally granted during the covered fiscal year. Because the Earned Compensation Table aims to show compensation outcomes, we believe the approach taken to option awards by the Summary Compensation Table is inapposite in this context. However, we are proposing to take an approach to option awards similar to that taken by the Summary Compensation Table (with certain changes) in the context of the Granted Compensation Table. *See infra* section II.C.2.c.

[122] Intrinsic value is defined as the amount by which the fair value of the underlying stock exceeds the exercise price of an option. *See* FASB ASC Topic 718–10.

[123] *See* 17 CFR 229.402(c)(2)(ix)(A).

[124] *See* 17 CFR 229.402(c)(2)(ix)(B).

[125] *See* 17 CFR 229.402(c)(2)(ix)(C).

[126] *See* 17 CFR 229.402(c)(2)(ix)(D).

[127] *See* 26 U.S.C. 401(k).

[128] *See* 17 CFR 229.402(c)(2)(ix)(E).

[129] *See* 17 CFR 229.402(c)(2)(ix)(F).

[130] *See* 17 CFR 229.402(c)(2)(ix)(G).

[131] *See* 17 CFR 229.402(c)(2)(vii)(A).

nonqualified defined contribution plans.[132]

Under the proposed rule, the Miscellaneous Compensation Received column of the Earned Compensation Table would consolidate into one column the following types of compensation earned or otherwise received during the covered fiscal year that the registrant could not properly report in any other column of the Earned Compensation Table:

- Perquisites and other personal benefits, unless the aggregate total value of such compensation for an NEO is less than $150,000;[133]
- All ''gross-ups'' or other amounts reimbursed during the fiscal year for payment of taxes, including any reimbursements of taxes owed with respect to perquisites or other personal benefits;[134]
- The compensation cost, if any, computed in accordance with FASB ASC Topic 718 for certain securities purchased at a discount from the registrant or its subsidiaries, unless such discount is available generally, either to all security holders or to all salaried employees of the registrant;
- The value of payments for any exercises of options where the registrant paid the exercise or base price or related taxes or provided any other consideration with respect to the option exercise to or on behalf of the NEO;[135]
- The amount paid or accrued pursuant to a plan or arrangement in connection with any termination (*e.g.,* retirement, resignation, severance, or constructive termination) of the NEO's employment or a change in control of the registrant;
- Registrant contributions or other allocations to vested and unvested defined contribution plans and nonqualified deferred compensation plans, and any above-market or preferential earnings on compensation that is deferred on a basis that is not tax-qualified, including earnings on nonqualified defined contribution plans;[136]
- For any plan that provides for the payment of retirement benefits or benefits that will be paid primarily following retirement, including but not limited to tax-qualified defined benefit plans and supplemental executive retirement plans (such as pensions based on the executive's salary history, number of years of service, or other factors), but excluding tax-qualified defined contribution plans and nonqualified defined contribution plans, the aggregate of:
  - Service costs, calculated as the actuarial present value of each NEO's benefit under all such plans attributable to services rendered during the covered fiscal year, and
  - Prior service costs, calculated as the entire cost of benefits granted (or credit for benefits reduced) in a plan amendment (or initiation) during the covered fiscal year that are attributed by the benefit formula to services rendered in periods prior to the amendment;[137]
- The dollar value of any insurance premiums paid by, or on behalf of, the registrant with respect to life insurance for the benefit of the NEO;
- The dollar value of any dividends or other earnings on outstanding stock or option awards;[138] and
- The dollar value of any other compensation earned by or paid to the NEO for or during the fiscal year that the registrant determines is material or otherwise elects to disclose.

The proposed rule text with respect to the above-referenced items would largely track the current rule text for those items under the Summary Compensation Table, with certain exceptions as discussed below.

As proposed, registrants would be required to disclose in the Miscellaneous Compensation Received column compensation that falls into the enumerated categories under that column (including the catch-all category for any other compensation earned by or paid to the NEO for or during the fiscal year that the registrant determines is material or otherwise elects to disclose),[139] but (in contrast to the current requirement with respect to the ''All other compensation'' column of the Summary Compensation Table) registrants would not be required to analyze whether the enumerated categories of compensation under that column cover ''all'' compensation ''regardless of the amount''[140] (including immaterial compensation that falls outside the enumerated categories). The proposed Miscellaneous Compensation Received column of the Earned Compensation Table also would not (in contrast to the ''All other compensation'' column of the Summary Compensation Table) require detailed footnote disclosures regarding items of compensation reported under that column.[141] Consistent with the principles-based approach discussed below,[142] we believe that the proposed requirements for the Miscellaneous Compensation Received column would provide registrants with appropriate flexibility, while still ensuring that all material items of miscellaneous compensation would be reported in the Earned Compensation Table.[143]

As proposed, the current dollar-value threshold for reporting perquisites and other personal benefits would be increased. For a more detailed discussion of the proposed amendments with respect to the reporting of perquisites and other personal benefits, as well as proposed changes to related Commission guidance regarding what constitutes a perquisite or other personal benefit, see section II.D below.

The proposed rule text with respect to certain service costs and prior service costs for defined benefit retirement plans (such as pensions based on the executive's salary history, number of years of service, and other factors) would largely track the current rule for those items under the current pay-versus-performance disclosure requirements.[144] Accordingly, in

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[132] *See* 17 CFR 229.402(c)(2)(vii)(B).

[133] For a discussion of the proposed amendments and changes to Commission guidance with respect to perquisites and other personal benefits, see section II.D below.

[134] The proposed rule text with respect to gross-ups combines the current text in 17 CFR 229.402(c)(2)(ix)(B) with related language in Instruction 4 to 17 CFR 229.402(c)(ix).

[135] The proposed rule text with respect to this item combines the current text in 17 CFR 229.402(c)(2)(ix)(C) with related language in Instruction to 17 CFR 229.402(g)(2).

[136] The proposed rule text with respect to this item combines the current text in 17 CFR 229.402(c)(2)(ix)(E) and 17 CFR 229.402(c)(2)(viii)(B).

[137] As proposed, the required disclosure would focus on service costs of retirement benefit plans similar to the requirement in the pay-versus-performance rule. *See* 17 CFR 229.402(v)(2)(iii)(B)(*1*)(*i*) and (*ii*).

[138] Under the current rule, this item is caveated to include only amounts not factored into the grant date fair values required to be reported in column (e) (''Stock awards'') or column (f) (''Option awards'') of the Summary Compensation Table. *See* 17 CFR 229.402(c)(2)(ix)(G). We are not proposing to include a similar caveat for this item in the context of the Earned Compensation Table given that the Earned Compensation Table would not report the grant date fair values of equity awards (rather, as discussed above, the Earned Compensation Table would report the aggregate dollar value realized on vesting of stock and exercise of options).

[139] *See* proposed Item 402(b)(2)(viii)(H).

[140] *See* 17 CFR 229.402(c)(2)(ix).

[141] *See, e.g.,* Instruction 2 to 17 CFR 229.402(c)(2)(ix) (requiring any item reported under the ''All other compensation'' column of the Summary Compensation Table that is not a perquisite or personal benefit whose value exceeds $10,000 be identified and quantified in a footnote).

[142] *See infra* section II.E.1; *see also supra* section II.A.

[143] *See* proposed Item 402(b)(2)(vii)(J) (providing for disclosure of any other compensation that the registrant determines is material or otherwise elects to disclose).

[144] *See* 17 CFR 229.402(v)(2)(iii)(B). We are proposing to require all registrants, including EGCs, to disclose service costs and prior service costs for defined benefit plans. Disclosure of these costs would be newly required for EGCs; however, we believe that most registrants already conduct these

contrast to what is currently required under column (h) of the Summary Compensation Table (''Change in pension value and nonqualified deferred compensation earnings''), the proposed Miscellaneous Compensation Received column would not reflect the overall change in the aggregate pension value as of the end of the covered fiscal year (as compared to the end of the prior fiscal year). The proposed approach instead would seek to track the incremental pension benefit amount earned for the covered fiscal year (based on the executive's services, and any plan amendment or initiation, during the covered fiscal year), rather than fluctuations in the overall value of the pension (based on all years of service). Treating fluctuations in the overall value of the pension as compensation for the covered fiscal year may cause volatility in reported compensation levels due to exogenous factors not specific to the executive or related to the compensation intentions of the registrant (*e.g.,* due to market-wide factors such as changes in actuarial assumptions relating to long-term discount rates or mortality rates). The proposed approach would also eliminate pension value as a separate column, which would reduce the complexity of the table.

Many commenters suggested that the current rules should be revised to remove the requirement to include the change in accumulated pension in the Summary Compensation Table.[145] One commenter explained that changes in pension value represent ''an unrealized amount that fluctuates based on factors that are outside of the control of the company.'' [146] We believe the inclusion of service costs and prior service costs in the proposed Miscellaneous Compensation Received column, rather than the change in pension value in a separate column, would reduce such concerns.

Finally, to further streamline disclosure, we are proposing that nonqualified deferred compensation earnings be required to be disclosed under the proposed Miscellaneous Compensation Received column, rather than in a separate column.

Request for Comment

8. Should the Earned Compensation Table be adopted as proposed? What modifications, if any, should we consider to the proposed Earned Compensation Table to, among other things, enhance the clarity, comprehensibility, and efficiency of executive compensation disclosure? Would the proposed Earned Compensation Table reduce costs for registrants? What, if any, effects would the proposed Earned Compensation Table have on investors and the market, including with respect to the availability of material information for making investment or voting decisions?

9. Should the Earned Compensation Table be required to cover the last three completed fiscal years, as proposed? Should all registrants be required to cover only the last two completed fiscal years, similar to what is proposed with respect to SRCs and EGCs?

10. Should the Earned Compensation Table call for the presentation of one consolidated column for all non-equity awards, as proposed, or take an alternate approach? For example, should the Earned Compensation Table call for the presentation of more than one column of non-equity awards (*e.g.,* one column for *ad hoc* non-equity awards, one column for annual non-equity awards, and one column for long-term non-equity awards)? Does having one consolidated column for all types of non-equity awards, as proposed, represent an appropriate balance between conciseness and simplicity on the one hand (as fewer columns would be required), and flexibility on the other hand (as the registrant would still have the option to split bonus awards into multiple columns under proposed Item 402(a)(5)(ii)(B))?

11. Is proposed Instruction 2 to Item 402(b)(2)(iii) and (iv) clear? Should any additional guidance be provided regarding what it means for a non-equity award to be ''earned''? If so, how should such additional guidance be formulated? For example, should any such additional guidance specify that a non-equity award must be considered ''earned'' when all performance conditions (if applicable) are met, or when all vesting conditions (such as all time-based and performance-based conditions) are met?

12. Is there an alternative methodology for how options should be reflected in the Earned Compensation Table that would be, on balance, more appropriate than the method proposed (*i.e.,* reflecting the value realized when the options are exercised)? For example, should the Earned Compensation Table instead reflect (i) the intrinsic value of options on the date that they vest (or become exercisable), or (ii) the fair value of options on the date that they vest (or become exercisable)? Would any such alternative method provide investors with more meaningful or timely information? Would any such alternative method result in increased (or decreased) burdens on registrants? Would the proposed methodology (*i.e.,* reflecting the value realized when the options are exercised) be less burdensome for registrants than an alternative test based on the fair value of the options on the date that they vest (or become exercisable)?

13. Should registrants be required to add footnotes to the Miscellaneous Compensation Received column that disclose (i) the actuarial present value of the accumulated benefit under any defined benefit pension plans, and/or (ii) the total balance of the NEO's account under any nonqualified deferred compensation plan, each as of the end of the registrant's last completed fiscal year? Should such footnote disclosure be required in all cases given the proposed deletion of the Pension Benefits Table and the Nonqualified Deferred Compensation Table currently required under 17 CFR 229.402(h) (''Item 402(h)'') and 17 CFR 229.402(i) (''Item 402(i)''), respectively, or would the proposed tabular disclosure requirements, together with the principle-based disclosure requirements set out under proposed Item 402(a)(1) and 402(a)(5)(i), be sufficient?

14. Should any additional columns or categories of compensation be added to the Earned Compensation Table?

15. Should the Earned Compensation Table (or other tables or disclosure requirements under the proposed amendments) align with, reference, or otherwise utilize FASB's definition of ''employee compensation'' under ASU 2024–03—Disaggregated Income Statement Expenses (DISE) (FASB ASC Topic 220–40)? Why or why not?

16. Proposed Item 402(b)(2)(vii)(I) would require the dollar value of any dividends or other earnings paid on outstanding stock or option awards to be reported in the Miscellaneous Compensation Received column of the proposed Earned Compensation Table. Current 17 CFR 229.402(c)(2)(ix)(G) requires the dollar value of any dividends or other earnings paid on stock or option awards, *when those amounts were not factored into the grant date fair value required to be reported in column (e) or (f) of the current Summary Compensation Table,*

computations and anticipate any additional burden would be low.

[145] *See* letters from ABA (stating that the number of registrants providing post-employment benefits to their employees, including their executives, through defined benefit pension plans is relatively small; especially when compared to the number of plans that existed in 2006); Chamber of Commerce (stating that change in pension value included in the Summary Compensation Table is based upon changes in interest rates (not realized compensation)); McGuireWoods & Brownstein; Meridian Compensation Partners (July 11, 2025) (''Meridian''), available at *https://www.sec.gov/comments/4-855/4855-624747-1840454.pdf.*

[146] Letter from Meridian.

to be reported in the ''All other compensation'' column of the Summary Compensation Table. Given that the proposed Earned Compensation Table would not report the grant date fair value of equity awards, we have not proposed to include a carveout from proposed Item 402(b)(2)(vii)(I) based on whether dividends or other earnings paid on stock or option awards were factored into the grant date fair value. Should proposed Item 402(b)(2)(vii)(I) be adopted as proposed? If not, how should proposed Item 402(b)(2)(vii)(I) be modified and why?

17. Given that the ''All other compensation'' column of the current Summary Compensation Table requires disclosure of all other compensation without regard to its amount, what scope of compensation should the Miscellaneous Compensation Received column of the proposed Earned Compensation Table include? For example, should we adopt the proposed approach of requiring disclosure of any other compensation that the registrant determines is material or otherwise elects to disclose or take another approach? Are there any elements of compensation required to be disclosed pursuant to proposed Item 402(b)(2)(vii)(A) through (I) that should not be specifically enumerated for disclosure and that should instead be required to be disclosed only if the registrant determines the element is material or otherwise elects to disclose, pursuant to proposed Item 402(b)(2)(vii)(J)?

2. Granted Compensation Table—Proposed Item 402(c)

The proposed Granted Compensation Table aims to capture the primary elements of compensation granted to the NEO during the covered fiscal year and to reflect the primary components of compensation generally at their target value. As proposed, the Granted Compensation Table would take the following form:

Granted Compensation Table

Name and Position	Year	Annualized Salary ($)	Non-Equity Awards Granted ($)	Equity Awards		Total Compensation Granted ($)
				Stock Awards Granted ($)	Option Awards Granted ($)	
(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g)*
[PEO]						
[PFO]						

As proposed, the Granted Compensation Table would retain many concepts currently used in the Summary Compensation Table and Grants of Plan-Based Awards Table. We discuss each of the primary proposed columns below.

a. Annualized Salary Column—Proposed Item 402(c)(2)(iii)

Under the current rule and as discussed above, registrants are required to disclose in column (c) of the Summary Compensation Table (''Salary'') the dollar value of base salary (cash and non-cash) earned by the NEO during the fiscal year covered.[147]

Under the proposed rule, the Annualized Salary column of the Granted Compensation Table would report the annualized dollar value of base salary for the NEO as of the last day of the fiscal year covered. The Granted Compensation Table generally aims to capture elements of compensation granted to the NEOs at their target value. We believe that the annualized dollar value of base salary for the NEO as of the last day of the fiscal year covered offers the closest analogy to target value in the context of salary, as it would reflect any raises or other adjustments to the NEO's base salary during the covered fiscal year.

b. Non-Equity Awards Granted Column—Proposed Item 402(c)(2)(iv)

Under the current rule, registrants are required to disclose in columns (c), (d), and (e) of the Grants of Plan-Based Awards Table (''Threshold,'' ''Target,'' and ''Maximum'' columns under the heading ''Estimated future payouts under non-equity incentive plan awards'') the dollar value of the estimated future payout upon satisfaction of the conditions in question under non-equity incentive plan awards granted in the fiscal year or the applicable range of estimated payouts denominated in dollars (threshold, target, and maximum).[148]

Under the proposed rule, the Non-Equity Awards Granted column of the Granted Compensation Table would report the aggregate target dollar value of non-equity awards (including annual cash bonuses and *ad hoc* cash bonuses, such as signing and retention bonuses) and the aggregate target dollar value of payouts pursuant to awards under non-equity incentive plans, in each case granted to the NEO during the fiscal year covered.

The proposed rule text with respect to Non-Equity Awards Granted therefore would be similar to the current rule text for column (d) of the Grants of Plan-Based Awards Table (''Target'' column under heading ''Estimated future payouts under non-equity incentive plan''), except that it would also cover *ad hoc* non-equity awards (such as signing and retention bonuses) and other non-equity awards not granted under an incentive plan (such as a discretionary annual cash bonus) to the NEO during the fiscal year covered.

We believe that the target amount of non-equity awards generally reflects the compensation intentions of registrants. While the Granted Compensation Table would not require separate disclosure of amounts beyond the target amount (such as threshold and maximum amounts), there may be circumstances where additional disclosures are needed to provide investors with material information relevant to an assessment of NEO compensation or necessary to an understanding of the information disclosed in the table. In such cases, registrants would be required to supplement the disclosures called for by the Granted Compensation Table with such material information, consistent with the principles-based approach discussed below.[149]

As proposed, the aggregate target dollar value of a non-equity award generally would be reportable in the fiscal year during which the award was granted. However, if a non-equity award was earned in a fiscal year prior to the

[147] *See* 17 CFR 229.402(c)(2)(iii).

[148] *See* 17 CFR 229.402(d)(2)(iii).

[149] *See infra* section II.E.1; *see also supra* section II.A.

grant year, then such award would be required to be reported in the Granted Compensation Table in that prior fiscal year.[150] We do not believe it makes sense conceptually for an award to be reported as earned before it is reported as granted. So while non-equity awards are generally reportable in the Granted Compensation Table when granted, we are proposing this exception to the general rule to ensure that a non-equity award is not reported as earned in the Earned Compensation Table before it has been reported as granted in the Granted Compensation Table. For example, if a discretionary annual cash bonus (*i.e.,* a bonus not granted under an incentive plan) was granted during the first quarter of the fiscal year immediately following the last completed fiscal year but was based on performance during the last completed fiscal year and earned in that year, then the bonus would be required to be reported in the Granted Compensation Table for the last completed fiscal year.

As proposed, non-equity awards generally would be reported at their aggregate target dollar value. For non-equity awards with multiple potential outcomes (*e.g.,* minimum, target, and maximum), the target outcome would be the achievement of the target outlined in the award at the 100 percent level. For non-equity awards that have a binary outcome (*i.e.,* awards that are either fully earned or not earned at all), the target outcome is that the award criteria are met and the award is fully earned.[151]

c. Equity Awards Columns—Proposed Item 402(c)(2)(v) and (vi)

Under the current rule, registrants are required to disclose in column (e) (''Stock awards'') and column (f) (''Option awards'') of the Summary Compensation Table the aggregate grant date fair value for stock awards and option awards, respectively, computed in accordance with FASB ASC Topic 718.[152] For any awards that are subject to performance conditions, under the current rule, registrants are required to report the grant date fair value based upon the probable outcome of such conditions.[153]

Under the proposed rule, the Stock Awards Granted column of the Granted Compensation Table would report for stock awards granted during the covered fiscal year, and the Option Awards Granted column of the Granted Compensation Table would report for option awards granted during the covered fiscal year, the aggregate grant date fair value computed in accordance with FASB ASC Topic 718, except that it will be assumed that the award's target outcome(s) will be achieved.

The proposed rule text with respect to the Stock Awards Granted column and the Option Awards Granted column therefore would largely track the current rule text for reporting such awards in the Summary Compensation Table, except with respect to how such awards are valued and the timing for reporting such awards, each as discussed below.

With regard to how equity awards would be valued for purposes of the Granted Compensation Table, we are proposing to continue to have fair value computed generally in accordance with FASB ASC Topic 718, with the exception that the aggregate grant date fair value be based on the *target* outcome(s) of performance, market, and/or service conditions (if applicable).[154] As proposed, for equity awards with multiple potential outcomes (*e.g.,* minimum, target, and maximum), the target outcome would be the achievement of the target outlined in the award at the 100 percent level and, for equity awards that have a binary outcome (*i.e.,* awards that are either fully earned or not earned at all), the target outcome would be that the award criteria are met and the award is fully earned.[155] We recognize that the change to target outcome(s) (from probable outcome under the current rule) may result in differences between the aggregate grant date fair value calculation as presented in the Granted Compensation Table and the calculation under FASB ASC Topic 718 as presented in the registrant's financial statements, particularly with respect to awards with market conditions, and awards with service or performance conditions where the target outcome is not probable of being achieved. We are proposing this shift to target outcome(s) for consistency in how non-equity awards and equity awards are reported in the proposed Granted Compensation Table—*i.e.,* generally based on their target value, if applicable.[156] We also believe this approach may be more consistent with how many registrants view the compensation opportunity that is being granted to the NEOs.[157]

With regard to the timing for reporting equity awards, we are proposing that, while reporting the value of an equity award in the fiscal year during which the award was granted would remain the default approach, registrants would have the flexibility to elect to report an equity award in the fiscal year immediately prior to the grant year (rather than in the grant year) if:

- The registrant considers the award to be for performance in that prior year; and
- The award is granted in the first fiscal quarter of the grant year.[158]

As proposed, the registrant would be required to report equity awards on a consistent basis across the fiscal years covered in the Granted Compensation Table and, if the registrant elects to report equity awards in the fiscal year immediately prior to the grant year, to disclose that it is reporting equity awards in the fiscal year immediately prior to the grant year.[159]

[150] *See* proposed Instruction 1 to Item 402(c)(2)(iv).

[151] *See* proposed Instruction 2 to Item 402(c)(2)(iv).

[152] *See* 17 CFR 229.402(c)(2)(v) and (vi).

[153] *See* Instruction 3 to 17 CFR 229.402(c)(2)(v) and (vi).

[154] *See* proposed Instruction 3 to Item 402(c)(2)(v) and (vi).

[155] *See* proposed Instruction 3 to Item 402(c)(2)(v) and (vi).

[156] Proposed Item 402(a)(5)(i) would require disclosure of any material information necessary to an understanding of the information disclosed in the Granted Compensation Table. To the extent that there is a divergence between the target and probable outcomes (*e.g.,* in the case of a ''moonshot'' award where there is a very low probability that the target outcome will be achieved, or in the case of an award where there is a very high probability that the award will be achieved at a level above target) and such divergence constitutes material information necessary to an understanding of the grant date fair value disclosed in the Granted Compensation Table, proposed Item 402(a)(5)(i) would require supplemental disclosures regarding the divergence.

[157] *See, e.g.,* letters from ABA (recommending the Summary Compensation Table be revised and reorganized ''to present compensation information in a manner consistent with how a registrant's board of directors and compensation committee makes decisions, focusing primarily on each element of the target total direct compensation opportunity. . . .'' and stating that ''the current disclosure requirements . . . may obscure the board's or compensation committee's intent and decisions in establishing the target [total direct compensation] opportunity for a registrant's NEOs.''); Infinite Equity (July 11, 2025) (''Infinite Equity–3''), available at *https://www.sec.gov/comments/4-855/4855-623947-1837554.pdf* (defining total target direct compensation as the sum of target salary, target bonus and non-equity incentive awards, and target equity awards, and stating that this measure ''is often used as a primary point of reference for Boards and their compensation consultants when benchmarking and making pay decisions''); Semler Brossy Consulting Group (Sept. 26, 2025) (''Semler Brossy''), available at *https://www.sec.gov/comments/4-855/4855-663688-1981874.pdf* (suggesting requiring a table that focuses on the target compensation approved by the Compensation Committee or Board of Directors).

[158] If this flexibility is adopted as proposed, we believe that the reported fair value still should be calculated as of the grant date as defined under FASB ASC Topic 718, but based on target outcomes, even if the award is reported in the fiscal year immediately prior to the grant year.

[159] *See* Instruction 1 to proposed Item 402(c)(2)(v) and (vi); *see also* letter from Johnson & Johnson (July 1, 2025) (''Johnson & Johnson''), available at *https://www.sec.gov/comments/4-855/4855-619187-1817714.pdf* (suggesting that the Commission allow companies to report long-term incentive awards

Continued

We are proposing this accommodation to address the concern raised by some commentators that there may be a timing discrepancy between how annual cash bonuses and equity awards are reported in the Summary Compensation Table.[160] Under the current rule, in the Summary Compensation Table, registrants generally report equity awards in the fiscal year during which the award was granted. As a result, with respect to an annual cash bonus granted for performance during the last completed fiscal year but paid in the first quarter of the fiscal year immediately following the last completed fiscal year, under the current rule, a registrant would report the value of the annual cash bonus in the last completed fiscal year in the Summary Compensation Table (as that is when the annual cash bonus was earned).[161] In contrast, with respect to an equity award also granted for performance during the last completed fiscal year and also granted in the first quarter of the fiscal year immediately following the last completed fiscal year, the registrant would report the value of the equity award in the fiscal year immediately following the last completed fiscal year in the Summary Compensation Table (as that is when the equity award was granted).[162]

While we understand that there are differing views among registrants on these topics, those registrants who view annual cash bonuses and equity awards as both being granted with the intention of rewarding performance in the last completed fiscal year may take the view that the current rule necessitates a presentation in the Summary Compensation Table that is inconsistent with their compensation intentions.[163] The proposed approach to the Granted Compensation Table would give registrants more flexibility with respect to when equity awards are reported. Providing registrants with this flexibility may also reduce the likelihood that a registrant will take the view that it needs to include additional, supplemental disclosures to present information that differs from the required tables in order to more clearly reflect the registrant's compensation strategy and decisions, thereby reducing burdens on registrants and providing more registrant-specific information to investors.

Request for Comment

18. Should the Granted Compensation Table be adopted as proposed? What modifications, if any, should be made to the proposed requirement? Would the proposed Granted Compensation Table be burdensome for registrants to produce? What, if any, effects would the proposed Granted Compensation Table have on investors and the market, including with respect to the availability of material information for making investment or voting decisions?

19. Should the Granted Compensation Table be required to cover the last three completed fiscal years, as proposed? Should all registrants be required to cover only the last two completed fiscal years, similar to what is proposed with respect to SRCs and EGCs?

20. Should the Granted Compensation Table call for the presentation of one consolidated column for all types of non-equity awards, as proposed, or take an alternative approach? For example, should the Granted Compensation Table call for the presentation of more than one column for non-equity awards (*e.g.,* one column for *ad hoc* non-equity awards, one column for annual non-equity awards, and one column for long-term non-equity awards)? Does having one consolidated column for all types of non-equity awards, as proposed, represent an appropriate balance between conciseness and simplicity on the one hand (as fewer columns would be required), and flexibility on the other hand (as the registrant would still have the option to split bonus awards into multiple columns pursuant to proposed Item 402(a)(5)(ii)(B))?

21. Should we adopt the proposed methodology as to how equity awards would be reflected in the Granted Compensation Table (*i.e.,* report grant date fair value assuming that the award's target outcome(s) will be achieved)? How different would such values be from the equity valuations currently reported in the Summary Compensation Table? Are there any alternative methodologies we should consider? For example, should the Granted Compensation Table instead (i) reflect the target dollar value of equity compensation communicated by the registrant's board of directors (or compensation committee) to the NEO, (ii) reflect the grant date fair value based on the probable outcome, similar to what is required under the current rule,[164] or (iii) not show any dollar value and instead reflect the number of securities under relevant scenarios (*e.g.,* threshold, target, maximum)? Would any such alternative methodology provide investors with more meaningful information? Would any such alternative methodology impose increased burdens on registrants?

22. Given that FASB ASC Topic 718 has prescriptive guidance for valuing awards, would reporting the value based on the proposed methodology (*i.e.,* assuming the award's target outcome will be achieved) be more burdensome for registrants (*e.g.,* would it require registrants to perform calculations that are inconsistent with its financial

granted up to 2.5 months after the end of a fiscal year in the prior fiscal year to ''better reflect decisions on compensation for a fiscal year'' and stating that ''allowing 'up to 2.5 months' after the end of the fiscal year would align with tax laws that influence when many companies pay annual incentives for a fiscal year.''). We are proposing to require the award be granted in the first fiscal quarter of the grant year (*i.e.,* within the first three months, rather than the first 2.5 months) for simplicity and to give registrants some additional flexibility.

[160] *See, e.g.,* letters from Johnson & Johnson (stating that it provides ''additional disclosure to reconcile the CEO's total direct compensation as described in [its] Compensation Discussion & Analysis with [its] Summary Compensation Table[ ]'' in order to help ''explain the timing mismatch between the long-term incentives granted based on [its] performance year and those granted in [its] fiscal year''); McGuireWoods & Brownstein (stating that the rules should be revised to allow for alignment between cash and equity incentive awards because the current ''misalignment creates obvious problems for companies to be able to accurately describe their compensation decisions'' and that ''current disclosure rules suffer from the same potential misalignment of disclosure for incentive plan awards granted in a subsequent fiscal year that relate to performance in the covered fiscal year (*i.e.,* non-equity-awards are disclosed based on the year to which performance relates and equity awards are disclosed based on the year of grant)''); Society for Corporate Governance (suggesting that registrants ''should have discretion to align the timing for reporting of their cash-based incentive awards and equity incentive awards in the Grants of Plan-Based Awards table.''); The Travelers Companies, Inc. (June 30, 2025) (''Travelers''), available at *https://www.sec.gov/comments/4-855/4855-618887-1816514.pdf* (noting that the current rule establishes a ''bifurcation'' of the executive compensation disclosures where ''for many issuers, the Summary Compensation Table does not contain full information on an NEO's compensation awarded for the most recent year's performance (as cash awards are reported in one year while equity grants for the same performance year are reported in another year)'').

[161] *See* 17 CFR 229.402(c)(2)(iv).

[162] *See* 17 CFR 229.402(c)(2)(v) and (vi); Instruction 3 to 17 CFR 229.402(c)(2)(v) and (vi); 17 CFR 229.402(d)(1).

[163] *See, e.g.,* letter from Davis Polk (''Currently, issuers are required to disclose equity grants in the year they are granted and treated as compensation for the forward-looking period. However, a number of issuers, especially in certain industries such as financial services, consider the value of the equity incentive compensation to be based on the issuer's performance for the prior year. . . . [and] [h]ow a compensation program is designed can vary greatly among issuers, so requiring a single, one-size-fits-all approach to reporting these programs can result in burdens on the issuer to develop this disclosure and the distortion of the total compensation picture. While allowing for flexibility might detract from investors' ability to easily compare across issuers, the opposite is true: providing flexibility enhances comparability by giving investors a more accurate idea of how different compensation committees set compensation and how this might affect the total compensation picture, such as how the issuer determines grant values for equity awards.'').

[164] *See* 17 CFR 229.402(c)(2)(v) and (vi).

reporting)? Would calculating the grant date fair value based on the target outcome(s) or the probable outcome provide more meaningful information to investors? Should the grant date fair value based on target outcome(s) be presented in the Granted Compensation Table when there is a low likelihood that the award's target outcome(s) will be achieved (*e.g.,* in the case of a ''moonshot'' award)?

23. Would the proposed methodology of reporting equity awards in the Granted Compensation Table distort or otherwise affect the compensation decisions of registrants? For example, would the proposed methodology affect how registrants set targets (*e.g.,* would registrants be more likely to set more easily achieved targets) or the types of equity awards that registrants would choose to grant (*e.g.,* would registrants be less likely to award performance-based equity awards)?

24. Should any additional guidance be provided regarding what it means for an award to be ''granted''? If so, how should such additional guidance be formulated?

25. Is the guidance provided in proposed Instruction 2 to Item 402(c)(2)(iv) (for non-equity awards) and in proposed Instruction 3 to Item 402(c)(2)(v) and (vii) (for equity awards) regarding the meaning of target outcome(s) clear? Should any additional guidance be provided regarding the meaning of target outcome(s) or for additional types of awards? Are there circumstances where the target outcome would not be readily determinable (*e.g.,* uniquely designed award structures where target outcomes are not clearly defined based on the award structure and terms)? In these instances, should the target outcome be based on the most probable outcome or based on something else (*e.g.,* a representative amount based on the previous fiscal year's performance)?

26. Do the proposed tables appropriately account for the current (and potential future) variation in incentive award structures and terms? How often is a ''target'' payout level not available for equity or non-equity awards? In what types of cases, and how often, would the Grant Amount or Range column of the proposed Status of Equity Awards Table not be well suited to describing the potential outcomes of an incentive award?

27. Should we allow registrants to elect to report an equity award in the fiscal year immediately prior to the grant year if the registrant considers the award to be for performance in that prior year, and the award is granted in the first quarter of the grant year, as proposed? Would an alternative approach be more appropriate (*e.g.,* a simple rule requiring all registrants to report equity awards in the grant year, without exception)? Are there any other factors we should consider in providing flexibility for registrants regarding when equity awards are reported? For example, would providing registrants with flexibility reduce the likelihood of registrants presenting supplemental disclosure to more accurately reflect their compensation strategy and decisions?

28. Should we require registrants to report non-equity awards in the fiscal year granted, unless the non-equity award was earned in a fiscal year prior to the grant year, in which case the non-equity award must be reported in that prior fiscal year (rather than in the grant year), as proposed? Should we amend the proposed requirement so that it only applies in specific circumstances (*e.g.,* only if the award is granted during the first quarter of the grant year)? Would an alternative approach be more appropriate (*e.g.,* a simple rule requiring all registrants to report non-equity awards in the grant year, without exception)?

29. Should any additional columns or categories of compensation be added to the Granted Compensation Table? For example, should a miscellaneous column be added to the Granted Compensation Table and, if so, what categories of compensation should be included therein?

3. Status of Equity Awards Table—Proposed Item 402(d)

The proposed Status of Equity Awards Table is intended to ''bridge the gap'' between the Granted Compensation Table and the Earned Compensation Table by tracking each equity award from the first year it is introduced in the Granted Compensation Table until after it has been reflected in the Earned Compensation Table or otherwise has fully expired. As proposed, the Status of Equity Awards Table would take the following form:

Status of Equity Awards Table

Name and Position	Equity Award Terms						Equity Award Status	
	Grant Date	Award Type	Grant Amount or Range (#)	End of Performance Period, If Applicable	Final Vesting Date, If Known	Exercise Price, If Applicable	Amount Vested (#)	Amount of Options Exercised / Expired (#)
(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g)*	*(h)*	*(i)*
[PEO]								
[PFO]								

As proposed, the Status of Equity Awards Table would be, in effect, a revised version of the Outstanding Equity Awards at Fiscal Year-End Table that also would incorporate certain concepts from the Grants of Plan-Based Awards Table. The proposed Status of Equity Awards Table seeks to make it easier for investors to track equity awards throughout their lifecycle by showing certain information regarding each equity award on an award-by-award basis, all in one consolidated location.[165] At the same time, by

[165] We understand that, under the current rule, some investors may find it difficult to track equity awards throughout their lifecycle in registrants' executive compensation disclosure. During the 2025 Roundtable, one panelist noted that ''it is incredibly hard to follow one equity award through its life[cycle]'' and that attempting to do so requires ''significant guesswork.'' Gjessing, 2025 Roundtable Transcript at 50:15 and 80:2–10; *see also* Adamson, 2025 Roundtable Transcript at 175:17–25 and 176:1–11 (commenting that the three current tables are duplicative, and indicated it would be easier ''with a life cycle that reconciles, this is what was outstanding at the beginning of the year, this is anything new that was granted . . . this is what vested during the year, and this is what's outstanding at the end of the year, grant by grant by grant, all the way through.''); letters from CEC–2 (stating that the current ''Outstanding Equity

Continued

limiting the disclosures to information that registrants should have readily available and by not requiring registrants to perform value recalculations each year, the proposed amendments aim to reduce burdens on registrants. We discuss each of the proposed columns below.

a. Equity Award Terms Columns—Proposed Item 402(d)(2)(ii) Through (vii)

Under the proposed rule, information with respect to equity award terms would be reported in the following six columns:

- *Grant Date:* Report the grant date for each equity award.[166]
- *Award Type:* Describe the award type or designation (*e.g.,* option award with a service condition, or performance-based stock award).
- *Grant Amount or Range:* Report the number of shares of stock, or the number of shares underlying options, to be vested upon satisfaction of the conditions, or the range of potential payouts denominated in the number of shares of stock or the number of shares underlying options (*e.g.,* threshold, target, and maximum amount).[167]
- *End of Performance Period, If Applicable:* Report the date on which the performance period ends, if applicable.[168]
- *Final Vesting Date, If Known:* Report the last date on which shares of stock, or shares underlying options, may vest, if known.
- *Exercise Price, If Applicable:* Report the exercise or base price, if applicable.

As proposed, the Grant Amount or Range column would show equity awards in terms of number of securities rather than in terms of their dollar value. In cases where an equity award specifies a range of potential payouts, registrants would be required to provide and clearly label the amounts for each relevant scenario (*e.g.,* ''Threshold: 25,000; Target: 100,000; Maximum: 200,000'').

Under the current rule, the Outstanding Equity Awards at Fiscal Year-End Table requires registrants to compute the aggregate market value or payout value of unvested stock awards in dollar terms,[169] and potentially to change the assumed outcome of performance conditions, each year.[170] This reported value is a hypothetical figure given that:

- The awards may ultimately fail to vest at all or may vest at a level different from what the calculation assumed; and
- The market price at vesting may differ, potentially substantially, from the market price assumed in the calculation.

The proposed approach seeks to provide clearer, more objective, and more consistent information to investors by showing the equity awards in terms of the number of securities, which generally would be based on the underlying contractual arrangements already known at the time of grant. The proposal to show the amounts for each relevant scenario (*e.g.,* ''Threshold: 25,000; Target: 100,000; Maximum: 200,000'') is intended to give investors a clear sense that there is a range of potential outcomes rather than a single, already known amount. The proposed approach is also intended to reduce burdens on registrants by eliminating the need to perform award-by-award value recalculations each year.

b. Equity Award Status Columns—Proposed Item 402(d)(2)(viii) Through (ix)

Under the proposal, information with respect to the status of an equity award would be reported in the following two columns:

- Amount Vested: Report the number of shares of stock, or the number of shares underlying options, that have vested; and
- Amount of Options Exercised/Expired: Report the number of shares underlying options that have been exercised and that have expired.

The Amount of Options Exercised/Expired column would require registrants to provide and clearly label the numbers for each relevant scenario (*e.g.,* ''Exercised: 50,000; Expired: 10,000'').[171]

In general, registrants would report the terms and status of each equity award as of the end of the last completed fiscal year; however, if a registrant reports an equity award granted during the first quarter of the fiscal year immediately following the last completed fiscal year in the Granted Compensation Table,[172] then the registrant must report the terms and status of all equity awards as of the end of the first quarter of the fiscal year immediately following the last completed fiscal year (or, if earlier, the latest practicable date).[173] Registrants would be required to disclose the date as of which the information in the Status of Equity Awards Table is reported.[174] We are proposing this approach for clarity and to ensure consistency in the reporting between the Granted Compensation Table and the Status of Equity Awards Table.

c. Disclosure of Other Information Relating to the Status of Equity Awards Table—Proposed Item 402(d)(3)

Proposed Item 402(d)(3) would require the disclosure of the following additional information relating to the Status of Equity Awards Table:

- The date as of which the information in the table is reported; [175]
- The vesting schedule of each equity award reported in the table; and
- The material terms of any performance, market, and/or service

Awards Table may present values based on assumptions inconsistent with those used elsewhere in financial reporting or incentive design, requiring further explanation and cross-referencing that ultimately detracts from clarity.''); Towers Watson (suggesting that the rules be revised to include tables that ''disclose the entire life-cycle values (from grant to monetization) for each tranche of equity and cash granted.''). *See also* Summary Compensation Table Petition (suggesting that the Commission should revise the Summary Compensation Table by focusing on depicting ''*pay realizable* by an executive during the year'' because such an approach ''depicts what the executive actually earned (or lost) in stock value during the year, and would be an extremely valuable change for shareholders seeking clarity on this issue.'') (emphasis in original).

[166] As proposed, the rule text with respect to the Grant Date column would largely track the current rule text for the ''grant date'' column of the Grants of Plan-Based Awards Table, except that, if the grant date is different than the date on which the compensation committee or board of directors takes action or is deemed to take action to grant the award, the proposed amendments would not require a separate, adjoining column to be added showing such additional date. *See* 17 CFR 229.402(d)(2)(ii).

[167] As proposed, the rule text with respect to the Grant Amount or Range column would largely track the current rule text for the ''threshold,'' ''target,'' and ''maximum'' columns (under the heading ''estimated future payouts under equity incentive plan awards'') of the Grants of Plan-Based Awards Table. *See* 17 CFR 229.402(d)(2)(iv).

[168] As proposed, registrants would be required to disclose the material terms of any performance, market and/or service conditions with respect to each equity award. *See* proposed Item 402(d)(3)(iii).

[169] *See* 17 CFR 229.402(f)(2)(x); Instruction 3 to 17 CFR 229.402(f)(2).

[170] *See* Instruction 3 to 17 CFR 229.402(f)(2) (generally instructing the registrant to assume threshold performance will be achieved, but if the previous fiscal year's performance exceeded threshold, then instructing the registrant to assume the next higher performance level—*e.g.,* target, maximum—that exceeds the previous fiscal year's performance will be achieved).

[171] *See* proposed Instruction 2 to Item 402(d)(2).

[172] *See* proposed Instruction 1 to Item 402(c)(2)(v) and (vi); *see also supra* section II.C.2.c.

[173] *See* proposed Instruction 1 to Item 402(d)(2).

[174] *See* proposed Item 402(d)(3)(i).

[175] Typically the Status of Equity Awards Table would be stated as of the end of the last completed fiscal year. Given the proposal to give registrants the flexibility to report equity awards granted during the first quarter of the fiscal year immediately following the last completed fiscal year under certain conditions, however, the Status of Equity Awards Table may be stated as of the end of the first quarter of the fiscal year immediately following the last completed fiscal year (or, if earlier, the latest practicable date). *See* proposed Instruction 1 to Item 402(d)(2). Accordingly, the requirement to disclose the date as of which the information in the table is reported is designed to avoid any lack of clarity on this point.

conditions with respect to each equity award reported in the table.

As proposed, the registrant would have flexibility in the manner and location in which it provides the above disclosures, including in the Status of Equity Awards Table, any footnotes thereto, any supplemental narrative disclosures thereto, or in conjunction with other disclosures called for by proposed Item 402 such as, if applicable, in the CD&A. Moreover, as proposed, the requirement to disclose the vesting schedule may be satisfied by disclosing any standard vesting schedule that the registrant applies to all awards of a given type (including, if applicable, any material deviations from the standard vesting schedule for a specific award).

Proposed Item 402(d)(3) is designed to provide investors with material information relevant to an assessment of the compensation of the NEOs, while also giving registrants flexibility in the manner and location in which they provide such information.

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30. Should we adopt the Status of Equity Awards Table as proposed? Would having some or all of this information collected in a single table for each equity award provide investors with meaningful information and/or improve the ability of investors to track an equity award through its lifecycle? Are the components of information proposed to be required factual details that the registrant would already have available?

31. Are there any additional categories of information that should be added to the Status of Equity Awards Table? For example, should columns be added that disclose (i) expiration date (if applicable), (ii) performance period beginning date (if applicable), or (iii) amounts earned based on satisfaction of applicable conditions (in addition to the proposed Amount Vested column)? Would including some or all of this information in a column facilitate use or understanding of the information for investor investment and voting decisions? Would requiring some or all of this information to be included result in increased burdens on registrants and, if so, to what extent?

32. Should proposed Item 402(d)(3) be expanded to require disclosure of any additional information relating to the awards in the Status of Equity Awards Table? If so, what additional information should be required to be disclosed and why?

33. Should the Status of Equity Awards Table have separate columns for (i) End of Performance Period, If Applicable, and (ii) Final Vesting Date, If Known, or could one of these columns be eliminated? If both columns are not needed, which of the two columns should be retained and why?

34. Should the Status of Equity Awards Table be expanded to also cover non-equity awards (*e.g.,* any short-term or long-term non-equity incentive plan awards)? Is the information about the range of potential payouts on short-term and/or long-term non-equity incentive plan awards material to investors? Is our estimate in section IV.C.4 below that only approximately four percent of registrants use long-term non-equity incentive awards accurate? Would expanding the Status of Equity Awards Table to cover non-equity awards while the awards are ''in flight'' (granted but not yet earned or fully expired) provide material information to investors or should the table instead just focus on equity awards? Would including non-equity awards in the table reduce the amount of material information that registrants would otherwise have to provide in supplemental disclosure such as footnotes? Whether or not non-equity awards are included in this table, should we explicitly require disclosure of the material terms of any performance, market, and/or service conditions that are relevant under each non-equity award, similar to what is required for equity awards?

4. Illustrative Example of Primary Tabular Disclosures Based on a Hypothetical Scenario

The proposed amendments would substantially reconceptualize the primary tabular disclosures required under Item 402. In order to facilitate understanding of the proposed tabular disclosure requirements, below we provide an illustrative example of how the proposed primary tabular disclosures (*i.e.,* the Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table) may look in practice based on a hypothetical scenario. The illustrative example is intended merely to assist the reader in understanding the tabular disclosures required by proposed Item 402(b), (c), and (d) and does not attempt to cover any other required disclosures under Item 402. The manner of presentation in the illustrative example is not necessarily the only way to provide the primary tabular disclosures and may not be appropriate in all situations, and (if the proposed amendments are adopted as proposed) registrants would not be required to rigidly follow the illustrative example.[176] Furthermore, we provide supplemental footnote disclosures by way of example only and for clarity to the reader. We do not suggest that the content of the footnote disclosures would necessarily be required by proposed Item 402 or that such content must be provided through footnote disclosures (instead of, for example, through supplemental narrative disclosures to the tables or, if applicable, as part of the CD&A).[177]

For brevity, the illustrative example shows the primary tabular disclosures for a PEO only and is based on the following simplified hypothetical scenario:

- *Basic factual background:* Dorothy Gale became CEO of Oz Inc. on January 1, 2020. Oz Inc.'s fiscal year is based on the calendar year. Oz Inc. is producing executive compensation disclosures for Ms. Gale in March 2028 in connection with Oz Inc.'s proxy statement for its 2028 annual shareholder meeting. Oz Inc.'s board of directors certifies achievement of performance goals for equity and non-equity awards on February 15 of the year immediately following the end of the performance period for an award. Equity awards that are earned will vest on the date of board certification. Oz Inc.'s closing market price was $10 per share on February 15, 2020 and increased by $1 per share each year thereafter such that, on February 15, 2027, the closing market price was $17 per share. No amounts were recovered from Ms. Gale pursuant to Oz Inc.'s compensation recovery policy required by the listing standards adopted pursuant to 17 CFR 240.10D–1.
- *Salary:* Ms. Gale's salary when she became CEO on January 1, 2020 was $1

[176] Under the proposed amendments, the registrant would have flexibility in the manner of the tabular presentation and may, for example, split a single column into multiple columns (or a supplemental table) at the registrant's election. *See* proposed Item 402(a)(5)(ii).

[177] The objective of proposed Item 402 would be to provide investors with material information relevant to an assessment of the compensation of the registrant's NEOs and directors, and the registrant could provide additional information relevant to such an assessment in any format it determines to be appropriate, including in a supplemental table, in additional columns in an existing table, in footnotes to the tabular disclosures, or in supplemental narrative disclosures. *See* proposed Item 402(a)(1). Under the proposed amendments, the registrant also would be required to disclose any material information necessary to an understanding of the information disclosed in the Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table, but similarly would have the flexibility to disclose such information in any format it determines to be appropriate, including in a supplemental table, in additional columns in an existing table, in footnotes to the tabular disclosures, or in supplemental narrative disclosures. *See* proposed Item 402(a)(5)(i).

million per year. Effective from July 1 of each year thereafter, she received a raise of $100,000 such that, from July 1, 2027, her salary was $1,700,000 per year.[178]

- *Annual cash bonuses:* On February 15 of each year, Oz Inc.'s board of directors granted to Ms. Gale an annual cash bonus that is earned based on the company's net income during the grant year. The annual cash bonuses are subject to the following scaling factors: 25 percent, 100 percent, or 200 percent payouts if Oz Inc. achieves the net income goal at the threshold, target, or maximum level, respectively. Oz Inc. pays Ms. Gale the amount, if any, of the annual cash bonus earned following the board of directors' certification of the achievement level (on February 15 of the year immediately following the grant year).
  - The target value of the annual cash bonus award with respect to 2020 net income (granted on February 15, 2020) was $1 million and the target value of each subsequent annual cash bonus award increased by $100,000 each year thereafter such that the target value of the annual cash bonus award with respect to 2027 net income (granted on February 15, 2027) was $1,700,000.
  - Ms. Gale earned her 2027, 2026, and 2025 annual cash bonus awards at 100 percent, 25 percent, and 200 percent of target, respectively.
- *Long-term cash bonuses:* On February 15 of each year, Oz Inc.'s board of directors granted to Ms. Gale a long-term cash bonus award that is earned based on the company's market capitalization on the third anniversary of the grant date. The long-term cash bonuses are subject to the following scaling factors: 25 percent, 100 percent, or 200 percent payouts if Oz Inc. achieves the market capitalization goal at the threshold, target, or maximum level, respectively. Oz Inc. pays Ms. Gale the amount, if any, of the long-term cash bonus earned following the board of directors' certification of the achievement level (on the third anniversary of the grant date).
  - The target value of the long-term cash bonus award with respect to market capitalization as of February 15, 2023 (granted on February 15, 2020) was $2 million and the target value of each subsequent long-term cash bonus award increased by $100,000 each year thereafter such that the target value of the long-term cash bonus award with respect to market capitalization as of February 15, 2030 (granted on February 15, 2027) was $2,700,000.
  - Ms. Gale achieved her long-term cash bonus with respect to market capitalization as of February 15, 2027, 2026, and 2025 at 100 percent, 25 percent, and 200 percent of target, respectively.
- *Discretionary cash bonus:* On February 15, 2028, Oz Inc. granted Ms. Gale a discretionary cash bonus of $100,000, which was earned based on her and the company's performance during 2027.
- *Retention bonus:* On July 1, 2026, Ms. Gale received an offer from another company to become its CEO. To retain Ms. Gale, Oz Inc. granted her on July 15, 2026 a retention bonus of $6 million, which was earned based on Ms. Gale remaining with the company through December 31, 2026 and paid in early January 2027.
- *Stock awards:* On February 15 of each year, Oz Inc.'s board of directors granted to Ms. Gale a stock award that is earned based on the company's aggregate revenues for the grant year and the two years immediately following the grant year (*e.g.,* for the stock award granted on February 15, 2020, the company's aggregate revenues for 2020, 2021, and 2022). Oz Inc. does not consider the stock awards to be granted for Ms. Gale's performance in the immediately prior year; rather, it sees such awards as forward-looking incentives.[179] The stock awards are subject to the following scaling factors: 25 percent, 100 percent, or 200 percent payouts if Oz Inc. achieves aggregate revenues at the threshold, target, or maximum level, respectively. Earned stock awards, if any, vest following the board of directors' certification of the achievement level (on the third anniversary of the grant date).
  - The target value of the stock award with respect to 2020–2022 aggregate revenues (granted on February 15, 2020) was $4 million and the target value of each subsequent stock award increased by $100,000 each year thereafter such that the target value of the stock award with respect to 2027–2029 aggregate revenues (granted on February 15, 2027) was $4,700,000. Oz Inc. converts the target value of the stock awards into a number of shares based on its closing market price on the grant date, rounded to the nearest share.
  - Ms. Gale earned her stock award with respect to 2025–2027 aggregate revenues, 2024–2026 aggregate revenues, and 2023–2025 aggregate revenues at 100 percent, 25 percent, and 200 percent of target, respectively.
- *Option awards:* On February 15 of each year, Oz Inc.'s board of directors granted to Ms. Gale an option award that vests on the fourth anniversary of the grant date based on a service condition (*i.e.,* Ms. Gale remaining in her position in good standing as of the fourth anniversary of the grant date). Oz Inc. does not consider the option awards to be granted for Ms. Gale's performance in the immediately prior year; rather, it sees such awards as forward-looking incentives.[180] The option awards are not subject to any scaling factors (*i.e.,* they vest at 100 percent or not at all). The option awards were granted at-the-money (*i.e.,* the exercise price was set at the closing market price on the grant date) and the expiration date was set at the tenth anniversary of the grant date.
  - The dollar value of the option award granted on February 15, 2020 (vested based on fulfilling the service condition as of February 15, 2024) was $4 million and each subsequent option award increased by $100,000 each year thereafter such that the dollar value of the option award granted on February 15, 2027 (vesting based on fulfilling the service condition as of February 15, 2031) was $4,700,000. Oz Inc. converts the dollar value of the option award into a number of shares underlying the option award based on a Black-Scholes model that valued the options at 20 percent of the closing market price on the grant date, rounded to the nearest share (*e.g.,* the option award granted on February 15, 2020 was valued at $2 per share, when the closing market price was $10 per share).
  - On February 15, 2027, Ms. Gale exercised in full the option award originally granted on February 15, 2020 (the closing market price on February 15, 2027 was $17 per share compared to an exercise price of $10 per share).
- *Miscellaneous compensation:* Oz Inc. provided the following additional types of compensation to Ms. Gale: (1) pension service costs attributable to Ms. Gale of $150,000 per year; and (2) registrant contributions to Ms. Gale's 401(k) account of $50,000 per year.
- *Personal security services:* Oz Inc. also provided Ms. Gale with security services at her personal residence and during personal travel of $1 million per year, and reasonably determined in

[178] For simplicity, the illustrative example assumes there are an equal number of days in the first half (*i.e.,* January 1 through June 30) and second half (*i.e.,* July 1 through December 31) of each year.

[179] Accordingly, Oz Inc. reports the stock awards in the Granted Compensation Table in the grant year and does not elect to report the stock awards in the fiscal year immediately prior to the grant year as permitted under proposed Instruction 1 to Item 402(c)(2)(v) and (vi).

[180] Accordingly, Oz Inc. reports the option awards in the Granted Compensation Table in the grant year and does not elect to report the option awards in the fiscal year immediately prior to the grant year as permitted under proposed Instruction 1 to Item 402(c)(2)(v) and (vi).

good faith that the security services were integrally and directly related to the performance of Ms. Gale's work duties.[181]

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Earned Compensation Table							
Name and Position	Year	Salary Earned ($)	Non-Equity Awards Earned ($)	Equity Awards		Miscellaneous Compensation Received ($)[(h)]	Total Compensation Earned ($)
				Stock Awards Vested ($)	Option Awards Exercised ($)		
Dorothy Gale, CEO	2027	$1,650,000	$4,200,000[(a)]	$5,342,862[(d)]	$14,000,000[(g)]	$200,000	$25,392,862
	2026	$1,550,000	$6,975,000[(b)]	$1,323,072[(e)]	$0	$200,000	$10,048,072
	2025	$1,450,000	$7,400,000[(c)]	$10,500,000[(f)]	$0	$200,000	$19,550,000

(a) This amount consists of (i) earnings of $2,400,000 under a long-term cash bonus award (granted on February 15, 2024) based on the achievement of performance goals related to Oz Inc.'s market capitalization as of February 15, 2027 at the target level, resulting in a payout of 100% of the target value of the award; (ii) earnings of $1,700,000 under an annual cash bonus award (granted on February 15, 2027) based on the achievement of performance goals related to Oz Inc.'s net income during 2027 at the target level, resulting in a payout of 100% of the target value of the award; and (iii) a discretionary cash bonus award of $100,000 earned based on Oz Inc.'s and Ms. Gale's performance during 2027 (granted on February 15, 2028).

(b) This amount consists of (i) a retention bonus of $6,000,000 (granted on July 15, 2026) earned based on Ms. Gale remaining employed with Oz Inc. through December 31, 2026; (ii) earnings of S575,000 under a long-term cash bonus award (granted on February 15, 2023) based on the achievement of performance goals related to Oz Inc.'s market capitalization as of February 15, 2026 at the threshold level, resulting in a payout of 25% of the target value of the award; and (iii) earnings of $400,000 under an annual cash bonus award (granted on February 15, 2026) based on the achievement of performance goals related to Oz Inc.'s net income during 2026 at the threshold level, resulting in a payout of 25% of the target value of the award.

(c) This amount consists of (i) earnings of $4,400,000 under a long-term cash bonus award (granted on February 15, 2022) based on achievement of performance goals related to Oz Inc.'s market capitalization as of February 15, 2025 at the maximum level, resulting in a payout of 200% of the target value of the award; and (ii) earnings of $3,000,000 under an annual cash bonus award (granted on February 15, 2025) based on the achievement of performance goals related to Oz Inc.'s net income during 2025 at the maximum level, resulting in a payout of 200% of the target value of the award.

(d) This amount reflects the vesting of 314,286 shares on February 15, 2027 at a closing market price of $17 per share under a performance-based stock award (granted on February 15, 2024) that vested based on the achievement of performance goals related to Oz Inc.'s aggregate revenues from January 1, 2024 to December 31, 2026 at the target level, resulting in a payout of 100% of the target number of shares underlying the award.

(e) This amount reflects the vesting of 82,692 shares on February 15, 2026 at a closing market price of $16 per share under a performance-based stock award (granted on February 15, 2023) that vested based on the achievement of performance goals related to Oz Inc.'s aggregate revenues from January 1, 2023 to December 31, 2025 at the threshold level, resulting in a payout of 25% of the target number of shares underlying the award.

(f) This amount reflects the vesting of 700,000 shares on February 15, 2025 at a closing market price of $15 per share under a performance-based stock award (granted on February 15, 2022) that vested based on the achievement of performance goals related to Oz Inc.'s aggregate revenues from January 1, 2022 to December 31, 2024 at the maximum level, resulting in a payout of 200% of the target number of shares underlying the award.

(g) This amount reflects the exercise of options for 2,000,000 shares (whose exercise price was $10 per share) on February 15, 2027 (when the closing market price was S17 per share).

(h) This amount includes (for 2027, 2026, and 2025) (i) pension service costs attributable to Ms. Gale's services during the year under Oz Inc.'s defined benefit pension plan in the amount of S150,000; and (ii) Oz Inc. contributions to Ms. Gale's 401(k) account of $50,000.

[181] For a discussion of the proposed amendments and changes to Commission guidance with respect to perquisites and other personal benefits, see section II.D below.

Granted Compensation Table						
Name and Position	**Year**	**Annualized Salary ($)**	**Non-Equity Awards Granted ($)**	**Equity Awards**		**Total Compensation Granted ($)**
				Stock Awards Granted ($)[d]	**Option Awards Granted ($)[e]**	
Dorothy Gale, CEO	2027	$1,700,000	$4,500,000[a]	$4,700,000	$4,700,000	$15,600,000
	2026	$1,600,000	$10,200,000[b]	$4,600,000	$4,600,000	$21,000,000
	2025	$1,500,000	$4,000,000[c]	$4,500,000	$4,500,000	$14,500,000

(a) This amount consists of (i) a long-term cash bonus award with a target dollar value of $2,700,000 granted on February 15, 2027; (ii) an annual cash bonus with a target dollar value of $1,700,000 granted on February 15, 2027; and (iii) a discretionary cash bonus award of $100,000 granted on February 15, 2028 and earned based on Oz Inc.'s and Ms. Gale's performance during 2027. Payouts under the long-term cash bonus award depend on the achievement of performance goals related to Oz Inc.'s market capitalization as of the third anniversary of the grant date. Payouts under the annual cash bonus award depend on the achievement of performance goals related to Oz Inc.'s net income during 2027. The long-term and annual cash bonus awards are subject to the following scaling factors: 25%, 100%, or 200% payouts if the performance goals are achieved at threshold, target, or maximum levels, respectively

(b) This amount consists of (i) a retention bonus of $6,000,000 granted on July 15, 2026; (ii) a long-term cash bonus award with a target dollar value of $2,600,000 granted on February 15, 2026; and (iii) an annual cash bonus with a target value of $1,600,000 granted on February 15, 2026. Payouts under the long-term cash bonus award depend on the achievement of performance goals related to Oz Inc.'s market capitalization as of the third anniversary of the grant date. Payouts under the annual cash bonus award depend on the achievement of performance goals related to Oz Inc.'s net income during 2026. The long-term and annual cash bonus awards are subject to the following scaling factors: 25%, 100%, or 200% payouts if the performance goals are achieved at threshold, target, or maximum levels, respectively.

(c) This amount consists of (i) a long-term cash bonus award with a target dollar value of $2,500,000 granted on February 15, 2025; and (ii) an annual cash bonus with a target dollar value of $1,500,000 granted on February 15, 2025. Payouts under the long-term cash bonus award depend on the achievement of performance goals related to Oz Inc.'s market capitalization as of the third anniversary of the grant date. Payouts under the annual cash bonus award depend on the achievement of performance goals related to Oz Inc.'s net income during 2025. The long-term and annual cash bonus awards are subject to the following scaling factors: 25%, 100%, or 200% payouts if the performance goals are achieved at threshold, target, or maximum levels, respectively.

(d) The amounts reported in this column reflect performance-based stock awards granted on February 15 of the covered year. The amounts reported in this column are the grant date fair values computed in accordance with FASB ASC Topic 718, except that the valuation assumes that the award's target outcome will be achieved (i.e., achievement at the 100% level). The number of shares that vest under the awards depends on the achievement of performance goals related to Oz Inc.'s aggregate revenues for the performance period consisting of the fiscal year in which the award was granted and the immediately following two fiscal years. The awards are subject to the following scaling factors: 25%, 100%, or 200% payouts if the performance goals are achieved at threshold, target, or maximum levels, respectively.

(e) The amounts reported in this column reflect time-based option awards granted on February 15 of the covered year. Vesting of the options depends on the fulfillment of the service condition that Ms. Gale remain in her position in good standing as of the fourth anniversary of the grant date. The amounts reported in this column are the grant date fair values computed in accordance with FASB ASC Topic 718.

Status of Equity Awards Table – As of December 31, 2027								
	Equity Award Terms						Equity Award Status	
Name and Position	Grant Date[a]	Award Type	Grant Amount or Range (#)	End of Performance Period, If Applicable	Final Vesting Date, If Known[b]	Exercise Price, If Applicable	Amount Vested (#)	Amount of Options Exercised / Expired (#)
Dorothy Gale, CEO	2/15/2027	Performance-based stock	Threshold: 69,118 Target: 276,471 Maximum: 552,941	12/31/2029	2/15/2030			
	2/15/2026	Performance-based stock	Threshold: 71,875 Target: 287,500 Maximum: 575,000	12/31/2028	2/15/2029			
	2/15/2025	Performance-based stock	Threshold: 75,000 Target: 300,000 Maximum: 600,000	12/31/2027	2/15/2028[c]			
	2/15/2024	Performance-based stock	Threshold: 78,571 Target: 314,286 Maximum: 628,571	12/31/2026	2/15/2027		314,286	
	2/15/2027	Time-based option	1,382,353		2/15/2031	$17 per share		
	2/15/2026	Time-based option	1,437,500		2/15/2030	$16 per share		
	2/15/2025	Time-based option	1,500,000		2/15/2029	$15 per share		
	2/15/2024	Time-based option	1,571,429		2/15/2028[d]	$14 per share		
	2/15/2023	Time-based option	1,653,846		2/15/2027	$13 per share	1,653,846	
	2/15/2022	Time-based option	1,750,000		2/15/2026	$12 per share	1,750,000	
	2/15/2021	Time-based option	1,863,636		2/15/2025	$11 per share	1,863,636	
	2/15/2020	Time-based option	2,000,000		2/15/2024	$10 per share	2,000,000	Exercised: 2,000,000

(a) The option awards reflected in this column were granted at-the-money (i.e., the exercise price was set at the closing market price on the grant date) and expire on the tenth anniversary of the grant date.

(b) The stock awards reflected in this column vest upon the board of directors' certification of the achievement of performance goals related to Oz Inc.'s aggregate revenues during the fiscal year in which the award was granted and the immediately following two fiscal years. Oz. Inc.'s board of directors expects to certify such achievement, if any, on February 15 of the year immediately following the end of the performance period for an award. The option awards reflected in this column vest at 100% depending on the fulfillment of a service condition (i.e., Ms. Gale remaining in her position in good standing as of the fourth anniversary of the grant date).

(c) On February 15, 2028, Oz Inc.'s board of directors certified achievement of the performance goals related to aggregate revenues from January 1, 2025 to December 31, 2027 at the maximum level, resulting in vesting of 600,000 shares on that date.

(d) On February 15, 2028, options for 1,571,429 shares vested based on Ms. Gale's fulfilment of the service condition (i.e., Ms. Gale remaining in her position in good standing as of the fourth anniversary of the grant date).

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5. Structured Data Requirements—Inline XBRL

We are proposing to require registrants that are LAFs to tag the information disclosed within the Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table in Inline eXtensible Business Reporting Language (''Inline XBRL'') in accordance with 17 CFR 232.405 (''Rule 405 of Regulation S–T'') and the EDGAR Filer Manual.[182] We are not proposing to require block text tagging or detail tagging of any footnotes to the tabular disclosures or other narrative disclosures made under proposed Item 402.

Currently, registrants are required to tag the pay-versus-performance information disclosed under Item 402(v) and compensation recovery disclosures under Item 402(w) in Inline XBRL.[183] We are proposing to eliminate those tagging requirements. Other information disclosed under Item 402 is not currently required to be tagged in structured (*i.e.,* machine-readable) data language.

Many comments received in connection with the 2025 Roundtable supported tagging the Summary Compensation Table in Inline XBRL, stating that it would increase transparency and investor access to compensation data and allow investors to better analyze the data.[184] We believe that the proposed amendments would benefit investors by making the primary tabular disclosures from LAFs more readily available and accessible to investors, market participants, and other users for aggregation, comparison, filtering, and other analysis. The proposal would enable automated extraction and analysis of LAF executive compensation disclosures, allowing investors and other market participants to more efficiently perform large-scale analysis and comparison of LAF executive compensation across registrants and time periods, including quantitative information on registrants' incentives and awards.[185] Inline XBRL tagging of the consolidated information disclosed in the proposed Status of Equity Awards Table would further augment the ability of investors to track awards throughout their lifecycle.[186]

[182] Non-LAF registrants would also be able to voluntarily tag this information, if they choose to do so. The Commission recently adopted joint standards that established certain properties for data transmission, structuring and formatting (the ''Joint Standards''). Inline XBRL is one of the available schema and taxonomy formats that have the properties established under the Joint Standards. *Financial Data Transparency Act Joint Data Standards,* Release No. 33–11420 (May 21, 2026) [91 FR 38246 (June 25, 2026)].

[183] *See* 17 CFR 229.402(v)(7) and (w)(4).

[184] *See* letters from Infinite Equity-2 (proposing to ''[e]xpand tagging beyond Pay vs. Performance tables to include key disclosures like the Summary Compensation Table, enabling better data analysis''); Chad Sandstedt, Tagnifi (June 6, 2025) (''Tagnifi''), available at *https://www.sec.gov/comments/4-855/4855-610387-1785614.html* (stating that tagging of the Summary Compensation Table ''represents an optimal use of structured data to significantly improve investor and aggregator access to executive compensation information.''); XBRL US (June 25, 2025), available at *https://www.sec.gov/comments/4-855/4855-616867-1809854.pdf* (recommending that the Commission expand compensation disclosure variables to be covered by XBRL ''including the Summary Compensation Table, the Outstanding Equity Awards at Fiscal Year-End Tables, and the Table of Grants''); *see also* Rees, 2025 Roundtable Transcript at 104:17–20 (recommending that the Summary Compensation Table data and other quantitative disclosures in the proxy statement be made in XBRL or another machine-readable data language).

[185] *See* letters from Erste Asset Management GmbH (June 26, 2025) (''Erste''), available at *https://www.sec.gov/comments/4-855/4855-617187-1810754.pdf* (stating that publishing their suggested dashboard of CEO and CFO total pay in Inline XBRL with a standard taxonomy would enable automated comparisons across registrants); Tagnifi; Towers Watson (Aug. 21, 2025) (''Towers Watson''), available at *https://www.sec.gov/comments/4-855/4855-641247-1918514.pdf* (commenting that making the life-cycle values of awards available in XBRL ''preserves and enhances access to this data for investors who then could perform their own calculations of whether a company pays for performance'').

[186] *See, e.g.,* Joung W. Kim, Jee-Hae Lim, & Won Gyun No, *The Effect of First Wave Mandatory XBRL Reporting Across the Financial Information Environment,* 26 J. Info. Sys. 127, 127–53 (2012) (finding evidence that ''mandatory XBRL disclosure decreases information risk and information asymmetry in both general and uncertain information environments''); Yuyun Huang et al., *Information-Processing Gap and Insider Trading Profitability: Evidence from the XBRL Mandate,*

Continued

Some commenters opposed tagging disclosures under Item 402, stating it was burdensome and did not provide any benefit to investors.[187] One such commenter expressed the view that Inline XBRL tagging should not apply to EGCs and SRCs.[188] Another commenter suggested that the Commission simplify XBRL requirements by limiting tagging to structured data tables and by not requiring tagging of every number and footnote.[189]

We acknowledge that the proposed amendments to tag the primary tables could increase costs for LAFs; however, we believe that these costs would be incremental since LAFs are subject to Inline XBRL tagging requirements for many other disclosures. We further believe that costs would be mitigated by the proposed removal of the Inline XBRL tagging requirements from pay-versus-performance disclosures and compensation recovery disclosures. In addition, we intend to reduce compliance burdens on non-LAFs by proposing to remove existing XBRL tagging requirements and to allow the tagging of any tabular executive compensation disclosure to remain optional.

Request for Comment

35. Should we require LAFs to tag the information disclosed in the Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table in Inline XBRL as proposed? Should we modify the scope of executive compensation disclosures required to be tagged by LAFs? For example, should footnote disclosures to the Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table be required to be tagged? Would tagging these disclosures be valuable to investors or enhance comparability among different registrants?

36. Should we also require non-LAFs to tag these tables in Inline XBRL, instead of making it optional, as proposed? Do investors use LAF executive compensation data more than non-LAF executive compensation data?

37. Should we require registrants to use a different structured data language to tag these disclosures? If so, what structured data language should we require and why?

38. What was the incremental cost for registrants to tag disclosures within proxy statements following the 2022 Pay-versus-Performance Amendments? Would the incremental cost to LAFs for tagging information disclosed in the proposed Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table be more or less? How would these costs differ for non-LAFs who may elect to provide the tabular information in Inline XBRL?

39. Should the Commission retain current Item 402(v)(7) requiring that the pay-versus-performance disclosures be tagged in Inline XBRL? Do shareholders and investors use the tagged registrant TSR to analyze their investments or make investment decisions? Could such analysis be done using the proposed primary tabular disclosures such as the proposed Earned Compensation Table? What would be the incremental cost savings to registrants due to removing the requirement to tag pay-versus-performance disclosures, as proposed?

40. Should the Commission retain current Item 402(w)(4) requiring that the compensation recovery disclosures be provided in an Interactive Data File pursuant to Rule 405 of Regulation S–T and the EDGAR Filer Manual? What are the incremental costs for tagging this information? Do investors find the Inline XBRL tagging of the compensation recovery disclosures under Item 402(w) valuable?

D. Perquisite Disclosure Requirements

1. Perquisite Interpretive Guidance

We are proposing to revise the Commission's current interpretive guidance with respect to the disclosure of perquisites and other personal benefits by:

- Stating that registrants have flexibility in making the determination of whether a benefit is ''integrally and directly related'' to the performance of an executive's duties, so long as the determination is reasonable and made in good faith; and
- Removing the examples of items requiring disclosure as perquisites or personal benefits, including that security provided at an executive's personal residence or during personal travel are perquisites.[190] We are requesting comment on whether the Commission should again provide guidance with respect to the application of this more flexible approach on any notable or common situations.

In the 2006 Adopting Release, the Commission provided interpretive guidance regarding factors to be considered in determining whether an item is a perquisite or other personal benefit. The Commission stated that, among the factors to be considered in determining whether an item is a perquisite or other personal benefit, a registrant should consider the following two-part analysis:

- An item is not a perquisite or personal benefit if it is integrally and directly related to the performance of the executive's duties.
- Otherwise, an item is a perquisite or personal benefit if it confers a direct or indirect benefit that has a personal aspect, without regard to whether it may be provided for some business reason or for the convenience of the registrant, unless it is generally available on a non-discriminatory basis to all employees.[191]

The Commission further stated, with respect to the first part of the two-part analysis, that the concept of a benefit that is ''integrally and directly related'' to job performance is a ''narrow one.'' [192] In particular, the Commission stated that ''the analysis draws a critical distinction between an item that a company provides because the executive needs it to do the job, making it integrally and directly related to the performance of duties, and an item provided for some other reason, even where that other reason can involve both company benefit and personal benefit.'' [193] The Commission also expressed the view that whether an expense is an ''ordinary'' or ''necessary'' business expense for tax or other purposes, or whether an expense is for the benefit or convenience of the registrant, is not responsive to the inquiry as to whether the expense provides a perquisite or other personal benefit for disclosure purposes under Item 402.[194]

In addition, the Commission included a non-exhaustive list of examples that, applying the Commission's interpretive guidance, would require disclosure as perquisites or personal benefits. Among these examples were items provided for security purposes.[195] Other examples

Brit. Acct. Rev. (publication forthcoming) (finding that XBRL levels the playing field between insiders and non-insiders by lowering disclosure processing costs and reducing information asymmetry), available at *https://doi.org/10.1016/j.bar.2026.101941*.

[187] *See, e.g.,* letters from Davis Polk; Society for Corporate Governance.

[188] *See* letter from Davis Polk (suggesting that LAFs are better able to implement XBRL tagging by engaging with third-parties with XBRL tagging experience).

[189] *See* letter from Society for Corporate Governance.

[190] *See* 2006 Adopting Release at 53177.

[191] *See* 2006 Adopting Release at 53176.

[192] *Id.* at 53177.

[193] *Id.*

[194] *See id.*

[195] *See id.* Specifically, the Commission stated that ''a company's decision to provide an item of personal benefit for security purposes does not affect its characterization as a perquisite or personal benefit,'' and, as a result, ''[a] company policy that for security purposes an executive (or an executive and his or her family) must use company aircraft

related to such items as executive commuting expenses, professional services provided to the executives, and the personal use of properties, vehicles, or other assets of the registrant.[196]

Several commenters expressed the view that the Commission's current guidance is unclear and/or should be updated to keep up with developments both with respect to the work environment in general, such as how and where individuals work, and in how registrants grant perquisites to their executives.[197] Other commenters stated that the current perquisite guidance remains useful and supported maintaining or bolstering the current guidance.[198] Commenters included a number of suggestions related to the disclosure of perquisites, including: deferring to a board of directors' determination that an expense is necessary for the registrant's business and therefore declining to treat such expenses as perquisites[199] and instituting a principles-based approach to disclosure focused on the primary purpose of the benefit.[200]

In the 2006 Adopting Release, the Commission noted that the elements of the two-part analysis were among the factors to be considered in determining whether an item required disclosure as a perquisite. These factors, including the guidance that the first element should be construed narrowly, together with the inclusion of a non-exhaustive list of example items that the Commission had determined constituted perquisites under the two-part analysis, appear to have constrained the analysis by registrants in certain cases, potentially leading to disclosure of items that could reasonably be concluded are not perquisites, and which the board does not consider as part of the executive's compensation.

We propose to revise our guidance as follows:

- An item is not a perquisite or personal benefit if it is integrally and directly related to the performance of the executive's duties, as determined by the registrant, so long as such determination is reasonable and made in good faith.
- An item is a perquisite or personal benefit if it is determined by the registrant, reasonably and in good faith, that it is not integrally and directly related to the performance of the executive's duties, *and* it confers a direct or indirect personal benefit to the executive, unless it is generally available on a non-discriminatory basis to all employees.

Consistent with the Commission's views in 2006, we continue to believe that the rule should not define perquisites or personal benefits, given that different forms of these items have continued to develop and evolve and that such a definition may become outdated. Consistent with this view, we also believe that registrants, not the Commission, are in the best position to determine what is properly categorized as a perquisite or personal benefit, so long as such determinations are reasonable and made in good faith. Accordingly, we believe it is appropriate to update the prior guidance to state that, in applying the two-part analysis, registrants have flexibility to determine, based on their specific facts and circumstances, whether an item is integrally and directly related to the performance of an executive's duties.

The proposed revisions to the Commission's interpretive guidance are intended to underscore that registrants can utilize the two-part analysis without the outcome being predetermined. For example, in applying the first prong of the analysis, as proposed to be revised, if a registrant acting in good faith reasonably concludes that providing personal security services at all times to a PEO or PFO, or requiring the PEO or PFO to use a company aircraft for personal travel due to security concerns, is integrally and directly related to the performance of the executive's duties, then such security services would not be a perquisite. As under the current guidance, the elements of the second prong of the analysis (*e.g.,* whether there is also a personal benefit or whether the item is generally available to all other employees on a non-discriminatory basis) are irrelevant to the first prong of the analysis. Likewise, if a registrant reasonably determines in good faith that an item is integrally and directly related to the performance of an executive's duties under the first prong of the two-part analysis, then there is no need to proceed to the second prong of the analysis.

As to the second element of the analysis, registrants that determine an item is not integrally and directly related to the performance of an executive's duties should continue to evaluate whether the item confers a direct or indirect benefit that has a personal aspect. If there is no such personal benefit, the item is not a perquisite. If there is such benefit, the registrant should consider whether it is generally available on a nondiscriminatory basis to all employees.[201] A company may reasonably conclude that an item is generally available to all employees on a non-discriminatory basis if it is

or other company means of travel for personal travel, or must use company or company-provided property for vacations, does not affect the conclusion that the item provided is a perquisite or personal benefit.''

[196] *See id.*

[197] *See* letters from ABA (recommending that ''the two-step analysis for determining whether an item is a perquisite or other personal benefit be clarified to address specific disclosure challenges resulting from its current application to various items which benefit both an executive officer and the registrant''); CEC–1 (stating that the ''two-part analysis has proven to be overly subjective and inconsistent in application, resulting in disclosure uncertainty and legal risk.''); McGuireWoods & Brownstein (stating that ''[e]xisting rules concerning perquisite disclosures have not kept up with today's climate and discourage companies from adequately protecting their executives, and by extension, their business and the interests of shareholders''); Society for Corporate Governance (''While the Commission's existing guidance indicated that developments and evolution in work arrangements and work technology would affect what is and is not considered a perquisite, the Commission has not updated or provided additional interpretive guidance on what constitutes a perquisite for nearly two decades[.]''); *see also* Levine, 2025 Roundtable Transcript at 120:12–19 and 121:5 (explaining that registrants ''spend so much time'' on the disclosure of perquisites, that it is ''challenging,'' and that the tracking and disclosure of perquisites is ''not always intuitive'').

[198] *See* letters from American Federation of Labor and Congress of Industrial Organizations, American Federation of State, County and Municipal Employees (AFSCME), Americans for Financial Reform Education Fund, Institute for Policy Studies, Global Economy Project, Public Citizen, and SOC Investment Group (June 25, 2025) (''AFL–CIO et al.''), available at *https://www.sec.gov/comments/4-855/4855-619667-1818694.pdf* (stating that they supported ''maintaining disclosure of the value of perquisites, which investors consider when voting on say-on-pay and compensation committee director elections.''); Farient Advisors (June 20, 2025) (''Farient-1''), available at *https://www.sec.gov/comments/4-855/4855-614947-1802715.pdf* (stating that it has ''not generally seen companies determine whether to provide a [perquisite] solely based on disclosure considerations'' and that it believes ''including perquisite costs in the [Summary Compensation Table] disclosure as currently defined allows investors to better assess an executive's total pay package[.]''); *see also* Rees, 2025 Roundtable Transcript at 131:13–15 and 17–20 (stating that ''the disclosure [of] perks helps boards of directors and compensation committees push back on excessive requests for perks'' and that ''the disclosure has a sanitizing effect, by giving boards and compensation committees the opportunity to say no to excessive [perquisite] requests'').

[199] *See* letter from Davis Polk.

[200] *See, e.g.,* letter from Cooley LLP (Aug. 15, 2025) (''Cooley''), available at *https://www.sec.gov/comments/4-855/4855-639727-1910274.pdf* (''[A] more workable alternative to the existing framework would be a 'primary purpose' test where the determinative inquiry would be based on whether the primary purpose of any benefit is to further a registrant's legitimate business objectives, not whether it is necessary for the job to be completed.'').

[201] For example, discounts on a registrant's products or services that are generally available to all employees on a non-discriminatory basis would not be a perquisite for purposes of disclosure under Item 402.

available to those employees to whom it lawfully may be provided.[202]

The proposed guidance would also eliminate the portion of the current guidance that indicates that whether a benefit is provided for business reasons or the convenience of the company should not be considered in applying this second prong of the analysis. Furthermore, we recognize that, pursuant to the more flexible approach reflected in the proposed guidance, consideration of the benefit to the company and the business purpose is more relevant for the first prong of the analysis and we find that it can be one of the factors that registrants consider in determining whether an item is integrally and directly related to the performance of the executive's duties, and thus not a perquisite or a personal benefit. The elimination of this portion of the guidance in the second prong of the analysis is also consistent with our view that registrants should have flexibility in making this determination under the first prong of the analysis.

Finally, consistent with a more flexible approach to applying the two-part analysis, we are proposing to rescind the Commission's prior statement of examples of items requiring disclosure as perquisites or personal benefits, including security provided at an executive's personal residence or during personal travel. We believe that a registrant is in the best position to determine what benefits are integrally and directly related to an executive's duties, and providing examples of items that would definitively be considered perquisites could be in tension with our view that a registrant should have flexibility to make this determination based on its own set of facts and circumstances.

We believe the primary concern of commenters with the current guidance regarding perquisites is the perceived lack of flexibility in applying the guidance due to prior Commission statements, as opposed to the substantive nature of the guidance itself. We believe the proposed guidance addresses this concern.[203] Accordingly, we have not proposed the suggestions by commenters highlighted above.[204]

Request for Comment

41. Should we modify the Commission's existing guidance regarding perquisites, as proposed? Alternatively, should we rescind the current guidance in its entirety and issue new guidance under a new analytical framework? If so, what should the new analytical framework be and why?

42. Should we retain the Commission's existing guidance regarding perquisites and instead should the Commission itself affirmatively exclude particular categories as not being perquisites, such as NEO and director personal security? If so, what categories should be affirmatively excluded by the Commission as not being perquisites?

43. Does the proposed guidance provide registrants with an appropriate degree of flexibility in determining what items constitute perquisites? Rather than requiring the registrant's determination be reasonable and made in good faith as proposed under the first prong, should the Commission instead apply some other standard? If so, what standard should the Commission apply and why?

44. Should any new or modified guidance be codified as Commission rules?

45. We are proposing to explicitly rescind the examples of items requiring disclosure as perquisites provided in the 2006 Adopting Release. Should we retain some of these or provide any other examples of what items are and are not perquisites? Should we provide guidance with respect to the application of the proposed, more flexible approach on any other notable or common situations? Would providing more explicit examples of the application of the two-part analysis result in such items being deemed *de facto* perquisites by registrants, or otherwise constrain a registrant's flexibility to make such determinations based on their own facts and circumstances?

46. Under our current guidance, an item is not a perquisite if it is generally available on a non-discriminatory basis to all employees of the registrant. Should we revise the guidance to instead reference whether the item is generally available on a non-discriminatory basis to all executive officers? What types of compensation or perquisites would such a revision likely exclude from disclosure and what is their value? Would those types of compensation or perquisites typically be excluded under the proposed *de minimis* exclusion? Would an item provided to executive officers of the registrant, but not necessarily to other employees, represent the type of matter that would, by its nature, be viewed as a perquisite? What would be the costs and benefits of such a change to the guidance?

2. Minimum Aggregate Reporting Threshold and De Minimis Tracking Exclusion—Proposed Item 402(b)(2)(vii)(A)

Under the current rule, registrants must disclose perquisites in column (i) of the Summary Compensation Table (''All other compensation'') for each NEO when the total amount of perquisites is $10,000 or more, an amount which has not been updated since the 2006 Amendments.[205] The current rule does not include a *de minimis* tracking exclusion, meaning that registrants must track all potential perquisites in order to determine if the minimum aggregate reporting threshold is met for each NEO.

Under the proposed rule, perquisites would be disclosed in the Miscellaneous Compensation Received column (proposed column (g)) of the Earned Compensation Table. We are proposing to increase the minimum aggregate reporting threshold and add a *de minimis* tracking exclusion for perquisites. Specifically, we are proposing to:

- Increase the minimum aggregate reporting threshold for perquisites (below which such perquisites would not be required to be included in the Miscellaneous Compensation Received column of the Earned Compensation Table) to $150,000; and
- Add a *de minimis* tracking exclusion for perquisites (below which individual perquisites would be excluded when calculating whether the minimum aggregate reporting threshold had been met and thus would not need to be tracked by the registrant) that would exclude any individual perquisite that is considered a *de minimis* fringe benefit under section

[202] As under the current guidance, for this purpose, a company may recognize jurisdictionally based legal restrictions (such as for foreign employees) or the employees' ''accredited investor'' status. In contrast, merely providing a benefit consistent with its availability to employees in the same job category or at the same pay scale does not establish that it is generally available on a nondiscriminatory basis to all employees.

[203] We are aware that the Commission in prior administrative proceedings may have applied the current guidance to make determinations about a registrant's disclosure obligations with respect to perquisites or personal benefits. If the Commission revises the guidance as proposed, registrants should look to the revised guidance, rather than those prior proceedings, to understand the Commission's current views with respect to perquisites disclosure.

[204] *See infra* notes 199 and 200.

[205] The $10,000 aggregate reporting threshold adopted in the 2006 Amendments was a decrease as compared to the threshold previously in place under the 1992 Amendments (*i.e.,* the lesser of either $50,000 or 10% of total annual salary and bonus as reported in the Summary Compensation Table). *See* 2006 Adopting Release; 1992 Adopting Release.

132(a)(4) of the Internal Revenue Code, or any successor provision.[206]

We continue to believe that disclosure regarding perquisites is important for investors to understand the overall compensation package made available to the PEO and PFO; however, we believe that the current aggregate reporting threshold is unnecessarily low. In addition, because the current rule does not have a *de minimis* tracking exclusion, registrants must compile and track any perquisite, regardless of how small the amount, for purposes of this disclosure item. The proposed amendments are intended to reduce compliance burdens for registrants while retaining disclosure of material perquisites for investors. The proposed increase in the minimum aggregate reporting threshold is intended to modernize the threshold given the passage of time since the 2006 Amendments (including to reflect the impact of inflation), as well as developments in executive compensation over the past decades (as benefits that are only modestly above a $10,000 threshold may often be immaterial in light of modern executive compensation levels).

The addition of a *de minimis* tracking exclusion should further reduce burdens on registrants by eliminating the need for registrants to track small, individual benefits over the course of the year, which investors are unlikely to consider material to an NEO's overall compensation. By using a *de minimis* threshold already applied by registrants for U.S. tax purposes, the proposal also aims to simplify the analysis for registrants.[207]

We are also proposing to eliminate the requirement that perquisites must be valued on the basis of the aggregate incremental cost to the registrant.[208] The 2006 Adopting Release indicated that the amounts attributed to perquisites for Federal income tax purposes should not be used for purposes of our executive compensation disclosure unless, independently of the tax characterization, such amounts constitute the incremental cost to the registrant.[209] However, we understand from engagement with market participants that there is no uniform way to value certain perquisites, and as a result of the Commission's prior statements, registrants may need to attribute different values to the same perquisite for Federal income tax and Federal securities law purposes, which can be burdensome without a commensurate benefit in the disclosure.[210] We are therefore proposing to eliminate the requirement that perquisites must be valued on the basis of the aggregate incremental cost to the registrant so as to provide registrants with greater flexibility in how perquisites are valued, and to reduce burdens on registrants by not requiring them to revalue perquisites already valued for Federal income tax purposes solely for purposes of their executive compensation disclosures under Item 402.

Request for Comment

47. Should we increase the minimum aggregate reporting threshold and add a *de minimis* tracking exclusion for perquisites as proposed? If not, please explain why not. If we should adopt a different approach instead, please describe the approach and why you believe it is preferable to the proposal.

48. Do the proposed amendments set the minimum aggregate reporting threshold for perquisites at an appropriate level (*i.e.,* $150,000)? Are there alternative aggregate reporting thresholds that would be more appropriate? If so, please describe the alternative threshold and explain why it would be more appropriate. For example, should we modify the proposed aggregate reporting threshold to a higher or lower numerical dollar value, eliminate the proposed dollar threshold in favor of a figure calculated on some other basis (*e.g.,* based on a percentage of total compensation, or certain components of compensation, as reported in the Granted Compensation Table or the Earned Compensation Table), or adopt some other approach (*e.g.,* a ''lesser of'' or a ''greater of'' structure that combines both a dollar value and a figure calculated on some other basis, such as a percentage)?

49. Do the proposed amendments set the *de minimis* tracking exclusion at an appropriate level (*i.e.,* any individual perquisite that is considered a *de minimis* fringe benefit under section 132(a)(4) of the Internal Revenue Code)? Are there alternative thresholds that we should consider, such as basing the exclusion on the dollar value of the perquisite? Are there alternative legal or regulatory provisions (other than section 132(a)(4) of the Internal Revenue Code) that we should consider for purposes of setting a *de minimis* tracking exclusion (*e.g.,* other subparts of section 132(a) of the Internal Revenue Code)? If so, please describe the alternative threshold and/or alternative legal or regulatory provision and explain why it would be preferable.

50. Should we eliminate the requirement that perquisites be valued on the basis of the aggregate incremental cost to the registrant, as proposed? Would providing registrants with greater flexibility in how perquisites are valued reduce burdens on registrants? Should we provide registrants with alternative guidance on how perquisites should be valued and, if so, how should such guidance be formulated? Would providing registrants with greater flexibility in how perquisites are valued eliminate material information that investors require to make informed investment and voting decisions?

51. Should we require the registrant to describe the methodology it used to value perquisites (*e.g.,* the aggregate incremental cost to the registrant or the value attributed to the perquisite for Federal income tax purposes)? Would requiring the registrant to describe the methodology used provide material information to investors? Would requiring such a description be burdensome for registrants? Would requiring registrants to describe the methodology it used to value perquisites make sense in the absence of a requirement to separately identify and quantify each perquisite that exceeds a certain value in a footnote or in supplemental disclosures?

[206] *See* 26 U.S.C. 132(a)(4). Given that whether a perquisite is a *de minimis* fringe benefit under the Internal Revenue Code is a matter of U.S. tax law that should be assessed by the registrant for U.S. tax purposes, the Commission would not anticipate providing further interpretative guidance on this topic.

[207] The *de minimis* tracking exclusion would provide registrants with the option to exclude *de minimis* fringe benefits under section 132(a)(4) of the Internal Revenue Code when calculating whether an NEO exceeds the minimum aggregate reporting threshold, but would not require registrants to do so. Accordingly, if a registrant is not subject to U.S. taxation or otherwise does not already apply the *de minimis* fringe benefit definition under the Internal Revenue Code, the registrant could either choose to apply the *de minimis* benefit definition just for purposes of proposed Item 402, or choose not to apply the *de minimis* tracking exclusion at all (*i.e.,* choose to include all perquisites regardless of size when calculating whether an NEO exceeds the minimum aggregate reporting threshold).

[208] *See* Instruction 4 to 17 CFR 229.402(c)(2)(ix). As proposed, registrants still would be permitted to value perquisites on the basis of the aggregate incremental cost to the registrant; however, this approach would not be mandatory.

[209] *See* 2006 Adopting Release at 53177.

[210] *See* letter from Meridian (stating that ''the current disclosure regime requires time-consuming, fact-specific assessment and incremental cost valuations'' and that ''[c]urrently, the SEC requires a company to compute and disclose the incremental value associated with personal use, which is a complicated calculation. Moreover, the amount included in the [Summary Compensation Table] generally does not align with the amount an executive recognizes as income under the tax code. In conjunction with additional guidance on perquisites and personal benefits, the SEC would likely need to coordinate with the Internal Revenue Service with respect to what is taxable compensation to ensure consistency and symmetry.'').

E. Certain Matters With Respect to Presentation

1. Information Necessary to an Understanding of the Tables—Proposed Item 402(a)(5)(i)

Under 17 CFR 229.402(e) (''Item 402(e)''), registrants are required to provide a narrative description of any material factors necessary to an understanding of the information disclosed in the Summary Compensation Table and the Grants of Plan-Based Awards Table.[211] Current Item 402(e) also includes a non-exhaustive list of four example topics that may be material for discussion, depending on the facts and circumstances.[212] The current rule further contains a number of other provisions that require registrants to provide supplemental narrative disclosures to the tabular disclosures. For example, registrants are required to include a narrative description of any material factors necessary to an understanding of each plan covered by the Pension Benefits Table and the Nonqualified Deferred Compensation Table.[213] These requirements were intended to make the disclosures more meaningful by requiring information that may not be expressly included in the tables, but that would otherwise be needed to provide a clear understanding of the compensation being provided.[214]

Under proposed Item 402(a)(5)(i), we would require registrants to disclose any material information necessary to an understanding of the information disclosed in the tables required by proposed Item 402(b) (the Earned Compensation Table), Item 402(c) (the Granted Compensation Table), and Item 402(d) (the Status of Equity Awards Table). As proposed, the registrant would be permitted to disclose such supplemental information in any format it determines to be appropriate, including in a supplemental table, in additional columns in an existing table, in footnotes to the tabular disclosures, or in supplemental narrative disclosures.[215] In contrast to current Item 402(e) but consistent with the principles-based approach discussed above, proposed Item 402(a)(5)(i) would not include a list of example topics that may be material for discussion, depending on the facts and circumstances. Under the proposed amendments, registrants would be required to consider the context around the quantitative disclosure in the tables to determine what supplemental information is necessary to an understanding of their tabular disclosures. The extent and nature of such supplemental information will vary depending on the registrant's particular facts and circumstances, but may include, among other things, material terms in employment agreements, material award terms not otherwise required by the tabular disclosures, or repricing or other material modifications of outstanding awards.

Request for Comment

52. Should we adopt the requirement to disclose any material information necessary to an understanding of the information disclosed in the proposed Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table, as proposed? Should we modify the proposed requirement? If so, how should we modify the requirement to continue to provide necessary information to investors?

53. Should we consider expanding application of the proposed requirement to other executive compensation disclosure, such as to all of the disclosure provided pursuant to Item 402? What would be the benefits and costs of this expansion?

2. Flexibility in the Manner of Tabular Presentation—Proposed Item 402(a)(5)(ii)

Under the current rule, registrants are permitted to omit a table or column for which there has been no compensation,[216] but there are no specific provisions that permit registrants to split a single column into multiple columns or a supplemental table.

We are proposing to give registrants more flexibility in the manner in which they present their tabular disclosures. Specifically, we are proposing to permit registrants to:

- Omit a table or column if no compensation is required to be reported in that table or column in any fiscal year covered by that table or column; [217] and
- Split a single column into multiple columns (or into a supplemental table) so long as the multiple columns (or supplemental table) are clearly labeled and in aggregate cover all items of compensation required to be reported in such single column.

The proposed amendments are intended to allow registrants more flexibility in presenting and explaining their executive compensation based on their particular facts and circumstances in a way that is more consistent with the compensation intentions of the registrant and its board of directors. We believe this additional flexibility would allow registrants to better tailor the tabular disclosures based on their particular compensation structure. The additional flexibility may also benefit investors by facilitating the provision of information in clearer and more digestible formats and in a manner more relevant to the specific compensation programs and decisions being described.

Request for Comment

54. Should we adopt the proposed flexibilities in the manner of tabular presentation? What would be the benefits and costs of the proposed flexibilities? Are there any additional flexibilities in the manner of tabular presentation that, if provided to registrants, would improve the quality and conciseness of executive compensation disclosures without compromising the ability of investors to read and understand them? If so, what additional flexibilities should be provided and why?

55. Would providing registrants with the proposed flexibilities reduce the value of executive compensation disclosures to investors (*e.g.,* by reducing comparability between registrants or other reasons)? If so, what changes to the proposed flexibilities should be implemented to alleviate or eliminate any such concerns?

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[211] *See* 17 CFR 229.402(e)(1).

[212] The current rule lists the following factors as examples: a description of the material terms of each NEO's employment agreement or arrangement; a description of any repricing or other material modification of outstanding equity awards; a description of the material terms of equity awards (*e.g.,* state whether dividends will be paid on stock and if so at what rate, describe any performance-based conditions); and an explanation of the amount of salary and bonus in proportion to total compensation. *See* 17 CFR 229.402(e)(1)(i) through (iv).

[213] *See* 17 CFR 229.402(h)(3); 17 CFR 229.402(i)(3). There are also similar requirements to provide a narrative description of any material factors necessary to an understanding of director compensation in current 17 CFR 229.402(k)(3), relating to golden parachute disclosure in current 17 CFR 229.402(t)(3), and in the scaled disclosure requirements for SRCs in current 17 CFR 229.402(o) and current 17 CFR 229.402(r)(3). The current rule also explicitly requires certain disclosures in footnotes to the tables. *See* 17 CFR 229.402(c); 17 CFR 229.402(d); 17 CFR 229.402(f); 17 CFR 229.402(g); 17 CFR 229.402(h); 17 CFR 229.402(i); 17 CFR 229.402(k).

[214] *See* 2006 Adopting Release at 6557.

[215] *See* proposed Instruction to Item 402(a)(5)(i).

[216] *See* 17 CFR 229.402(a)(5).

[217] As proposed, the wording with respect to the omission of a table or column tracks what is currently permitted under 17 CFR 229.402(a)(5).

3. Compensation in a Currency Other Than U.S. Dollars—Proposed Item 402(a)(5)(iii)

Under the current rule, all values reported in the Summary Compensation Table must be reported in U.S. dollars and, where compensation was paid to or received in a different currency, a footnote must be provided to identify the currency and describe the rate and methodology used to convert the amount to U.S. dollars.[218]

Under the proposed rule, if an amount required to be reported in U.S. dollars in a table was granted to, earned by, or paid to an NEO or director in a currency other than U.S. dollars, the registrant would be required to report such amount in U.S. dollars and to disclose, by adding a footnote to the table or otherwise, the rate and methodology used to convert the amount to U.S. dollars.

Accordingly, the proposed amendments would largely maintain the current approach as to how registrants should report the currency of compensation, but would generalize the requirement to all tables.

Request for Comment

56. Should we adopt the proposed amendments with respect to compensation in a currency other than U.S. dollars? If not, why not?

F. Compensation Discussion and Analysis—Proposed Item 402(e)

Under the current rule, certain registrants [219] are required to provide a CD&A that discusses the compensation awarded to, earned by, or paid to the NEOs and that explains all material elements of the registrant's compensation of the NEOs.[220] The purpose of the CD&A is to provide investors material information that is necessary to an understanding of the registrant's compensation policies and decisions, and the CD&A should discuss and analyze the information contained in the tables and otherwise disclosed pursuant to Item 402, as well as actions regarding executive compensation that were taken after the registrant's last fiscal year's end.[221] Accordingly, the CD&A provides an overview of both the separate elements of NEO compensation and also NEO compensation as a whole. Under the current rule, registrants subject to the CD&A requirement must address seven topics.[222] The current rule also includes a list of fifteen example topics that may be material for discussion in the CD&A, depending on the registrant's facts and circumstances.[223]

We are proposing to continue to require certain registrants to provide a CD&A, but are proposing to revise the requirement to be more principles-based.[224] As proposed, registrants subject to the CD&A requirement would be required to address fewer topics, and the rule would no longer include the current non-exhaustive list of example topics that may be material for discussion in the CD&A.[225] Specifically, the proposed amendments would consolidate and simplify the topics that the CD&A must cover into the following three required topics:

- The objectives of the registrant's compensation program in relation to its corporate strategy;
- The material elements of compensation and how those amounts are determined; and
- If applicable, whether the registrant has considered the results of the most recent say-on-pay vote in determining compensation policies and decisions and, if so, how that consideration has affected its compensation policies and decisions.

Accordingly, the following three topics required under the current rule would be eliminated as separate topics under the proposed rule: (i) What the compensation program is designed to award; (ii) Why the registrant chooses to pay each element; and (iii) How each element and the registrant's decisions regarding that element fit into the registrant's overall compensation objectives and affect decisions regarding other elements.[226] In addition, the following two topics required under the current rule would be consolidated into one new topic that would be more principles-based and limited to material elements of compensation: (i) Each element of compensation; and (ii) How the registrant determines the amount (and, where applicable, the formula) for each element to pay.[227] Moreover, the required topic regarding the objectives of the registrant's compensation programs under the current rule [228] would be amended to relate the objectives to the registrant's corporate strategy.

Many commenters expressed concerns with respect to the length of current CD&A disclosures and the requirements related to the CD&A.[229]

[218] *See* Instruction 2 to 17 CFR 229.402(c).

[219] Under the current rule, SRCs, EGCs, and foreign private issuers are not required to provide a CD&A. *See infra* section II.M; 17 CFR 229.402(*l*); 17 CFR 229.402(a)(1).

[220] *See* 17 CFR 229.402(b).

[221] *See* Instruction 1 to 17 CFR 229.402(b); Instruction 2 to 17 CFR 229.402(b).

[222] Under the current rule, the following seven topics are required to be discussed in the CD&A: (i) the objectives of the registrant's compensation program; (ii) what the compensation program is designed to reward; (iii) each element of compensation; (iv) why the registrant chooses to pay each element; (v) how the registrant determines the amount (and, where applicable, the formula) for each element; (vi) how each element and the registrant's decisions regarding that element fit into the registrant's overall compensation objectives and affect decisions regarding other elements; and (vii) whether and how the registrant has considered the results of the most recent shareholder advisory vote. *See* 17 CFR 229.402(b)(1)(i) through (vii).

[223] Under the current rule, the following fifteen topics are included as example topics that may be material for discussion in the CD&A, depending on the facts and circumstances: (i) policies for allocating between long-term and currently paid out compensation; (ii) policies for allocating between cash and non-cash compensation; (iii) the basis for allocating compensation to each different form of long-term award; (iv) how the determination is made as to when awards are granted; (v) what specific items of corporate performance are taken into account; (vi) how specific forms of compensation are structured to reflect these items of the registrant's performance, including whether discretion can be or has been exercised; (vii) how specific forms of compensation are structured and implemented to reflect the NEO's individual performance; (viii) policies and decisions regarding the adjustment or recovery of awards or payments if the relevant registrant performance measures upon which they are based are restated or otherwise adjusted; (ix) factors considered in decisions to increase or decrease compensation materially; (x) how compensation or amounts realizable from prior compensation are considered in setting other elements of compensation; (xi) with respect to any arrangement that provides for payment in connection with any termination or change-in-control, the basis for selecting particular events as triggering payment; (xii) the impact of the accounting and tax treatments of the particular form of compensation; (xiii) equity or other security ownership requirements or guidelines; (xiv) whether the registrant engaged in any compensation benchmarking; and (xv) the role of executive officers in determining executive compensation. *See* 17 CFR 229.402(b)(2).

[224] In the 2026 Filer Status Proposing Release, the Commission proposed to extend the accommodations provided to current SRCs or EGCs to all registrants that would be NAFs under that proposal. As the current rule does not require SRCs to provide a CD&A, the 2026 Filer Status Proposing Release would extend that accommodation to the proposed category of NAFs. *See infra* section II.M.

[225] As proposed, the rule text would also continue to clarify that the disclosure of any target levels that are non-GAAP financial measures would not be subject to 17 CFR 244.100–102 (''Regulation G'') or 17 CFR 229.10(e). The proposed wording with respect to any target levels that are non-GAAP financial measures largely tracks the existing wording in Instruction 5 to 17 CFR 229.402(b), but (as discussed below) would apply to proposed Item 402 generally. *See* proposed Instruction 2 to Item 402.

[226] *See* 17 CFR 229.402(b)(ii), (iv), and (vi).

[227] *See* 17 CFR 229.402(b)(iii) and (v).

[228] *See* 17 CFR 229.402(b)(i).

[229] *See* letters from Baillie Gifford (stating that ''CD&A averages 25–30 pages and often reads like marketing copy, burying the key drivers of pay''); Chamber of Commerce (stating that ''[r]ecent estimates place the average CD&A in a company's proxy statement at roughly 10,000 words, or 15 pages with a 10-point font''); Society for Corporate Governance (stating that 72% of its members indicated that they believe there are too many factors to consider in drafting the CD&A and 73% of members indicated that the rules on CD&A disclosure should be changed).

Commenters stated that CD&A discussions are often complex and repetitive, and sometimes include information that is not material or that obscures material disclosures.[230] We believe that the proposed simplified list of required topics should help address these concerns, as a more principles-based approach should allow registrants greater flexibility to craft concise disclosures focused on material information that is necessary to an understanding of the registrant's compensation policies and decisions and should reduce the inclusion of repetitive, boilerplate disclosures. Additionally, we believe that requiring disclosure about how the objectives of the compensation program relate to the registrant's corporate strategy would provide meaningful information for investors and may provide context for other relevant disclosures (such as pay-versus-performance disclosures).[231]

The proposed amendments would also eliminate the current list of fifteen example topics that, depending on the facts and circumstances, may be material for discussion in the CD&A. One commenter asserted that the list of ''illustrative examples'' set forth in 17 CFR 229.402(b)(2) is overly broad and redundant and covers elements that are not material.[232] We are proposing to eliminate the example topics listed in the current rule because their inclusion in the rule text may create a perception that those particular topics always must be addressed in the CD&A and, in some cases, may have resulted in repetitive, immaterial, or otherwise unnecessary disclosures.[233]

Overall, the proposed amendments are intended to reemphasize a principles-based approach to the CD&A, reduce burdens on registrants, and improve readability and usefulness for investors. Streamlining the list of required topics by focusing on the registrant's objectives and material elements of compensation should give registrants more flexibility and allow them to be more concise when drafting the CD&A. While any of the fifteen example topics included in the current rule may warrant discussion depending on the registrant's particular facts and circumstances, eliminating the list of such example topics from the rule text, as proposed, may reduce any perceived need for registrants to cover all such topics in all cases, regardless of materiality, and may thereby reduce the inclusion of repetitive, boilerplate disclosures.

The proposed amendments would also streamline the instructions to the CD&A section by moving certain current instruction text into proposed Item 402(e) itself,[234] eliminating certain current instructions as superfluous or no longer relevant in light of the proposed amendments,[235] and moving certain current instructions from the CD&A section to apply instead to all of proposed Item 402.[236]

In particular, proposed Instruction 2 to Item 402 would address the disclosure of target levels or company-selected financial performance measures provided pursuant to Item 402 that are non-GAAP financial measures. Proposed Instruction 2 would (similar to current Instruction 5 to 17 CFR 229.402(b)) state that disclosure of a target level or company-selected financial performance measure that is a non-GAAP financial measure will not be subject to Regulation G (17 CFR 244.100–102) or Item 10(e) (§ 229.10(e)).

The proposed instruction would also provide that any non-GAAP target level or company-selected financial performance measure that is based on historical financial results (including performance, financial position, or cash flows) must be accompanied by a quantitative reconciliation of the differences between the non-GAAP financial measure and the most directly comparable GAAP financial measure.[237] Disclosure of target levels that are non-GAAP financial measures based on projections (*i.e.,* not based on historic financial results), on the other hand, must include a narrative description of how the non-GAAP financial measure is calculated from the registrant's audited financial statements.[238] The proposed instruction would further require that the registrant provide disclosure as to why the registrant believes the non-GAAP financial measure is more appropriate than a GAAP financial measure for (1) determining executive compensation, in the case of targets, or (2) showing the relationship between executive compensation and registrant performance, in the case of a company-selected financial performance measures.[239] These requirements would be in addition to what is required under current Instruction 5 to 17 CFR 229.402(b).

We are proposing to add (1) the required quantitative reconciliation for any non-GAAP measure that is based on historical financial results (including performance, financial position, or cash flows), and (2) disclosure of the reasons that the registrant believes the non-

[230] *See* letters from Center on Executive Compensation (June 20, 2025) (''CEC–1''), available at *https://www.sec.gov/comments/4-855/4855-614967-1802734.pdf* (''[T]he volume and complexity of required disclosures can obscure what is material to a particular company when it comes to executive compensation.''); Chamber of Commerce (citing a 2015 Stanford Business School Survey concluding that only 38% of institutional investors found executive compensation disclosure clear and easy to understand).

[231] *See also* Ani Huang (Center on Executive Compensation), 2025 Roundtable Transcript at 62:6–10 (stating that ''the strategy and objectives [of the company] come first, then we choose metrics that we think are going to align with those objectives''); Lennartz, 2025 Roundtable Transcript at 84:9–13 (stating that ''it's incumbent upon companies to demonstrate how their compensation programs align with the business strategy''); Fortt, 2025 Roundtable Transcript at 184:11–17 (stating that most boards of directors ''think about executive compensation . . . really as a tool of corporate strategy'').

[232] *See* letter from Society for Corporate Governance (stating that while ''illustrative examples'' set forth in 17 CFR 229.402(b)(2) might be helpful, ''the list of elements in the current disclosure rules are overly broad and redundant, covering elements that are *not* material, a result that is in direct tension with the stated purpose of the CD&A'' and that ''[t]o address the overbreadth of Item 402(b), [it] request[s] that the Commission clarify that the elements listed therein should only be required to the extent that they are material to investors'').

[233] *See, e.g.,* letter from Society for Corporate Governance (referring to 17 CFR 229.402(b)(2)(xii) regarding the *potentially* material ''impact of the accounting and tax treatments of a particular form of compensation'' and stating that ''[w]hile not strictly required, issuers may feel compelled to include such disclosure as a precautionary matter, even though such information might not be material to investor decision-making'').

[234] Proposed Item 402(e) would include text that largely tracks the text contained in current Instruction 3 to 17 CFR 229.402(b).

[235] Current Instruction 1 to 17 CFR 229.402(b) would be eliminated as superfluous in light of proposed Item 402(a)(1), proposed Item 402(a)(5)(i), and proposed Item 402(e). Current Instruction 6 to 17 CFR 229.402(b) would be eliminated as no longer relevant given that proposed Item 402(e) would eliminate the list of example topics in current 17 CFR 229.402(b)(2), including the example topic cited in current Instruction 6 to 17 CFR 229.402(b).

[236] Proposed Instruction 1 to Item 402 would include text that largely tracks the text contained in current Instruction 4 to 17 CFR 229.402(b). Proposed Instruction 2 to Item 402 would include text that largely tracks the text contained in current Instruction 5 to 17 CFR 229.402(b).

[237] Such a quantitative reconciliation could be included in the relevant filing or incorporated by reference from another filing. *See* 17 CFR 230.411; 17 CFR 240.12b–23.

[238] Because company-selected financial performance measures disclosed under proposed Item 402(f) would always be presented for historical periods, we do not expect that this narrative requirement would apply to disclosure of any company-selected financial performance measures.

[239] Proposed Instruction 2 to Item 402 describes certain information a registrant would be required to include when it discloses a non-GAAP target level or company-selected financial performance measure, but the proposed instruction would not mandate the disclosure of a target level or company-selected financial performance measure. Under proposed Instruction 1 to Item 402, which largely tracks current Instruction 4 to 17 CFR 229.402(b), registrants would be permitted to omit disclosure of target levels that involve confidential trade secrets or confidential commercial or financial information, the disclosure of which would result in competitive harm for the registrant. In addition, disclosure of company-selected measures would be optional under proposed Item 402(f)(3).

GAAP target or company-selected financial performance measure is more appropriate than a GAAP measure to address concerns expressed by commenters that, without a quantitative reconciliation of the differences between the non-GAAP and GAAP financial measures, investors often struggle to understand how registrants assess performance in approving complex executive compensation packages.[240]

Request for Comment

57. Should we adopt the proposed revisions to the CD&A requirement? If not, why not and what modifications, if any, should we make to the proposal?

58. The proposed amendments would provide a more principles-based requirement that would permit registrants more flexibility to assess what disclosure is material and should be disclosed and would reduce the number of required topics in the CD&A, including by eliminating required disclosure of (i) what the compensation program is designed to award, (ii) why the registrant chooses to pay each element, and (iii) how each element and the registrant's decisions regarding that element fit into the registrant's overall compensation objectives and affect decisions regarding other elements. Should the CD&A requirement instead continue to require disclosure of these topics or should we take a more principles-based approach as proposed?

59. Should we adopt the proposed required topic for the CD&A to discuss the objectives of the registrant's compensation program in relation to the registrant's corporate strategy? If not, why not? Is this topic likely to elicit disclosure similar to content that is provided in current CD&As, or to require discussions beyond what is included in current disclosures? Should we modify the proposed requirement to discuss the objectives of the registrant's compensation program in relation to the registrant's corporate strategy? If so, how should the proposed requirement be modified and why?

60. Should we eliminate the current list of example topics that may be material for discussion in the CD&A as proposed? Is the list of topics helpful to registrants in preparing their disclosure (thereby supporting retaining the list) or does it create a presumption or perception that those particular topics must be addressed regardless of materiality (thereby supporting eliminating the list)? If we should retain the list, should we include any other example topics or remove any additional example topics from the list, and how should we address any concerns that the list encourages repetitive or otherwise unnecessary disclosure?

61. Should we adopt proposed Instruction 2 to Item 402 relating to the disclosure of any target levels or company-selected financial performance measures that are non-GAAP financial measures? If not, why not and what amendments, if any, should we make to the proposed instruction? If so, should the instruction apply to all of proposed Item 402, or just the CD&A section, pay-versus-performance section, or other specific sections? Should we add the proposed additional requirement that the registrant disclose why the registrant believes the non-GAAP financial measure is more appropriate for determining executive compensation, in the case of targets, or for showing the relationship between executive compensation and registrant performance, in the case of a company selected measure, than a GAAP financial measure? Should we add the proposed additional requirement that, if a historical non-GAAP financial measure is included, the registrant must provide a quantitative reconciliation of the differences between the historical non-GAAP financial measure and the most directly comparable GAAP financial measure?

G. Pay-Versus-Performance Disclosure Requirements—Proposed Item 402(f)

We are proposing to amend the pay-versus-performance disclosure requirements in Item 402(v) to simplify and streamline the presentation of executive pay in relation to registrant performance and to reduce compliance burdens while remaining faithful to the statutory mandate. Specifically, the proposed amendments would, among other things, revise the measure of executive compensation for purposes of the pay-versus-performance disclosure and conform the content to track more closely other proposed executive compensation disclosures.[241]

Section 953(a) of the Dodd-Frank Act requires the Commission to adopt a rule that directs issuers to disclose the relationship between ''executive compensation actually paid'' and ''the financial performance of the issuer, taking into account any change in the value of the shares of stock and dividends of the issuer and any distributions.'' [242] The current rule, adopted in 2022 requires registrants to disclose, for each of the previous five fiscal years,[243] the relationship between the value of a specialized measure of executive compensation, Compensation Actually Paid,[244] and the value of three financial performance measures: net income, the cumulative TSR of the registrant, and a measure selected by the registrant (''Company-Selected Measure'').[245] The current rule requires prescriptive tabular disclosure, detailed footnotes, and a description of the relationship between Compensation Actually Paid and each of the financial performance measures. This disclosure, including both the Compensation Actually Paid value and the Summary Compensation Table value for total compensation, must be provided for the PEO and the remaining non-PEO NEOs on average. The rule includes detailed and extensive instructions about the required calculation of Compensation Actually Paid. The current rule also requires registrants to calculate and disclose cumulative TSR for a peer group and describe the relationship between the peer group TSR and the registrant's TSR. Finally, a registrant must disclose an additional tabular list of the names of three to seven financial

[240] *See* letter from Council of Institutional Investors (''CII acknowledges that alternative measures of performance targets for executive compensation may be useful for incentivizing prudent executive decisions benefitting long-term investors. But the bottom line is that GAAP is still the standard, so any deviations from GAAP need to be clear and put in context through disclosure of a quantitative reconciliation of GAAP to non-GAAP for executive compensation performance targets in the CD&A. This is important given that investors, including institutional investors, often struggle to make sense of how companies assess performance in approving large and complex executive compensation packages.'') (footnotes omitted); *see also* Non-GAAP Petition (''Companies that use executive compensation targets based on non-GAAP financial measures currently are not required to adequately disclose how those measures relate to GAAP. This information should be presented in proper context, within the proxy statement CD&A. This is clearly not being done by many companies using non-GAAP or 'adjusted' earnings and other non-GAAP measures to help determine how executives are paid.'').

[241] In addition to the proposed changes discussed here, in the 2026 Filer Status Proposing Release the Commission proposed to eliminate SRC filer status and to exempt all NAFs from the pay-versus-performance disclosure requirements. See the discussion relating to that release and SRC and EGC accommodations in section II.M below. We are also proposing to remove the requirement to structure pay-versus-performance disclosures under 17 CFR 229.402(v) in Inline XBRL. *See infra* section II.C.5.

[242] *See* Public Law 111–203, 124 Stat. 1376 (2010), sec. 953(a).

[243] 17 CFR 229.402(v)(1). Currently, SRCs are only required to provide three years of pay-versus-performance disclosure under 17 CFR 229.402(v)(8).

[244] Compensation Actually Paid is a measure of pay derived from the Summary Compensation Table that is used only in the pay-versus-performance disclosure context.

[245] Under 17 CFR 229.402(v)(2)(vi) the Company-Selected Measure must consist of an additional financial performance measure which in the registrant's assessment represents the most important financial performance measure used by the registrant to link compensation actually paid to the registrant's NEOs to company performance.

performance measures used by it to link Compensation Actually Paid to the registrant's NEOs during the last fiscal year to company performance (''Tabular List''). The current rule exempts EGCs from pay-versus-performance disclosure and provides scaled disclosure accommodations to SRCs.

Our proposed amendments are intended to reduce the burden of calculating and presenting pay-versus-performance disclosure by, among other things, replacing the specialized Compensation Actually Paid measure of compensation with the Total Compensation Earned amount presented in the proposed Earned Compensation Table. We believe that using the Total Compensation Earned amount presented in the proposed Earned Compensation Table may more closely serve the Dodd-Frank Act mandate to present ''executive compensation actually paid.'' We also propose to amend the current rule to eliminate or make optional all performance measures, including the Tabular List, other than the registrant's cumulative TSR.[246] In addition, our proposal to limit the disclosure to information about the PEO and PFO should simplify compliance with the rule by eliminating the complex averaging calculations currently necessitated in producing the non-PEO NEO compensation disclosure. Finally we expect that limiting the period of disclosure to three years for all registrants, which mirrors the time period of executive compensation disclosure under Item 402 more generally, will streamline the resulting disclosure.

Our proposed changes to Item 402(v) would continue to satisfy the statutory mandate while reducing registrant burdens and simplifying disclosure. Specifically, our proposal to use the total compensation amounts from the Earned Compensation Table, amounts to which the executive is immediately entitled, addresses the statutory mandate that registrants disclose compensation *actually* paid, while eliminating the need for both specialized pay-versus-performance calculations and additional disclosure, as currently required. In addition, we believe that our proposal to retain disclosure of the cumulative TSR of the registrant directly addresses the specific requirement of section 953(a) of the Dodd-Frank Act to take into account ''any change in the value of the shares of stock and dividends of the issuer and any distributions.'' Focusing on cumulative TSR of the registrant and eliminating the requirement for the other performance measures that are not mandated by statute would also decrease the length and complexity of disclosure.

We believe that the proposed amendments would address concerns about registrant burden and disclosure complexity that have arisen during the first four years of required pay-versus-performance disclosure.[247] Many comments received in connection with the 2025 Roundtable cited the need for registrants to devote significant internal resources and engage outside advisors to prepare the required pay-versus-performance disclosure.[248] While a number of commenters indicated that the required disclosures are useful or provide additional insights to investors,[249] other commenters suggested that the current Item 402(v) disclosures are not used by or useful to investors.[250] Among other concerns, these commenters suggested that the disclosures are too boilerplate,[251] that differing approaches to the disclosure reduce comparability,[252] and that the five-year horizon does not reflect how boards think about compensation.[253]

1. Compensation Actually Paid

We are proposing to replace the current Item 402(v)-specific Compensation Actually Paid amount with the amount shown in the Total Compensation Earned column of the proposed Earned Compensation Table (column (h)).[254] Today, Compensation Actually Paid is required to be calculated by taking the total compensation amount shown in the registrant's Summary Compensation Table and adding or subtracting various amounts determined through a series of complex calculations. As noted above,

[246] Section 953(a) of the Dodd-Frank Act requires that the performance information disclosed takes into account any change in the value of the shares of stock and dividends of the issuer and any distributions. *See* Public Law 111–203, 124 Stat. 1376 (2010), sec. 953(a). Indeed, the Commission noted in the 2022 Pay-versus-Performance Adopting Release its belief that ''the disclosure of the relationship between executive compensation actually paid and TSR will satisfy the language of Section 14(i) that registrants disclose the 'relationship' between executive compensation and registrant performance.'' 2022 Pay-versus-Performance Adopting Release at 55140.

[247] *See, e.g.,* David Lynn (Goodwin Procter), 2025 Roundtable Transcript at 96:15–20 (stating that ''everyone seems to agree that [CAP] is a very complex calculation that makes it hard not only to produce the disclosure, but actually interpret the disclosure and compare the disclosure across companies.''); Mark Borges (Compensia), 2025 Roundtable Transcript at 139:16–25 (suggesting that the pay-versus-performance rule be reevaluated, stating that ''the relationship between investor information and the compliance burden is out of balance.''); *see also* letter from Society for Corporate Governance (providing data from an internal member survey indicating that ''[o]ne quarter of survey respondents (26%) reported that they spend between twenty-five to seventy-five thousand dollars annually for outside advisors to prepare pay-versus-performance disclosures, and nearly 10% of respondents (9.5%) reported that they spend more than seventy-five thousand dollars annually on outside advisors to prepare pay-versus-performance disclosures.'').

[248] *See, e.g.,* letters from ABA; Axcelis (indicating that the calculation of Compensation Actually Paid requires a minimum of 75 calculations per year); Business Roundtable; CEC–2; Chamber of Commerce (noting that outside help was necessitated due to mark to market calculations needed to determine compensation actually paid); Compensia, Inc. (Oct. 4, 2025) (''Compensia''), available at *https://www.sec.gov/comments/4-855/4855-671748-2031714.pdf;* Cravath, Swaine & Moore LLP (June 20, 2025) (''Cravath''), available at *https://www.sec.gov/comments/4-855/4855-614887-1802674.pdf;* Davis Polk; Johnson & Johnson (citing complex simulations needed to create a value for outstanding performance share units that is not used for any other purpose); Jones Day (Aug. 18, 2025) (''Jones Day''), available at *https://www.sec.gov/comments/4-855/4855-640247-1914354.pdf;* McGuireWoods & Brownstein; Meridian; NAM–1; NAM–2; National Healthcare Properties (May 16, 2025) (''NHP''), available at *https://www.sec.gov/comments/4-855/4855-602935-1757042.html* (indicating that smaller companies have been particularly affected by the burden of compliance); NYSE; Rethink Legal Services (June 25, 2025) (''Rethink''), available at *https://www.sec.gov/comments/4-855/4855-616767-1809614.pdf;* Travelers.

[249] *See, e.g.,* letters from AFL–CIO et al.; AFREF (indicating that standardization of disclosure creates comparability which impacts voting decisions, citing several supporting studies); Dan and Jan Blair (July 12, 2025) (''Blair''), available at *https://www.sec.gov/comments/4-855/4855-1841194.htm;* Council of Institutional Investors; Nathan Harling (July 11, 2025) (''Harling''), available at *https://www.sec.gov/comments/4-855/4855-1830779.htm;* Public Citizen (June 25, 2025) (''Public Citizen''), available at *https://www.sec.gov/comments/4-855/4855-619687-1818714.pdf;* James F. Reda (Aug. 5, 2025) (''Reda''), available at *https://www.sec.gov/comments/4-855/4855-635967-1890954.pdf;* Shareholder Value Advisors (May 30, 2025) (''Shareholder Value Advisors''), available at *https://www.sec.gov/comments/4-855/4855-608307-1776514.pdf* (providing various calculations showing how the pay-versus-performance data can be used to provide insights); Brad Snyder (Aug. 5, 2025) (''Snyder''), available at *https://www.sec.gov/comments/4-855/4855-1890614.htm.*

[250] *See, e.g.,* letters from The American Securities Association (June 26, 2025) (''ASA''), available at *https://www.sec.gov/comments/4-855/4855-617227-1810874.pdf* (suggesting that executive compensation disclosure in general, specifically including pay-versus-performance, is ''completely immaterial for investors,'' and questioning whether pay-versus-performance is ''still relevant and necessary given that companies already disclose information about the relationship between pay and performance.''); Business Roundtable; CEC–1; EOS; Sullivan & Cromwell; Travelers.

[251] *See* letter from EOS (suggesting that current pay-versus-performance disclosure is ''too boilerplate in nature to reveal genuine insight or generate productive dialogue with management and at board level''); *see also* letter from Sullivan & Cromwell (asserting that the mandated metrics (TSR, Net Income) as well as the strictures around selecting and presenting the Company-Selected Measure in many cases create disclosure that is not material to the company or investors).

[252] *See, e.g.,* letters from CEC–1; Travelers.

[253] *See* letter from Business Roundtable.

[254] *See* section II.C.1 above for a detailed explanation of the proposed Earned Compensation Table and earned compensation.

we are proposing to eliminate the Summary Compensation Table, which presently contains the starting values for conducting Compensation Actually Paid calculations, necessitating a reconsideration of the appropriate means to derive ''executive compensation actually paid.''

The proposed Earned Compensation Table and related disclosure seek to reflect pay outcomes when receipt of the pay is no longer subject to conditions, which we believe would appropriately reflect executive compensation actually paid as contemplated by section 953(a) of the Dodd-Frank Act. Under the current pay-versus-performance rule, Compensation Actually Paid relies to a greater extent on theoretical future pay outcomes in that amounts attributable to *unvested* equity are included in the executive's Compensation Actually Paid at a value determined using estimates and assumptions about future events.[255] We believe that the information in the proposed Earned Compensation Table would provide investors with a clearer understanding of the compensation that an executive officer has earned, without further restrictions on receipt (*i.e.,* what has been actually paid). We further believe that using the Total Compensation Earned amount reflected in the proposed Earned Compensation Table would reduce registrant burdens by using an amount that registrants would already be calculating and eliminating complex Compensation Actually Paid calculations required under the current rule. In addition, using the Earned Compensation Table values might avoid the potential confusion that could result from continuing to use the current Compensation Actually Paid measure, a highly specialized measure derived from calculations that start with the Summary Compensation Table, which would no longer appear in or be prepared for purposes of a registrant's executive compensation disclosure under the proposed rules.

Section 953(a) of the Dodd-Frank Act uses the term ''executive compensation actually paid'' in discussing the requirement to disclose information that shows the relationship between executive compensation and financial performance, but the statute does not define that term. One challenge the Commission faced when developing the current rule was that there was not then a single definition or table in the existing Item 402 disclosure requirements that could represent compensation actually paid.[256] When adopting the rule, the Commission acknowledged this challenge, indicating its view that ''actually paid'' differs from disclosure required under current Item 402 of ''compensation awarded to, earned by or paid to'' the NEOs, reasoning that Item 402 does not use the term compensation ''actually paid.'' [257] In further support of this conclusion, the Commission noted that ''Congress was aware of the language of Item 402 *at the time of the Dodd-Frank Act,* and adopted text that did not mirror the language of that provision'' [258] (emphasis added). We believe the disclosure in the proposed Earned Compensation Table, which differs from the disclosure that is currently required, appropriately captures ''executive compensation actually paid'' as that term is used in section 953(a) of the Dodd-Frank Act.

Under the current rule, for each fiscal year covered by the disclosure, registrants must determine the Compensation Actually Paid to the PEO and the average Compensation Actually Paid to the non-PEO NEOs, using a series of complex, time consuming, and prescriptive calculations.[259] These calculations, for each fiscal year, involve deducting from the total compensation amount in the Summary Compensation Table for the NEO both (1) the aggregate change in the actuarial present value of the NEO's accumulated benefit under all defined benefit and actuarial pension plans; and (2) the total value of stock and option awards and then conducting, as applicable, the following additional calculations for stock and option awards:

- Adding the fair value (as of the end of the applicable fiscal year) of all awards granted in that year that are outstanding and unvested at the end of that year;
- Adding the change in fair value (from the end of the prior fiscal year to the end of the covered fiscal year) of each award granted in any prior fiscal year that was outstanding and unvested as of the end of the covered fiscal year;
- Adding the fair value (as of the vesting date) of any awards that are both granted and vest in the applicable fiscal year;
- Adding the change in fair value (from the end of the prior fiscal year to either the end of the covered fiscal year or the vesting date, as applicable) of awards granted in any prior fiscal year that vest at the end of or during the covered fiscal year;
- Subtracting the fair value (as of the end of the prior fiscal year) of awards granted in any prior fiscal year that failed to meet vesting conditions during the covered fiscal year;
- Adding the dollar value of dividends or other earnings paid on awards in the covered fiscal year prior to the vesting date that are not otherwise included in the total compensation disclosed in the Summary Compensation Table; and
- Adding the aggregate of service cost and prior service cost for all defined benefit and actuarial pension plans, as defined in the rule.[260]

In addition to these prescriptive calculation requirements, in the current Item 402(v) tabular disclosure, registrants must (1) present both the Summary Compensation Table total compensation value and Compensation Actually Paid for the PEO and (2) separately calculate and present the average value for the non-PEO NEOs collectively of both the Summary Compensation Table total compensation and Compensation Actually Paid.

The complex calculations necessary to determine Compensation Actually Paid are often described as a significant burden on registrants.[261] In addition, some commenters suggested that the current requirement to disclose these detailed calculations is an important contributor to the complexity of the proxy statement, is not relevant to

[255] 17 CFR 229.402(v)(2)(iii)(C) requires that registrants determine the value or change in value of unvested equity based upon various factors, including when the equity was originally granted and whether it vests within the relevant fiscal year. These valuations are required to be made using the same accounting methodologies, assumptions and judgments used in determining the original grant date fair value.

[256] Some of the approaches proposed included: using vesting date valuation of stock awards, but exercise date valuation of options; requiring the vesting date valuation of performance awards but the grant date value of option awards; valuing awards at the end of a multi-year period, such as a three-year period; valuing equity at grant date but reversing the value at the vesting date for awards that fail to vest; revaluing outstanding equity awards annually; and revaluing all equity granted during a period at the end of the most recent completed fiscal year. *See* 2022 Pay-versus-Performance Adopting Release at 55147.

[257] 2022 Pay-versus-Performance Adopting Release at 55143.

[258] *Id.*

[259] 17 CFR 229.402(v)(2)(vi).

[260] *See* 17 CFR 229.402(v)(2)(iii).

[261] *See, e.g., infra* notes 263 and 264; Lennartz, 2025 Roundtable Transcript at 34:17–24 (indicating that ''[i]t requires a Herculean effort to produce all of the numbers that go into the tables'' and that the pay versus performance table ''requires the revaluation of all outstanding equity awards, and equity awards can be quite complicated.''); *see also* Brandon Gantus et al., ''*Pay Versus Performance*'' *Rule Increase Disclosure Obligations for Public Firms,* Harv. L. Sch. F. on Corp. Governance (Sept. 28, 2022), available at *https://corpgov.law.harvard.edu/2022/09/18/pay-versus-performance-rule-increase-disclosure-obligations-for-public-firms/* (noting that ''the final rules are expected to create significant burdens on the company to run these calculations'').

investors, and does not provide corresponding insights.[262] Many comments received in connection with the 2025 Roundtable strongly objected to the current method for calculating Compensation Actually Paid, stating that it is unnecessarily complex, misleading, immaterial, and burdensome.[263] Some commenters pointed to the significant resources, including outside advisors and experts, needed to prepare these valuations.[264] Other commenters expressed concern that Compensation Actually Paid is not a good representation of executive compensation, indicating that: Compensation Actually Paid combines compensation elements that *have* been paid with hypothetical estimates that *have not* been paid; [265] the required calculations to determine Compensation Actually Paid can result in negative compensation values; [266] and the required ''non-standard'' equity valuations and pension changes create volatility unrelated to performance.[267] A number of commenters further suggested that Compensation Actually Paid may not be used by or useful to investors,[268] that proxy advisory firms have their own proprietary methodologies for calculating NEOs' pay-versus-performance,[269] and that the five-year horizon does not reflect how boards think about compensation.[270]

Other letters were supportive of the current rule,[271] with many of these indicating that the resulting disclosure is promising [272] and useful.[273] Some supportive commenters and other sources suggest a correlation between pay-versus-performance disclosure and shareholders' decisions in their say-on-pay votes.[274] Several commenters advocated alternative, often simpler, calculations of executive compensation ''actually paid'' that reflect variations of ''realized'' or ''realizable'' pay.[275]

The current definition of Compensation Actually Paid begins with the total compensation amount calculated for purposes of the Summary Compensation Table. Since we are proposing to replace Compensation

[262] *See. e.g.,* letters from Allen Overy Shearman Sterling US LLP (Aug. 6, 2025) (''A&O Shearman''), available at *https://www.sec.gov/comments/4-855/4855-636607-1893054.pdf* (asserting that disclosure of the reconciliation from the Summary Compensation Table to Compensation Actually Paid amounts is ''not relevant to investors and only serves to obscure the purpose of the rule''); Infinite Equity (Apr. 25, 2025) (''Infinite Equity–1''), available at *https://www.sec.gov/comments/4-855/4855-602995-1757162.pdf* (pointing out that even complex financial statement reporting does not mandate the level of reconciliation disclosure required by 17 CFR 229.402(v) and that the required reconciliation ''adds complexity without delivering meaningful additional insight''); Pearl Meyer (June 27, 2025) (''Pearl Meyer''), available at *https://www.sec.gov/comments/4-855/4855-617647-1811734.pdf* (indicating that the ''reconciliation of CAP to SCT adds unnecessary complexity without providing material insight, and should be eliminated'').

[263] *See, e.g.,* letters from ABA; A&O Shearman; CEC–1; CEC–2; Equity Methods–1; Pearl Meyer; Reda; Travelers (further noting that, for each fiscal year, registrants must make at least six adjustments to the Summary Compensation Table grant date fair value of equity awards for each NEO); *see also* letter from *Axcelis.*

[264] *See, e.g.,* letters from ABA; Axcelis; Business Roundtable; CEC–2; Chamber of Commerce (noting that outside help was necessitated due to mark-to-market calculations needed to determine compensation actually paid); Compensia; Cravath; Davis Polk; Johnson & Johnson (citing complex simulations needed to create a value for outstanding performance share units that is not used for any other purpose); Jones Day; McGuireWoods & Brownstein; Meridian; NAM–1; NAM–2; NHP (pointing out that smaller companies have been particularly affected by the burden of compliance); NYSE; Rethink; Travelers.

[265] *See, e.g.,* CEC–1 (analogizing the use of year over year changes in unvested equity value under the pay-versus-performance disclosure rule to determine the value of executive pay to ''determining the winner of a baseball game based on the score in the seventh inning since the outcome of the pay-for performance linkage cannot be known until the end of the performance period and unvested incentives are earned''); *see also* letters from Compensation Advisory Partners, LLC (Aug. 25, 2025) (''Compensation Advisory Partners''), available at *https://www.sec.gov/comments/4-855/4855-642147-1923414.pdf;* Cravath; Davis Polk.

[266] *See, e.g.,* letter from NAM–2. Because 17 CFR 229.402(v) requires that executive compensation actually paid reflect year over year changes in the value of an executive's unvested equity awards, the Compensation Actually Paid number will be negative in any fiscal year where a decrease in the value of such awards exceeds the value of the other compensation amounts included in that year's Compensation Actually Paid calculation.

[267] *See, e.g.,* letter from CEC–1.

[268] *See, e.g.,* letters from ASA; Axcelis; Business Roundtable; CEC–1; Davis Polk; Johnson & Johnson; NAM–2; NHP; NYSE; Total Rewards Strategies (June 25, 2025) (''Total Rewards''), available at *https://www.sec.gov/comments/4-855/4855-617047-1810034.pdf.*

[269] *See, e.g.,* letters from Cravath (noting that since proxy advisors have their own pay-versus-performance calculations ''this new disclosure may not be providing a benefit to investors commensurate with the burden to investors.''); Total Rewards (suggesting that pay-versus-performance disclosure ''does not properly convey the compensation earned relative to company performance'' as evidenced by the fact that proxy advisors and large institutional investors use their own methodologies.). *But see* letter from Farient–1 (indicating that proxy advisors typically use information gathered from the Summary Compensation Table in assessing pay and performance alignment, which is problematic since ''the grant date value of equity is shown in the Summary Compensation Table, proxy advisors analyze the value of equity grants before performance occurs rather than after performance has occurred'').

[270] *See* letter from Business Roundtable.

[271] *See, e.g.,* letters from AFL–CIO et al.; AFREF (indicating that standardization of disclosure creates comparability which impacts voting decisions, citing several supporting studies); Baillie Gifford; Blair; Council of Institutional Investors; Erste; Harling; Infinite Equity–1; Infinite Equity–2; Public Citizen; Reda; Shareholder Value Advisors (showing how the pay-versus-performance data can be used to provide insights into ''three basic objectives of executive pay: providing strong incentives to increase shareholder value, retaining key talent and limiting shareholder cost''); Snyder.

[272] *See* letter from Baillie Gifford (suggesting that the first year of pay-versus-performance disclosure was useful at ''signal[ing] long-term alignment,'' but also indicating that the disclosures are not comparable across registrants due to wide variations in calculating compensation actually paid, lack context for high growth companies, and should include both a measure of realized pay and a discussion of deviations between realized and granted pay).

[273] *See, e.g.,* letters from Better Markets (June 26, 2025) (''Better Markets''), available at *https://www.sec.gov/comments/4-855/4855-617307-1810974.pdf;* Council of Institutional Investors; Equity Methods, LLC (May 27, 2026) (''Equity Methods-2''), available at *https://www.sec.gov/comments/4-855/4855-792399-2398406.pdf* (indicating that, ''[b]y remeasuring the fair value of outstanding equity awards at fiscal year-end and at vesting dates, CAP tracks the real-time evolution of executive wealth in relation to shareholder outcomes. This is the new information that CAP provides that is otherwise not available to shareholders, and is deeply material to their understanding of executive pay and the pay-for-performance relationship.''); Farient–1; Farient Advisors LLC (Apr. 16, 2026) (''Farient–2''), available at *https://www.sec.gov/comments/4-855/4855-749787-2316534.pdf* (noting that ''the Compensation Actually Paid (CAP) figures in the PvP disclosure are uniquely relevant to assessing alignment between management and shareholders and now require only a relatively incremental cost to continue calculating and disclosing''); Shareholder Value Advisors (strongly recommending that the disclosure be retained because it is highly informative for investors, allowing them to estimate four key pay dimensions (incentive strength, alignment, performance adjusted cost, and relative pay risk)).

[274] *See, e.g.,* letters from AFREF; Baillie Gifford; *see also* Aiyesha Dey, *Pay Versus Performance and Investor Voting Decisions,* Harv. L. Sch. F. on Corp. Governance (Dec. 26, 2024), available at *https://corpgov.law.harvard.edu/2024/12/26/pay-versus-performance-and-investor-voting-decisions/* (summarizing results from a study of over 2,500 registrants, concluding that pay-versus-performance disclosure improves the ''decision-usefulness'' of pay disclosure by simplifying compensation analysis, but also stating that ''we do not evaluate whether CAP is a superior measure of pay-performance alignment'').

[275] *See, e.g.,* letters from Baillie Gifford; Compensation Advisory Partners (proposing a revision to compensation actually paid that reflects ''amounts disclosed in the Shares Vested and Options Exercised Table, which better represents realized compensation.''); CEC–1; Infinite Equity–1; Infinite Equity–2; Meridian (advocating a focus on ''realizable pay'' to show the alignment between compensation outcomes and company performance); NAM–1 (suggesting that ''the SEC should explore whether the Section 953(a) mandate could be satisfied by adding a new 'realized' or 'take-home' pay column to the Summary Compensation Table''); Semler Brossy (provides example of ''Compensation Actually Earned'' which includes earned salary and cash incentives and the value of vested equity); Sullivan & Cromwell; Total Rewards. While there does not appear to be a universal definition of either ''realized'' or ''realizable'' pay, our proposed approach to determining executive compensation actually paid, as discussed below, most closely resembles what is commonly referred to as ''realized'' pay because it only includes amounts to which the executive is immediately entitled.

Actually Paid with the amount reflected in the Total Compensation Earned column of the proposed Earned Compensation Table, it is important to note where the individual elements of the Earned Compensation Table may differ from those in the Summary Compensation Table. In general, the same non-equity-related compensation items that are required to be included in the Summary Compensation Table would also be required disclosure in the proposed Earned Compensation Table, as more fully discussed above.[276] We note, however, that the proposed Miscellaneous Compensation Received column of the proposed Earned Compensation Table, which requires disclosure of certain types of additional compensation and any other compensation that the registrant determines is material or chooses to disclose, may result in disclosure of fewer non-material compensation amounts than are currently required to be included in the Summary Compensation Table ''all other compensation'' column.[277]

Using the Total Compensation Earned amount in the Earned Compensation Table would eliminate the need to calculate interim valuations for equity awards and instead include stock award values when vested and option award values when exercised. The current Compensation Actually Paid calculation combines changes in unvested equity values, *i.e.,* amounts that may never be paid, and the value of equity upon vesting. The current requirement to revalue unvested equity awards for each year covered by the disclosure provides information about potential pay to which the executive is not yet entitled, rather than amounts to which the executive is immediately entitled.[278] The Total Compensation Earned amount in the proposed Earned Compensation Table, in contrast, would show equity compensation values only when they have been realized (*i.e.,* for stock awards once they have vested and for option awards once they have been exercised). We believe that this simpler presentation represents an accurate picture of executive pay outcomes, and, as such, addresses the requirement stated in section 953(a) of the Dodd-Frank Act that the disclosure reflect compensation *actually paid.* In addition, Compensation Actually Paid calculations under the current rule can yield negative amounts notwithstanding that the executive does not actually owe money to the employer. For these reasons, in comparison to the current approach, we believe the amount reported in the Total Compensation Earned column of the proposed Earned Compensation Table would better reflect compensation actually paid to and received by NEOs.[279]

In addition, we believe that the Total Compensation Earned amount as determined for purposes of the proposed Earned Compensation Table, when presented in relation to registrant performance, would facilitate an evaluation of executive compensation generally and may provide further insights into the effectiveness of compensation committees and compensation packages.[280] Specifically, presenting realized compensation values relative to registrant performance may help to reveal whether *ultimate* pay outcomes align with company results.

We are aware that using vesting or exercise date values in the calculation of compensation actually paid may in some instances result in timing misalignment between actual performance and related executive compensation actually paid. Some commenters have expressed the view that, for example, when performance metrics span several years from the grant date to the vesting date, presenting equity values only in the relevant vesting or exercise year would result in spikes in compensation numbers during those years and no potential values during the remainder of the performance period.[281] Indeed, the Commission was persuaded in part by these views when adopting the current Compensation Actually Paid equity valuation method, stating that ''the adopted approach will more effectively allow registrants to describe the relationship between compensation and registrant performance, as the reported amounts of compensation will annually adjust based on the registrant's performance, among other things, in that year.'' [282] However, we note that section 953(a) of the Dodd-Frank Act contemplates disclosure showing ''the relationship between executive compensation actually paid and the financial performance of the issuer,'' but does not require that the disclosure demonstrate whether there is year over year alignment between the value of unvested pay and executive performance. Further, we believe that questions raised by our proposed approach related to vesting spikes or other perceived mismatches between the timing of pay and performance could be mitigated by the proposed Status of Equity Awards Table, which would provide useful information about stock awards that are not yet vested and option awards that are not yet exercised,

[276] *See supra* section II.C.1.

[277] For a full discussion of our proposed treatment of each item currently required to be disclosed in the ''all other compensation'' column of the Summary Compensation Table, see section II.C.1.e above.

[278] The current rule aims to provide a complete picture of the executive's compensation package and ''at risk'' pay, showing the year-over-year changes in unvested equity awards. Under this approach, annual revaluations help to show the amount that an executive could receive upon vesting; however, the actual outcome at vesting could be very different if at the end of the performance period vesting conditions are not met.

[279] The proposed Earned Compensation Table treats stock awards as ''earned'' when vested, whereas option awards are treated as ''earned'' when the executive exercises them. This formulation most closely supports our current view that compensation is ''actually paid'' not merely when it represents *potential* value, but when the actual value is realized by the executive. With respect to stock awards, the value upon vesting can be seen as representing actual pay, whereas an option's compensation value may not be realized until after vesting, especially because the option may not be in-the-money upon vesting and potential future value may be part of the consideration in the compensation-setting process. As explained in section II.C.1 above, we believe that showing the value of option awards only once they have been exercised may more fully reflect the economic value of the option awards.

[280] Our proposed use of the Total Compensation Earned amount from the proposed Earned Compensation Table, which is based upon vesting or exercise date valuations, is different from the grant date fair value methodology used in the Summary Compensation Table. As noted, under our proposed approach, the Total Compensation Earned amount would reflect an amount as compensation only when realized (*i.e.* for stock awards once they have vested and for option awards once they have been exercised). Grant date fair value depends on future performance and is based upon assumptions and estimates, not actual pay. In contrast, the specific methods and dates used to determine final compensation outcomes for vested stock awards and exercised option awards in the Earned Compensation Table applies equally to the pay-versus-performance disclosure. These valuations are intended to reflect the value actually received by the executive.

[281] *See, e.g.,* 2022 Pay-versus-Performance Adopting Release at 55147 (discussing proposed approaches to valuing equity awards for the Compensation Actually Paid calculation). We recognize that using the Total Compensation Earned amount from the Earned Compensation Table to represent executive compensation actually paid could result in a certain degree of directional mismatch between pay and performance from year to year due to volatility associated with equity award vesting patterns that can create spikes in pay during vesting years.

[282] 2022 Pay-versus-Performance Adopting Release at 55150. The Commission noted that awards vesting over multiple years contingent on registrant performance could give investors the ''misleading impression'' that an executive was compensated for performance in the vesting year only, even if performance in that year did not appear to support the compensation. For example, for a performance award spanning three years, where registrant performance was positive in years one and two, when no compensation would be shown, and negative in year three when vesting occurred, using a vesting date valuation of compensation ''actually paid'' could give the impression that executives are being compensated for years of poor performance and not compensated in years of positive performance.

as well as any additional contextual disclosure a registrant might choose to provide.

We also recognize that *any* practicable approach could result in misalignment based upon the specific facts and circumstances. For example, under the current method for estimating compensation actually paid, the payouts on non-equity incentive awards are recorded only in the year they are paid out, even if they reflect performance over multiple years. In contrast, the payouts on equity incentives are effectively marked-to-market over time as performance is realized. The compensation actually paid values may thereby imply that a registrant relying more heavily on non-equity incentive awards has pay that is less sensitive to performance than a registrant that relies more heavily on equity incentives, even if this is not the case. Given that both the current and proposed approaches result in a degree of misalignment, we believe that the reduced burden on registrants by avoiding the complexity involved in calculating the current version of Compensation Actually Paid would justify a change in approach.

The proposed amendments are intended to simplify and reduce the burden [283] of producing pay-versus-performance disclosure. By using the information in the Earned Compensation Table, the proposed approach would eliminate the need for a separate set of calculations and provide a clearer integration of the pay-versus-performance disclosure with the remaining executive compensation disclosure under proposed Item 402.[284] We believe that using the Total Compensation Earned amount set forth in the proposed Earned Compensation Table would continue to meet the Dodd-Frank Act mandate to show the relationship between compensation actually paid and the registrant's financial performance, while providing a clearer picture of the PEO's realized pay.

[283] We note that, because we are proposing to eliminate the Summary Compensation Table, requiring registrants to continue to produce pay-versus-performance disclosure based on information that registrants would no longer be required to prepare or disclose would be unduly burdensome and impractical.

[284] The current rule requires one set of equity valuations for the Summary Compensation Table, based on grant date fair valuations, and an entirely separate set of valuations for Compensation Actually Paid. Using the Total Compensation Earned amount from the proposed Earned Compensation Table would reduce both the burden of creating an entirely separate set of valuations and the complexity of proxy disclosure.

2. Performance Measures

We are also proposing to simplify the pay-versus-performance presentation by removing required disclosure of several performance measures that can be burdensome to provide, are not mandated by the Dodd-Frank Act, significantly increase the length of the disclosure, and, in some cases, may have little relationship to executive pay. Our proposed amendments would retain a single financial performance measure, registrant cumulative TSR, which we believe would provide shareholders with an easily understandable financial performance measure that ultimately represents the core of shareholder value. Currently, registrants are required to quantify in a table and separately describe the relationship between executive compensation and three financial performance measures: GAAP net income, the cumulative TSR of the registrant, and the Company-Selected Measure. Registrants must also select a peer group and disclose the relationship between the registrant's TSR and the peer group's TSR. Finally, registrants must disclose a Tabular List of three to seven financial performance measures that, in the registrant's assessment, represent the most important financial performance measures used by the registrant to link compensation actually paid to its NEOs to company performance.[285]

Our proposed amendments are intended to shorten and simplify such requirements. Specifically, we propose to retain the registrant's cumulative TSR as the sole required performance measure, with the goal of emphasizing a metric that reflects the registrant's financial performance and frequently impacts executive compensation and investor value. To this end, we propose to remove tabular and relationship disclosure of GAAP net income and peer group total shareholder return, metrics that not only are already available [286] but also may have a less clear connection to executive pay at many registrants, and to make disclosure of a Company-Selected Measure optional. In addition, we propose to eliminate required disclosure of the Tabular List.

The calculation and presentation of the registrant's cumulative TSR information in our proposed amendments would be the same as the current requirement.[287] Section 953(a) of the Dodd-Frank Act specifically requires that pay-versus-performance disclosure take into account changes in the value of the shares of stock and dividends of the issuer and any distributions, which TSR does.[288] In addition, we agree with commenter feedback in the 2022 Pay-versus-Performance Adopting Release that the benefits of using registrant cumulative TSR as a performance measure include that it is well-understood by investors; is widely used by companies in setting compensation; is generally a fair representation of company performance; assists companies in articulating and providing justification for their compensation practices; promotes comparability; and reflects stock price fluctuations that regularly occur in response to publicly known information and company leadership.[289] As a result, we believe that retaining registrant cumulative TSR as the required financial performance measure both satisfies the statutory requirement and provides investors with the most useful information for evaluating pay-versus-performance while reducing the burdens of preparing the comparative disclosure.

When requiring the disclosure of additional financial performance measures in 2022, the Commission did not indicate a belief that additional measures were necessary to satisfy the Congressional mandate of section 953(a) of the Dodd-Frank Act. The Commission did indicate in the Reopening Release, however, that additional measures ''may

[285] *See* 17 CFR 229.402(v)(6). A registrant may include non-financial performance measures under certain circumstances, but not in lieu of the required financial performance measures. *See* 17 CFR 229.402(v)(6)(iii).

[286] Net income information is available in the registrant's audited financial statements, and peer group total shareholder return can be found in various stock data platforms or financial data aggregators.

[287] We are proposing to simplify the description of the cumulative TSR calculation, consistent with our goal of creating disclosures and disclosure requirements that are clearer, more concise and easier for investors to read and understand. As proposed, the disclosure requirement would remain the same, but would be revised to more clearly provide that a registrant must present the dollar value as of the end of each fiscal year covered by the disclosure, assuming dividend reinvestment, of a single $100 investment made at market close on the last trading day of the fiscal year immediately prior to the period covered by the disclosure. The disclosure provided in response to current 17 CFR 229.402(v) represents the full value of the initial $100 investment, assuming dividend reinvestment at the end of each year presented in the disclosure, not a percentage change or the net change in value of the investment. Using our proposed description of the measure of cumulative TSR would result in the same disclosure.

[288] The Commission in 2022 similarly made clear its belief that TSR is consistent with that statutory language that the ''disclosures should 'tak[e] into account any change in the value of the shares of stock and dividends of the issuer and any distributions.'" 2022 Pay-versus-Performance Adopting Release at 55153.

[289] 2022 Pay-versus-Performance Adopting Release at 55151.

help address concerns that using only TSR may mislead investors or provide an incomplete picture of performance'' and ''each of the additional disclosures . . . may broaden the picture of financial performance presented in the disclosure . . . [and] could enhance the usefulness of the disclosure by certain registrants or for certain investors.'' [290] We are now proposing to eliminate the additional financial performance measures based on commenter feedback [291] that TSR provides a well understood measure of shareholder value, and, in practice, the inclusion of the additional measures has not served to substantially enhance the usefulness of the disclosure.

Our goal in eliminating the other required performance measures is to simplify disclosure by removing requirements that may not be necessary to understand the link between executive pay and the registrant's performance. Based on the staff's experience reviewing pay-versus-performance disclosure, we believe that registrants frequently struggle to explain the link between some of these other performance measures and executive pay, which can result in lengthy disclosure explaining why a direct link does or does not exist. Many comments echo this concern, indicating the additional disclosures provide little insight into the pay/performance link.[292]

In the case of net income, for example, it appears that disclosure may often deviate from the rule's requirement by substituting a measure other than GAAP net income (such as adjusted net income or revenue) [293] or stating that there is no relationship between net income and executive pay. These deviations seem to reflect the viewpoint expressed in many comment letters [294] received in connection with both the original rule's adoption and the 2025 Roundtable, that ''few registrants use GAAP net income as a financial performance measure in their incentive programs.'' [295] Commenters also noted that GAAP net income information can already be found elsewhere.[296] When adopting Item 402(v), the Commission gave several reasons for including net income as a required financial performance measure, including that it is closely related to other profitability measures that may be used by registrants in setting compensation, is widely understood and standardized, and could complement the market-based performance measure of cumulative TSR.[297] Based upon staff experience, required pay-versus-performance net income disclosure (including numerical financial statement data and relationship disclosure) is frequently boilerplate and provides little meaningful insight about its relationship, if any, to executive pay. Although net income is widely understood and standardized, its inclusion as a financial performance measure does not appear to have enhanced either investors' understanding of other profitability measures or to have provided a complement to market-based TSR.

Similar to net income, it appears based on the staff's observation that, in many cases, presentation of a Company-Selected Measure may provide little insight into the registrant's executive compensation program because the direct link between the two is unclear.[298] The Company-Selected Measure is a financial performance measure which the registrant believes represents the most important financial performance measure used by it to link executive compensation to company performance.[299] In many cases, registrants' compensation programs include complex combinations of multiple financial inputs, over multiple timeframes, without individual weightings or rankings. The staff has observed that registrants often struggle to find a single ''most important'' financial measure and that disclosure is often rendered less meaningful by attempts to do so. On the other hand, where a registrant *is* able to identify a single most important measure, that disclosure can enhance investors' understanding of the link between executive pay and company's financial performance. As such, we are proposing that registrants would have the option, but not the obligation, to disclose a company-selected measure.

We are also proposing to eliminate the requirement to disclose the Tabular List of three to seven financial performance measures that are used to link compensation with the financial performance of the registrant. The staff has observed that, out of context, the names of these measures alone provide very little information about the relationship between executive pay and registrant performance. In addition, this information is often redundant with disclosures of performance conditions applicable to incentive awards, which appear elsewhere in the executive compensation disclosure.

As with net income and the Company-Selected Measure, we believe that the requirement to disclose the cumulative TSR of a peer group may not measurably and consistently enhance a shareholder's understanding of the link between pay and performance. Currently, registrants are required to provide cumulative TSR for a peer group, either the one used for purposes of Item 201(e) of Regulation S–K,[300] or the companies it uses as a peer group for purposes of its disclosures under Item 402(b).[301] While the inclusion of peer group cumulative TSR and relative pay-versus-performance information is not mandated by section 953 of the Dodd-

[290] *Reopening of Comment Period for Pay Versus Performance,* Release No. 34–94074 (Jan. 27, 2022) [87 FR 5751 (Feb. 2, 2022)] (''Reopening Release'') at 5754.

[291] *See, e.g.,* McCauley, 2025 Roundtable Transcript at 107:20–22 (indicating that ''as an investor, we're obviously biased towards total shareholder return, so TSR is kind of central.''); *see also* letters from Equity Methods-1 (explaining that measures other than company TSR can raise non-GAAP issues and are less comparable across registrants); Farient-1; McGuireWoods & Brownstein; Semler Brossy.

[292] *See, e.g.,* letters from ABA (''few registrants use GAAP net income as a financial performance measure in their incentive programs.''); Business Roundtable (''The requirement to identify the 'most important' financial performance measures to link compensation to company performance significantly oversimplifies a complex set of considerations''); Davis Polk (''Comparing a company-selected measure, which was selected by the board to improve an issuer's performance, with CAP, a compensation measure not used by the board, can lead to inconsistent and misleading results for investors.'').

[293] *See* David Outlaw, *What the SEC's 2024 PvP Comment Letters Mean for Year 3 Disclosure Preparation—Equity Methods* (Nov. 30, 2024), available at *https://www.equitymethods.com/articles/what-the-secs-2024-pvp-comment-letters-mean-for-year-3-disclosure-preparation/* (identifying net income concerns as a common concern raised in staff comment letters in 2024, explaining that the ''figure must be GAAP net income, not an alternative like net income attributable to shareholders.'').

[294] *See, e.g.,* letters from A&O Shearman; CEC–2; Compensia; Equity Methods-1; Farient-1; Infinite Equity-1; Johnson & Johnson; NAM–2; Pearl Meyer.

[295] *See, e.g.,* letter from ABA; *see also* letter from Davis Polk; 2022 Pay-versus-Performance Adopting Release at 55154. We also believe that net income is not frequently a measure by which companies or investors assess performance, particularly for early-stage companies or those in industries that typically operate at a net loss.

[296] *See* letter from Infinite Equity-1.

[297] *See* Pay-versus-Performance Adopting Release at 55155.

[298] *See also* Adamson, 2025 Roundtable Transcript at 189: 3–4 (stating that he does not ''feel a utility in the company selected measure.''); letters from ABA; Business Roundtable (stating that ''the requirement to identify the 'most important' financial performance measures to link compensation to company performance significantly oversimplifies a complex set of considerations''); Compensia; Davis Polk (''Comparing a company-selected measure, which was selected by the board to improve an issuer's performance, with CAP, a compensation measure not used by the board, can lead to inconsistent and misleading results for investors.''); Pearl Meyer.

[299] 17 CFR 229.402(v)(2)(vi).

[300] 17 CFR 229.201(e).

[301] 17 CFR 229.402(v)(2)(iv).

Frank Act, in the 2022 Pay-versus-Performance Adopting Release, the Commission noted that registrant TSR alone may not be a sufficient basis for comparison between companies, and that inclusion of peer group TSR could facilitate an assessment of whether the registrant's performance was driven by factors common to its peers or instead by the registrant's own strategy and other choice.[302] While side-by-side comparisons of peer and registrant TSR may provide such information, it is not clear that the disclosure has supplied peer-to-peer pay for performance comparability, since such a comparison would necessarily involve presenting peer companies' *pay* information as well.[303] A requirement to present such relative pay-versus-performance disclosures would increase not only registrant burdens, but also the volume of information in the proxy, running counter to our goal of streamlining and simplifying disclosure.

In addition, to the extent investors seek to analyze peer stock performance or relative pay and performance data, public company, industry and line of business stock performance, as well as peer executive compensation, data are readily available in public filings and other sources. As a result, we believe that removing the peer group cumulative TSR disclosure requirement would simplify the pay-versus-performance disclosure without substantially affecting investors' ability to evaluate a registrant's executive compensation.

3. Executives Covered

We are proposing to simplify the pay-versus-performance disclosure by limiting its coverage to the PEO and the PFO to conform to the coverage of the remaining proposed Item 402 executive compensation disclosure requirements. Currently, pay-versus-performance compensation-related disclosure is required to be provided for the PEO and, as a group, the other NEOs. Calculating the average total compensation for the non-PEO NEOs collectively in accordance with the methodology applicable under the pay-versus-performance rule, as currently required, can be especially time-consuming for registrants and obscure specific details about individual NEOs and their compensation.[304] In addition, based on staff experience, disclosures related to the additional non-PEO NEOs typically double the length of required pay-versus-performance disclosure.

In response to the 2025 Roundtable, many commenters suggested eliminating non-PEO NEOs from required pay-versus-performance disclosure or limiting the disclosure to information about the PEO only or the PEO and PFO.[305] These commenters reasoned that averaging other NEO compensation can cause distortions due to year-over-year changes in the identities and pay packages of named NEOs,[306] termination events resulting in spikes (such as accelerated vesting), and other one-time events, like signing bonuses.[307] These same factors can reduce the utility of such disclosure by obscuring the link between registrant performance and individual NEO pay and minimize insights into NEO pay practices overall.

We recognize that the addition of the average other NEO compensation adds additional burdens to preparing the pay-versus-performance disclosure and we acknowledge commenters' concerns about the burden and potential distortions that may complicate this disclosure. These burdens should be eliminated by our proposal to require compensation disclosure for only the PEO and PFO, without complex averaging. In addition, limiting the required disclosure to the PEO and PFO should help focus the disclosure on the information that is most likely to be material to investors. As discussed in section II.B, we are proposing to limit the NEOs for which Item 402 disclosure is required to only the PEO and PFO. This proposed change alone would reduce the burdens of the pay-versus-performance disclosure, and address many of the commenter concerns with the average other NEO compensation disclosure, because the average other NEO compensation disclosure would simply reflect the compensation of the PFO.

We recognize that the PEO's pay package may receive more scrutiny from investors than the pay packages for the other NEOs, including the PFO.[308] We note, however, the Commission's stated belief in the 2022 Pay-versus-Performance Adopting Release that ''Congress intended for the rules to provide disclosure about both PEOs and the remaining NEOs because Section 14(i) specifically refers to 'compensation required to be disclosed by the issuer under [Item 402 of Regulation S–K],' and Item 402 requires disclosure of NEO compensation.'' [309] Since we are proposing to limit Item 402 disclosure to only the PEO and PFO, we also are proposing to require pay-versus-performance disclosure for only the PEO and PFO. Inclusion of the PFO should minimally impact registrant burden since the proposed Earned Compensation Table would include the required compensation information for both executives.

4. Years Covered

We are proposing to simplify the pay-versus-performance disclosure by conforming the number of years it covers, from five fiscal years to three fiscal years, to match the remaining proposed Item 402 executive compensation disclosure. Currently, registrants are required to provide five years of tabular and narrative pay and performance disclosures under the rule,

[302] *See* 2022 Pay-versus-Performance Adopting Release at 55151. Even though the Commission did not specifically identify peer TSR as a tool for pay-versus-performance comparisons, it did refer to peer TSR as a ''performance measure.'' 2022 Pay-versus-Performance Adopting Release at 55153.

[303] The Commission acknowledged this concern in the Pay-versus-Performance Proposing Release, indicating that ''[t]here are also practical implementation considerations, as peer compensation for the last fiscal year is not likely to be available at the time a registrant is compiling the disclosure. Further, even if these practical considerations could be mitigated (*e.g.,* by permitting peer information to be excluded when unavailable), requiring relative pay-versus-performance would most likely impose higher compliance costs.'' *See Pay Versus Performance,* Release No. 34–74835 (Apr. 29, 2015) [80 FR 26329, 26356 (May 7, 2015)] (''2015 Pay-versus-Performance Proposing Release''). The Commission did reason, however, that presentation of peer TSR (even without peer compensation data) ''should help shareholders to understand when registrant performance could be driven by market moves, sector opportunities, commodity prices, or other factors unrelated to managerial effort or skill.'' 2015 Pay-versus-Performance Proposing Release at 26356. Given that the same peer TSR comparisons are available through various stock data platforms or financial data aggregators, we believe that the information available to investors should not be affected by the removal of peer TSR from the pay-versus-performance disclosure.

[304] *See, e.g.,* letter from Pearl Meyer.

[305] *See, e.g.,* letters from Compensation Advisory Partners; Compensia; Equity Methods-1; Infinite Equity-1 (reasoning that the non-PEO NEOs as well as their compensation can change due to various factors, such as new hire bonuses and prorated salaries as well as termination payments); Meridian; Pearl Meyer; Semler Brossy. Some commenters that suggested limiting disclosure to the PEO only (or eliminating the non-PEO NEOs) typically reasoned that removing the complications created by averaging the non-PEO NEO compensation would both reduce the burden of preparing the disclosure and eliminate concerns that it is not helpful or could be ''misleading.''

[306] *See* letter from Pearl Meyer.

[307] *See, e.g.,* letter from Infinite Equity-1.

[308] *See, e.g.,* letters from ABA (indicating that ''with the exception of the PEO, the volume of detailed information presented in the CD&A and the accompanying tabular disclosure about the remaining NEOs is often immaterial to investors and, if anything, tends to obscure the information that they genuinely seek.''); Infinite Equity-1 (stating that ''[t]he most valuable disclosure is with respect to the Principal Executive Officer (PEO) so the average of the non-PEO Named Executive Officers (NEO) should be removed.''); NAM–1 (asserting that ''most investors . . . primarily focus on CEO Pay.'').

[309] 2022 Pay-versus-Performance Adopting Release at 55142.

and SRCs are permitted to provide only three years instead. In contrast, most other Item 402 disclosures are currently limited to, at most, three years. Better alignment of the years covered by pay-versus-performance disclosure with the other executive compensation information included in the registrant's filing should help alleviate the need to refer to prior proxy statements or other filings to understand compensation for periods prior to what is presented in the current filing. To the extent that investors seek to assess pay and performance over a five-year period, that information would remain available in the registrant's filings with the Commission from prior years. Further, in light of recent studies suggesting a notable increase in PEO turnover rates, a longer time horizon can create substantial burdens for registrants in presenting and describing pay patterns for multiple PEOs.[310]

When adopting the current five-year requirement, the Commission stated that it would ''provide a meaningful period over which a relationship between annual measures of pay and performance over time can be evaluated.'' [311] The Commission also noted, when discussing the five-year time period in the 2015 Pay-versus-Performance Proposing Release that ''the stock performance graph required by Item 201(e) of Regulation S–K requires disclosure for the previous five fiscal years, although it does not include any compensation information.'' [312] Section 953(a) of the Dodd-Frank Act does not contain a specific period of coverage for the pay-versus-performance disclosure. In light of our goal to simplify and streamline and reduce the compliance burdens of executive compensation disclosure, we are proposing to align the pay-versus-performance disclosure with the remainder of the executive compensation disclosures, rather than with the stock performance chart, which appears outside of the proxy statement and does not include compensation information.

Request for Comment

62. Should we adopt the proposed amendments to the pay-versus-performance disclosure requirements? If not, please explain why not.

63. Does the amount reported in the Total Compensation Earned column of the Earned Compensation Table, as proposed, represent an appropriate ''executive compensation actually paid'' measure? Are there other components not included in the Total Compensation Earned column of the Earned Compensation Table that should be considered in calculating compensation actually paid for purposes of the pay-versus-performance disclosure?

64. Is the disclosure currently provided by registrants showing each of the numerical calculations made to determine Compensation Actually Paid material? Do investors or other stakeholders use the year-over-year changes in the value of unvested equity in assessing pay-versus-performance? If so, how?

65. Is there a reason to retain GAAP net income as a performance measure? In what context, if any, is GAAP net income relevant to investors in assessing executive pay and performance alignment?

66. Under the proposed amendments to the pay-versus-performance requirements, disclosure of a Company-Selected Measure would no longer be required. If a registrant elects voluntarily to include a Company-Selected Measure in its disclosure, should there be specific format or content requirements? For example, should we require that the Company-Selected Measure be the same measure for each of the years presented and, if so, should we require that it be calculated in the same way each year? Would it be material to investors for the registrant to discuss why the registrant chose a Company-Selected Measure or whether and how it is related to setting their executive compensation?

67. Should we retain disclosure of peer group cumulative TSR? How is this information currently used by investors? If investors use peer group cumulative TSR disclosure to conduct peer executive pay comparisons, is it possible to access peer group cumulative TSR information from the same source or sources as peer executive pay information? Do investors consult other sources for comparative TSR information, such as industry or line of business indexes?

68. Does TSR for the registrant, as currently required to be disclosed, provide a comprehensive and accurate measure of a registrant's financial performance? Is TSR alone, as proposed, a sufficient measure by which investors would be able to assess a registrant's financial performance for purposes of pay-versus-performance disclosure? If not, should any additional performance measures be required? If so, why?

69. Should we require pay-versus-performance disclosure only for the PEO and PFO, as proposed? If we were to adopt a definition of NEO that includes any additional executive officers other than the PEO and PFO, should the pay-versus-performance disclosure requirements instead apply to all NEOs including to the PEO and PFO, such as under the current rule?

70. Should we use our exemptive authority to require pay-versus-performance disclosure for the PEO only? How would investors use pay-versus-performance disclosure for the PFO, if at all, when making investment or voting decisions? What would be the potential cost savings for registrants if we were to not require pay-versus-performance disclosure for the PFO? How would requiring pay-versus-performance disclosure only for the PEO impact the burden of producing the pay-versus-performance disclosure given that we are proposing the use of the Total Compensation Earned from the proposed Earned Compensation Table total, which will include information for both the PEO and PFO?

71. We are proposing to require only three years of pay-versus-performance disclosure. Is there any reason to retain the current five-year time-period covered by the disclosure requirement? Should we consider the typical performance periods of incentive awards when determining the appropriate time period for the disclosure? If the period is reduced to three years as proposed, would disclosure in prior years' proxy statements be a sufficient source in light of the two years of information no longer required to be included in the registrant's proxy statement, to the extent investors wish to review the information from those two years?

72. Currently pay-versus-performance disclosure is only required in registrants' proxy statements and information statements in which Item 402 of Regulation S–K executive compensation disclosure is required. Unlike the majority of Item 402 disclosure, pay-versus-performance information is not required to be provided or incorporated by reference in any other filings, including the Form 10–K or any registration statement. We are not currently proposing to change the filings requiring pay-versus-performance disclosure or this

[310] *See, e.g., The Transformation of the CEO: Global CEO Turnover Index Annual Report,* Harv. L. Sch. F. on Corp. Governance (Feb. 13, 2025), available at *https://corpgov.law.harvard.edu/2025/02/13/the-transformation-of-the-ceo-global-ceo-turnover-index-annual-report/.*

[311] 2022 Pay-versus-Performance Adopting Release at 55161. The Commission further noted that ''a shorter time period . . . may not provide investors with enough data to evaluate the pay-versus-performance relationship, while . . . a longer period may be overly burdensome to registrants.''

[312] *Id.* at 26342.

limitation on incorporation by reference. In light of the significant simplification we are proposing, should we require incorporation by reference of this disclosure and inclusion in the Form 10–K and registration statements?

73. Should we adopt the approach to determining cumulative TSR and the applicable measurement period as provided in proposed Item 402(f)? Are there any modifications to the approach we should consider that could make the calculation methodology clearer, more practicable, or more appropriate? Should we permit registrants the flexibility to instead present TSR in other formats, such as an annualized percentage return or a cumulative percentage return, rather than a scaled cumulative return on a $100 investment? Would such flexibility facilitate registrants' ability to clearly describe how the specified measure of pay relates to registrant financial performance? Would such flexibility enhance or detract from investors' ability to evaluate the disclosures?

74. If the proposed amendments in the 2026 Filer Status Proposing Release expanding the exemption from pay-versus-performance disclosure to all NAFs, which would include current SRCs and EGCs, are not adopted, should we exempt or provide other accommodations to SRCs with respect to the pay-versus-performance disclosure requirements?

H. Disclosure on Actions To Recover Erroneously Awarded Compensation (''Clawbacks'')—Proposed Item 402(g)

We are proposing to amend certain disclosure requirements under current Item 402(w) regarding the application of a registrant's [313] policy on the recovery of erroneously awarded compensation to reduce compliance burdens and streamline disclosure.[314] We are also proposing to remove both check boxes on the cover pages of Forms 10–K, 20–F,[315] and 40–F relating to the correction of an error to previously issued financial statements. Neither these check boxes nor the disclosure requirements we are proposing to eliminate are required by section 954 of the Dodd-Frank Act.

Under the current rule, registrants must separately indicate by check box on the cover pages of Forms 10–K, 20–F, and 40–F whether:

- The financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements, and
- Any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to Exchange Act Rule 10D–1(b).[316]

In adopting these check box requirements, the Commission observed that ''little r'' restatements [317] are typically not reported as prominently as ''Big R'' restatements [318] and stated that the check boxes would ''provide greater transparency around such restatements and easier identification for investors of those that triggered a compensation recovery analysis.'' [319]

The inclusion of these check boxes, however, appears to have created confusion for some registrants.[320] Additionally, registrants must ensure that every error correction to a previously issued financial statement, whether or not required, is accurately conveyed via the check boxes. We are concerned that the need to check the box even for restatements that are not required may cause registrants to avoid voluntarily making and reporting these restatements, the disclosure of which may benefit investors and market participants. Further, we believe that the check box relating to whether error corrections are restatements requiring a recovery analysis is not necessary, given that Item 11 of Form 10–K and current Item 402(w) of Regulation S–K already require a registrant to disclose any action to recover erroneously awarded compensation that arose from an accounting restatement.[321]

We are also proposing to amend current Item 402(w) of Regulation S–K by removing current paragraph (w)(2), which requires a registrant to disclose, if, at any time during or after its last completed fiscal year, the registrant was required to prepare an accounting restatement and the registrant concluded that recovery of erroneously awarded compensation was not required by the listing standards adopted pursuant to Exchange Act Rule 10D–1, and why it concluded that the recovery of erroneously awarded compensation was not required pursuant to the registrant's compensation recovery policy. The Commission added Item 402(w)(2) to provide context for the information elicited by the check boxes on the cover pages of Forms 10–K, 20–F, and 40–F.[322] The explanation was

[313] In this section, the term ''registrant'' is meant to refer to a ''listed issuer'' that is described in Exchange Act Rule 10D–1 and subject to the disclosure requirements of current 17 CFR 229.402(w).

[314] These requirements were adopted in 2022 in response to the requirement in section 10D of the Exchange Act, as added by section 954 of the Dodd-Frank Act. Pursuant to other proposed changes discussed in this proposing release, 17 CFR 229.402(w) would be redesignated. The Commission is proposing that the language that currently appears in 17 CFR 229.402(w) be renumbered to appear as 17 CFR 229.402(g). With the goal of further reducing compliance burdens, we are also proposing to remove the requirement in current 17 CFR 229.402(w)(4) to tag compensation recovery disclosures under Item 402(w) in Inline XBRL. *See infra* section II.C.5. We are also proposing to amend certain disclosure requirements under Form N–CSR, applicable to registered management investment companies. The disclosure requirements set forth in Item 18 of Form N–CSR mirror the requirements of Item 402(w).

[315] As noted in section II.N below, we are proposing to eliminate the following language from current 17 CFR 229.402(a)(1): ''A foreign private issuer that elects to provide domestic Item 402 disclosure must provide the disclosure required by Item 402(w) in its annual report or registration statement, as applicable.'' We are proposing to eliminate this language as a technical matter. Because foreign private issuers are required by the first sentence of 17 CFR 229.402(a)(1) to comply with Item 6.F of Form 20–F, which sets forth requirements related to the disclosure of a registrant's action to recover erroneously awarded compensation, it is duplicative to state that foreign private issuers electing to provide domestic Item 402 disclosure must provide disclosure required by current 402(w).

[316] *See* Form 10–K; Form 20–F; Form 40–F.

[317] Restatements that correct errors that are not material to previously issued financial statements but would result in a material misstatement if the errors were left uncorrected in the current report or the error correction was recognized in the current period are commonly referred to as ''little r'' restatements. *See* 2022 Clawback Adopting Release at 73083–84. A ''little r'' restatement generally does not trigger the filing of a Form 8–K under Item 4.02, and a registrant may make any corrections the next time the registrant makes a filing that includes the prior year financial statements. *Id.* at 73084.

[318] Restatements that correct errors that are material to previously issued financial statements are commonly referred to as ''Big R'' restatements. *See id.* at 73083. A ''Big R'' restatement requires the registrant to file an Item 4.02 Form 8–K and to amend its filings promptly to restate the previously issued financial statements. *Id.* at 73084.

[319] *Id.* at 73108.

[320] Staff in the Division of Corporation Finance received many inquiries regarding the application of various aspects of the rule. For example, some registrants and their representatives were unsure about the types of error corrections that required them to check the first box; yet others were unsure of what was meant by the second check box as to a restatement that requires a recovery analysis (such as, for example, where a required restatement did not implicate compensation and whether that amounted to a ''recovery analysis''). On Apr. 11, 2025, Commission staff issued several Corporation Finance Interpretations to address some of the more common questions received. *See* Corporation Finance Interpretations Exchange Act Forms Questions 140.20–140.25 dated Apr. 11, 2025. These Corporation Finance Interpretations and any other staff statements or guidance referenced in this release represent the views of Commission staff. Any such staff statements are not a rule, regulation, or statement of the Commission. Further, the Commission has neither approved nor disapproved their content. These statements, like all staff statements, have no legal force or effect; they do not alter or amend applicable law, and they create no new or additional obligations for any person.

[321] One commenter suggested that the check boxes lead to ''over-disclosure that confuses and potentially misleads investors and does not benefit their decision-making with respect to an issuer's financials.'' *See* letter from Davis Polk.

[322] 2022 Clawback Adopting Release at 73108 (stating that the Commission added this disclosure requirement to ''allow investors to understand the

intended to provide investors and exchanges with a better understanding of how a registrant is applying its recovery policy.[323] In the staff's experience, however, this disclosure often is boilerplate and frequently does not elicit relevant information on the application of these policies. Because the Commission required this narrative disclosure in connection with the check boxes on the cover pages which we are proposing to eliminate, we believe the narrative disclosure mandated by Item 402(w)(2) is also no longer necessary. Furthermore, we think that retaining current Item 402(w)(1), which requires disclosure when the registrant has determined a restatement requires recovery of erroneously awarded compensation, is more likely to elicit information that is considered material by investors. We believe that the proposed elimination would reduce compliance burdens for registrants and streamline disclosure.

We are proposing to remove Item 18(b) from Form N–CSR. That item requires registered management investment companies subject to the requirements of Rule 10D–1 to provide the same disclosure required by Item 402(w)(2). We are similarly proposing to make conforming changes to Item 6.F(2) of Form 20–F, and General Instruction B.19(c) of Form 40–F. We are proposing to remove these disclosure items for the same reasons we are proposing to remove current paragraph (w)(2) of Item 402 of Regulation S–K.[324]

We are also proposing to amend Item 402(w)(1)(ii), related to amounts determined to be recoverable but for which recovery would be impracticable. Specifically, we propose to remove the current requirement in Item 402(w)(1)(ii) that such amounts be separately disclosed for each current and former NEO and all other current and former executive officers as a group. In adopting current Item 402(w), the Commission indicated that ''[t]he disclosure requirements are intended to inform shareholders and the listing exchange as to both the substance of a listed issuer's recovery policy and how the listed issuer implements that policy in practice.'' [325] While disclosure about when and to what extent a registrant determines that recovery is impractical likely is important to an understanding of how an issuer implements its recovery policy, it is not clear that prescribing that the disclosure separate these amounts by executive is necessary to an understanding of the application of the impracticability exceptions. We propose to make conforming changes to Item 18(a)(2) of Form N–CSR, Item 6.F(1)(ii) of Form 20–F, and General Instruction B.19(b)(2) of Form 40–F, which includes the same disclosure requirements as current paragraph 402(w)(1)(ii) of Item 402.

We would still require registrants to disclose an action to recover erroneously awarded executive compensation stemming from an accounting restatement, including aggregate amounts that were determined to be recoverable but recovery would be impracticable.[326] We believe that our proposed rule would continue to meet the mandate of section 954 of the Dodd-Frank Act, which does not require the check boxes or the related disclosure we are proposing to remove.

In response to the 2025 Roundtable, some commenters suggested revisions to Exchange Act Rule 10D–1 (''Rule 10D–1''). Rule 10D–1 directs the national securities exchanges and associations that list securities to establish listing standards requiring listed issuers to develop and implement policies providing for the recovery, in the event of a required accounting restatement, of incentive-based compensation received executive officers where that compensation is based on the erroneously reported financial information.[327] The required listing standards are now in effect, and listed registrants are required to have such policies in place. The commenters that sought revisions to Rule 10D–1 suggested changes to how and when a registrant's policy to recover erroneously awarded executive compensation should be applied.[328] We acknowledge the concerns highlighted by these commenters; however, this proposing release is focused on amendments to the disclosure requirements in Item 402. Amendments to Rule 10D–1, such as how and when a registrant's policy to recover erroneously awarded executive compensation should be applied, are outside the scope of this proposal. We nevertheless believe that the changes we are proposing to eliminate certain disclosure requirements regarding the application of a registrant's recovery policy and remove the check boxes from Forms 10–K, 20–F, and 40–F should meaningfully reduce registrant compliance burdens arising from implementation of Rule 10D–1.

Request for Comment

75. Should we adopt the proposed amendments to remove Item 402(w)(2), Item 6.F(2) of Form 20–F, General Instruction B.19(c) of Form 40–F and Item 18(b) of Form N–CSR, revise Item 402(w)(1)(ii), Item 6.F(1)(ii) of Form 20–F, General Instruction B.19(b)(2) of Form 40–F and Item 18(a)(2) of Form N–CSR and eliminate the check boxes on the cover pages of Forms 10–K, 20–F, and 40–F? If we should not adopt these amendments, please explain why not. For example, do these requirements provide material information to investors regarding whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements that would support maintaining these requirements?

76. Should we consider any other changes to Item 402(w), Item 6.F of Form 20–F, General Instruction B.19 of Form 40–F and Item 18 of Form N–CSR?

77. If the Commission adopts the proposal to remove the two check boxes on the cover pages of Forms 10–K, 20–F, and 40–F indicating the correction of an error to previously issued financial statements and whether those error corrections are restatements that required a compensation recovery analysis, but does not adopt the proposal to remove the disclosure requirements in Item 402(w)(2), Item 6.F(2) of Form 20–F, General Instruction B.19(c) of Form 40–F and Item 18(b) of Form N–CSR, is the disclosure requirement set forth in current Item 402(w)(2), Item 6.F(2) from Form 20–F, General Instruction B.19(c) from Form 40–F and Item 18(b) of Form N–CSR still necessary or useful?

78. Is the information typically elicited by the check boxes sufficiently captured by other disclosure rules, such as Item 11 of Form 10–K and the remaining elements of Item 402(w)?

79. Should we remove the check box indicating whether the financial statements in the filing reflect an error correction to previously issued financial

check boxes in the appropriate context of the issuer's application of its recovery policy'').

[323] *Id.*

[324] The Commission added Item 18 to Form N–CSR to require listed funds that would be subject to Rule 10D–1 provide information that would generally mirror the disclosure requirements of Item 402(2) of Regulation S–K. *See* 2022 Clawback Adopting Release at note 66. Our proposal to remove Item 18(b) from Form N–CSR would be consistent with the Commission's policy goal of having listed funds subject to Rule 10D–1 provide similar relevant disclosure to that of listed operating companies.

[325] 2022 Clawback Adopting Release at 73106.

[326] *See* proposed Item 402(g)(1)(ii). Additionally, under the proposed rule, a foreign private issuer that elects to provide Item 402 disclosure would still be required to provide the disclosure required by proposed Item 402(g) in its annual report or registration statement, as applicable.

[327] *See* letters from ABA; Davis Polk; McGuireWoods & Brownstein.

[328] *See* letters from ABA; Davis Polk; McGuireWoods & Brownstein.

statements (which includes a voluntary error correction), but retain the check box regarding whether such error correction is a restatement that required a recovery analysis? If we remove the first check box, should we clarify that the remaining check box should be marked when the financial statements of the registrant in the filing reflect a required restatement? If we retain only that check box, should we broaden the scope of the requirement beyond listed issuers? Are there any other approaches with respect to the elimination or modification of the current check boxes that we should consider?

80. We understand that registrants may not complete their analysis of whether a recovery of erroneously awarded compensation is required prior to the related 10–K, 20–F or 40–F filing deadline. Should we include additional guidance for registrants about how to meet their disclosure obligations in these circumstances?

81. We are proposing to remove the current requirement in Item 402(w)(1)(ii) to separately disclose, for each current and former NEO and all other current and former executive officers as a group, amounts for which recovery would be impracticable. Does the separate disclosure of these amounts provide information that is meaningful to or considered by investors?

I. Pay Ratio Disclosure Requirements—Proposed Item 402(h)

We are proposing to amend the pay ratio disclosure rule to reduce compliance burdens, enhance comparability across registrants, and streamline the requirements.[329] Current Item 402(u), adopted in 2015 in response to section 953(b) of the Dodd-Frank Act,[330] requires registrants to disclose the ratio between the annual total compensation of the principal executive officer and that of a median employee, each determined in accordance with the methodology of the current Summary Compensation Table. Under the current rule, the median employee is identified from among all individuals employed by the registrant or any of its consolidated subsidiaries[331] whether as a full- or part-time, seasonal, or temporary U.S. or non-U.S. worker, but excluding certain independent contractors or ''leased'' workers.[332] In addition, registrants must determine the median employee once every three years, or more frequently under certain circumstances,[333] and each year disclose the median employee's annual total compensation, the annual total compensation of the PEO, and the ratio of the annual total compensation of the median employee to that of the PEO. The rule also requires certain disclosures about the methodology used to identify the median employee and the calculation used to determine total compensation for employees other than the PEO. The rule also provides lengthy guidance related to the use of adjustments, estimates, and sampling in determining the median employee and the treatment of employees resulting from recent acquisitions.[334] Due to the rule's inclusion of foreign, part-time, temporary, and seasonal workers, identifying the median employee annual compensation can involve numerous steps, such as identifying the world-wide employee population and converting foreign currencies and calculating the median employee compensation using the Summary Compensation Table methodology.

Our proposed revisions to the pay ratio rule would continue to require disclosure of the ratio of the annual total compensation of the median employee of the registrant with the annual total compensation of the PEO of the registrant. As proposed, however, the rule would limit the employee population from which the median employee is identified to those employed on a full-time basis, excluding seasonal and temporary employees, in any jurisdiction of the U.S. or its territories. In addition, because we are proposing to change the tabular presentation of executive compensation under Item 402, including replacing the Summary Compensation Table, we propose to revise provisions in the pay ratio disclosure rule relating to the methodology for determining annual total compensation of the PEO and median employee. Further, we are proposing to change the frequency with which registrants must determine the median employee from once every three years to once every five years. We are also proposing to streamline the rule text and simplify the guidance and disclosure requirements related to the process for identifying the median employee.

1. Employee Population

We are proposing to limit the scope of the population from which the median employee is identified. Specifically, under the proposed rule, the median employee would be determined based upon the annual total compensation of all employees of the registrant or any of its consolidated subsidiaries who are employed on a full-time basis in any jurisdiction of the United States or its territories, which would exclude temporary or seasonal workers. Under the current rule, a registrant must consider the annual total compensation of all its employees, whether they are employed on a full-time, part-time, seasonal, or temporary basis, as well as those of its consolidated subsidiaries, wherever they are located.[335] For registrants with international employees, determination of the median employee may entail, among other things, collection of compensation data for workers on different payroll systems, and conversion of compensation data from foreign currencies to U.S. dollars.

Many comments received in connection with the 2025 Roundtable expressed views that pay ratio disclosure provided under the current rule may not provide information that is useful to investors and does not impact compensation decisions.[336] Many

[329] We are also proposing to continue to exempt both SRCs and EGCs from these disclosure requirements as set forth in proposed Item 402(h). *See infra* section II.M. We also note that the rule changes currently contemplated in the 2026 Filer Status Proposing Release would expand to all non-accelerated filers (as defined in that release) the exemptions available to SRCs and EGCs from the pay ratio disclosure requirements.

[330] *See* Public Law 111–203, 124 Stat. 1376, sec. 953(b) (2010).

[331] Section 953(b) specifically excepts ''the chief executive officer (or any equivalent position)'' from ''all employees.''

[332] *See* 17 CFR 229.402(u). The current rule excludes those workers who are employed, and whose compensation is determined, by an unaffiliated third party but who provide services to the registrant or its consolidated subsidiaries as independent contractors or ''leased'' workers. *See* 17 CFR 229.402(u)(3); *see also infra* note 372 (describing limited exemptions under the current rule permitting registrants to exclude certain non-U.S. employees).

[333] *See* Instruction 2 to 17 CFR 229.402(u).

[334] *See* Instructions 4, 5, and 7 to 17 CFR 229.402(u).

[335] *See* 17 CFR 229.402(u)(1)(i) and (u)(3). As noted above, section 953(b) provides that for purposes of determining the median of the annual total compensation the chief executive officer or any equivalent person is excepted from the determination for ''all employees.'' In keeping with the statute, the current rule does and the proposed rule would except the PEO.

[336] *See, e.g.,* letters from Axcelis; ASA (asserting that ''[t]he rule provides no information that is of any use to investors''); Compensation Advisory Partners (stating that ''the pay ratio disclosure has not gained traction with investors and imposes a significant compliance burden on issuers''); EOS (stating that ''[t]he SEC requirement for disclosure of the CEO to median employee pay ratio does not appear to have played a material role in compensation committee discussions, investor decision-making, or the rapid rate of increase in executive pay relative to that of the wider workforce.''); Farient-1 (stating that pay ratio disclosure is rarely questioned, used, or referenced by proxy advisors or investors and that it ''provides

commenters also stated that the disclosure and is highly burdensome for registrants to produce.[337] One commenter, in contrast, stated that the final pay ratio rule provided adequate flexibility to companies to identify their median employee and that arguments that the rule creates undue compliance costs should be rejected.[338] Other commenters expressed support for the current rule, indicating that the disclosure can reveal possible problems with employee morale and productivity, which can adversely affect a company's performance.[339]

Some commenters that expressed concern with the current rule asserted that the burden reported is largely due to the inclusion of non-U.S., part-time, seasonal, and temporary workers in determining the median employee.[340] According to these commenters, inclusion of such employees also limits comparability across registrants, due, in part, to things like different countries' pay practices and workforce structures, variations in workforce composition, geographic distribution, reliance on outsourcing talent, and employee demographics.[341] Commenters report that these factors have contributed to the compliance burdens under the current rule despite certain accommodations provided in the rule.[342]

For purposes of determining the median employee, we propose eliminating the current lengthy definition of ''employee,'' which presently includes all global full-time, part-time, seasonal, and temporary workers, with limited exceptions. Our proposed revision would require the registrant to identify the median employee from among all employees of the registrant or any of its consolidated subsidiaries who are employed on a full-time basis in any jurisdiction of the U.S. or its territories, excluding temporary or seasonal workers. In addition, consistent with our principles-based approach to these amendments, ''employees'' will not expressly carve out independent contractors or ''leased'' workers. We believe that it is well understood that these categories of workers are not employees. In addition, we do not wish to create a special definition of employee for purposes of Item 402. As the Commission indicated in a 2017 interpretive release related to pay ratio disclosure, ''registrants already make determinations as to whether a worker is an employee or independent contractor in other legal and regulatory contexts, such as for employment law or tax purposes, . . . [and] we believe it would be consistent with Item 402(u) for a registrant to apply a widely recognized test under another area of law that the registrant otherwise uses to determine whether its workers are employees.'' [343] We believe that this same guidance would continue to apply when determining whether a worker is an employee under our proposed pay ratio rule, and, as such, our proposed rule does not provide for extensive carve-outs or other detailed guidance on this topic. The proposed amendments are intended both to increase the value of the disclosure to investors by enhancing comparability across registrants and to reduce compliance burdens for registrants.

Section 953(b) of the Dodd-Frank Act directed the Commission to amend Item 402 of Regulation S–K to require disclosure of ''the median of the annual total compensation of all employees of the issuer, except the chief executive officer (or any equivalent position) of the issuer,'' ''the annual total compensation of the chief executive officer . . . of the issuer,'' and the ratio of these amounts.[344] In adopting the current rule, the Commission noted that ''Congress did not expressly state the specific objectives or intended benefits of section 953(b)'' [345] and concluded that ''Section 953(b) should be interpreted consonant with [the] general purpose [of the relevant subtitle of the Dodd-Frank Act] of . . . facilitating shareholder engagement with executive compensation,'' particularly say-on-pay voting.[346] At that time, the Commission decided that a company-specific executive compensation metric, rather than one that would facilitate a comparison between registrants, would better facilitate shareholder engagement with and evaluation of a registrant's executive compensation and determined to include all U.S., non-U.S., part-time, seasonal, and temporary employees within the definition of *all employees*.[347]

At the time of adoption of the 2015 rules, the Commission carefully considered but declined to exercise its discretion to grant a wholesale exemption for non-U.S. employees from

no information about attraction, retention, alignment, or distinct data on compensation costs''); NAM–1; Pearl Meyer; Reda (''Analysis of voting patterns indicates that firms with very high CEO pay ratios generally still receive strong Say-on-Pay support, unless other performance issues exist. For example, among Russell 3000 firms, those with above-median ratios received average Say-on-Pay support around 89 percent, compared to approximately 92 percent for those below median. This suggests that investors are reluctant to penalize pay packages solely based on the ratio.''); Society for Corporate Governance; *see also* Southlea Group, *Rethinking the CEO Pay Ratio* (August 12, 2025), available at *https://www.southlea.com/rethinking-the-ceo-pay-ratio/* (stating that ''[g]overnance influencers such as proxy advisors . . . largely agree that the CEO pay ratio does not provide meaningful information to investors to support Say on Pay voting,'' referring to ISS and Glass Lewis).

[337] *See, e.g.,* letters from ABA; ASA; Axcelis (summarizing the work involved as: identifying the world-wide median employee, converting foreign currencies, calculating full-time equivalents, determining median employee compensation using Summary Compensation Table methodologies and dividing it into the CEO compensation); Compensation Advisory Partners; Chamber of Commerce; Davis Polk (discussing the additional burden created by the requirement to determine median employee more frequently than every three years under certain circumstances); Farient-1; International Bancshares Corporation (July 9, 2025) (''IBC''), available at *https://www.sec.gov/comments/4-855/4855-622807-1826934.pdf* (quoting Congressman Bill Huizenga's statement that the rule ''creates an enormous burden for publicly traded companies while offering no corresponding benefit''); NAM–1; Pearl Meyer; Rethink.

[338] *See* letter from Public Citizen.

[339] *See, e.g.,* letters from AFL–CIO et al.; AFREF.

[340] *See, e.g.,* letters from ABA; ASA (urging the Commission to reduce the burdens created by the pay ratio rule by ''at a minimum, exclud[ing] all non-U.S., seasonal, and part-time workers from the calculation of 'median employee' ''); Business Roundtable; Chamber of Commerce; Compensia; McGuireWoods & Brownstein (suggesting that limiting ''comparisons of compensation to the CEO and U.S.-based employees'' would help ''reduce the burden on the human resources and accounting teams in gathering all of the necessary information while still allowing shareholders to review a standard CEO pay ratio''); Meridian (noting in particular that ''the inclusion of non-North American and seasonal employees in determining the median employee makes the outcome less relevant, while materially increasing the calculation burden''); Pearl Meyer.

[341] *See, e.g.,* letters from A&O Shearman; Axcelis; Compensation Advisory Partners; Farient-1; NYSE; Pearl Meyer; Reda (''A challenge with the CEO pay ratio is its limited comparability across companies and industries. Differences in workforce composition, such as part-time versus full-time employees and domestic versus international workers, as well as hiring practices and geographic location, can cause significant variation in the ratio. This variability reduces the ratio's usefulness as a standalone measure.''); Society for Corporate Governance; Total Rewards; *see also* Steven A. Bank & George S. Georgiev, *Securities Disclosure as Soundbite: The Case of CEO Pay Ratios,* 60 B.C. L. Rev. 1123 (2019).

[342] *See, e.g.,* letters from ABA (suggesting expanding the *de minimis* exception for non-U.S. employees would ease registrant burden in preparing pay ratio disclosure); Chamber of Commerce (suggesting, as one of several changes needed to reduce registrant burden, that the rule allow the foreign data privacy exemption to operate independently from the *de minimis* exemption); Society for Corporate Governance (requesting that ''if the de minimis exemption for excluding non-US employees is maintained, eliminate the additional disclosure requirements, such as the jurisdictions, number of employees in each jurisdiction, and total number of US and non-US employees used for the de minimis calculation'').

[343] *See* Commission Guidance on Pay Ratio Disclosure, Release No. 33–10415 (Sept. 21, 2017) [82 FR 44917 (Sept. 27, 2017)] (''2017 Pay Ratio Interpretive Release'') at 44918.

[344] *See* Public Law 111–203, 124 Stat. 1376 (2010), sec. 953(b)(1).

[345] *See* 2015 Pay Ratio Adopting Release at 50105.

[346] *See id.* at 50106.

[347] *See id.* at 50105–06, 50111, 50117.

inclusion in the median employee determination. The Commission stated it did not believe it would be appropriate ''to second-guess Congress by granting a wholesale exemption for non-U.S. employees in a manner that we believe could fundamentally change the pay ratio information that Congress directed be provided to shareholders.'' [348] The Commission acknowledged concerns raised by commenters, however, that the inclusion of non-U.S. employees could raise compliance costs for multinational companies, introduce cross-border compliance issues, and have an adverse impact on competition. The Commission, therefore, provided two tailored exemptions that permit registrants to exclude non-U.S. employees from the median employee calculation under certain circumstances, which it believed would alleviate some of these concerns.[349] The first exemption applies when the individual is employed in a foreign jurisdiction in which the data privacy laws or regulations are such that, despite the registrant's reasonable efforts to obtain or process the information necessary to comply with the rule, the registrant is unable to do so without violating those laws or regulations.[350] The second is the *de minimis* exemption that permits a registrant to exclude non-U.S. employees when they account for five percent or less of the registrant's total employees, with certain limitations.[351]

We acknowledge the Commission's determination, at the time of the rule's adoption, that ''Congress thought that it was important for shareholders to have pay ratio disclosure that reflects 'all employees' of a registrant when making their say-on-pay votes;'' [352] however, our experience and commenter feedback suggest that inclusion of more than U.S. full-time employees in the median employee determination has not been an essential factor in pay ratio disclosure's impact on shareholder engagement with executive compensation or shareholder voting. We also no longer believe that granting a wholesale exemption for non-U.S. employees would fundamentally change the pay ratio information that Congress directed be provided to shareholders. In the years since the Commission adopted the current pay ratio rule, it has not been apparent that the information provided by the ratio has been contingent upon capturing both U.S. and non-U.S.-based employees. Many comments received in connection with the 2025 Roundtable indicated that the pay ratio disclosure in general may not be used or useful.[353] Commenters also stated that the burden of compliance with the rule is significant.[354] Even comments supporting the current pay ratio rule often focused on the link between pay ratio information and other matters of interest to stakeholders, such as employee morale or corporate performance, and not on the pool of employees from which the median employee is identified.[355] We believe that our proposed rule would produce pay ratio disclosure that would continue to provide similar information for investors to engage with executive compensation as the disclosure required under the current rule, while reducing the burden on registrants.

We continue to believe that the statutory intent of section 953(b) of the Dodd-Frank Act was to facilitate shareholder evaluation of and engagement with a registrant's executive compensation, and particularly to inform say-on-pay votes. We also believe, based upon our experience with the current pay ratio rule and commenter feedback, that our proposed rule would continue to serve that statutory intent, even when narrowing the scope of the employee pool from which the median employee is identified. Our proposed changes may also enhance comparability across registrants,[356] which could provide further insights that would enhance shareholder evaluation of and engagement with executive compensation and related say-on-pay votes.[357] Identifying the median employee from the types of workers that are most prevalent among registrants subject to the rule [358] could provide more comparable disclosure, not only across registrants in general, but also across registrants within specific

[348] 2015 Pay Ratio Adopting Release at 50123.

[349] *See* 2015 Pay Ratio Adopting Release at 50123. The Commission's proposing release for the pay ratio disclosure rule proposed a definition of ''employee'' that included U.S. and non-U.S. employees, without exemptions for specific categories of employees, such as non-U.S. employees. *See Pay Ratio Disclosure,* Release No. 33–9452 (Sept. 18, 2013) [78 FR 60560, 60566 (Oct. 1, 2013)]. At adoption, the Commission acknowledged its authority under section 36 of the Exchange Act and section 28 of the Securities Act to exempt registrants from including non-U.S. employees in the median employee determination, but declined to exercise that discretion in favor of the two tailored exemptions. *See* 2015 Pay Ratio Adopting Release at 50122–23.

[350] *See* 17 CFR 229.402(u)(4)(i). We would eliminate the data privacy and *de minimis* exemptions as part of our proposed amendments, since registrants would no longer need to consider foreign employees. As part of this change, we also propose to remove the requirement from Item 25(a) of Schedule 14A, which requires filing of a legal opinion when a company relies on the data privacy exemption.

[351] *See* 17 CFR 229.402(u)(4)(ii).

[352] 2015 Pay Ratio Adopting Release at 50123.

[353] *See supra* note 336; *see also* letters from ASA (''The rule provides no information that is of any use to investors, and it allows public companies to become subject to attacks from special interest groups that regularly exploit SEC rules to achieve their objectives—all at the expense of everyday investors''); Axcelis; Chamber of Commerce (''The intent behind the pay ratio rule has always been overtly political, as the rule attempts to address a problem that should be addressed through the political system and Americans' elected representatives; the rule has never been about providing investors with material, decision-useful information''); NYSE; Professor Steven M. Bainbridge (June 27, 2025) (''Prof. Bainbridge''), available at *https://www.sec.gov/comments/4-855/4855-618127-1813274.pdf.*

[354] *See supra* note 337.

[355] *See, e.g.,* letters from AFL–CIO et al.; AFREF; Public Citizen.

[356] Registrants take varying approaches to foreign operations and fluctuating labor needs, with some outsourcing these labor needs to other entities while others directly employing non-U.S. and/or part-time, seasonal, or temporary workers. These differences in approaches to fulfilling similar labor needs can lead to variation in pay ratios that does not reflect true differences in underlying labor expenditures, or the quantum of employee pay. Further, because the current rule does not permit part-time pay to be converted to a full-time equivalent or for seasonal or temporary worker pay to be annualized, comparing part-time, seasonal or temporary compensation to the full-time, annual compensation of a PEO can artificially inflate pay ratios.

[357] We are mindful of the Commission's statement in the 2015 Pay Ratio Adopting Release that ''[w]hile we do not believe a purpose of the rule is to facilitate comparisons among registrants, the opportunity to supplement the pay ratio disclosure and to provide additional pay ratios should help mitigate some concerns that shareholders may draw unwarranted conclusions from comparing one registrant's disclosed ratio to the ratio of others.'' 2015 Pay Ratio Adopting Release at 50118. We believe, however, that the goal of enhancing shareholder engagement with executive compensation would only be helped by increased comparability across registrants, and the ability to provide supplemental explanations would still be available to registrants that determine to provide them. *See, e.g.,* Bank & Georgiev, *supra* note 341, at 1186 (''For any individual firm's pay ratio to attain meaning . . . it must be compared against the pay ratios of other firms. Put simply, even if all ratios are 'bad,' some must be 'less bad' than others. But . . . the SEC has expressly stated that such cross-firm comparisons are meaningless due to the design of the rule. This presents a Catch-22 situation: The information of any given firm has utility for investors only when it is compared with the information released by other firms, and yet the pay ratio information cannot be compared across firms.'').

[358] While we acknowledge that multinational companies may employ a significant percentage of their workforce overseas, likely through majority-owned subsidiaries, data suggest that even these companies have historically continued to employ at least a majority of their workforce within the United States. *See* Bureau of Economic Analysis, U.S. Department of Commerce, *Activities of U.S. Multinational Enterprises, 2022* (August 23, 2024), available at *https://www.bea.gov/news/2024/activities-us-multinational-enterprises-2022.* In addition, even if there is a significant concentration of foreign employees at multinational companies, using only the individuals employed in the United States should provide the pertinent information available about these companies' United States-based compensation practices.

industries.[359] We believe that our proposed revisions, by creating a more uniform pool of employees (*i.e.,* U.S. full-time employees excluding seasonal and temporary workers) may permit more effective cross-registrant comparisons and, in so doing, may make the disclosures more useful to investors. To the extent that the Commission suggested otherwise when it adopted the original rule, we tentatively conclude that the Commission's prior suggestion was incorrect. We find no support in the text or legislative history of section 953(b) of the Dodd-Frank Act for the view that a company-specific metric, rather than one that would enhance comparability across registrants would better facilitate shareholder engagement. As a policy matter, we believe that revising the rule to enhance cross-registrant comparability may add benefits to investors in terms of the usefulness of the disclosure.

a. Full-Time Employees

We propose to exercise our exemptive authority to exclude part-time, seasonal, and temporary employees from the determination of the median employee.[360] When adopting the current rule, the Commission determined to include part-time, seasonal, and temporary employees because it believed that their inclusion would be more reflective of the actual composition of the registrant's workforce and would help provide shareholders with relevant information about a registrant's compensation practices.[361] As noted above, in the years since its adoption, it has appeared that the usefulness to investors of the disclosure is not grounded in the specific pool of employees used in computing the ratio. Comments in support of the rule generally mention its usefulness as a tool in assessing things like employee morale and productivity [362] or impact on registrant performance.[363] We do not believe that the benefits to investors of pay ratio disclosure would be diminished by limiting its application to full-time employees. Indeed, commenters frequently point to the considerable variation in global workforce composition as a weakness of the rule, potentially causing significant year-over-year fluctuations in a registrant's pay ratio [364] and hindering useful comparisons among registrants.[365] As proposed, the rule would focus only on full-time employees other than temporary or seasonal workers, eliminating such variability and complexity in favor of a simple, easy-to-apply standard that would still provide the kinds of insights that investors seek. We believe that this change would both reduce the burdens associated with producing this disclosure and result in more comparability across registrants. Even among those registrants that would have a smaller pool of full-time employees from which to identify the median employee under the proposed rule, the median employee would presumably represent a more stable datapoint over time than the part-time, seasonal, or temporary workforce.

Based on our experience with the current rule and commenters' expressed concerns regarding its usefulness, and in spite of the broad scope of the term ''*all employees*'' set forth in section 953(b) of the Dodd-Frank Act, we are proposing to limit the scope of the rule to full-time employees other than temporary or seasonal workers, which we believe would better reflect a registrant's compensation practices within a more stable, consistent employee population.[366] In considering recent U.S. employment data, most U.S. employees work on a full-time basis.[367] Although we acknowledge that different industries may have different average concentrations of full-time employees, the proposed rule would allow for more comparability across industries even with such variability, and, as noted above, we believe that facilitating cross-registrant comparisons may add benefits to investors in spite of the contrary suggestion in the 2015 Pay Ratio Adopting Release.[368] In addition, a ratio comparing the pay of employees who work on a full-time basis without a specific endpoint of employment to that of the PEO (also typically a full-time employee with an open-ended term of employment) would compare full-time employees to each other, creating a more meaningful comparison than one that likely requires supplemental disclosure to explain factors that could reduce the usefulness of quantitative pay ratio information.[369]

[359] Notably, foreign private issuers are not subject to the pay ratio rule. *See* 17 CFR 229.402(a)(1); 2015 Pay Ratio Adopting Release at 50116.

[360] Section 36(a) of the Exchange Act and section 28 of the Securities Act afford the Commission general exemptive authority to conditionally or unconditionally exempt any person, security, or transaction, or any class or classes of persons, securities, or transactions, from any provision or provisions of this title (*i.e.,* the Exchange Act and the Securities Act, respectively) or of any rule or regulation thereunder, to the extent that such exemption is necessary or appropriate in the public interest, and is consistent with the protection of investors. Although section 953(b) was not expressly incorporated into either Act, our view is that, to the extent that the statutory criteria for invoking exemptive authority under these sections are met, the exemptive authorities afforded by section 36(a) and section 28 are available here. We construe section 953(b) as a Congressional directive to us to rely on our Exchange Act and Securities Act rulemaking authorities to amend section 229.402 of Title 17, Code of Federal Regulations to require the pay ratio disclosure. The pay ratio amendments that we are proposing, therefore, are rules or regulations under the Exchange Act and the Securities Act and, thus, fall within the express terms of section 36(a) and section 28.

[361] *See* 2015 Pay Ratio Adopting Release at 50117.

[362] *See, e.g.,* letters from AFREF; Public Citizen.

[363] *See, e.g.,* letter from AFL–CIO et al.

[364] *See, e.g.,* letter from Reda.

[365] *See, e.g.,* letters from Axcelis (noting that the relative compensation of a median employee in a clothing manufacturing business is going to be significantly different than that of the median employee in a biotech company and explaining that ''[t]he composition of employees at a company is largely the result of (i) internal decisions on how to achieve needed work, *e.g.,* whether to hire employees or use out-sourced services, and (ii) the needs of a particular industry, where some industries require much different composition of workers in comparison to others.''); Farient-1 (factors that can impact a company's median employee include the ''company's industry, capital intensity, and geographic distribution of employees'').

[366] We further believe that full-time employees would be easier for registrants to identify, and focusing on full-time employees would no longer require registrants to determine whether and which part-time, seasonal, or temporary employees must be included for purposes of the pay ratio determination, reducing the burden on registrants in preparing this disclosure. *See, e.g.,* letter from Business Roundtable (noting the high compliance burdens associated with including part-time, seasonal, and temporary workers, and also that their inclusion ''generates an arbitrary and often misleading figure that varies widely based on factors unrelated to executive compensation practices—such as the use of seasonal or part-time workers, outsourcing models, or the geographic distribution of a company's workforce'').

[367] *See* U.S. Department of Labor, Bureau of Labor Statistics, *News Release: Work Experience of the Population—2024* (Jan. 22, 2026), available at *https://www.bls.gov/news.release/pdf/work.pdf* (stating that the percentage of workers that worked full time, year-round (working 50 to 52 weeks) in 2024 was 69.8, which was similar in 2023).

[368] *See, e.g.,* Daniel Culberson/Hiring Lab, *Part-Time Party: Charting the Rise of Part-Time Opportunities* (June 20, 2024), available at *https://www.hiringlab.org/2024/06/20/part-time-opportunities/* (discussing research showing that ''[f]ull-time work is, by far, the most common schedule type offered by employers in job postings'').

[369] Commenters cited in the adopting release expressed concern that ''applying the rule to part-time, temporary, and seasonal employees would make the pay ratio disclosure less meaningful because the compensation of these different types of employees are not comparable to each other or to the PEO's compensation.'' *See* 2015 Pay Ratio Adopting Release at 50116. Pay determinations for part-time workers often involve different types of considerations and calculations that would not be used with full-time workers. *See* Sébastien Moyon/CloudPay Inc. *Part-time vs full-time employees: the key differences for employers* (Nov. 14, 2024) available at *https://www.cloudpay.com/blog/full-time-vs-part-time-employees-differences/.* In addition, Instruction 5 to 17 CFR 229.402(u) expressly prohibits both annualizing compensation for seasonal and temporary employees and making

Continued

Considering the wide variability in employee populations, we believe that the median pay of full-time employees other than seasonal or temporary workers may provide the most consistent and stable measure across registrants for assessing the ratio of PEO to employee compensation, at a lower burden and with improved comparability; and that exclusion of part-time, seasonal, and temporary employees would not significantly alter the overall substance of the disclosure and accordingly still serve the purpose Congress intended for this rule. Specifically, as noted above, we believe that the usefulness of the disclosure to investors would not be diminished, and may be enhanced by the proposed amendment that would limit its application to full-time employees with an open-ended term of employment, since we believe that these employees' compensation should represent a stable, consistent signal of the registrant's pay practices for non-PEO employees. This proposed amendment is also expected to provide significant relief to registrants. For example, excluding part-time, seasonal, and temporary employees should reduce registrant costs created by integrating their non-full-time pay and, for seasonal and temporary employees who work on a full-time basis, their pay for a shorter time period than other full-time employees into the median employee determination, as well as supplementary narrative disclosures necessary to explain the impact of such integration. Overall, we believe that this proposed exemption would be necessary and appropriate in the public interest and consistent with the protection of investors.

b. U.S. Employees

We are also proposing to exercise our exemptive authority [370] to exclude non-U.S. employees from the determination of the median employee, which would as a result be based only on workers employed in the U.S. and its territories.[371] The current rule requires that registrants identify the median employee from among all of its employees regardless of their location, with limited exemptions.[372] Limiting the scope of employees to those employed in the U.S. and its territories is consistent with our goals of increasing the usefulness of the pay ratio disclosure to investors and reducing a registrant's burdens in preparing this disclosure.

The current inclusion of non-U.S. employees raises compliance costs for multinational companies, introduces cross-border compliance issues, and raises concerns about the impact of non-U.S. pay structures and labor markets on the comparability of the data.[373] In addition, implementation of the current rule necessitates the additional burden of evaluating foreign data privacy laws and applying the *de minimis* exemption.[374] Although some registrants may have significant foreign employee populations, including many of the larger U.S.-headquartered multinational companies,[375] we recognize that there may be a significant burden on registrants in identifying them and determining their compensation. Furthermore, the compensation-setting process for employees located in foreign jurisdictions, where highly disparate norms, employment and contract laws, expectations, local and national government rules, and practices, as well as differences in economic and labor market conditions may apply, is likely to be very different from the process used for U.S. employees. As such, the inclusion of foreign employees could reduce the comparability of pay ratio disclosure across registrants and provide less useful information to investors about the compensation setting process.

The pay ratio rule largely applies to U.S.-domiciled registrants. Although we acknowledge that the rule can apply to multinational registrants [376] with worldwide operations, we also believe that allowing registrants to focus on those employees to whom U.S. laws apply (*e.g.,* tax, employment, and labor laws) is appropriate for the largely U.S.-domiciled companies to which U.S. corporate (including employment-related) laws also apply.[377] We believe that this uniform application of the laws of the U.S. could further enhance consistent application of the rule, reduce burdens on registrants in preparing the disclosure, and yield more comparable disclosure across registrants.[378]

As discussed in section II.I.1. above, it does not appear that the usefulness of the pay ratio disclosure to investors is grounded on the specific pool of employees used in creating the ratio.[379] Based on our experience with pay ratio disclosure and feedback from registrants and other commenters, inclusion of non-U.S. employees has not been a factor in pay ratio disclosure's impact on shareholder engagement with executive compensation or shareholder

a full-time equivalent adjustment for part-time employees. As a result, a business relying substantially on temporary, seasonal, or part-time employees is likely to show a larger ratio than one with predominantly full-time workers which we anticipate registrants would, likely view as necessitating supplemental explanation, further lengthening executive compensation disclosures and reducing comparability.

[370] We discuss the basis for and details of our exercise of exemptive authority for the proposed amendments to the Pay Ratio rule at note 360 above.

[371] In contrast, as proposed, PEOs that are not U.S. employees would be treated the same as PEOs that are U.S. employees. Because the PEO compensation is only a single data-point, and is generally determined from a pool of one person or a small number or people, using PEOs that are not U.S. employees would not create the same burdens for registrants as does the entire employee population, while, at the same time, excluding a non-U.S. PEO could eliminate the disclosure altogether.

[372] 17 CFR 229.402(u)(4) allows registrants to exclude employees in a non-U.S. jurisdiction who (1) cannot be included without violating foreign data privacy laws (the ''data privacy exemption'') or (2) in the aggregate represent five percent or less of the registrant's total employee population (the ''*de minimis* exemption''). These exemptions were intended to reduce potential burdens of complying with the rule but some commenters have expressed the view that they are too limited to provide meaningful relief. *See, e.g.,* letters from ABA; Society for Corporate Governance.

[373] In its letter, Compensation Advisory Partners suggests that, short of repealing the pay ratio rule, the Commission should amend the rule so that ''the median employee calculation [is] based solely on the full-time U.S. workforce to reduce discrepancies arising from international compensation practices.''

[374] Because the proposed rules would exclude all foreign employees, we are proposing to remove the data privacy and *de minimis* exemptions that currently apply to these workers and removing and reserving Item 25(a) of Schedule 14A that concerns filing of the legal opinion supporting the data privacy exclusion.

[375] *See* Mark J. Perry/American Enterprise Institute, *Many Large US Firms Sell, Hire and Invest More Overseas Than in the US and Have to Think Globally to Survive* (June 22, 2020), available at *https://www.aei.org/carpe-diem/many-large-us-firms-sell-hire-and-invest-more-overseas-than-in-the-us-and-have-to-think-globally-to-survive/* (showing data for the 18 U.S. headquartered companies that were among the top 100 multinationals by foreign assets in 2019. Among these almost all ''have close to half, or more than half, of their global staffing outside the US'').

[376] Multinational registrants maintain headquarters in one country, but own or control production, services, or sales facilities in other countries. While the rule does not apply to foreign private issuers, it may apply to foreign issuers that are not foreign private issuers or to U.S. issuers that are multinational.

[377] The proposed rule changes include instructions about how registrants should determine whether an individual is employed in a jurisdiction of the United Stated or its territories, including by reference to its own internal policies and applicable laws.

[378] *See supra* notes 341 and 357.

[379] As we noted in the discussion above, we acknowledge the Commission's determination, at the time of the rule's adoption, that ''Congress thought that it was important for shareholders to have pay ratio disclosure that reflects 'all employees' of a registrant when making their say-on-pay votes.'' 2015 Pay Ratio Adopting Release at 50123. For the reasons discussed in this section, however, we believe it is appropriate to exercise our exemptive authority to limit the pool of employees from which the median employee determination is made, as proposed.

voting. At the same time, the burden on registrants resulting from the broad scope assigned to the term ''all employees'' at the time of the current rule's adoption does not appear to be necessary in order to retain the intended benefit to investors. We believe that investors should be better positioned to evaluate and engage with executive compensation and related say-on-pay votes if the pool of employees from which the median employee is identified are all subject to the same laws and standards affecting terms of employment and compensation (for example. minimum and overtime wage laws, anti-discrimination laws, including those protecting wages of employees with disabilities, and retirement income related laws), thereby enhancing comparability. Accordingly, we believe the proposed amendment to limit the determination of the median employee to employees located in the U.S. and its territories is necessary and appropriate in the public interest and consistent with the protection of investors.

Request for Comment

82. Should we adopt the proposed amendments to limit the scope of the population from which the median employee is identified for purposes of pay ratio disclosure to full-time workers employed in the U.S. and its territories? If not, please explain why not. If, instead, we should adopt a different approach, please describe the approach and why you believe it is preferable to the proposal. Should we include seasonal or temporary employees that are ''full-time'' when they are employees and if so, should we permit their compensation to be annualized? If so, explain how these workers' inclusion could impact disclosure overall or in certain industries.

83. How do investors presently use the pay ratio disclosure? In what ways does the pay ratio disclosure enhance investor engagement? What information included in the pay ratio disclosure is or could be useful to investors generally, and in making say-on-pay voting determinations in particular? Do investors currently compare pay ratio disclosures across registrants? Does the current rule's inclusion of non-U.S., part-time, seasonal, and temporary workers in determining the median employee limit comparability? Would the proposed amendments to the rule enhance comparability? Would focusing the disclosures on full-time workers employed in the U.S. and its territories across registrants, contributing to greater comparability, make the pay ratio disclosure more or less useful?

84. Should we omit from the amended pay ratio rule, as proposed, the current language excluding certain independent contractors and ''leased'' workers from the definition of ''employee''? Why or why not?

85. Should we include non-U.S. employees in the population from which a registrant identifies the median employee? What impact would the exclusion of non-U.S. employees, as proposed, have on pay ratio disclosure, including effects on investors and the market? Is the size or significance of the non-U.S. employee population of registrants overall or in certain industries such that their exclusion would impact the usefulness of pay ratio disclosure? If so, how? Alternatively, should we require the inclusion of employees in foreign jurisdictions in cases where most (or the largest distinct segment) of a registrant's employees are employed in non-U.S. jurisdictions?

86. If non-U.S.-based employees continue to be included in the population of employees for identification of the median employee, are there other changes that could reduce burdens on registrants? For example, should we expand the *de minimis* exemption provided in the current rule? If so, would a ten percent or 25 percent *de minimis* exemption be appropriate? Are there alternative exemptions or thresholds that would reduce burdens while still capturing relevant information regarding workers employed outside of the U.S.?

87. As proposed, PEOs that are not U.S.-based employees would be treated the same as U.S.-based PEOs. Are there specific factors or approaches that should be considered for registrants with such PEOs? Would the pay ratio disclosure in these instances be material to investors, particularly in evaluating and engaging with executive compensation and in say-on-pay votes?

88. As proposed, the pool of employees from which the median employee is identified would include those workers employed in the U.S. or any U.S. territory. Do registrants employ individuals who are outside of the U.S., but treat them as U.S. employees for salary, benefits, tax and other purposes?

89. We are proposing to provide in Item 402(h)(4) that a registrant may use reasonable methods to identify the median employee. What, if any, guidance should we provide in any adopting release or the rule to clarify how to distinguish between U.S. and non-U.S. employees? Should we allow registrants to use reasonable methods to make this determination, as proposed, or provide guidance regarding how registrants define the pool of employees for purposes of the median employee identification to distinguish U.S. and non-U.S. employees? If so, should we provide principles-based guidance or more prescriptive guidance? Alternatively, should the rule take a different approach to excluding non-U.S. employees? For example, should we limit the pool to employees for whom the registrant's tax and/or payroll systems use Internal Revenue Service Form W–2?

90. Should we provide guidance in the release or the rule regarding how to calculate the employee population when an employee is furloughed on the date used to determine the employee population from which a registrant identifies the median employee and, if included in the population, how to calculate the compensation of a furloughed employee? If so, what should that guidance or rule look like? Should it take a more principles-based or prescriptive approach?

2. Determination of Annual Total Compensation

We are proposing to align the approach to the determination of the PEO's and median employee's annual total compensation for purposes of the pay ratio disclosure rule with the proposed revisions to the tabular presentation of executive compensation.

Section 953(b)(2) of the Dodd-Frank Act requires that annual total compensation under the pay ratio rule be determined ''in accordance with [current Item 402(c)(x)] as in effect on the day before the date of enactment of this Act,'' referring to the then-current calculation of total compensation in the Summary Compensation Table. As described above, our proposed revisions to Item 402 would remove Item 402(c)(x), and the proposed amendments would not contain an equivalent table to the current Summary Compensation Table. Rather than retaining the substance of Item 402(c)(x) simply for purposes of the pay ratio rule, which we believe would be unduly burdensome, we are proposing to use our exemptive authority to look instead to the closest corollary to current Item 402(c)(x) in the proposed amendments.

We continue to believe that the principal compensation elements that are currently used to calculate annual total compensation for purposes of the pay ratio disclosure, including salary, bonus, and equity awards valued as of the grant date, are appropriate. Because we are proposing to replace the Summary Compensation Table with new tables and the proposed Granted Compensation Table would include

most of the same compensation elements as the Summary Compensation Table needed to calculate annual total compensation, we propose to use the information from the proposed Granted Compensation Table as the basis for determining annual total compensation for the PEO and median employee for purposes of the pay ratio disclosure. For example, for the PEO's annual total compensation, registrants would use the Total Compensation Granted amount from the proposed Granted Compensation Table (column (g)). With respect to the determination of compensation of the median employees, registrants would correspondingly apply the methodology of the proposed Granted Compensation Table.

We recognize that the proposed Granted Compensation Table does not include all of the elements included in the current Summary Compensation Table, including those related to pension benefits and compensation that is not reportable under another column of the table (*i.e.,* the all other compensation column); however, we believe that the total compensation amount included in the proposed Granted Compensation Table would provide the material elements of PEO compensation, for purposes of determining the pay ratio, and thus serve as a reasonable basis upon which to compare PEO and median employee compensation.[380] In addition, eliminating these elements (pension benefits and miscellaneous compensation items) would further reduce the burden on registrants since tracking these items for non-executive employees is generally not standard practice. Furthermore, we believe that using the proposed Granted Compensation Table as the basis for annual total compensation would not create additional burdens for registrants because the proposed rules do not change the current method of valuing employees' equity awards (using grant date fair value). In contrast, using the Earned Compensation Table valuation method for calculating pay ratio total compensation could require registrants to track employee grants of equity awards beyond the grant date to determine their values upon vesting or exercise.

In light of the proposed changes to the tabular presentation of executive compensation in Item 402, which we believe would improve executive compensation disclosure generally but also would eliminate current Item 402(c)(2)(x), we believe that the corresponding proposed changes to the determination of annual total compensation in the pay ratio disclosure rules are necessary and appropriate in the public interest, and consistent with the protection of investors.

Request for Comment

91. Should we adopt the proposed amendments to use the annual total compensation calculation amounts and methodology from the proposed Granted Compensation Table for purposes of the pay ratio disclosure? If not, please explain why not. If, instead, we should adopt a different approach, please describe the approach and why you believe it is preferable to the proposal.

92. Should we instead use the annual total compensation calculation methodology from the proposed Earned Compensation Table for purposes of the pay ratio disclosure? Are there elements of compensation from the Earned Compensation Table that should be included in PEO or median employee annual total compensation for purposes of pay ratio disclosure that are not included in the proposed Granted Compensation Table? For example, are there reasons that PEO or median employee annual total compensation for purposes of pay ratio disclosure should include one or more miscellaneous items, such as perquisites, tax gross ups, or pension-related expenses?

93. Should the value of equity awards be included at grant date or vesting date for purposes of determining annual total compensation? Do non-PEO employees in general receive equity awards to a sufficient extent to impact this determination?

3. Elimination of Certain Instructions; Timing of Determination of Median Employee

In keeping with the principles-based approach to these amendments, we propose to retain flexibility for registrants relating to the identification of the median employee but to eliminate the detailed requirements and instructions about the use of estimates and exclusion of certain employees. The current rule requires certain disclosures about the identification of the median employee, and provides lengthy guidance related to the use of adjustments, estimates, sampling, the treatment of employees resulting from recent acquisitions, and other matters. We believe that registrants should continue to have flexibility, but we propose to eliminate some of the detailed guidance from the current rule because we believe it may have resulted in disclosure that is unnecessary to an understanding of pay ratio disclosure and unintentionally constrained registrants' flexibility in preparing the disclosure. We also propose removing the disclosure requirements related to the identification process for the median employee because we believe the additional disclosure is not necessary for investor understanding of the pay ratio disclosure.

Specifically, we propose to remove the following current instructions to the pay ratio rule and incorporate some of their components into the proposed rule:

- *Instruction 1 to Item 402(u)—Disclosing the date chosen for identifying the median employee.* (Requiring disclosure relating to the date chosen for identifying the median employee.)
- *Instruction 2 to Item 402(u)—Identifying the median employee.* (Requiring, in part, that the registrant identify its median employee once every three years but also indicating that, every year, the registrant must determine if there has been a change in its employee population or employee compensation arrangements that the registrant reasonably believes would result in a significant change to its pay ratio disclosure and, if the registrant concludes there is no such a change, the registrant must include disclosure about that determination and use of the same median employee.)
- *Instruction 3 to Item 402(u)—Updating for the last completed fiscal year.* (Specifying the due date for pay ratio disclosure.)
- *Instruction 4 to Item 402(u)—Methodology and use of estimates.* (Providing guidance and requirements regarding the determination of the median employee and annual total compensation of employees other than the PEO, which concerns, among other things, (1) the use of reasonable estimates, (2) the use of reasonable methods to determine the median employee, like statistical sampling, (3) the ability to use annual total compensation or other compensation measures when consistently applied to all employees included in the calculation, (4) the ability to make cost-of-living adjustments to total compensation and required disclosure when such adjustments are made, and (5) the ability to include personal benefits that aggregate less than $10,000 and compensation under non-discriminatory benefit plans, which may

[380] As proposed, the Granted Compensation Table would include miscellaneous compensation items (such as perquisites, tax gross-ups, retirement-plan-related compensation and security expenses). By relying on the Total Compensation Granted in the Granted Compensation Table these items would not be included in CEO or median compensation for purposes of the pay ratio disclosure.

be excluded from the ''All other compensation'' column of the Summary Compensation Table, in total compensation.)

• *Instruction 5 to Item 402(u)—Permitted annualizing adjustments.* (Permitting annualizing adjustments for full- or part-time employees who were not employed for the full fiscal year, but prohibiting annualizing seasonal or temporary worker pay or making full-time equivalent adjustments for any employee.)

• *Instruction 6 to Item 402(u)—PEO compensation not available.* (Specifying disclosure required when a registrant is relying on current Instruction 1 to 17 CFR 229.402(c)(2)(iii) and (iv) to delay disclosure of salary or bonus of the PEO.)

• *Instructions 7 and 8 to Item 402(u)—Transition periods for registrants and Emerging Growth Companies.* (Providing transition timing for registrants that are newly required to provide the disclosure (*i.e.,* registrants that lost EGC or SRC status and registrants that have become subject to the reporting requirements of section 13(a) or 15(d) of the Exchange Act) and permitting omission of employees that became employees of the registrant as a result of an acquisition or business combination from the median employee calculation for the fiscal year in which the transaction became effective.)

• *Instruction 9 to Item 402(u)—Additional information.* (Permitting registrants to include additional information to supplement the required ratio disclosure and providing guidance regarding the presentation of such information.)

• *Instruction 11 to Item 402(u)—Employees' personally identifiable information.* (Clarifying that registrants are prohibited from disclosing an employee's personally identifiable information and need not identify the position of the median employee and, indeed, should not do so if that information would identify the employee.) [381]

While the instructions have provided some helpful guidance to registrants, many of them have also required that registrants disclose some additional details that may be unnecessary to an understanding of pay ratio disclosure and may have unintentionally constrained registrants' flexibility in gathering and presenting information, including identifying the median employee and calculating the annual total compensation of its employees other than the PEO. Accordingly, we do not find all of the information and guidance included in the current instructions to the rule necessary. Rather, we believe that the proposed rule itself provides sufficient guidance and also allows for flexibility by following a more principles-based approach.

Under this approach, the proposed rules provide a registrant with sufficient flexibility to maintain its current processes for gathering and presenting information that were implemented consistent with the current instructions and guidance. Registrants would also not be precluded from using other methods in preparing and presenting their pay ratio disclosure.[382]

We are proposing to eliminate Instructions 1 and 2 to Item 402(u) regarding disclosure of the date chosen for identification of the median employee and triennial identification of the median employee.[383] We are proposing these changes in order to streamline the disclosure requirement because it is not clear that information about the date used to identify the median employee or why the registrant selected a new date for that purpose is necessary to understand the pay ratio disclosure, particularly in light of our proposal to exclude seasonal workers since they can cause significant changes in employee populations during different times of the year. Instruction 2 provides that the registrant identify the median employee at least once every three years. We are proposing to eliminate this language in Instruction 2, replacing it with a similarly structured requirement that the registrant identify the median employee at least once every five years in proposed Item 402(h)(2). We believe that the increase from three to five years would reduce registrant burdens without a materially negative impact on information available to investors.

Instructions 3, 6, 7, and 8 address the timing for providing pay ratio information when: (1) updating for the last completed fiscal year; (2) the compensation of the PEO is not yet available; (3) the registrant must comply with the rule after losing SRC or EGC status or upon becoming a reporting company; or (4) the registrant gains employees through a business combination or acquisition. Because the proposed rule would significantly simplify the pay ratio disclosure requirements, we are proposing to no longer provide the additional guidance [384] and transition periods for registrants after losing SRC or EGC status or entering the reporting system currently found in Instructions 3, 7, and 8 to Item 402(u).[385] In addition, our proposed revisions remove the requirement to file a Form 8–K for executive compensation information that later becomes available (current Instruction 6 to Item 402(u)), consistent with our proposal to eliminate current Instructions to 17 CFR 229.402(c)(2)(iii) and (iv), as discussed above in section II.P. We also propose to remove the accommodation of Instruction 7(2) that permits a registrant to omit any employees that became its employees as the result of the business combination or acquisition of a business for the fiscal year in which the transaction becomes effective from the text of the rule because, consistent with a more principles-based disclosure requirement, we believe that omitting employees in that scenario would be a reasonable adjustment in identifying the median employee under proposed Item 402(h)(4).

We are also proposing to provide in Item 402(h)(4) that a registrant may use any reasonable methods, adjustments (including annualizing the total compensation for all full-time employees that were employed by the

[381] We are proposing to retain current Instruction 10 to 17 CFR 229.402(u) that provides guidance relating to a registrant with more than one non-concurrent PEO serving during a fiscal year as proposed Instruction to Item 402(h).

[382] The 2017 Pay Ratio Interpretive Release provided additional guidance regarding: the use of reasonable estimates, assumptions, methodologies, and statistical sampling to identify the median employee and calculate the median employee's annual total compensation; the use of internal records, such as tax or payroll records, to determine the median of the annual total compensation of all employees excluding the PEO; and the scope of the exclusion for independent contractors or ''leased workers'' from the definition of ''employee.''

[383] Proposed Item 402(h)(2) would include a requirement that the registrant identify its median employee at least once every five years, replacing language in current Instruction 2 providing that this be done once every three years. Proposed Item 402(h)(2) would retain the related requirement of current 17 CFR 229.402(u)(3) that registrants must select the median employee in the last three months of the last completed fiscal year.

[384] Instruction 3 to 17 CFR 229.402(u) provides specific guidance relating to when pay ratio information is required to be disclosed for the last completed fiscal year. In light of our proposal that would significantly simplify the disclosure and would address concerns relating to the timing of executive compensation disclosure that covers the last completed fiscal year in registration statements (see section II.P below), we believe this guidance would be unnecessary, and pay ratio disclosure should be included with a registrant's other Item 402 disclosures.

[385] We note that the 2026 Filer Status Proposing Release has proposed to extend the accommodations provided to current SRCs or EGCs to all registrants that would be NAFs under that proposal. As such, if the 2026 Filer Status Proposing Release is adopted as proposed, all NAFs would be exempt from providing pay ratio disclosure during the sixty-month period after becoming subject to the requirements of section 13(a) or 15(d) of the Exchange Act. *See infra* section II.M.

registrant for less than the full fiscal year), and estimates to (1) identify the median employee (including to distinguish U.S. and non-U.S. employees) and (2) calculate the annual total compensation for employees other than the PEO. By providing the key elements that are included in the current detailed Instructions 4 and 5 to Item 402(u), which respectively relate to the use of estimates, adjustments, and sampling in determining the median employee and annualization of total compensation of employees other than the PEO, we do not believe that additional instructions would be necessary and are proposing to eliminate the detailed instructions in favor of a more principles-based approach in the rule.

We do not intend to limit or remove any of the examples of flexibilities in Instruction 4 but are concerned that listing certain permitted flexibilities may have inadvertently had the effect of limiting flexibility.[386] For example, we continue to believe that using the employee population or statistical sampling are examples of reasonable methods of determining the median employee. Similarly, a registrant may identify the median employee using annual total compensation or any other compensation measure that is consistently applied to all employees included in the calculation such as information derived from the registrant's tax and/or payroll records.

Further, in an effort to reduce lengthy executive compensation disclosure, we propose to remove requirements for specific disclosures explaining a registrant's application of estimates, adjustments, and sampling in determining the median employee and calculating annual total compensation. We are also proposing to remove as unnecessary Instructions 9 and 11, which concern the disclosure of supplemental information and employees' personally identifiable information, in order to streamline the rule, consistent with the more principles-based approach. Notwithstanding the elimination of Instructions 9 and 11, registrants may consider the general principles they reflect. That is, a registrant may, but need not, present additional information, like an additional ratio, but should clearly identify the information, ensure it is not misleading, and not present it with greater prominence than the required ratio. Registrants also should not disclose any personally identifiable information about the median employee other than his or her compensation—and are not required to identify an employee's position, even at a general level, and, indeed, should not do so if that information could identify a specific individual.

Request for Comment

94. Should we adopt the proposed amendments to eliminate the current instructions to Item 402(u)? If not, please explain why not.

95. Are there elements of the proposed rule that would be unclear absent the current instructions such that registrants would find additional clarification in instructions useful? Are there specific, current instructions about the use of methods, assumptions, and estimates in determining the median employee that continue to be useful or necessary? Should we retain Instruction 11 regarding the treatment of personally identifiable information?

96. Should the rule continue to specify that a registrant is not required to provide pay ratio disclosure until the first fiscal year commencing on or after the date the registrant became subject to the reporting requirements or ceases to qualify as an SRC or EGC? In light of the breadth of the proposed simplifications to the pay ratio disclosure rule, is such a transition period necessary? Should the rule continue to include the accommodation of Instruction 7(2) regarding the inclusion of acquired employees in the median employee calculation?

97. Should registrants continue to be required to disclose the date on which the median employee is identified and why the date changes, as applicable? Is this information necessary information for investors?

98. Should we adopt the proposal to change the frequency with which registrants must determine the median employee from once every three years to once every five years or another alternative cadence? Do employee populations, salaries, and/or registrant pay practices change significantly over a three-year versus five-year period? How would registrants' compliance costs change under a five-year requirement compared to a three-year requirement?

99. Is disclosure regarding a registrant's use of these methods, assumptions, and estimates necessary information for investors? Should we require disclosure that explains how the registrant identified the median employee and calculated annual total compensation? If so, should we require that a registrant briefly describe its methodology of identifying the median employee and any material adjustments or estimates used to identify the median employee and calculate the annual total compensation for employees other than the PEO? Should we identify particular reasonable methods that are permissible for identifying the median employee? If so, which reasonable methods should we identify? Should we take another approach to any explanatory disclosure requirements, such as by maintaining some or all of the aspects of Instruction 4 that we are not proposing to include in the rule in the same or a modified form?

J. Potential Payments Upon Termination or Change-in-Control—Proposed Item 402(i)

We are proposing to amend and redesignate 17 CFR 229.402(j) (''Item 402(j)'') to eliminate the current prescriptive quantitative requirement to disclose potential payments and benefits to an NEO in various termination or change-in-control scenarios.[387] We are also proposing to require the qualitative disclosure of only the material terms of both written and unwritten arrangements related to such payments and to eliminate the prescriptive qualitative and quantitative disclosure requirements of 17 CFR 229.402(j)(1) through (5) and current Instructions 1 through 3 to Item 402(j).

[386] Several comments received in connection with the 2025 Roundtable requested flexibilities not specifically mentioned in the current Instructions to 17 CFR 229.402(u), suggesting that some registrants may view the current instructions as the outer limit of permitted discretion in preparing the disclosure. *See, e.g.,* letters from McGuireWoods & Brownstein (suggesting that the rules allow companies to utilize a safe harbor determination methodology that compares W–2 compensation of the CEO to that of the U.S.-based median employee); CEC–2 (recommending, among other changes, allowing the use of W–2 records in determining employee count and compensation). These two letters are notable in their requests to use W–2 records to determine compensation and employee count, given that current Instruction 4 already permits the use of tax records as a method for identifying the median employee, so long as that method is consistently applied to all employees included in the calculation. *See also* letters from Prof. Bainbridge (suggesting that the Commission allow the use of statistical sampling from the Bureau of Labor Statistics); Chamber of Commerce (requesting a safe harbor to use data from the Bureau of Labor Statistics in determining the median employee, allow registrants to exclude employees who are on leave, and a standard definition of ''independent contractor'').

[387] *See* Instruction 1 to 17 CFR 229.402(j). We are also proposing that, in contrast to current 17 CFR 229.402(j) but consistent with current 17 CFR 229.402(c)(2)(ix)(D) (''All other compensation'' column of the Summary Compensation Table), a change in the NEO's responsibilities would be treated as an example of constructive termination, rather than as a separate prong of circumstances covered by proposed Item 402(i). We are proposing this change for consistency between how the termination and change-in-control scenarios are described in proposed Item 402(b)(2)(vii)(E) (Miscellaneous Compensation Received column of the proposed Earned Compensation Table) and proposed Item 402(i).

This disclosure would be required for any person who served as the PEO or PFO of the registrant during the last completed fiscal year. We also would retain the substance of current Instruction 5, which permits exclusion from disclosure of contracts, agreements, plans, or arrangements that do not discriminate in scope, terms, or operation in favor of executive officers and are available generally to all salaried employees, as proposed Instruction 2 to Item 402(i).[388]

We are also proposing a new instruction that would permit omission of this disclosure if the registrant has fulfilled the requirements of the rule in a filing made under Item 5.02 of Form 8–K.[389]

Under the current rule, registrants are required to provide a range of qualitative disclosures with respect to any written or unwritten arrangements that provide for payments or benefits to an NEO in connection with termination or change-in-control scenarios. Registrants are required to provide quantitative disclosures in this regard as well. The proposed amendments would instead require registrants to describe only the material terms of such arrangements.

Several commenters suggested that disclosure requirements related to potential payments upon termination or change-in-control be either simplified or eliminated entirely.[390] Some of these commenters expressed the view that these disclosure requirements are problematic, in part, because they require registrants to perform costly and extensive calculations based on hypothetical fact patterns that have not occurred.[391]

The proposed amendments would eliminate the requirement to include quantitative disclosures that:

- Are based on hypothetical scenarios; [392]
- Are often presented by registrants in multiple additional, complex tables that are not expressly prescribed by Item 402(j); and
- May require the registrant to make numerous, complex calculations and estimates.

We do not believe that detailed, complex, qualitative and quantitative disclosures that address a range of hypothetical scenarios are likely to be material to investors when the registrant would already present the material terms of arrangements that contain potential payments and benefits to an NEO in various termination or change-in-control scenarios. We additionally note that current Item 402(q)(2) provides an accommodation to SRCs that allows those registrants to provide a narrative description, to the extent material, of each contract, agreement, plan, or arrangement, whether written or unwritten, that provides for payment(s) to an NEO at, following, or in connection with the resignation, retirement, or other termination of an NEO, or a change in control of the SRC, or change in the NEO's responsibilities following a change in control, with respect to each NEO. We are proposing to extend a similar, more generalized requirement to all registrants, namely that they disclose only the terms of the termination or change in control arrangements that are likely to be material.[393]

By eliminating the prescriptive qualitative and quantitative disclosure requirements, the proposed amendments are intended to reduce compliance burdens for registrants and the length and complexity of their proxy disclosures, while retaining for investors relevant disclosures about the material terms of arrangements that provide for potential payments and benefits in connection with various termination and change-in-control scenarios.

Request for Comment

100. Should we eliminate the qualitative and quantitative disclosure requirements in current 17 CFR 229.402(j)(1) through (5) and Instructions 1 through 3 to Item 402(j) regarding potential payments and benefits in various termination or change-in-control scenarios, as proposed? Why or why not? What changes, if any, should be made to the disclosure requirements related to potential payments and benefits in termination or change-in-control scenarios under proposed Item 402(i)? Would eliminating or modifying the quantitative or qualitative disclosure requirements reduce costs for registrants?

101. Do investors use registrants' quantitative and qualitative disclosure related to potential payments and benefits in termination or change-in-control scenarios under current Item 402(j) and, if so, how? What, if any, effects would eliminating the quantitative disclosure requirement under Item 402(j), as proposed, have on investors and the market, including with respect to the availability of material information for making investment or voting decisions? Would eliminating or modifying the quantitative or qualitative disclosure requirements under current Item 402(j) result in the loss of material information for investors or otherwise affect investor protection?

102. Should a change in an NEO's responsibilities be treated as an example of constructive termination, rather than as a separate prong of circumstances covered by proposed Item 402(i), as proposed? Under the current rule, are there circumstances where a change in responsibilities would trigger a disclosure requirement under current 17

[388] *See* 17 CFR 229.402(j)(1) through (5) (requiring a range of qualitative disclosures about any contract or other arrangement that provides potential payments and benefits in connection with various termination and change-in-control scenarios, including descriptions of the circumstances that would trigger such payments or benefits, the type of payments or benefits and by whom they would be provided, how the payment and benefit levels would be determined, any material conditions or obligations that would be applicable to the recipient such as non-compete and confidentiality agreements, and any other material factors). Disclosure is not required with respect to contracts or other arrangements that do not discriminate in favor of executive officers and are available generally to all salaried employees. *See* Instruction 5 to 17 CFR 229.402(j).

[389] *See* Item 5.02 (Departure of Directors or Certain Officers; Election of Directors; Appointment of Certain Officers; Compensatory Arrangements of Certain Officers) of Form 8–K.

[390] *See* letters from ABA (''[W]e recommend the disclosure requirement be limited to a narrative description of the material elements of the NEOs' post-employment compensation plans and arrangements and the requirement to quantify the estimated payments and benefits under such plans and arrangements be removed.''); McGuireWoods & Brownstein (recommending that the disclosure requirements under the ''potential payments upon termination or change-in-control'' be eliminated); Society for Corporate Governance (''We recommend that the Commission eliminate this disclosure requirement and instead allow companies to provide simplified narrative disclosure without quantification of material terms of any contractual obligations that provide for payments to an NEO at, following, or in connection with their resignation, retirement or other termination, or a change in control of company or a change in the NEO's responsibilities following a change in control.'').

[391] *See* letters from McGuireWoods & Brownstein; Society for Corporate Governance.

[392] The current rule requires the registrant to quantify the payments and benefits that would have been provided to each NEO in connection with a range of termination or change-in-control scenarios, assuming that the triggering event for such termination or change-in-control scenario took place on the last business day of the registrant's last completed fiscal year. *See* Instruction 1 to 17 CFR 229.402(j).

[393] The SRC provision set forth in current 17 CFR 229.402(q)(2) differs somewhat from the non-SRC provision (17 CFR 229.402(j)) in that the list of change in control arrangements for which disclosure is required for SRCs includes a change in responsibilities *only* when it follows a change in control. The non-SRC provision, in contrast, requires disclosure for a change in responsibilities whether or not it follows a change in control. Although we are proposing to largely adopt the accommodation currently provided to SRCs, we are not proposing to limit disclosure related to a change in responsibilities to only those cases where it follows a change in control, consistent with the approach taken by the Commission in 2006. *See* note 313 in the 2006 Adopting Release at 53188.

CFR 229.402(j) but not under 17 CFR 229.402(c)(2)(ix)(D) (''All other compensation'' column of the Summary Compensation Table)? Is the set of circumstances covered by proposed Item 402(i) equivalent to those covered by current 17 CFR 229.402(j)? Should we use consistent wording to describe the termination and change-in-control scenarios covered by proposed Item 402(b)(2)(vii)(E) (Miscellaneous Compensation Received column of the proposed Earned Compensation Table) and proposed Item 402(i)? If not, why not?

K. Golden Parachute Compensation—Proposed Item 402(j)

We are proposing to simplify the existing golden parachute compensation disclosure requirements in 17 CFR 229.402(t) (''Item 402(t)'') and make them more principles-based.[394] More specifically, we are proposing to streamline the tabular disclosure requirements and provide more flexibility for narrative disclosure about golden parachute compensation.

Some commenters expressed the view that the Commission should reexamine or streamline the golden parachute disclosure requirements.[395] These commenters suggested that golden parachute shareholder advisory votes are of limited utility and not uniformly required in acquisition transactions.[396]

Under the current rule, which was adopted in accordance with section 14A(b)(1) of the Exchange Act as added by section 951 of the Dodd-Frank Act,[397] registrants are required to provide golden parachute compensation disclosure for each NEO for whom compensation disclosure is required pursuant to Item 402.[398] The current rule requires a detailed tabular presentation of the following information:

- Name of the NEO (column (a)); [399]
- Aggregate dollar value of any cash severance payments, including but not limited to payments of base salary, bonus, and pro-rated non-equity incentive compensation plan payments (column (b)); [400]
- Aggregate dollar value of: (1) stock awards for which vesting would be accelerated, (2) in-the-money option awards for which vesting would be accelerated, and (3) payments in cancellation of stock and option awards (column (c)); [401]
- Aggregate dollar value of pension and nonqualified deferred compensation benefit enhancements (column (d)); [402]
- Aggregate dollar value of perquisites and other personal benefits or property, and health care and welfare benefits (column (e)); [403]
- Aggregate dollar value of any tax reimbursements (column (f)); [404]
- Aggregate dollar value of any other compensation that is based on or otherwise relates to the transaction not properly reported in any other column (column (g)); [405] and
- Aggregate dollar value of the sum of all amounts reported in the columns that contain dollar figures (column h)).[406]

The current rule also requires a succinct narrative description of any material factors necessary to an understanding of each golden parachute-related contract, agreement, plan, or arrangement and the payments quantified in the tabular disclosure.[407] Finally, the rule provides the following non-exhaustive list of examples of such material factors: (1) the specific circumstances that would trigger payment(s); (2) whether the payments would or could be lump sum, or annual, disclosing the duration, and by whom they would be provided; and (3) any material conditions or obligations applicable to the receipt of payment or benefits, including but not limited to non-compete, non-solicitation, non-disparagement or confidentiality agreements, including duration of such agreements and provisions regarding waiver or breach of such agreements.[408]

We are proposing to consolidate the tabular disclosure of golden parachute compensation by revising the required table as follows:

Golden Parachute Compensation Table				
Name	**Cash ($)**	**Equity ($)**	**Miscellaneous ($)**	**Total ($)**
(a)	*(b)*	*(c)*	*(d)*	*(e)*
[PEO]				
[PFO]				

The purpose of the revised Golden Parachute Compensation Table is to streamline the disclosure requirements and create a simpler presentation of the required information. The proposed Golden Parachute Compensation Table

[394] In addition to the changes discussed below, the proposed amendments also would change ''shall'' to ''must'' and convert a number of instructions into rule text.

[395] *See* letters from A&O Shearman (suggesting that the disclosure requirements related to golden parachute shareholder advisory votes be reviewed by the Commission); McGuireWoods & Brownstein (stating that the Commission should ''dramatically streamline the say on golden parachute disclosure requirements'').

[396] *See* letters from A&O Shearman (''[T]he Say-on-Golden Parachute vote does not even uniformly apply to provide shareholders with a vote in all change-in-control transactions. For example, a Say-on-Golden Parachute vote is not required in a transaction structured as a tender offer followed by a short-form merger. This anomalous result given variations in transaction structure further reduces the utility of the Say-on-Golden Parachute vote.''); McGuireWoods & Brownstein (stating that ''[s]ay on golden parachute votes are also advisory/non-binding in nature, but are even more meaningless than say on pay votes as the company proposing the advisory shareholder vote will no longer exist following the closing of the transaction.'').

[397] *See* Public Law 111–203, 124 Stat. 1376, section 951 (2010).

[398] *See* 2011 Say-on-Pay Adopting Release. Current 17 CFR 229.402(t) requires the disclosure of golden parachute compensation in any proxy or consent solicitation material distributed in connection with a transaction that necessitates a shareholder advisory vote pursuant to 17 CFR 240.14a-21(c) (other than such a solicitation made by an EGC) or in any proxy consent solicitation that includes disclosure under Item 14 of Schedule 14A pursuant to Note A of Schedule 14A (excluding any proxy or consent solicitation made by an EGC). The current rule applies to SRCs, but specifically exempts EGCs. The 2026 Filer Status Proposing Release proposes to exempt registrants that qualify as NAFs, which would include all current SRCs and EGCs, from the requirement to conduct golden parachute shareholder advisory votes and from providing the associated golden parachute disclosure. We have not proposed to exempt SRCs in this proposal to avoid duplicating the pending proposal, but if the 2026 Filer Status Proposing Release is adopted as proposed, all NAFs would be exempt from the golden parachute disclosure requirements under Item 402 as well as the golden parachute shareholder advisory votes. See section II.M. for further discussion.

[399] *See* 17 CFR 229.402(t)(i).

[400] *See* 17 CFR 229.402(t)(ii).

[401] *See* 17 CFR 229.402(t)(iii).

[402] *See* 17 CFR 229.402(t)(2)(iv).

[403] *See* 17 CFR 229.402(t)(2)(v).

[404] *See* 17 CFR 229.402(t)(2)(vi).

[405] *See* 17 CFR 229.402(t)(2)(vii).

[406] *See* 17 CFR 229.402(t)(2)(viii).

[407] *See* 17 CFR 229.402(t)(3).

[408] *See* 17 CFR 229.402(t)(3)(i) through (iii).

would reduce the number of total columns from eight to four by consolidating current columns (d) through (g) into a single ''Miscellaneous'' column. Under the proposed rule, the disclosure requirements for columns (b) and (c) would be retained in their entirety and the column for the aggregate dollar value of the sum of all amounts reported in the columns that contain dollar figures (what is currently column (h) in the existing table) would be retained as well, except that it would be redesignated as column (e) in the new table.

Under the proposed rule, the registrant would be required to provide, in the tabular format discussed above, material information relevant to an assessment of any agreement or understanding, whether written or unwritten, between an NEO and the acquiring company or target company, concerning any type of compensation, whether present, deferred, or contingent, that is based on or otherwise relates to an acquisition, merger, consolidation, sale, or other disposition of all or substantially all assets of the issuer. The proposed ''Miscellaneous'' column would therefore require, pursuant to an assessment made by the registrant in light of the requirement set forth in proposed Item 402(j)(1), the disclosure of any other material compensation that is based on or otherwise related to the transaction that is not properly reported in either the proposed ''Cash'' or ''Equity'' columns. Such compensation may include what is currently required to be disclosed in 17 CFR 229.402(t)(2)(iv) through (vi) (*i.e.,* the aggregate dollar value of pension and nonqualified deferred compensation benefit enhancements, the aggregate dollar value of any perquisites and other personal benefits or property, and health care and welfare benefits, and/or the aggregate dollar value of any tax reimbursements) to the extent the compensation is material. The proposed rule would require registrants to consider and determine, based on their own particular facts and circumstances, the types and amounts of golden parachute compensation that should be disclosed in the ''Miscellaneous'' column.

We are also proposing to eliminate the following, in favor of more principles-based disclosure:

- Mandatory footnote requirements for each of the proposed columns; [409]
- Instructions to provide additional golden parachute compensation tables to cover new arrangements and understandings, and/or revised terms of agreements and understandings; [410] and
- The non-exhaustive list of examples of material factors necessary to an understanding of golden parachute compensation.[411]

We note that registrants would be required to continue to disclose material information that is necessary to an understanding of the payments quantified in the proposed tabular disclosure, and may continue to provide information that is similar in nature to the factors currently identified in 17 CFR 229.402(t)(3) or the additional tables currently referenced in Instructions 6 and 7 to 17 CFR 229.402(t)(2) to satisfy their disclosure requirements. However, the proposed rule would eliminate the requirements to provide specific disclosure of such factors or such additional tables.

In connection with our proposal to limit the definition of the NEOs in Item 402 to cover only the PEO and PFO, the required golden parachute compensation disclosure would also be limited to the PEO and PFO.[412] We believe that this proposed change is consistent with the statutory requirements of section 14A(b)(2), which specifically requires disclosure regarding golden parachute-related agreements or understandings with ''any named executive officers'' and does not mandate the executive officers that the definition of NEO must include.

Overall, the proposed changes to the golden parachute compensation disclosure requirements are meant to provide a more principles-based approach to the disclosure requirements, permitting registrants to have more flexibility in how they disclose the material aspects of these kinds of compensation arrangements and simplifying the required disclosures. We believe that the overly prescriptive nature of the current golden parachute compensation disclosure requirements has created a burden on registrants to disclose potentially immaterial information about golden parachute compensation that may have limited utility for investors and the marketplace.

Request for Comment

103. Should we revise the golden parachute disclosure requirements as proposed? Should any different or additional changes be made to these requirements? For example, should the required disclosure be limited to compensation that is likely to be paid or will be paid within a specific timeframe in connection with the subject transaction or any compensation that ''is based on or otherwise relates to'' the subject transaction, as proposed? Should we consolidate columns (d) through (g) of the current Golden Parachute Compensation Table, as proposed? Should we eliminate tabular disclosure requirements regarding golden parachute disclosure in their entirety? What would be the effects of eliminating tabular golden parachute disclosure on registrants' costs and burdens and investor protection?

104. Should we revise the instruction to remove reference to whom the requirements should apply,[413] as proposed?

105. If we should require golden parachute compensation disclosure about other executive officers besides just the PEO and PFO, what other executive officers would it be appropriate for the disclosure to cover?

[409] *See* Instructions 4 and 5 to 17 CFR 229.402(t)(2). The proposed rule does not prohibit footnote disclosure if a registrant deems that the use of footnotes with respect to its tabular disclosure is appropriate based on its facts and circumstances. Rather, the proposed rule eliminates the requirement to provide footnote disclosure for all registrants.

[410] *See* Instructions 6 and 7 to 17 CFR 229.402(t)(2). As proposed, new Item 402(j)(3) would continue to require that registrants separately disclose both the agreements and amounts previously disclosed and subject to a shareholder advisory vote and the new agreements and revised terms subject to a separate shareholder advisory vote without requiring that the disclosure be provided in a tabular format. *See* Instruction 6 to 17 CFR 229.402(t). Additionally, as proposed, new Item 402(j)(4) would continue to require, in cases where disclosure of agreements and understandings between an acquiring company and the named executive officers of the soliciting target company is required, clarification of whether the agreements and understandings are subject to the separate shareholder advisory vote by providing separate disclosure of all agreements and understandings subject to the shareholder advisory vote. *See* Instruction 7 to 17 CFR 229.402(t).

[411] 17 CFR 229.402(t)(3) requires a description of the specific circumstances that would trigger payment(s); whether payments would or could be lump sum, or annual, disclosing the duration, and by whom they would be provided; and any material conditions or obligations applicable to the receipt of payment or benefits, including but not limited to non-compete, non-solicitation, non-disparagement, or confidentiality agreements, including the duration of such agreements and provisions regarding waiver or breach of such agreements.

[412] *See supra* section II.B. If the rules are adopted as proposed, because disclosure would only be required regarding the PEO and PFO, the instruction that disclosures should be applied with respect to the NEOs for whom disclosure was required in the registrant's most recent filing with the Commission that required disclosure pursuant to Item 402(c) (Summary Compensation Table) would also be unnecessary and we are proposing to eliminate this portion of the current instruction. *See* Instruction 1 to 17 CFR 229.402(t)(2).

[413] *See* current Instruction 1 to 17 CFR 229.402(t)(2) (''Apply Instruction 1 to Item 402(t) with respect to those executive officers for whom disclosure was required in the issuer's most recent filing with the Commission under the Securities Act . . . or Exchange Act . . . that required disclosure pursuant to Item 402(c).'').

106. If the amendments expanding the exemption from golden parachute compensation disclosure to all NAFs, which would include current SRCs and EGCs, in the 2026 Filer Status Proposing Release are not adopted, should we exempt or provide other accommodations to SRCs relating to the golden parachute disclosure requirements?

107. Should golden parachute disclosure requirements be removed from Item 402 of Regulation S–K in their entirety and only mandated elsewhere, such as within Schedule 14A and Schedule 14C? What would be the effects of moving golden parachute disclosure requirements out of Item 402 and placing them within Schedule 14A and Schedule 14C (and elsewhere as appropriate) on registrants' costs and burdens and investor protection?

L. Compensation of Directors—Proposed Item 402(k)

We are proposing to continue to require qualitative and quantitative disclosure of the cash, equity and other material compensation amounts earned by members of the board of directors (or similar governing body) for the registrant's last completed fiscal year, but to amend the rule in favor of a more principles-based approach. The proposed rules would eliminate certain prescriptive requirements, including mandatory disclosure related to the change in value of pension plans, earnings on nonqualified deferred compensation and total director compensation; mandatory tabular presentation requirements; and a list of ''all other compensation'' amounts. Consistent with a principles-based approach, we are proposing to require that registrants describe the material aspects of the registrant's director compensation program and disclose any material information necessary to an understanding of the compensation amounts disclosed pursuant to the rule. Additionally, the proposed rule specifies the quantified information that would be required as to each person that served as a director during any part of the last fiscal year, and provides registrants with flexibility to present such information in a format they choose, including narrative, tabular, or a combination.

Under the current rule, the registrant is required to present the compensation of the directors for the last completed fiscal year in a tabular format, the Director Compensation Table, that largely tracks the Summary Compensation Table and to include a narrative description of any material factors necessary to an understanding of the compensation disclosed in the table.[414] Some commenters suggested that the disclosure rules related to director compensation be revised to permit presentation via narrative disclosure only.[415] In support of limiting director compensation disclosure to narrative presentation only, one commenter noted that ''[i]nvestors are typically interested in the director compensation policy and individual arrangements, from which they can determine whether director compensation is excessive.'' [416]

Although we are proposing to eliminate the prescriptive tabular presentation requirement currently set forth in Item 402(k), our proposed amendments would continue to require quantified disclosure of material director compensation elements. The current director compensation rule requires tabular disclosure of the following specific elements of compensation:

- The dollar amount of all fees earned or paid for services as a director, including annual retainer fees, committee and/or chairmanship fees, and meeting fees (17 CFR 229.402(k)(2)(ii));
- The grant date fair value (computed in accordance with FASB ASC Topic 718) of stock and option awards (17 CFR 229.402(k)(2)(iii) and (iv));
- Earnings for services performed during the fiscal year pursuant to non-equity incentive plans and all earnings on any outstanding awards (17 CFR 229.402(k)(2)(v));
- The sum of the aggregate change in the actuarial present value of the director's accumulated benefit under all defined benefit and actuarial pension plans and above-market or preferential earnings on compensation that is deferred on a basis that is not tax-qualified (17 CFR 229.402(k)(2)(vi)); and
- All other compensation for the covered fiscal year, including an enumerated list of required items (17 CFR 229.402(k)(2)(vii)).

Our proposed amendments to the director compensation requirements would largely retain the substance of the quantitative content requirements of current Item 402(k).

Specifically, proposed Item 402(k)(1) would require separate quantification of retainer fees for board, committee, chairmanship, and other director services. Proposed Item 402(k)(2)(i) would require specific disclosure of the aggregate dollar amount of all cash earned by directors, which is intended to cover the substance of current 17 CFR 229.402(k)(2)(ii) related to cash compensation and current 17 CFR 229.402(k)(2)(v) related to non-equity incentive plan earnings. With respect to equity awards, proposed Item 402(k)(2)(ii) would retain the requirement to disclose the value of stock and option awards; however, rather than valuing equity awards at grant date fair value under FASB ASC Topic 718, our proposed rule would require disclosure of the dollar value realized upon the vesting of stock awards and exercise of option awards. This proposed equity valuation approach is consistent with the methodology we are proposing for the Earned Compensation Table for PEO and PFO compensation. Proposed Item 402(k)(2)(iv) would retain the ''catch-all'' nature of current 17 CFR 229.402(k)(2)(vii). Consistent with the principles-based approach we are taking in this release, however, our proposed catch-all item would eliminate the current requirement to disclose a prescriptive list of required ''other'' items and would also limit the disclosures to material compensation.[417]

We are not proposing to retain or replace the requirements of current 17 CFR 229.402(k)(2)(vi) to disclose

[414] *See* 17 CFR 229.402(k) (for registrants other than SRCs and EGCs); 17 CFR 229.402(r) (for SRCs and EGCs). 17 CFR 229.402(k)(3) and 17 CFR 229.402(r)(3), as applicable, also require registrants to provide a narrative description of any material factors necessary to an understanding of the director compensation disclosed in the table.

[415] *See, e.g.,* letters from Compensia (stating the belief that ''the information presented in this table is of little value to investors who, in our experience, are most interested in the annual 'cost of governance' embodied by the plan or policy and/or how that 'cost' is allocated among the directors based on their various responsibilities.''); Davis Polk (stating that ''[t]he Director Compensation Table, set forth in Item 402(k), should be removed because any material information concerning directors can be sufficiently covered by narrative disclosure, and the current tabular approach results in excess costs to [registrants].'').

[416] *See* letter from Davis Polk (this commenter also noted that ''[u]nlike executive compensation, which includes performance metrics which investors want to follow, director compensation is typically limited to cash retainers and service-vesting restricted stock units ('RSUs'), so there are no elements of director compensation which need to be tracked.'').

[417] Current Item 402(k)(2)(vii) requires disclosure of ''all other compensation'' paid to each director (regardless of amount) that could not properly be reported under another column in the director compensation table and lists nine categories of compensation that a registrant is required to disclose as ''all other compensation.'' These nine categories include, among other things, retirement contributions, tax gross-ups, consulting fees, and costs associated with director legacy programs. Consistent with the goal of focusing on material information and adopting a more principles-based approach, our proposed amendments would replace the requirement to disclose ''all other compensation'' (regardless of amount) with a general materiality catch-all that would capture compensation amounts falling into the currently enumerated nine categories, where material.

compensation related to pension plans and earnings on nonqualified deferred compensation plans. Although we are proposing to retain some disclosure related to these types of compensation for the PEO and PFO,[418] for director compensation, we do not believe that these requirements are necessary. Specifically, it does not appear that these benefits are common in director compensation packages although in the past they may have been.[419] As such, we propose to update the director compensation disclosure requirements to more closely reflect current director compensation practices. In addition, to the extent that a registrant's director compensation program includes pension or nonqualified deferred compensation, the registrant would need to consider whether any such compensation is required to be disclosed under proposed Item 402(k)(2)(iv).

In addition to the elements described above, we are also proposing to continue to require that registrants provide certain information about outstanding equity awards held by directors in proposed Item 402(k)(iii). These details include the number of equity awards outstanding as of the end of the last completed fiscal year, and, for each award, the grant date, vesting schedule, and any other material terms of any performance, market, and/or service conditions. As with the proposed Status of Equity Awards Table related to PEO and PFO disclosure discussed above in section II.C.3, the requirements we are proposing related to director equity awards are intended to make it easier for investors to track director equity awards. Although we do not intend the disclosure we are proposing for director equity awards to be as detailed as the proposed tabular disclosure requirements for the PEO and PFO, we believe that there is value for investors in understanding the status of director equity awards.

Our proposed amendments would also largely retain the narrative director compensation requirements set forth in current 17 CFR 229.402(k)(3), while also applying the principles-based approach of this release. Specifically, proposed Item 402(k)(1) would require a description of the registrant's director compensation program, including separate quantification of retainers for various director roles and responsibilities. Although our proposed amendments would retain required disclosure of basic director compensation elements, in an attempt to make our disclosure rules more principles-based and streamlined, and in response to the concerns expressed by commenters, we propose to amend the current rule to provide more flexibility to registrants in presenting and explaining their director compensation. Because, in many cases, director compensation is less structurally complex than PEO and PFO compensation, we believe there may be less need to require, in all cases, highly detailed disclosure for directors. By providing this flexibility, registrants with relatively simple director compensation arrangements would not be compelled to prepare detailed (but potentially immaterial) compensation information but could still choose to disclose the information in a tabular format if they prefer. We recognize, however, that there is value to investors in knowing how directors are compensated, for example, to understand their alignment with shareholder interests. We believe that the more principles-based approach we are proposing that also retains basic compensation elements (cash and equity), and which is rooted in materiality, will continue to ensure that investors receive key information about director pay.

We acknowledge that moving to a more principles-based approach for director compensation disclosure could lead to less standardization of the disclosure and could make it more difficult for investors to compare director compensation across registrants. However, we note, as we did in 2006, that director compensation continues to evolve.[420] We believe that allowing flexibility in the presentation of this information would permit registrants to reflect the material elements of their directors' compensation in an evolving marketplace while continuing to provide investors with information that is likely to be material to their investment and voting decisions. Further, while all registrants would have flexibility regarding how to present their director compensation, we anticipate that some registrants may satisfy the requirement in the rule by providing director compensation information similar to what we are proposing to require for NEOs in the Earned Compensation Table and/or the Granted Compensation Table on an individual director basis.[421]

Additionally, under the proposed rule, if a director is also the PEO or PFO, the registrant would be required to disclose any compensation the director receives solely for his or her services as a director pursuant to proposed Item 402(k) and exclude such amounts from the information disclosed as executive compensation pursuant to proposed Items 402(b), (c) and (d). The Commission is proposing this change to clarify that registrants should not be required to disclose the same compensation in multiple locations as may currently sometimes be the case when a registrant discloses an individual's compensation in the Summary Compensation Table and the Director Compensation Table. We believe that this proposed change would allow for a simplified presentation of the compensation being earned by individuals who serve as both a director and an NEO and will help investors gain a better understanding of the differences between an individual's executive compensation and director compensation.[422]

Request for Comment

108. Should we revise the director compensation disclosure requirements as proposed, including eliminating the requirement for a prescriptive tabular format and making the rule more principles-based? Are there other more targeted revisions to the current requirements that we should consider, such as any revisions that would focus the disclosure on material information and be less costly to prepare? For example, is there a more appropriate format for tabular disclosure of director compensation than what is prescribed in the current rule? Would the proposed modifications to the director compensation disclosure requirements result in the loss of material information

[418] The proposed Earned Compensation Table would include amounts attributable to service costs and prior service costs related to certain retirement benefit plans (see discussion in section II.C.1.e above for more details).

[419] *See* Diane Lemer (Pay Governance LLC), *Board of Directors Compensation: Past, Present and Future* Harv. L. Sch. F. on Corp. Governance Blog (Mar. 14, 2017), available at *https://corpgov.law.harvard.edu/2017/03/14/board-of-directors-compensation-past-present-and-future/* (providing historic context for the decrease in popularity of various elements of Director compensation, including pensions). *See also* section IV.C.5 (discussing the typically simpler structures of director compensation programs compared to executive compensation programs).

[420] *See* 2006 Adopting Release at 53191 (''Director compensation has continued to evolve from simple compensation packages . . . to more complex packages[.]'').

[421] *See supra* section II.C.1 and II.C.2.

[422] *See* proposed Instruction 1 to Item 402(k) (providing that if an NEO is also a director who receives compensation for his or her services as a director, the individual's director compensation should be disclosed separately from the information contained in the Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table).

for investors or otherwise affect investor protection?

109. Are the quantitative elements of cash and equity compensation we propose to retain sufficient for investors to assess director compensation?

110. Should disclosure of the value of stock and option awards be disclosed as the dollar value realized upon the vesting of stock awards and exercise of option awards, as proposed? In the alternative, should equity awards be disclosed at grant date fair value under FASB ASC Topic 718, or based on grant date fair value as calculated for the Granted Compensation Table, or based on some other methodology?

111. Do investors find the current disclosure relating to director compensation material in making investment and voting decisions? Have the current director compensation disclosure requirements established standardized disclosure practices that are comparable across registrants such that investors rely on these disclosures for investment or voting decisions?

112. Should we require disclosure of director compensation information on an individual, director-by-director basis, as proposed? Is director-by-director information costly and burdensome for companies to compile and provide? In the alternative, would the proposed Item 402(k)(1) requirement to describe the registrant's director compensation program in general provide sufficient material information for investors in assessing director compensation without director-by-director information?

113. We are proposing to eliminate the explicit requirement in current Item 402(k)(2)(vi) to disclose compensation for directors related to pension and nonqualified deferred compensation plans. Should we instead retain or replace this requirement?

M. Scaled Disclosure—Proposed Item 402(a)(6)

As noted above, in the 2026 Filer Status Proposing Release, we proposed streamlining the filer statuses for reporting companies and extending to the proposed NAF category all accommodations currently available to SRCs and EGCs.[423] If those rules are adopted as proposed, they would accordingly extend to NAFs all the Item 402 accommodations currently available to SRCs and EGCs.[424] In light of the expansion of scaled disclosure in that release, we are not here proposing new accommodations. We are however proposing to streamline Item 402 by identifying the rule provisions governing the disclosure requirements and accommodations applicable to SRCs and EGCs respectively into paragraphs (a)(6)(i) and (ii) of Item 402, thereby eliminating the need for a separate set of executive compensation disclosure provisions for SRCs and EGCs. If the 2026 Filer Status Proposing Release is adopted as proposed, we would consolidate these provisions into one paragraph (a)(6) applicable to NAFs.

Currently, SRCs and EGCs may elect to provide executive compensation disclosure that is generally subject to scaled disclosure accommodations as set forth in a parallel set of disclosure rules under Item 402. Current Item 402(*l*) provides that SRCs and EGCs may use the scaled requirements in paragraphs (m) through (r) of Item 402, instead of reporting pursuant to paragraphs (a) through (k), (s), and (u), which apply to registrants that are not SRCs or EGCs.[425] Under the scaled executive compensation disclosure requirements currently set out in paragraphs (m) through (r) of Item 402, SRCs and EGCs may, among other things:

- Provide executive compensation disclosure for three NEOs in most cases (specifically including the PEO but not the PFO), rather than at least five as required of larger companies;
- Provide the Summary Compensation Table disclosure for only the last two completed fiscal years, rather than the three years required of larger companies;
- Provide only two of the six primary executive compensation tables required of larger companies; and
- Provide only a narrative description of the material terms of potential payments and benefits to an NEO for the payment of retirement benefits and upon termination or a change-in-control event contracts, agreements, plans, or arrangements, not the prescriptive quantitative and qualitative requirements that apply to larger companies.

Further, SRCs and EGCs are currently not required to provide the following:

- CD&A (Item 402(b));
- Narrative disclosure of compensation policies and practices as they relate to risk management (Item 402(s)); or
- Pay ratio disclosure (Item 402(u)).

Additionally, EGCs are currently not required to provide golden parachute compensation disclosure under current Item 402(t) or the pay-versus-performance disclosure under current Item 402(v), while SRCs may provide scaled pay-versus-performance disclosure rather than the more extensive disclosure required for larger companies.[426]

As noted above, we are proposing to consolidate the various provisions that address the scaled disclosure rules available to SRCs under Item 402 into proposed Item 402(a)(6)(i) and to EGCs under proposed Item 402(a)(6)(ii). Proposed Item 402(a)(6)(i) would specify that a registrant that qualifies as an SRC would be deemed to comply with Item 402 if it provides the information required by:

- Proposed Item 402(a) (General);
- Proposed Item 402(b) (Earned Compensation Table) for each of its last two completed fiscal years;
- Proposed Item 402(c) (Granted Compensation Table) for each of its last two completed fiscal years;
- Proposed Item 402(d) (Status of Equity Awards Table);
- Proposed Item 402(f) (Pay-versus-performance);
- Proposed Item 402(g) (Disclosure of a registrant's action to recover erroneously awarded compensation);
- Proposed Item 402(i) (Potential payments upon termination or change-in-control);
- Proposed Item 402(j) (Golden parachute compensation); and
- Proposed Item 402(k) (Compensation of directors).

Proposed Item 402(a)(6)(ii) would specify that a registrant that qualifies as an EGC would be deemed to comply with Item 402 if it provides the information required by:

- Proposed Item 402(a) (General);
- Proposed Item 402(b) (Earned Compensation Table) for each of its last two completed fiscal years;

[423] *See* 2026 Filer Status Proposing Release.

[424] As part of that proposal, the Commission would extend the current exemptions applicable to either SRCs or EGCs to all NAFs. If the proposal were to be adopted, NAFs would be exempt from, among other things, compliance with 17 CFR 229.402(t) (Golden parachute compensation), 17 CFR 229.402(u) (Pay ratio disclosure), 17 CFR 229.402(v) (Pay-versus-performance). *See* 2026 Filer Status Proposing Release.

[425] SRCs and EGCs that are listed on a national securities exchange and therefore the subject of Rule 10D–1 are currently required to comply with current 17 CFR 229.402(w) (disclosure of a registrant's action to recover erroneously awarded compensation) and 17 CFR 229.402(x) (disclosure of the registrant's policies and practices related to the grant of certain equity awards close in time to the release of material nonpublic information).

[426] *See* 17 CFR 229.402(v)(8). SRCs are provided with additional pay-versus-performance accommodations which are also set forth in 17 CFR 229.402(v)(8), including the ability to provide the pay-versus-performance disclosure for only two fiscal years in the first filing in which they provide this disclosure and not being required to provide the disclosure specified by 17 CFR 229.402(v)(2)(iv) or (v)(5) with respect to the total shareholder return of any peer group, the Company-Selected Measure disclosure specified by 17 CFR 229.402(v)(2)(vi), or the Tabular List specified by 17 CFR 229.402(v)(6).

• Proposed Item 402(c) (Granted Compensation Table) for each of its last two completed fiscal years;
• Proposed Item 402(d) (Status of Equity Awards Table);
• Proposed Item 402(g) (Disclosure of a registrant's action to recover erroneously awarded compensation);
• Proposed Item 402(i) (Potential payments upon termination or change-in-control); and
• Proposed Item 402(k) (Compensation of directors).

Accordingly, as proposed, SRCs and EGCs would continue to be exempt from:

• Proposed Item 402(e) (Compensation Discussion and Analysis); and
• Proposed Item 402(h) (Pay Ratio Disclosure).

EGCs would continue to be exempt from:

• Proposed Item 402(f) (Pay-versus-Performance); and
• Proposed Item 402(j) (Golden parachute compensation).[427]

The proposed amendments would reduce the length and complexity of Item 402 by addressing the treatment of SRCs and EGCs each in a single paragraph, rather than repeating a large quantity of text for SRCs and EGCs (in scaled form) as the current rule does.[428] The proposed amendments would not change the nature of the scaled disclosure accommodations available to SRCs and EGCs. SRCs and EGCs would, like all other registrants under the proposed rules, be required to provide executive compensation disclosures for only two NEOs in most circumstances (*i.e.,* just the PEO and PFO), as compared to at least three (*i.e.,* the PEO and at least the two most highly compensated executive officers other than the PEO) required under the current rule for SRCs and EGCs. Also, like all other registrants, SRCs and EGCs would be required to describe potential payments upon termination or a change in control under proposed Item 402(i).[429]

Overall, the proposed amendments in this release are intended to streamline the rules that apply to SRCs and EGCs (or NAFs, if the 2026 Filer Status Proposing Release is adopted as proposed), and reduce burdens on SRCs and EGCs (or NAFs, if the 2026 Filer Status Proposing Release is adopted as proposed).

Request for Comment

114. Should we continue to scale the requirements for SRCs and EGCs under the executive compensation disclosure rules, as proposed, given the other amendments we are proposing to Item 402? If not, are there any elements of executive compensation disclosure that we should require of SRCs or EGCs? Are there any elements of the disclosure requirements as to which we are proposing to provide an exemption that we should continue to require from SRCs and EGCs?

115. If the Commission does not adopt the accommodations in the 2026 Filer Status Proposing Release that would exempt SRCs from the Item 402 pay-versus-performance and golden parachute disclosure, should we exempt SRCs from those requirements as is currently provided for EGCs?

116. Are there any additional executive compensation disclosure requirements, or elements of any requirements, as to which we should consider granting SRCs and/or EGCs an exemption or accommodation? If so, please explain why an exemption or accommodation would be appropriate. For example, should we further scale the proposed disclosure relating to potential payments upon termination or change-in-control?

117. Would providing scaled disclosure for SRCs and EGCs, as proposed, result in the loss of material information for investors or otherwise affect investor protection? How, if at all, does the materiality of executive compensation disclosure for investors differ based on the size or status of the registrant that provides the disclosure?

N. Certain Sections of Current Rule Largely Retained in Proposed Amendments

We are proposing to largely retain the following provisions of the current rule with only relatively minor changes:

• 17 CFR 229.402(a)(1) (Treatment of foreign private issuers);
• 17 CFR 229.402(a)(4) (Information for full fiscal year); and
• 17 CFR 229.402(a)(6) (Definitions).

Proposed Item 402(a)(6)(iii) would largely retain the wording with respect to foreign private issuers[430] currently contained in 17 CFR 229.402(a)(1).[431] Accordingly, consistent with the current rule, a foreign private issuer would be deemed to comply with Item 402 if it provides the information required by Items 6.B, 6.E.2, and 6.F of Form 20–F, with more detailed information provided if otherwise made publicly available or required to be disclosed by the issuer's home jurisdiction or a market in which its securities are listed or traded, or required to be disclosed by paragraph (19) of General Instruction B of Form 40–F, as applicable.

Proposed Item 402(a)(3) would largely retain the wording with respect to information being required for the full fiscal year currently contained in 17 CFR 229.402(a)(4), with some streamlining. In particular, the second sentence of 17 CFR 229.402(a)(4) regarding NEOs other than the PEO and

[427] As noted in section II.K., the Commission proposed in the 2026 Filer Status Proposing release to exempt NAFs, which would include all registrants that are currently considered SRCs and EGCs, from the requirements to provide pay-versus-performance disclosure, golden parachute disclosure, and shareholder advisory votes on executive compensation, the frequency of such votes, and votes on golden parachute compensation. EGCs are already exempt from the pay-versus-performance disclosure requirements under 17 CFR 229.402(v) and the golden parachute compensation disclosure requirements under 17 CFR 229.402(t). In light of the concurrent proposal, we are not proposing to change the obligations relating to SRCs and are therefore proposing to include proposed Item 402(f) and proposed Item 402(j) in the list of SRC scaled disclosures in proposed Item 402(a)(6)(i).

[428] *See* 17 CFR 229.402(m) (repeating General section specifically for SRCs); 17 CFR 229.402(n) (repeating Summary Compensation Table section specifically for SRCs); 17 CFR 229.402(o) (narrative disclosure to Summary Compensation Table section specifically for SRCs); 17 CFR 229.402(p) (repeating Outstanding Equity Awards at Fiscal Year-End Table section specifically for SRCs); 17 CFR 229.402(q) (additional narrative disclosure section specifically for SRCs); 17 CFR 229.402(r) (repeating Director Compensation Table specifically for SRCs). The Commission chose to restate the requirements for SRCs separately and in full for clarity when it adopted new rules applying to SRCs in 2007 that replaced the small business issuer requirements in Regulation S–B. *See Smaller Reporting Company Regulatory Relief and Simplification,* Release No. 33–8876 (Dec. 19, 2007) [73 FR 934 (Jan. 4, 2008)] (''2007 SRC Adopting Release''). Given that Item 402 would be streamlined and the treatment of SRCs and EGCs would be made more consistent under the proposed amendments, we believe it is not necessary or helpful to restate the requirements for SRCs and EGCs separately and in full, and that it may be clearer to address the treatment of SRCs and EGCs in a single paragraph as proposed.

[429] SRCs and EGCs are currently required to provide a narrative description of the material terms of contracts, agreements, plans, or arrangements relating to termination or change in control under 17 CFR 229.402(q). Proposed Item 402(i) would require similar narrative disclosure to what is currently required under 17 CFR 229.402(q), but would apply those principles-based disclosure requirements more broadly to all registrants and clarify the requirement applies to each person who served as the registrant's PEO or PFO during the last completed fiscal year.

[430] *See* 17 CFR 230.405; 17 CFR 240.3b-4(c).

[431] As noted in section II.H above, we are proposing to eliminate the following language from current 17 CFR 229.402(a)(1): ''A foreign private issuer that elects to provide domestic Item 402 disclosure must provide the disclosure required by Item 402(w) in its annual report or registration statement, as applicable.'' We are proposing to eliminate this language as a technical matter. Because foreign private issuers are required by the first sentence of 17 CFR 229.402(a)(1) to comply with Item 6.F of Form 20–F, which sets forth requirements related to the disclosure of a registrant's action to recover erroneously awarded compensation, it is duplicative to state that foreign private issuers electing to provide domestic Item 402 disclosure must provide disclosure required by current 17 CFR 229.402(w).

PFO would be deleted as superfluous, given that, as proposed, the NEOs would be limited to individuals who had served as PEO or PFO.[432]

Finally, proposed Item 402(a)(7) would largely retain the existing definitions applicable to Item 402 currently contained in 17 CFR 229.402(a)(6), except that the definitions would be presented in alphabetical order and one defined term, ''incentive plan award,'' would be deleted as superfluous.[433] We also are proposing to amend the definition of ''plan'' in current Item 402(a)(6)(ii) by adding disability plans to the list of plans about which registrants may omit information when such plans do not discriminate in scope, terms, or operation in favor of executive officers or directors of the registrant and are generally available to all salaried employees. We are proposing to add disability plans to the list of plans about which information may be omitted as disability plans are generally similar to the other types of plans that may rely on this exclusion under the current rule (*i.e.,* group life, health, hospitalization, and medical reimbursement plans). Overall, we believe that the existing definitions are well understood by market participants and that there may be limited benefit in revising the definitions further.

Request for Comment

118. Should we largely retain the existing definitions contained in the current rule, as proposed? Are there any definitions which are proposed to be retained that are not helpful and should be deleted? Should we amend any of the definitions which are proposed to be retained and, if so, which ones, why, and in what way? Are there any definitions which should be added?

119. Should we, alternatively, largely remove the definitions section and instead rely on more general definitions under relevant accounting standards and guidance?

O. Certain Sections of Current Rule Not Retained in Proposed Amendments

1. Pension Benefits Table and Nonqualified Deferred Compensation Table—Items 402(h) and 402(i)

We are proposing to eliminate the Pension Benefits Table currently required under 17 CFR 229.402(h) (''Item 402(h)'') and the Nonqualified Deferred Compensation Table currently required under 17 CFR 229.402(i) (''Item 402(i)''), both applicable to registrants that are not SRCs or EGCs. Current Item 402(h) requires a separate Pension Benefits Table that includes the following information for each NEO: plan name; number of years of credited service; present value of accumulated benefit; and payments during the last fiscal year.[434] Current Item 402(i) requires a separate Nonqualified Deferred Compensation Table that includes the following details for each NEO: executive contributions in the last fiscal year; registrant contributions in the last fiscal year; aggregate earnings in the last fiscal year; aggregate withdrawals/distributions; and aggregate balance of the NEO's account as of the end of the last fiscal year.[435]

As we have reconceived the NEO disclosure tables in this proposal, we have sought to reduce the length and complexity of the required disclosures and decrease compliance burdens for registrants. At the same time, we have sought to continue to require disclosure of material information relevant to an assessment of NEO compensation. We believe that the information most likely to be material for investors with respect to any pension plan or nonqualified deferred compensation plan is the incremental amount earned during the fiscal year, including registrant contributions or other allocations to nonqualified deferred compensation plans, any above-market or preferential earnings on compensation that is deferred on a basis that is not tax-qualified, and service costs and prior service costs of pension plans. As proposed, such amounts would be required to be disclosed in the Miscellaneous Compensation Received column of the Earned Compensation Table.[436] We therefore believe that the information most likely to be material to investors would continue to be disclosed under the proposed amendments.[437]

Request for Comment

120. Should we eliminate the Pension Benefits Table currently required under Item 402(h) as a separate table, as proposed? Would the amounts proposed to be required to be disclosed in the Miscellaneous Compensation Received column of the Earned Compensation Table provide investors with all the material information they need with respect to any pension plans? Is the total from the Pension Benefits Table (*i.e.,* the actuarial present value of the NEO's accumulated benefit under any such plans, computed as of the same pension plan measurement date used for financial statement reporting purposes with respect to the registrant's audited financial statements for the last completed fiscal year) material information for investors? Why or why not? Should the proposal be modified to require the total from the current Pension Benefits Table to be disclosed (*e.g.,* in the footnotes to the Miscellaneous Compensation Received column of the Earned Compensation Table)?

121. Should we eliminate the Nonqualified Deferred Compensation Table currently required under Item 402(i) as a separate table, as proposed? Would the amounts proposed to be required to be disclosed in the Miscellaneous Compensation Received column of the Earned Compensation Table provide investors with all the material information they need with respect to nonqualified deferred compensation plans? Is the total amount from the ''Aggregate balance at last FYE'' column of the current Nonqualified Deferred Compensation Table (column (f)) (*i.e.,* the total balance of the NEO's account under any such plans as of the end of the registrant's last fiscal year) material information for investors? Why or why not? Should the proposal be modified to require the total as currently presented in the Nonqualified Deferred Compensation Table to be disclosed (*e.g.,* in the footnotes to the Miscellaneous Compensation Received column of the Earned Compensation Table)?

2. Compensation Policies and Practices Related to the Registrant's Risk Management—Item 402(s)

We are proposing to eliminate the requirement, applicable to registrants that are not SRCs or EGCs, to provide narrative disclosure of the registrant's compensation policies and practices as they relate to risk management currently

[432] *See* proposed Item 402(a)(2).

[433] The current rule defines the term *incentive plan award* to mean an award under an incentive plan. We are proposing to delete this definition as it does not appear to be necessary. *See* 17 CFR 229.402(a)(6)(iii).

[434] 17 CFR 229.402(h)(3) also requires registrants to provide a succinct narrative description of any material factors necessary to an understanding of each plan covered by the Pension Benefit Table and provides a non-exhaustive list of example factors that may be material, depending on the registrant's facts and circumstances.

[435] 17 CFR 229.402(i)(3) also requires registrants to provide a succinct narrative description of any material factors necessary to an understanding of each plan covered by the Nonqualified Deferred Compensation Table and provides a non-exhaustive list of example factors that may be material, depending on the registrant's facts and circumstances.

[436] *See* proposed Item 402(b)(2)(vii)(E) and (F); *see also supra* section II.C.1.e.

[437] Given that current Item 402(h) would be eliminated under the proposed amendments, we are also proposing to eliminate certain cross-references to current Item 402(h) contained in Schedule 14A. *See* Item 10(b)(1)(ii) of Schedule 14A; *Instruction to paragraph (b)(1)(ii).*

contained in 17 CFR 229.402(s) (''Item 402(s)''). Under the current rule, to the extent that risks arising from the registrant's compensation policies and practices for its employees are reasonably likely to have a material adverse effect on the registrant, the registrant is required to discuss its policies and practices of compensating its employees, including non-executive officers, as they relate to risk management practices and risk-taking incentives.[438] The current rule includes a list of example situations that may trigger the disclosure requirement, depending on the particular registrant and its compensation policies and practices. These examples include compensation policies and practices at a business unit:

- That carries a significant portion of the registrant's risk profile;
- With compensation structured significantly differently than other units within the registrant;
- That is significantly more profitable than others within the registrant; and
- Where compensation expense is a significant percentage of the unit's revenues.[439]

The current rule also includes an extensive, non-exclusive list of example issues that the registrant may need to address for the business units or employees discussed in the disclosure.[440]

When the Commission proposed the current rule in 2009, it noted concerns from some commentators that, at some companies, compensation policies had become insufficiently aligned with the long-term well-being of the company and that ''in some cases, the structure and the particular application of incentive compensation policies can create inadvertent incentives for management and employees to make decisions that significantly, and inappropriately, increase the company's risk, without adequate recognition of the risks to the company.'' [441] The Commission proposed to amend the CD&A requirements to broaden their scope to include a new section that would provide information about how registrants' overall compensation policies for employees create incentives that can affect registrants' risk and management of that risk.[442] In the adopting release, the Commission stated its belief that it is important for investors to be informed of the compensation policies and practices that are likely to expose registrants to material risk and explained that the rule was intended to elicit disclosure about incentives in the company's compensation policies and practices that would be most relevant to investors.[443] While we understand that many registrants, through their board of directors, compensation committee, or other similar mechanism, engage in an annual risk assessment regarding their compensation policies, the disclosure provided to comply with Item 402(s) has been observed by the staff to often be formulaic disclosure.[444]

We are of the view, based on staff experience, that the current rule generally has not provided investors with information that is likely to be material to their investment and voting decisions. As a result, we believe that eliminating the requirement in the current rule, as proposed, would streamline compensation disclosure for registrants without generally affecting investors' access to material information.

We believe that requirements of Regulation S–K outside of Item 402 will continue to provide investors with material information regarding whether registrants compensate their employees in ways that create incentives for employees to make decisions that significantly increase the registrant's risk. For example, the management's discussion and analysis requirement in Item 303 of Regulation S–K requires registrants to provide material information relevant to an assessment of the financial condition and results of operations of the registrant, and Item 105 of Regulation S–K requires a discussion of the material factors that make an investment in the registrant or offering speculative or risky.[445] To the extent a registrant's compensation policies have created incentives for its employees that may create risks that are reasonably likely to have a material adverse effect on a registrant, we expect that these requirements of Regulation S–K outside of Item 402 would require the disclosure of such risks.

Request for Comment

122. Should we eliminate the requirement to provide narrative disclosure of the registrant's compensation policies and practices as they relate to risk management currently contained in Item 402(s), as proposed? Alternatively, how could we revise the current rule to require relevant and material disclosure, without eliciting boilerplate disclosure?

123. Are the disclosures currently made by registrants in response to Item 402(s) material to investors? How often does the narrative disclosure of the registrant's compensation policies and practices as they relate to the registrant's risk management change from year to year?

124. Do existing disclosure requirements, such as Item 105 of Regulation S–K (Risk factors) and Item 303 (Management's discussion and analysis of financial condition and results of operations) make the requirements in current Item 402(s) unnecessary? Would the elimination of current Item 402(s), as proposed, have any effects on investor protection?

3. Policies and Practices Related to Grant of Equity Awards Close in Time To Release of Material Nonpublic Information—Item 402(x)

We are proposing to eliminate the narrative and tabular disclosure requirements related to the grant of certain equity awards close in time to the release of material nonpublic information currently contained in 17 CFR 229.402(x) (''Item 402(x)'').

Under the current rule, registrants are required to provide narrative

[438] *See* 17 CFR 229.402(s).

[439] *See id.* Under the current rule, the examples of situations that may require disclosure also include situations that vary significantly from the overall risk and reward structure of the registrant, such as when bonuses are awarded upon accomplishment of a task, while the income and risk to the registrant from the task extend over a significantly longer period of time.

[440] *See* 17 CFR 229.402(s)(1) through (6). Under the current rule, the examples of the issues that a registrant may need to address for the business units or employees discussed are: the general design philosophy of the registrant's compensation policies and practices for employees whose behavior would be most affected by the incentives established by the policies and practices; the registrant's risk assessment or incentive considerations in structuring its compensation policies and practices or in awarding and paying compensation; how the registrant's compensation policies and practices relate to the realization of risks resulting from the actions of employees in both the short term and the long term; the registrant's policies regarding adjustments to its compensation policies and practices to address changes in its risk profile; material adjustments the registrant has made to its compensation policies and practices as a result of changes in its risk profile; and the extent to which the registrant monitors its compensation policies and practices to determine whether its risk management objectives are being met with respect to incentivizing its employees.

[441] *See Proxy Disclosure and Solicitation Enhancements,* Release No. 33–9052 (July 10, 2009) [74 FR 35076 (July 17, 2009)] (citation omitted).

[442] *Id.* at 35078 (citation omitted).

[443] *See Proxy Disclosure Enhancements,* Release No. 33–9089 (Dec. 16, 2009) [74 FR 68334, 38336 (Dec. 23, 2009)].

[444] Such boilerplate disclosures often state that the compensation committee of the registrant's board of directors has conducted an annual risk assessment and concluded that its compensation policies do not create risks that are reasonably likely to have a material adverse effect on the registrant.

[445] *See* 17 CFR 229.303 (Management's discussion and analysis of financial condition and results of operations); 17 CFR 229.105 (Risk factors).

disclosures regarding their policies and practices on the timing of option awards in relation to the disclosure of material nonpublic information, including: how the board of directors determines when to grant such awards; whether the board or compensation committee takes material nonpublic information into account when determining the timing and terms of such awards; and whether the registrant has timed the disclosure of material nonpublic information for the purpose of affecting the value of executive compensation.[446] In addition, registrants are required to provide tabular disclosures regarding certain option awards to NEOs close in time to the filing or furnishing of periodic or current reports (with a limited exception) that disclose material nonpublic information, including: the grant date, exercise price, and grant date fair value of the option award; the number of securities underlying the award; and the percentage change in the closing market price of the securities underlying the award between the trading day ending immediately prior to the disclosure of material nonpublic information and the trading date immediately following the disclosure of material nonpublic information.[447]

When the Commission adopted the narrative disclosure requirements in 2022,[448] it acknowledged that investors could, with some effort, identify the timing both of option awards and earnings announcements (based on the registrant's other filings with the Commission), but indicated that the required narrative disclosures nonetheless may provide useful information to investors as such disclosures would also address the extent to which the board of directors considered, among other things, the effects of the timing of option awards and earnings announcements on its compensation practices, matters that would not necessarily be disclosed in a registrant's other filings.[449] While such information may be relevant for disclosure in certain circumstances (*e.g.,* where a registrant has presented its option awards as being granted at-the-money but has engaged in ''spring-loading'' or ''bullet-dodging'' of the sort discussed in the 2022 Insider Trading Arrangements Adopting Release),[450] we believe, based on staff observation, that requiring all registrants to include a narrative discussion of their policies and practices regardless of their particular facts and circumstances has led to many registrants to provide boilerplate disclosures that increase length and complexity of their executive compensation disclosures, without providing material information to investors beyond what could be identified from the registrant's other filings or disclosures with the Commission.

Similarly, the currently required tabular disclosure largely repeats information already included in the registrant's executive compensation disclosures (such as the grant date, exercise price, and grant date fair value of the option award) or includes information that could be learned from publicly available sources (such as the percentage change in the market price of the securities underlying the award immediately prior to, versus immediately following, an earnings release or other relevant registrant filing with the Commission).

Accordingly, we are proposing to eliminate the narrative and tabular disclosure requirements related to the grant of certain equity awards close in time to the release of material nonpublic information currently contained in Item 402(x) because we believe that, in practice, these disclosure requirements do not ''increase[] the mix of information available to investors.'' [451] Instead, we believe the current requirements add disclosure burdens on registrants by requiring them to provide unnecessary and duplicative information and have resulted in an increase in immaterial, boilerplate disclosures.

Request for Comment

125. Should we eliminate the narrative and tabular disclosure requirements related to the grant of certain equity awards close in time to the release of material nonpublic information currently required under Item 402(x), as proposed? Alternatively, should this rule be retained in a modified form? If so, how could we revise the current rule to require material information, without eliciting duplicative and/or boilerplate disclosures? For example, should we revise the rule to only require the disclosure in years when equity awards have been made close in time to the release of material nonpublic information?

126. Are the disclosures made by registrants in response to current Item 402(x) material to investors? Is the information currently included in the narrative and tabular disclosures otherwise available to investors? Would the elimination of the disclosure requirements under current Item 402(x), as proposed, have any effects on investor protection?

P. Timing of Executive Compensation Disclosure in Registration Statements

We are proposing to amend certain registration statement requirements to address the timing requirements for providing Item 402 disclosure that covers the last completed fiscal year. Currently, ''long form'' registration statements on Securities Act Forms S–1, S–4, and S–11, and Exchange Act Form 10, as well as Form N–2 under the Securities Act and Investment Company Act, enumerate Item 402 among the line-item disclosure requirements that must be included.[452] Because Item 402 requires disclosure for ''each of the registrant's last three completed fiscal years,'' any of these ''long form'' registration statements filed on or after the first day of a registrant's fiscal year must include Item 402 disclosure for the immediately preceding fiscal year.[453] Even when a registrant files a registration statement on the first day of its fiscal year, for example, it is required

[446] *See* 17 CFR 229.402(x)(1).

[447] *See* 17 CFR 229.402(x)(2).

[448] *See Insider Trading Arrangements and Related Disclosures,* Release No. 33–11138 (Dec. 14, 2022) [87 FR 80362 (Dec. 29, 2022)] (''2022 Insider Trading Arrangements Adopting Release'') (adopting Item 402(x)).

[449] *See* 2022 Insider Trading Arrangements Adopting Release at 80389.

[450] *See* 2022 Insider Trading Arrangements Adopting Release at 80387. We note that proposed Item 402(a)(5)(i) requires registrants to disclose any material information necessary to an understanding of the information disclosed in the Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table. To the extent a registrant has presented the option awards reported in those tables as being granted at-the-money but has engaged in ''spring-loading'' or ''bullet-dodging'' with respect to those awards, proposed Item 402(a)(5)(i) would require disclosure of the relevant facts and circumstances if material to understanding the disclosed option awards.

[451] *See* 2022 Insider Trading Arrangements Adopting Release at 80390.

[452] *See* Item 11(*l*) of Form S–1; Items 18 and 19 of Form S–4; Item 22 of Form S–11; Item 6 of Form 10; Item 18.14 of Form N–2 (requiring business development companies to provide the information required by Item 402). While Form N–2 can be used as a short-form registration statement in some cases, it currently refers to Item 402 in the same manner as the long-form registration statements discussed in this section and therefore is included when we refer to long-form registration statements in this section.

[453] Current Instruction 1 to 17 CFR 229.402(c)(2)(iii) and (iv) and Instruction 1 to 17 CFR 229.402(n)(2)(iii) and (iv) provide that if the amount of salary or bonus earned is not calculable through the latest practicable date, the registrant must include a footnote disclosing that fact and provide the date that the amount of salary or bonus is expected to be determined, and when the amount is determined provide the disclosure in a filing under Item 5.02(f) of Form 8–K. We are also proposing to eliminate this provision since we are proposing to provide registrants with up to 120 days within which to determine and disclose their executive compensation information.

to include Item 402 disclosure for the fiscal year ended on the previous day. Registrants that are only eligible to use ''long form'' Securities Act registration statements are therefore limited in their ability to offer securities in the public capital markets until they can provide Item 402 disclosure for the immediately preceding fiscal year, which can impact capital formation. This requirement effectively acts as an impediment to the ability of a registrant using a long form Securities Act registration statement to raise capital or conduct business combination transactions through a registered offering until it can provide that executive compensation disclosure.[454] For an Exchange Act registration statement, a registrant might need to delay important actions, like the voluntary registration of a class of equity securities under section 12(g) of the Exchange Act when seeking to have securities quoted on certain over-the-counter markets, until it has had adequate time to prepare Item 402 disclosure for the last completed fiscal year. In addition, we see no compelling reason to apply a different standard for disclosure timing based upon whether the registration statement is filed under the Securities Act or Exchange Act.

By contrast, registrants using registration statements that do not specifically enumerate Item 402 among the required disclosures, such as Form S–3 and Form S–8, may delay their Item 402 disclosure for the last completed fiscal year until they make a filing with a line item that specifically requires that disclosure.[455] That filing typically is the Form 10–K and, depending on the filer status of the registrant, the Form 10–K must be filed within either 60, 75, or 90 days of the end of a fiscal year.[456] In addition to that period of time, General Instruction G.(3) of Form 10–K permits a registrant to delay Item 402 disclosure. Specifically, a registrant may omit the information called for by Part III of Form 10–K, which includes Item 402 disclosure, as long as the information is disclosed within 120 days of the end of the fiscal year in either the registrant's definitive proxy or information statement involving the election of directors or an amendment to its Form 10–K.[457] As a result, unlike with a ''long form'' registration statement, an eligible registrant could file a short form registration statement (*e.g.,* Form S–3) without Item 402 disclosure for the most recently completed fiscal year and have that registration statement declared effective without that disclosure for up to 120 days after the end of the fiscal year.[458]

We are proposing to amend Forms S–1, S–4,[459] S–11, 10, and N–2 to address this disparity and mitigate the resulting implications for capital raising and other actions that may depend on a ''long form'' registration statement. We propose to amend long form registration statements so that a registrant is not required to provide updated Item 402 disclosure for the most recently completed fiscal year until the later of the date the registrant otherwise discloses that information in a document filed pursuant to section 13(a), 14, or 15(d) of the Exchange Act or 120 days after the end of that fiscal year. The Item 402 disclosure in any filing from which a registrant omits the most recently completed fiscal year pursuant to the proposed amendments should still include the number of fiscal years required by proposed Item 402 [460] using the time-period immediately preceding the omitted fiscal year.[461] The proposed amendments would further require, however, that, if a registrant files a registration statement without the Item 402 information for the immediately preceding fiscal year as permitted by the relevant Item, and the registration statement would go effective after the deadline for providing Item 402 information for that fiscal year, the registrant must file a pre-effective amendment to the registration statement which includes such Item 402 disclosure.[462]

The proposed changes would provide registrants using long form registration statements the same period of time to prepare their Item 402 disclosures for the most recently completed fiscal year that is currently available to registrants using short form registration statements. We believe that this proposed change appropriately balances registrants' disclosure obligations and burdens with the informational needs of investors and investor protection.

In light of our proposal to amend long form registration statements to provide registrants up to 120 days after their fiscal year end to provide updated Item 402 disclosure, we are proposing to remove certain Item 402 and Form 8–K provisions that relate to extended time to provide salary and bonus information in certain circumstances, as these would be duplicative and unnecessary. Current Instruction 1 to 17 CFR 229.402(c)(2)(iii) and (iv) and current Instruction 1 to 17 CFR 229.402(n)(2)(iii) and (iv) provide that if the amount of salary or bonus earned is not calculable through the latest practicable date, the registrant must include a footnote disclosing that fact and provide the date that the amount of salary or bonus is expected to be determined, and when the amount is determined provide the disclosure in a filing under Item 5.02(f) of Form 8–K. This relief from the obligation to provide salary and bonus that is not calculable through the latest practicable date has been part of the executive compensation disclosure rules since at least the 1992 Amendments. The rules adopted at that time required the omitted salary or bonus disclosure to be included in the executive compensation for the subsequent fiscal year. In the 2006 Amendments, the Commission amended this requirement to require a filing of a Form 8–K reporting the omitted amounts to eliminate ''the delay that existed under the former rules'' (*i.e.,* that the omitted information would not be provided for a whole year).[463] Because we are now proposing to extend the period of time all registrants will have before they must provide Item 402 disclosure for the last completed fiscal year generally, we do not believe there would continue to be a need to

[454] We note that the determination of executive compensation is often based in whole or part on the financial results of the fiscal year to which the compensation relates. For registrants using ''long form'' registration statements this requirement may cause those registrants to provide executive compensation disclosure before some of that compensation has been determined, or delay its offering until such information is available.

[455] For example, Form S–3 is a ''short form'' registration statement that only enumerates a limited number of line-item disclosure requirements, primarily related to the offering itself and the registrant's securities, and incorporates by reference, among other things, the registrant's latest Form 10–K and all future current and periodic Exchange Act reports.

[456] *See* General Instruction A.2 to Form 10–K, 17 CFR 239.10.

[457] *See* Item 11 of Form 10–K.

[458] A registrant, however, is responsible for ensuring that any prospectus used in connection with a registered offering contains the information required to be included therein by Securities Act section 10(a).

[459] This discussion does not apply to Form S–4 to the extent the registrant or the company being acquired is eligible to use Form S–3 and elects to incorporate Item 402 disclosure into Form S–4 by reference to its Exchange Act filings. *See* Item 18(b) of Form S–4.

[460] Proposed Items 402(b) and (c) would require, for example, that non-SRC registrants (other than newly-reporting issuers) provide relevant disclosure covering three fiscal years. For SRCs (other than newly-reporting issuers), proposed Item 402(6)(i)(B) and (C) would require disclosure covering two fiscal years. Newly reporting issuers would provide disclosure for the period of time required pursuant to proposed Item 402(a)(8).

[461] For example, the disclosure that a non-SRC registrant (other than newly-reporting issuers) would provide pursuant to proposed Items 402(b) and (c) should include the three-year period immediately preceding the omitted fiscal year.

[462] This updating requirement applies regardless of whether the registration statement would become effective by automatic operation of a statute or acceleration of the effective date.

[463] 2006 Adopting Release at 53171.

delay inclusion of any salary or bonus amounts when the information is finally provided. For this reason, we are proposing to eliminate current Instruction 1 to 17 CFR 229.402(c)(2)(iii) and (iv), current Instruction 1 to 17 CFR 229.402(n)(2)(iii) and (iv), and Item 5.02(f) of Form 8–K.

Request for Comment

127. Should we revise Forms S–1, S–4, S–11, 10, and N–2 as proposed, to permit registrants to file these forms without Item 402 information for their last completed fiscal year, as long as such information is disclosed by the earlier of the date that the registrant otherwise files that information in a document filed pursuant to section 13(a), 14, or 15(d) of the Exchange Act or 120 days following the end of that fiscal year? Should we also amend Schedule 14A to provide the same or a similar accommodation for Item 402 disclosure furnished under Item 8 in proxy or information statements, and, if so, why? Do investors need this information to be more current? If so, what accommodations could we provide to registrants while still requiring more current executive compensation disclosure?

128. Would the proposed revisions result in any loss of material information to investors or have any effects on investor protection? What effect would these revisions have on registrants' costs and burdens?

129. The Commission is proposing to eliminate current Instruction 1 to 17 CFR 229.402(c)(2)(iii) and (iv), current Instruction 1 to 17 CFR 229.402(n)(2)(iii) and (iv), and Item 5.02(f) of Form 8–K, permitting the filing of salary and bonus information on Form 8–K at a later date if the information cannot be calculated at the time of making a Commission filing. If the amendments proposed in this release are adopted, are there still likely to be circumstances under which registrants would have a need to submit at a later time executive compensation information that cannot be calculated at the time of filing, as contemplated by current Item 5.02(f) of Form 8–K?

Q. Compliance Date

We are proposing that, if adopted, the proposed amendments would become effective on the next January 1 after publication of the adopting release in the **Federal Register**. For example, if the adopting release is published during 2027, then we are proposing that the effective date would be January 1, 2028. We are proposing that registrants would be required to apply the proposed amendments, if adopted, for their first full fiscal year ending on or after the effective date (the ''mandatory compliance date''). With respect to registration statements and prospectuses, we are proposing that registrants would be required to apply the proposed amendments, if adopted, in any registration statement or prospectus that, on its initial filing date, is required to contain financial statements for a fiscal year ending on or after the effective date.

We believe that setting a mandatory compliance date for fiscal years ending on or after the next January 1 after publication of the adopting release would allow sufficient time for registrants to prepare for and come into compliance with the proposed amendments.

Although registrants would not be required to apply the proposed amendments until the mandatory compliance date, we are proposing that registrants would be permitted to elect to provide disclosure consistent with the proposed amendments, if adopted, any time after the effective date, so long as they provide disclosure responsive to the amended item in its entirety. We believe that allowing registrants to elect to apply the proposed amendments sooner would provide registrants that can prepare for and comply with the final rules sooner with the flexibility to do so.

Request for Comment

130. Are the proposed effective date and mandatory compliance date appropriate? If not, what time period would be necessary and appropriate for registrants to comply with the proposed amendments?

131. Are any special transition provisions necessary for any aspect of the proposed amendments? For example, would registrants require a phased-in transition period for the Earned Compensation Table and Granted Compensation Table (*e.g.,* in the initial filing subject to the proposed amendments, would registrants only be able to report the last completed fiscal year, resulting in a phased-in implementation over two years for SRCs and over three years for all other registrants)? If any special transition provisions are necessary, please explain what is needed and why.

R. General Request for Comment

We request and encourage any interested person to submit comments on any aspect of the proposed amendments, other matters that might have an impact on the proposed amendments, and any suggestions for additional changes. With respect to any comments, we note that they are of greatest assistance if accompanied by supporting data and analysis of the issues addressed in those comments and by alternatives to our proposals where appropriate.

III. Other Matters

This action is an economically significant regulatory action under section 3(f)(1) of Executive Order 12866 and has been reviewed by the Office of Management and Budget (''OMB''), consistent with Executive Order 14215. This action, if finalized as proposed, is expected to be an Executive Order 14192 deregulatory action.

IV. Economic Analysis

We are attentive to the costs that would be imposed by, and the benefits that would be obtained from, the proposed amendments.[464] The discussion below addresses the potential economic effects of the proposed amendments, including the likely benefits and costs, as well as the likely effects on efficiency, competition, and capital formation. We also analyze the potential costs and benefits of reasonable alternatives to the amendments.

A. Introduction

Certain information about the compensation of a registrant's key executives is likely to be material to investment and voting decisions, as detailed in the Broad Economic Considerations section (section IV.B) below. Mandating the disclosure of such information can help to reduce agency problems[465] and information

[464] Securities Act section 2(b) and Exchange Act section 3(f) require us, when engaging in rulemaking that requires us to consider or determine whether an action is necessary or appropriate in the public interest, to consider, in addition to the protection of investors, whether the action will promote efficiency, competition, and capital formation. *See* 15 U.S.C. 77b(b); 15 U.S.C. 78c(f). Exchange Act section 23(a)(2) requires us, when making rules under the Exchange Act, to consider the impact that the rules would have on competition and prohibits the Commission from adopting any rules that would impose a burden on competition not necessary or appropriate in furtherance of the purposes of the Exchange Act. *See* 15 U.S.C. 78w(a)(2).

[465] Agency problems are issues that arise from a principal (such as an investor) delegating responsibilities to an agent (such as managers or directors) whose interests are not perfectly aligned with their own. *See, e.g.,* Michael Jensen & William Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure,* 3 J. Fin. Econ. 305 (1976) (''Jensen & Meckling 1976 Study''). Requiring disclosure ensures that investors receive information that is important to them even when it is not in managers' and/or directors' personal interest to disclose that information. Executive compensation disclosure in particular can help investors understand the degree to which executives' interests are aligned with their own.

asymmetries [466] that could result if registrants were permitted to disclose details about their executive compensation on a purely voluntary basis. At the same time, the compliance burden and volume of required executive compensation disclosures have grown substantially over time, and certain of these requirements may call for disclosure that is of limited importance to investors' voting and investment decisions. Many registrants and investors have reported difficulties in producing and in digesting many aspects of current executive compensation disclosures.[467]

The proposed amendments would focus required executive compensation disclosures on the information that is most likely to be material so that investors can continue to make informed voting and investment decisions, while reducing the total amount of disclosure that registrants are required to provide.[468] For example, registrants would no longer be required to provide disclosure about the compensation of any executive officers other than the PEO and PFO or to undertake significant computations with respect to outstanding equity awards for purposes of certain disclosures. They would also be able to reduce the detail disclosed about executive benefits, such as retirement plans and perquisites. Registrants would still be required to disclose certain standardized quantitative information about the compensation of their PEO and PFO, organized into a new, more condensed set of tables. Larger registrants [469] would continue to be required to make some further disclosures about their executive compensation programs, including CD&A and pay ratio disclosures, although these requirements are also proposed to be simplified and/or made more principles-based than the current requirements for these disclosures.[470]

The proposed requirements are also intended to better reflect the way many registrants view their compensation programs. By more closely aligning the requirements with the registrant perspective, simplifying the required disclosures, and permitting a degree of flexibility in the content and presentation of disclosures, the proposed amendments may reduce the extent of voluntary supplementary disclosures that some registrants currently provide to clarify certain mandated elements of the disclosures.

The proposed amendments are expected to reduce the costs of producing executive compensation disclosures by a substantial fraction relative to current expenditures while maintaining the disclosure of the information about executive compensation that is most likely to be material.[471] We expect that the proposed disclosures would be significantly less burdensome for registrants to prepare than current disclosures.[472] Our monetized estimate of these compliance cost savings is approximately $244,000 per year per registrant, on average across registrants.[473] The cost savings are expected to be driven by three key factors. First, reducing the scope of the disclosures as proposed—particularly with respect to the scope of named executive officers, the employees included in the pay ratio determinations, and certain *de minimis* perquisites—would reduce registrants' need to undertake data collection and tracking. Second, the proposed amendments would eliminate current requirements to make certain complex computations such as valuations of outstanding equity awards (after grant but prior to vesting or exercise) for the purpose of the disclosures. Finally, the overall lower total volume of required disclosures (including proposed reductions in the number of tables as well as the extent of narratives and footnotes) should reduce the burdens involved in registrant staff, board, and external advisor review of the disclosures. The resulting compliance cost savings may be redirected to other, potentially more productive uses including being returned to shareholders.

The proposed amendments may also eliminate some incentives to deviate from the practices that the registrant would otherwise determine to be most appropriate. For example, they would limit the likelihood that registrants would feel reluctant to provide security services that are integrally and directly related to the performance of an executive's work duties only because of the implications for compensation disclosure or to pay a bonus to one executive officer only because the amount would change the composition of the registrant's group of NEOs. To the extent that these considerations distort [474] decisions by registrants,[475] the proposed amendments would allow registrants to make these types of decisions based on their view of what best serves the company, without needing to weigh the disclosure implications of those decisions. Even when registrant decisions would be unchanged, the proposed amendments may simplify compensation committee

Further, transparency around executive compensation can help to address agency problems that arise in setting the level and structure of executive compensation and benefits. *See infra* section IV.B.

[466] Information asymmetries arise when, for example, managers or a subset of investors have access to important information about a registrant (such as key features of its executive compensation plans that could shed light on managerial ability or incentives) that is unavailable to other investors. Such asymmetries can give rise to adverse selection, in which market participants who are less well informed, recognizing that better-informed parties may trade on information they do not have, demand compensation for that risk or withdraw from trading altogether. This can, among other things, reduce liquidity, raise the cost of capital, and impair the efficiency with which securities prices reflect available information. *See infra* section IV.N.

[467] *See, e.g.,* 2025 Roundtable Transcript. For a more detailed discussion of investor and registrant concerns with current disclosures, see section IV.C.6 below.

[468] Some investors, such as retail investors who read executive compensation disclosure linearly, may also find it easier to process a reduced volume of disclosure. *See infra* section IV.N.

[469] The more extensive executive compensation disclosures would apply to registrants that are not EGCs or SRCs, or a total of about 51% of registrants subject to Item 402 disclosure requirements in 2025. We note that the Commission recently proposed changes to the definitions of these filer status categories, which, if adopted, would result in the category of registrants subject to the proposed more extensive executive compensation disclosures representing about 19% of the registrants subject to Item 402 disclosure requirements in 2025. These estimates are based on staff analysis of EDGAR filings made in calendar year 2025. *See infra* section IV.C.1; 2026 Filer Status Proposing Release.

[470] In addition, registrants other than EGCs (and certain other registrants as discussed in more detail below) would remain subject to pay-versus-performance disclosure requirements, but these requirements are also proposed to be simplified significantly relative to the current requirements. *See infra* section IV.G. Overall, this paragraph is meant to provide an overview of some of the major changes being proposed but is not a comprehensive description of the proposed amendments. The proposed amendments are discussed in more detail in the body of this Economic Analysis.

[471] While we are unable to quantify all of the potential benefits and costs discussed in this economic analysis, we present a monetization analysis of the effects that we are able to quantify in section IV.M.

[472] As discussed in more detail in the discussion of specific costs and benefits below, the potential savings may be offset by any additional registrant staff time, resources, and reliance on external advisors that may be necessary to make materiality determinations under the more principles-based approach of the proposed amendments.

[473] *See infra* Table 11, section IV.M.1. This is the estimated monetized cost savings for registrants subject to Item 402 disclosure requirements. We separately estimate an aggregate monetized cost saving of $6,188 across all filers of Form N–CSR with respect to the proposed amendment with respect to clawbacks disclosures affecting registered management investment companies. *See infra* section IV.M (for our discussion of monetized costs and benefits).

[474] In this economic analysis, we use the terms ''distort'' and ''distortions'' to discuss changes in compensation design that result solely from disclosure considerations rather than what the registrant would otherwise believe to be optimal for the purpose of maximizing shareholder value.

[475] *See infra* notes 651 and 744.

deliberations and reduce any perceived encumbrance on registrant discretion.[476]

The effects on investor search and analysis costs are more difficult to predict. Some of the proposed amendments may make it easier for investors to review registrants' executive compensation programs, particularly with respect to tracking the status of a given equity award. Other elements of the proposed amendments, such as the elimination of disclosures about the valuation of these equity awards as performance is realized but before the award status changes (to vested or exercised), may make the review somewhat more difficult. The additional flexibility that would be afforded to registrants to tailor their disclosures to reflect their perspective on their executive compensation program and their individual circumstances could increase the efficiency of investors' review, by highlighting the most important elements in the context of a particular registrant's compensation program. Alternatively, this added flexibility could reduce efficiency by making it harder for investors to find the information they are looking for or to compare disclosures to those of other registrants.

The proposed amendments overall represent a significant change from current disclosure requirements and would likely generate some short-term adjustment costs for both registrants[477] and investors. Also, while the proposed disclosures would continue to provide the information that we understand to be most broadly relied on by investors, investors would face a loss of some information relative to what is provided in current disclosures. While some of the information that would be forgone may be of little consequence, the elimination of some currently required disclosure may reduce the precision with which investors evaluate executive compensation programs. This less precise understanding of executive compensation by some or all investors may introduce noise[478] into investment and voting decisions and may increase information asymmetries between investors and management or among investors.

The proposed amendments would also reduce the extent of public disclosure about certain executive benefits and could thus incentivize some executives to request, and/or some registrants to provide, more generous executive benefits than might currently be the case. Any increase in expenditures on executives could at least partially offset the compliance cost savings associated with the proposed amendments. However, the proposed executive compensation disclosures are, taken as a whole, intended to reflect the material elements of compensation that are included in current disclosures in some form, making it difficult to obscure large transfers of value to executives. The proposed amendments may also introduce new disclosure considerations that could distort executive compensation design. For example, the proposal could encourage a greater use of some types of equity awards than others, relative to what would be chosen in the absence of disclosure considerations, because the proposed valuation approach at grant date may value certain similar instruments differently.[479] The proposed amendments could also lead to an increased reliance on non-equity incentive awards because of their reduced transparency relative to equity awards under the proposed amendments. That said, given the degree to which current compensation structures common among registrants rely on equity-based incentives, apparently reflecting a strong investor and registrant preference for the use of equity awards, we believe that large-scale market-level shifts in executive compensation structures as a result of disclosure considerations under the proposed requirements would be unlikely in the near term.

Below, we discuss in more detail the anticipated economic effects of the proposed amendments and of significant alternatives to the proposed amendments, including how these effects may vary depending on how registrants, investors, and third-party service providers react to any changes that may be adopted.

B. Broad Economic Considerations

Our economic analysis of the proposed amendments reflects our consideration of the broader utility and consequences of executive and director compensation disclosures. In particular, we recognize that investing in a registrant involves a basic agency problem: it requires delegating decision-making authority to a management team, whose interests may not align perfectly with those of investors.[480]

Executive compensation disclosures help to address this agency problem in two ways. First, transparency around executive compensation can help to ensure that investor resources are used appropriately. While executive compensation typically represents a relatively small percentage of a registrant's total expenses,[481] the determination of the level of compensation paid to management involves a direct conflict between the managers' personal interests and their responsibilities to shareholders, in that an additional dollar of pay directly benefits a manager while the costs of such pay are borne by investors in the registrant.[482] Disclosure of the amount of executive compensation can help to address this conflict by allowing investors to directly monitor the extent of registrant resources used to compensate senior management. A

[476] As discussed later in this section, it is possible that the proposed amendments could lead to other types of distortions in compensation programs at some registrants, such as an increased use of perquisites or of non-equity incentive awards beyond what registrants grant currently when these elements are more transparent.

[477] We estimate initial implementation costs of approximately $82,000 per registrant subject to Item 402 disclosure requirements. *See infra* Table 9, section IV.M.1, and the related discussion.

[478] As used in economics, ''noise'' represents variation that is not related to information. Introducing noise into decisions thus means that a source of variation is introduced into the decisions that are made that is due to a form of randomness (*e.g.,* making a rough guess when information is not precise) rather than these decisions being better informed. Such noise generally results in decisions that, on average, are less optimal than those made under more precise information.

[479] Equity awards with performance-based vesting conditions, including market conditions, would generally be valued at their target value in the Granted Compensation Table. Stock awards with market conditions can be constructed to have very similar payoffs as option awards and are currently valued using similar fair value computation methodologies, but these awards would be valued differently under the proposed approach. *See infra* section IV.E.3.

[480] For example, executives may care about their own wealth, job security, leisure time, prestige, and other such factors, and optimizing these factors may not always align with shareholder value. *See, e.g.,* Yueran Ma & Andrei Shleifer, *The Invention of Corporate Governance,* 172 J. Fin. Econ. 104115 (2025) at 104115 (stating that ''[the separation of ownership and control in large corporations] entails several agency problems reflecting conflicts between managers and shareholders, such as self-dealing by managers, low effort, consumption of perquisites, and excessive growth and diversification'').

[481] *See, e.g.,* Pearl Meyer, *Definitive Data on Executive Cost Ratios* (January 2024), available at *https://pearlmeyer.com/insights-and-research/advisor-blog/definitive-data-on-executive-cost-ratios* (presenting survey results for 2023 indicating that total direct compensation for the top two levels of management, including the CEO and all of the CEO's direct reports, represent from less than 0.1% of revenues for companies with revenues of $50 billion or more to less than 1.6% of revenues for companies with revenues of under $3.5 billion).

[482] *See, e.g.,* Jensen & Meckling 1976 Study, *supra* note 465, at 312–313 (identifying one key agency conflict between investors and managers as ''deriving from the manager's tendency to appropriate [benefits] out of the firm's resources for his own consumption'' because, as long as the manager holds less than 100% of the equity, ''he will then bear only a fraction of the costs of any . . . benefits he takes out in maximizing his own utility'').

similar case can be made with respect to the transparency of director compensation.

Second, executive compensation disclosures can provide insights into executives' monetary incentives to take particular corporate actions. This benefit of executive compensation disclosure may be more consequential for shareholder value than the first.[483] Specifically, recognizing the risk of misalignment between manager and shareholder interests, registrants may design executive compensation packages to encourage executives to exert effort and make decisions that enhance shareholder value. Indeed, a large body of literature (discussed below in this section) provides evidence that various aspects of compensation design—including the level of pay, its performance sensitivity, and other components and terms of compensation—can be used to predict how executives will run the business and how registrants will perform. Disclosure about the design of executive compensation thus allows investors to understand the incentives of the managers to whom they entrust their capital and to assess registrants' future performance. When considering the double-layered agency problem (wherein shareholders delegate oversight of managers to the board of directors, and the board of directors delegates management to the executives), executive compensation disclosures also allow investors to evaluate the strategic priorities and effectiveness of boards of directors in overseeing these executives, while director compensation disclosures allow investors to evaluate the monetary incentives of the board itself.

All of these factors—the responsible use of investor resources, the incentives of managers and directors, and the strategic priorities and effectiveness of boards of directors—may be material and thus relevant to investment and voting[484] decisions. The disclosure of material information about executive and director compensation allows investors to evaluate these factors and make informed decisions.

A compensation package can reward or penalize certain managerial traits, actions, or outcomes. The level and structure of an executive's compensation may thereby affect such executive's behavior, including the executive's expenditure of effort, degree of risk-taking, prioritization of goals, and likelihood of remaining at a registrant.[485] Information about the design of executive compensation can, therefore, allow investors to form more informed expectations about executive decisions and a registrant's future performance. For this purpose, investors would generally seek to understand the executives' *ex ante* incentives—that is, the potential rewards and motivations in place before performance is realized[486]—because they are the drivers of future performance; by the time *ex post* payoffs are made, the performance outcome will also generally be known.[487] That said, it may be difficult to disclose complete information in advance about these incentives.[488] Interim ''in flight'' updates about the progress towards achieving compensation outcomes and *ex post* realized compensation outcomes from the recent past can thereby help to refine investors' understanding of executives' incentives.[489]

Academic research has found that various key aspects of the level and structure of compensation can affect expectations of registrant and executive performance. For example, based on survey evidence, researchers have found that the motivation of CEOs to perform well is sensitive to their perception of the fairness of the level of their pay.[490] Regarding the structure of pay, the primary sources of monetary incentives are generally believed to stem from compensation's sensitivity to stock prices (also known as ''delta''), its sensitivity to volatility (that is, the degree of variation) in stock prices (also known as ''vega''), its vesting horizon, and the choice and rigor of performance goals.[491] The linkage of executive compensation to a registrant's stock price through equity compensation is, in most cases, the dominant source of variation in compensation outcomes,[492] and stronger equity incentives have been associated with actions that enhance or preserve shareholder value.[493] Researchers have also

[483] *See, e.g.,* Alex Edmans et al., *Executive Compensation: A Survey of Theory and Evidence,* in Benjamin Hermalin & Michael Weisbach (eds.), Handbook Econ. Corp. Gov. 383 (2017) (''Edmans et al. 2017 Survey Paper'') at 386 (stating that ''[the] level of pay receives the most criticism, but usually amounts to only a small fraction of firm value. Badly structured incentives, on the other hand, can easily cause value losses that are orders of magnitudes larger'').

[484] Information about executive compensation is likely relevant in say-on-pay, say-on-frequency, and say-on-golden-parachute advisory votes, votes regarding the approval of equity compensation plans, and in director elections, particularly with respect to voting for directors who are members of the registrant's compensation committee. It may also be relevant in other shareholder voting settings, such as when voting on certain corporate transactions, because managerial incentives can provide context for evaluating the potential value of a proposal or recommendation put forth by management.

[485] *See, e.g.,* Edmans et al. 2017 Survey Paper, *supra* note 483 (summarizing theoretical and empirical research on executive compensation).

[486] In practice, an executive's *ex ante* incentives from a compensation program are generally characterized by the terms of incentive awards (including any market, performance, and service conditions as well as the exercise prices and expiration dates of option awards) and by the executive's expectations about how other elements of the executive's pay may change based on performance outcomes.

[487] There is also a risk that in the absence of transparency about ex ante incentives, the incentive structure may be changed ex post to give the appearance of incentives that are aligned with shareholders' interests even when compensation is not actually driven by performance. *See* Adair Morse et al., *Are Incentive Contracts Rigged by Powerful CEOs?* 66 J. Fin. 1779 (2011) at 1779 (finding that ''some powerful CEOs induce their boards to shift the weight on performance measures toward the better performing measures, thereby *rigging* incentive pay''). We acknowledge, however, that some *ex post* changes in the terms of compensation can be appropriate. *See, e.g.,* Viral Acharya et al., *On the Optimality of Resetting Executive Stock Options,* 57 J. Fin. Econ 65 (2000).

[488] For example, investors would likely be less able than insiders to gauge the rigor of performance hurdles (and even disclosing the hurdles themselves could risk competitive harm).

[489] Such ''in flight'' or *ex post* information can allow investors to refine their views of currently reported performance incentives demonstrating how a previously reported compensation structure is translating, or has translated, into an eventual compensation payout. For example, such information can demonstrate whether a particular board's past selection of performance targets turned out to be more or less rigorous and whether it used its *ex post* discretion (such as when paying discretionary bonuses, modifying outstanding awards, or making new grants) to intensify or dampen the performance sensitivity of pay. *See, e.g.,* Mascia Ferrari et al., *Competitive Pay Policies in CEO Compensation,* Columbia Business School Research Paper No. 4407139 (Mar. 31, 2025), available at *https://ssrn.com/abstract=4407139* (discussing equity granting practices that offset apparent *ex ante* pay for performance incentives through awards of larger numbers of shares following poor stock performance); Andrea Pawliczek, *Performance-Vesting Share Award Outcomes and CEO Incentives,* 96 Acct. Rev. 337 (2021) (''Pawliczek 2021 Study'') (finding that the difficulty of the performance targets of stock awards with performance-based vesting cannot be easily determined using *ex ante* disclosures and that, on average, the *ex post* payout level of such awards is at 115% of target).

[490] The study also finds that CEO motivation is sensitive to the perceived fairness of how the CEO's pay varies with performance. *See* Alex Edmans et al., *CEO Compensation: Evidence from the Field,* 150 J. Fin. Econ. 103718 (2023) (''Edmans et al. 2023 Study'').

[491] *See, e.g.,* Edmans et al. 2017 Survey Paper, *supra* note 483.

[492] *See infra* note 706.

[493] Research is mixed as to whether greater equity exposure is associated with actions to increase shareholder value or to reduce risks in the interest of preserving value (but often resulting in stock price underperformance), demonstrating that the effects are likely context dependent. *See, e.g.,* John E. Core et al., *Executive Equity Compensation and Incentives: A Survey,* 9 Econ. Pol. Rev. 27 (2003); Neil Brisley et al., *Required CEO Stock Ownership: Consequences for Risk-Taking and Compensation,* 66 J. Corp. Fin. 101850 (2021). Other research has concluded that the optimal level of equity incentives to maximize shareholder value varies

Continued

demonstrated that a higher sensitivity of CEO compensation to volatility in the registrant's stock price is predictive of less conservative strategic choices, such as a greater investment in R&D or in higher risk business segments.[494] Others have found that the vesting horizon of a CEO's outstanding equity awards is associated with whether the CEO's actions appear to prioritize short-term goals at the expense of long-term value creation, such as in the context of investment and acquisition decisions,[495] or, separately, with the likelihood that the CEO voluntarily departs from that role.[496] The choice of performance metrics and the difficulty of performance goals have also been shown to predict elements of registrant[497] and executive[498] performance.

While the elements of compensation design mentioned above (which we refer to broadly in this economic analysis as the level and performance sensitivity of pay) are generally believed to provide an executive's primary monetary incentives, other elements (which we refer to as other components and terms of compensation) can provide additional insight into executive decision-making and performance.[499] For example, researchers have found that executives with high pension (or deferred compensation) balances manage registrants more conservatively,[500] and that bond prices rise and stock prices fall when investors become aware of such compensation (and thus, presumably, adjust their expectations about managerial risk-taking).[501] Others have found that the incidence and/or size of severance plans and golden parachutes are associated with reduced managerial conservatism, registrant acquisition likelihoods and premiums, and shareholder value.[502] The terms of executive equity grants with respect to their entitlement to dividends or the sensitivity of performance metrics to share repurchases have been found to be associated with registrant payout policy and shareholder value.[503] Even certain perquisites have been found to provide meaningful signals about registrant performance.[504]

Altogether, this body of research provides evidence that various aspects of executive compensation design are associated with executive behavior and registrant performance in ways that may be relevant to investors' voting and investment decisions.

Information about executive pay packages may also be used by investors to evaluate the effectiveness of board oversight over the registrant and its executives, as the board (generally through or with the involvement of its compensation committee) is responsible for designing and approving executive compensation. While the board has certain fiduciary duties, the ability of shareholders to evaluate how well the board is upholding its duties and to make informed voting decisions in director elections is central to maintaining the accountability of directors.[505] Compensation decisions have been termed the ''acid test'' of corporate governance; they can provide insight into the board's effectiveness at addressing a direct conflict between shareholders' and managers' interests.[506] For example, depending on

with characteristics such as registrant size, growth opportunities, and monitoring costs. *See, e.g.,* John Core & Wayne Guay, *The Use of Equity Grants to Manage Optimal Equity Incentive Levels,* 28 J. Acct. Econ. 151 (1999).

[494] *See, e.g.,* Jeffrey L. Coles et al., *Managerial Incentives and Risk-Taking,* 79 J. Fin. Econ. 431 (2006); Nicholas F. Carline et al., *CEO Compensation Incentives and Playing It Safe: Evidence from FAS 123R,* 58 J. Fin. Quant. Analys. 2993 (2023); J. Carr Bettis et al., *Performance-Vesting Provisions in Executive Compensation,* 66 J. Acct. Econ. 194 (2018) (''Bettis et al. 2018 Study'').

[495] *See, e.g.,* Alex Edmans et al., *Equity Vesting and Investment,* 30 Rev. Fin. Stud. 2229 (2017); Adam C. Kolasinski & Nan Yang, *Managerial Myopia and the Mortgage Meltdown,* 128 J. Fin. Econ. 466 (2018); Alex Edmans et al., *The Long-Term Consequences of Short-Term Investment,* 60 J. Acct. Res. 2229 (2022).

[496] *See, e.g.,* Torsten Jochem et al., *The Retention Effects of Unvested Equity: Evidence from Accelerated Option Vesting,* 31 Rev. Fin. Stud. 4142 (2018); Radhakrishnan Gopalan et al., *The Role of Deferred Equity Pay in Retaining Managerial Talent,* 38 Contemp. Acct. Res. 2521 (2021).

[497] *See, e.g.,* Clara Xiaoling Chen et al., *Accounting Performance Goals in CEO Compensation Contracts and Corporate Risk Taking,* 68 J. Mgmt. Sci. 6039 (2021) (''Chen 2021 Study'').

[498] *See* Azi Ben-Rephael et al., *Uncovering the Hidden Effort Problem,* 80 J. Fin. 1261 (2025) (finding that the distance from the performance goals as the year progresses is associated with the degree of effort expended by CEOs, in the form of longer work hours). *But see* Benjamin Bennett et al., *Compensation Goals and Firm Performance,* 124 J. Fin. Econ. 307 (2017) (finding that managers may make suboptimal decisions to just beat performance thresholds rather than just falling short); Chen 2021 Study, *supra* note 497.

[499] *See, e.g.,* David Yermack, *Golden Handshakes: Separation Pay for Retired and Dismissed CEOs,* 41 J. Acct. Econ. 237 (2006) at 239 (stating that, based on the findings of this study and of several other cited studies, ''understanding top management incentives requires looking beyond routine annual compensation'').

[500] *See, e.g.,* Rangarajan Sundaram & David Yermack, *Pay Me Later: Inside Debt and Its Role in Managerial Compensation,* 62 J. Fin. 1551 (2007).

[501] *See* Chenyang Wei & David Yermack, *Investor Reactions to CEOs' Inside Debt Incentives,* 24 Rev. Fin. Stud. 3813 (2011).

[502] *See, e.g.,* Lucian A. Bebchuk et al., *Golden Parachutes and the Wealth of Shareholders,* 25 J. Corp. Fin. 140 (2014) (finding that golden parachute arrangements are associated with higher acquisition premiums but that registrants that adopt such arrangements experience negative abnormal stock returns during and subsequent to the period surrounding their adoption); Eliezer M. Fich et al., *On the Importance of Golden Parachutes,* 48 J. Fin. Quant. Analys. 1717 (2013) (finding that acquisitions have higher completion probabilities but lower takeover premiums when target CEOs have larger golden parachute payments relative to the expected value of their lost compensation after an acquisition); Brian D. Cadman et al., *Are Ex Ante CEO Severance Pay Contracts Consistent with Efficient Contracting?* 51 J. Fin. Quant. Analys. 737 (2016) (''Cadman et al. 2016 Study'') (finding that the total amount of pre-contracted severance payments for a CEO—but not just an indicator variable for whether or not a severance plan exists—is positively associated with CEO risk-taking as measured by, for example, the volatility of the registrant's stock price, changes in the registrant's debt level, and the propensity to invest in focusing rather than diversifying acquisitions); Andrew C. W. Lund & Robert Schonlau, *Golden Parachutes, Severance, and Firm Value,* 68 Fl. L. Rev. 875 (2017) (finding that the amount of a CEO's pre-contracted severance pay is negatively associated with shareholder value, as measured by Tobin's Q).

[503] *See, e.g.,* Z. Tingting Jia & Don M. Chance, *Dividends on Unearned Shares and Corporate Payout Policy: An Analysis of Dividend Equivalent Rights,* 12 Quart. J. Fin. 2250013 (2022); Kristina Minnick & Leonard Rosenthal, *Stealth Compensation: Do CEOs Increase their Pay by Influencing Dividend Policy?* 25 J. Corp. Fin. 435 (2014); Steven Young & Jing Yang, *Stock Repurchases and Executive Compensation Contract Design: The Role of Earnings per Share Performance Conditions,* 86 Acct. Rev. 703 (2011).

[504] *See, e.g.,* David Yermack, *Flights of Fancy: Corporate Jets, CEO Perquisites, and Inferior Shareholder Returns,* 80 J. Fin. Econ 211 (2006) (finding that registrants' stock prices drop by an average of 1.1% upon the disclosure of CEO personal usage of company airplanes, and then continue to underperform market benchmarks by about 4% per year); Angela B. Andrews et al., *Corporate Governance and Executive Perquisites,* 16 Rev. Acct. Fin. 21 (2017) (finding that registrants with weak governance that newly disclosed relatively high levels of CEO perquisites upon the 2006 changes in disclosure rules experienced a negative stock price reaction after such disclosure, while no such reaction was found for well-governed registrants). While these studies do not definitively identify the reason for an investor reaction to CEO perquisite disclosures, it is possible that the level of CEO perquisites provides investors with information about, *e.g.,* the effectiveness of board monitoring of CEOs and/or the degree of leisure consumption by CEOs.

[505] *See, e.g.,* Lucian Bebchuk, *The Myth of the Shareholder Franchise,* 93 Va. L. Rev. 675 (2007) at 680 (stating that ''the fear of replacement [by shareholders] is supposed to make directors accountable and provides them with incentives to serve shareholder interests''); Reena Aggarwal et al., *The Power of Shareholder Votes: Evidence from Uncontested Director Elections,* 133 J. Fin. Econ. 134 (2019) (finding that dissent votes in uncontested director elections are an effective disciplining mechanism in that they result in negative consequences for directors, such as departure from the board, the loss of committee membership, and reduced opportunities in the market for directors); *see also* Blasius Indus. v. Atlas Corp., 564 A.2d 651, 659 (Del. Ch. 1988) (''The shareholder franchise is the ideological underpinning upon which the legitimacy of directorial power rests.'').

[506] *See, e.g.,* Pablo Ruiz-Verdu & Ravi Singh, *Public Thrift, Private Perks: Signaling Board Independence with Executive Pay,* 76 J. Fin. 845 (2021).

the context, a relatively high level of executive compensation could provide insight into the board's assessment of the executive's skill and contribution,[507] or could reflect a weak board that may be a less effective steward of investor capital.[508] The design of executive compensation also provides insights into the priorities and goals of the board, based on how compensation is linked to registrant or executive performance (or other factors) and which performance metrics and thresholds are emphasized. Consistent with the hypothesis that executive compensation information is relevant for evaluating the board's performance, researchers have found an association between reduced shareholder support for directors and concerns about a registrant's executive compensation,[509] and such concerns are commonly cited in investors' self-reported rationales for their voting decisions in director elections.[510] The effectiveness of boards [511] and the nature of the relationship between a board and the CEO [512] also have potential implications for registrant performance and, thus, for informed investment decisions.

Disclosures about the directors' own compensation provide further information that may be relevant to voting [513] and investment [514] decisions. For example, some market participants as well as academics have expressed the view that granting some equity-based compensation for directors can provide ''skin in the game'' to align the interests of boards with shareholders, affecting the board's expected monitoring intensity.[515] On the other hand, certain compensation levels or structures may raise concerns from an investor perspective as to whether they may compromise director independence [516] or create incentives that are not consistent with long-term shareholder value maximization.[517] Because, under State corporate law, the board of directors generally has authority to determine the pay of its own members, subject to oversight by shareholders as provided under applicable law, transparency around director compensation can also help to ensure integrity in the director pay-setting process.[518]

Information about executive and director compensation is also used by registrants (either directly or through compensation consultants) to benchmark their own pay decisions and practices.[519] The availability of publicly disclosed compensation data reduces the need for registrants to base their compensation decisions on third party survey data, which may be less reliable, less detailed, or less comprehensive than data disclosed in public filings. Executives themselves may also use peer compensation data to evaluate their compensation relative to that of other executives to assess, for example, whether they view their own compensation as fair.[520] They may use this information in negotiating their compensation packages and in making decisions about their own careers.

The disclosure of executive compensation also has indirect effects. By facilitating the monitoring of compensation committee decisions, such disclosure may lead to more effective compensation design and better executive performance.[521] Further, transparency around executive compensation can discourage excessive pay or pay practices that investors view unfavorably. For example, a study of the initial institution of executive compensation disclosure requirements upon the enactment of the Exchange Act found that disclosure had a moderating effect on the level of CEO pay at the most extreme outliers, with pay at the top end dropping by about eighty percent, despite average CEO pay increasing.[522] In more recent times, studies of the practice of retroactively assigning an earlier grant date to an option award (to assign a lower exercise price) found that this practice of backdating was greatly diminished after executives were required to disclose grants of stock options within two business days of the grant (rather than

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[507] *See, e.g.,* Robert Daines et al., *The Good, The Bad, And The Lucky: CEO Pay and Skill,* University of Pennsylvania Institute for Law and Economics Research Paper Series (August 2005), available at *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=622223.*

[508] *See, e.g.,* John E. Core et al., *Corporate Governance, Chief Executive Officer Compensation, and Firm Performance,* 51 J. Fin. Econ 371 (1999).

[509] *See, e.g.,* Mary Elizabeth Badgett et al., *Director Reputational Penalties when Shareholders Disapprove of Executive Compensation,* 45 J. Fin. Res. 755 (2022).

[510] *See* Roni Michaely et al., *Voting Rationales,* Working Paper (June 2025), available at *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4521854.*

[511] *See, e.g.,* Renee B. Adams et al., *The Role of Boards of Directors in Corporate Governance: A Conceptual Framework and Survey,* 48 J. Econ. Lit. 58 (2010).

[512] *See, e.g.,* Renee B. Adams et. al., *Powerful CEOs and their Impact on Corporate Performance,* 18 Rev. Fin. Stud. 1403 (2005).

[513] *See, e.g.,* Institutional Shareholder Services, *United States Procedures and Policies Frequently Asked Questions* (Dec. 23, 2025), available at *https://www.iss-stoxx.com/file/policy/current/americas/us-procedures-and-policies-faq.pdf,* at 40–41 (describing one proxy advisory service's evaluation of director compensation, and specifying that adverse vote recommendations may be issued in the case of a recurring pattern of excessive director pay magnitude without disclosure of a compelling rationale).

[514] *See, e.g.,* Lily Fang & Sterling Huang, *The Governance of Director Compensation,* 155 J. Fin. Econ. 103813 (2025) (identifying a positive stock price reaction to reductions in director compensation at registrants that had awarded higher-than-average director compensation prior to a court ruling that addressed the legal standard applicable to directors' decisions about their own pay).

[515] *See, e.g.,* Yuting Qian et al., *Skin in the Game: Does Outside Directors' Equity-Based Compensation Induce or Mitigate Stock Price Crash Risk?,* 51 J. Acct. Pub. Pol. 107308 (2025) (finding evidence that equity pay can align outside directors' interests with shareholders by strengthening risk oversight and summarizing the results of other studies on the effects of director equity compensation).

[516] *See, e.g.,* Mustafa A. Dah & Melissa B. Frye, *Is Board Compensation Excessive?,* 45 J. Corp. Fin. 566 (2017); I. Brick et al., *CEO Compensation, Director Compensation, and Firm Performance: Evidence of Cronyism?,* 12 J. Corp. Fin. 403 (2006).

[517] *See, e.g.,* Deborah S. Archambeault et al., *Audit Committee Incentive Compensation and Accounting Restatements,* 25 Contemp. Acct. Res. 965 (2008); Kristina Minnick & Mengxin Zhao, *Backdating and Director Incentives: Money or Reputation?,* 33 J. Acct. Pub. Pol. 391 (2017).

[518] *See, e.g.,* Melissa B. Frye et al., *Director Self-Dealing,* 85 J. Corp. Fin. 102560 (2024) (providing evidence consistent with shareholders monitoring director pay).

[519] Benchmarking is employed by registrants for a variety of reasons, including seeking to remain competitive in the labor market relative to other companies, validating that their compensation decisions satisfy their fiduciary duties, proactively addressing potential investor and/or executive questions about compensation decisions, and generating new ideas and adopting best practices for executive compensation. *See, e.g.,* letters from ABA (referencing ''insights into competitive market practices'' as having a role in ''board's or compensation committee's decision-making''); Axcelis (stating that ''the uniform and comprehensive disclosure of actual executive compensation terms by all public companies provides critical data for all executive compensation decision-makers, allowing them to determine appropriate . . . compensation by referencing broad datasets of peer information''); Pearl Meyer; Reda; Society for Corporate Governance (stating that, in a survey of their members, ''some respondents also expressed that registrants may derive benefit from the current disclosure requirements, for example, by using the information on NEOs other than the CEO and CFO in assessing competitive compensation for those roles, without the need to rely on external consultants or other sources for market information'').

[520] *See, e.g.,* Edmans et al. 2023 Study, *supra* note 490.

[521] *See, e.g.,* Dichu Bao et al., *The Real Effects of Disclosure Regulation: Evidence from Mandatory CFO Compensation Disclosure,* 41 J. Acct. Pub. Pol. 106995 (2022) (''Bao et al. 2022 Study'') at 106995 (finding that registrants which started disclosing CFO compensation information under the 2006 rules, compared to a group of control firms, which already disclosed CFO compensation before 2006, experienced ''an improvement in CFO performance following these disclosures, as exhibited in decreases in accounting misstatements and unexplained audit fees'').

[522] *See* Alexandre Mas, *Does Disclosure affect CEO Pay Setting? Evidence from the Passage of the 1934 Securities and Exchange Act,* Working Paper (March 2016), available at *https://www.princeton.edu/~amas/papers/CEODisclosureMandate.pdf.*

up to 40 days after the grant, prior to the rule change).[523] Executive compensation disclosures can also help investors to better interpret broader corporate disclosures through an understanding of how executives' monetary incentives may affect their exercise of discretion over the content or timing of disclosures, such as in the issuance of management earnings forecasts.[524]

Executive and director compensation disclosure also has costs, including the direct costs of producing the disclosures and the unintended consequences of such disclosure. The direct costs to registrants include the use of internal resources and expenditures on outside advisors for the purposes of, for example, information collection; computations; the design of any principles-based elements; the drafting of tables, narratives, and footnotes; and review of the disclosure.[525] With respect to unintended consequences, the disclosure of executive compensation information has been tied to ''ratchet'' effects, whereby registrant practices of benchmarking executives' compensation to be above the median among peers lead pay at all registrants generally to increase.[526] This ''ratchet'' effect may be reinforced by cross-registrant comparisons made by executives themselves, with potential discontent and demotivation resulting from comparisons to pay at a registrant's peers that make an executive feel relatively underpaid, even if these peer registrants do not reflect the executive's actual potential alternative employment opportunities.[527] Benchmarking practices and shareholder scrutiny of executive compensation disclosures can also lead to more uniform pay structures, which might come at the expense of compensation incentives that are more optimally designed for the individual circumstances of different registrants.[528] Further, historical disclosure requirements treating certain elements of pay or benefits (such as options or deferred compensation) differently than others were associated by researchers with distortions in compensation, with growth in compensation in the form of those elements that were less transparent, even if such compensation were not otherwise optimal from a registrant's perspective.[529]

The users of executive and director compensation disclosures generally seek to compare data about such compensation across registrants.[530] Without the ability to compare these data, it can be difficult to gauge its appropriateness, because the broader labor market for executives and directors plays a key role in determining the pay level and incentives for performance that may be necessary to attract, retain, and motivate these individuals.[531] A registrant's executive and director compensation data can therefore be more effectively evaluated by investors if it can be generally understood in comparison to the disclosures of other registrants. Comparability is also likely to be important for registrants and executives to the extent they seek to benchmark pay practices.

While the consistency and comparability of data across registrants' compensation disclosures facilitate these uses of the disclosures, the ability of registrants to otherwise tailor disclosures to their own individual circumstances can also contribute to the effective communication of executive compensation information. Such flexibility may be particularly likely to contribute to more effective disclosure when, for example, compensation packages have unique features that may be harder to understand from information presented in standardized formats or when compensation structures evolve such that prescriptive requirements designed in the past no longer clearly convey their material elements.

In addition, while many of the current executive and director compensation disclosures may, as discussed above, individually provide certain relevant information to the market, the utility of the disclosures may not be uniform. Some disclosures may be more relevant to investors' voting and investment decisions than others, and a given disclosure's contribution may be limited where it adds little to information conveyed elsewhere. With respect to some registrants, certain disclosures may be essentially irrelevant given their compensation structures or specific circumstances. Reducing redundancies and disclosure of immaterial information, while preserving the disclosure of information about executive compensation practices that is more likely to be material, could improve the overall effectiveness of compensation disclosures by concentrating investor attention on the information most relevant to their decisions.[532]

Taking into account all of these considerations on both the utility and cost of executive and director compensation disclosure, we analyze the benefits and costs of the specific provisions of the proposed amendments in detail below.

C. Baseline

To assess the economic impact of the proposed amendments, our primary baseline is the current state of the market and requirements with respect to executive compensation disclosure. We also consider an alternative baseline that assumes the adoption of the amendments proposed in the 2026 Filer Status Proposing Release,[533] due to the important effects those proposed amendments would have on the application of executive compensation disclosure requirements.

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[523] *See, e.g.,* Kevin J. Murphy & Michael C. Jensen, *The Politics of Pay: The Unintended Consequences of Regulating Executive Compensation,* 3 J. L. Fin. Acct. 189 (2018) (''Murphy & Jensen 2018 Study''); *see also Ownership Reports and Trading by Officers, Directors and Principal Security Holders,* Release No. 34–46421 (August 27, 2002) [67 FR 56461 (Sept. 3, 2002)].

[524] *See* Jung Min Kim, *Uncertainty about Managerial Horizon and Voluntary Disclosure,* 28 Rev. Acct. Stud. 615 (2023).

[525] The direct costs associated with disclosure requirements that would be revised or eliminated under the proposed amendments are discussed in more detail below. *See infra* sections IV.D to IV.L.

[526] *See, e.g.,* John M. Bizjak et al., *Does the Use of Peer Groups Contribute to Higher Pay and Less Efficient Compensation,* 90 J. Fin. Econ. 152 (2008).

[527] *See* Edmans et al. 2023 Study, *supra* note 490.

[528] *See, e.g.,* Felipe Cabezon, *Executive Compensation: The Trend Toward One-Size-Fits-All,* 79 J. Acct. Econ. 101708 (2025) (finding that, since 2006, 24% of the variation in the distribution of CEO compensation across pay components disappeared).

[529] *See, e.g.,* Murphy & Jensen 2018 Study, *supra* note 523, at 202–204 (discussing the growth in option compensation prior to options expensing and disclosure requirements); Lucian A. Bebchuk & Jesse M. Fried, *Stealth Compensation Via Retirement Benefits,* NBER Working Paper (September 2004), available at *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=590730* (discussing pensions and deferred compensation arrangements under the more limited disclosure requirements for these items prior to the 2006 rules); Yaniv Grinstein et al., *The Economic Consequences of Perk Disclosure,* 34 Contemp. Acct. Res. 1812 (2017) (finding that registrants that did not previously disclose perquisites reduced perquisites by an average of 34% from 2006 to 2007 after disclosure of perquisites became mandatory).

[530] *See, e.g.,* letters from Baillie Gifford; CFA Institute; State Board Florida.

[531] *See, e.g.,* Edmans et al. 2017 Survey Paper, *supra* note 483, at 427–428 (discussing the theoretical role of a competitive labor market in the determination of the optimal executive compensation contract); Huasheng Gao et al., *Effects of Managerial Labor Market on Executive Compensation: Evidence from Job-Hopping,* 59 J Acct. Econ. 203 (2015) at 204 (stating that ''a surging amount of literature has proposed that executive compensation is better understood in the context of the managerial labor market'').

[532] As discussed below, including in section IV.N, more streamlined disclosures may be most likely to benefit retail investors and others who read the disclosures linearly and are thus most affected by the overall volume of disclosure.

[533] *See supra* note 32.

1. Affected Parties

We consider the impact of the proposed amendments on registrants (and their executive officers) and investors. As discussed above,[534] the proposed amendments would revise requirements for disclosures relating to executive compensation for all registrants with active reporting obligations under (a) section 13(a) of the Exchange Act due to a registration under section 12 of the Exchange Act [535] (''section 12 registrants'') or (b) section 15(d) of the Exchange Act [536] (when not also section 12 registrants, ''section 15(d) registrants''), in each case other than registered investment companies.[537] Registrants in different filer categories are currently subject to different executive compensation disclosure requirements, and the proposed amendments' effects on any given registrant would therefore vary across these categories. Similarly, investors may differ in how they review and use disclosures on executive compensation. We discuss some of these differences in section IV.C.6 below. We acknowledge that subgroups of investors (*e.g.,* institutional investors, financial intermediaries acting on behalf of investors, retail investors) may be differentially affected by certain provisions of the proposed amendments. Where possible, we discuss potential differential effects, and we invite comments to further our understanding of these differences and to help us quantify effects on investors.

Table 1 presents estimates of the numbers of registrants by filer category, including business development companies (''BDCs'') and foreign private issuers (''FPIs'').[538] Of the registrants included in the table, all are expected to be directly affected by at least one of the proposed amendments except the externally managed BDCs and FPIs that are not listed in the U.S.,[539] which may nevertheless also be included in some of the other subcategories presented in the table.

Table 1. Registrants by Filer Category

Section 12 registrants, other than registered investment companies and asset-backed securities issuers, of which:	6,535
SRCs	2,523
EGCs	1,615
All BDCs / Internally managed BDCs	142 / 5
All FPIs / U.S. listed FPIs	1,178 / 1,104
Not a member of any of these subcategories	2,589
Section 15(d) registrants, other than registered investment companies and asset-backed securities issuers, of which:	386
SRCs	189
EGCs	134
All BDCs / Internally managed BDCs	13 / 0
All FPIs / U.S. listed FPIs	28 / 5
Not a member of any of these subcategories	149

The filer subcategories in Table 1 are not mutually exclusive, such that the counts in the provided subcategories cannot be summed to produce the total number of registrants included in any combination of subcategories. The table, therefore, separately presents the total number of section 12 and section 15(d) registrants that are not members of any of the listed subcategories. Also, because the current executive compensation disclosure requirements applicable to SRCs and EGCs are substantially similar,[540] we note that the combined number of registrants that are either SRCs or EGCs (or both) based on their current filer status (using, as in the first column of the table, filings in calendar year 2025 to categorize registrants) is 3,189 in the case of section 12 registrants and 221 in the case of section 15(d) registrants.

Throughout this economic analysis, we also consider the ways in which the effects of the proposed amendments discussed in this release would differ if the proposed amendments in the 2026 Filer Status Proposing Release are adopted as proposed. That proposed rulemaking would define a new group of non-accelerated filers (''new NAFs'') that would include all SRCs and EGCs (and additional filers that are currently neither SRCs nor EGCs), extend to new NAFs the disclosure and other accommodations currently applicable to SRCs and EGCs, and eliminate the SRC category. Thus, if the proposed amendments in the 2026 Filer Status Proposing Release are adopted as proposed, the executive compensation disclosure accommodations currently available to SRCs and/or EGCs would

[534] *See supra* section II.

[535] 15 U.S.C. 78m(a). These registrants include those with securities registered under either section 12(b) of the Exchange Act [15 U.S.C. 78l(g)] or section 12(g) of the Exchange Act [15 U.S.C. 78l(g)].

[536] 15 U.S.C. 78o(d).

[537] To clarify, a registered management investment company with securities listed on a U.S. exchange would be affected by the proposed elimination of Item 18(b) of Form N–CSR, but registered investment companies would otherwise not be affected by any other elements of the proposed amendments.

[538] The estimates in this table are based on staff analysis of EDGAR filings in calendar year 2025. U.S. listed status for FPIs is determined based on data from the Center for Research in Security Prices (''CRSP'') database, which contains daily and monthly market data for securities with listings on the NYSE, NYSE American, Nasdaq, and NYSE Arca exchanges.

[539] We also note that the registrants in Table 1 include 152 co-registrants (not including the lead filer) who filed Form 10–K jointly with another registrant. We acknowledge that these co-filers often may not have independent executive compensation disclosure obligations separate from those of the lead filer. For example, under certain conditions, wholly-owned subsidiaries of a reporting company are generally permitted to omit executive compensation disclosures. *See infra* note 546 and associated text.

[540] *See supra* section II.M.

become available to a larger number of registrants.[541]

FPIs generally [542] file their annual reports on Form 20–F or Form 40–F, which require more limited executive compensation disclosures than domestic forms, though more detailed information is required if it is otherwise disclosed by the registrant or required to be disclosed in a different jurisdiction.[543] The proposed amendments would not change these requirements. However, FPIs with securities listed on a national U.S. exchange are subject to the check box disclosure requirements with respect to clawbacks and may thus be affected by the related elements of the proposed amendments.[544] Externally-managed BDCs, in contrast to internally-managed BDCs, generally do not have NEOs and thus are not subject to such disclosure.[545] Asset-backed securities issuers typically omit executive compensation disclosures in accordance with General Instruction J to Form 10–K because the issuing entity does not have executive officers or directors, and thus are unlikely to be affected by the proposed amendments. Similarly, a registrant that is a wholly-owned subsidiary of a reporting company may file an abbreviated Form 10–K, which omits Item 402 disclosure, if it meets the conditions of General Instruction I(1) to the form.[546] Principal executive compensation disclosure and advisory vote requirements for other domestic registrants, and how these vary across registrant categories, are summarized in brief in the following section.

2. Regulatory Baseline

The current requirements with respect to executive compensation disclosure are discussed in detail earlier in this release.[547] Here we provide only a brief summary to illustrate the different regulatory baselines that apply to different subsets of registrants.

All section 12 and section 15(d) registrants that are not EGCs or SRCs, other than FPIs and registered investment companies, are required to disclose annual compensation data about their NEOs [548] in six primary tables: [549] the Summary Compensation Table, the Grants of Plan-Based Awards Table, the Outstanding Equity Awards at Fiscal Year-End Table, the Option Exercises and Stock Vested Table, the Pension Benefits Table, and the Nonqualified Deferred Compensation Table, each with accompanying footnotes and narrative disclosures. As discussed in more detail in the previous section (section IV.C.1), asset-backed securities issuers, and, under certain conditions, wholly-owned subsidiaries of a reporting company are generally permitted to omit executive compensation disclosures whereas externally-managed BDCs generally do not have NEOs and thus are not required to provide executive compensation disclosures. Registrants subject to the Commission's proxy rules [550] generally include executive compensation disclosure in their proxy statements or information statements,[551] while section 15(d) registrants (which are not subject to the proxy rules) and some registrants with securities registered only under section 12(g) of the Exchange Act [552] (those that do not file a proxy statement or information statement in a given year, such as some limited partnerships) [553] include this annual disclosure in their reports on Form 10–K. This disclosure is also expressly required in several registration statements under the Securities Act and the Exchange Act.[554]

SRCs and EGCs are eligible to provide disclosure in accordance with a scaled version of these requirements, with only two primary tables (a Summary Compensation Table and an Outstanding Equity Awards at Fiscal Year-End Table, with accompanying footnotes and required narrative disclosures). SRCs and EGCs are also eligible to provide two rather than three years of executive compensation disclosure in the Summary Compensation Table, to exclude any amounts associated with pensions (except when benefits are accelerated pursuant to a change in control), and to apply a more limited definition of NEO.[555]

The registrants subject to the current tabular disclosure requirements, other than SRCs and EGCs, are also required to provide a CD&A explaining all material elements of the registrant's compensation of the NEOs, with a focus on the material principles underlying the registrant's executive compensation policies and decisions and the most important factors relevant to analysis of those policies and decisions.[556]

The Dodd-Frank Act Amendments also apply to varying subsets of registrants. Pay ratio disclosure is currently required for all registrants that must provide the principal tabular disclosures, other than EGCs and SRCs.[557] Pay-versus-performance

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[541] As discussed in the 2026 Filer Status Proposing Release, based on the data presented in that release (reflecting registrants filing annual reports in calendar year 2024), the number of new NAFs were estimated to be 4,825 registrants. Based on updated analysis reflecting 2025 calendar year filings, staff has estimated that the updated number of new NAFs would be 4,543 registrants, or 4,541 when excluding two registered investment companies that filed annual reports on Form 10–K. Of these 4,541 registrants, staff estimated that 4,183 were section 12 registrants while the remaining 358 were section 15(d) registrants. Further, based on these updated data, among registrants that are not registered investment companies or asset-backed securities issuers, staff estimated that a total of 1,168 registrants (all section 12 registrants) would neither be new NAFs nor a member of any of the other subcategories listed in Table 1.

[542] FPIs may choose to file their annual report on Form 10–K, in which case they must follow the rules for domestic issuers. Based on staff analysis of Form 10–K filings during CY 2023, at least nine FPIs filed on Form 10–K. *See Concept Release on Foreign Private Issuer Eligibility,* Release No. 33–11376 (June 4, 2025) [90 FR 24232 (June 9, 2025)] at 24237, n. 73 (identifying nine FPIs filing on Form 10–K).

[543] *See* Items 6.B, 6.E.2, and 6.F of Form 20–F and paragraph (19) of General Instruction B of Form 40–F.

[544] *See supra* section II.H.

[545] An externally-managed BDC generally contracts with a separate third-party investment advisor for managerial and advisory services rather than employing its own executive officers.

[546] While this paragraph focuses on annual reports in order to characterize the varying disclosure obligations of different types of registrants, several registration statements, such as Form S–1, Form 10, Form S–4, and Form S–11, also require Item 402 disclosures. In most cases, the annual report and registration statement disclosure obligations with respect to Item 402 are aligned. However, wholly-owned subsidiaries would need to provide Item 402 disclosure in their initial registration statement before omitting it from subsequent annual reports.

[547] *See supra* sections II.A through II.P.

[548] *See supra* section II.B.

[549] *See supra* section II.C.

[550] The Commission's proxy rules apply to the solicitation of proxies with respect to securities registered pursuant to section 12 of the Exchange Act [15 U.S.C. 78*l*].

[551] Item 11 of Form 10–K also calls for disclosure of the executive compensation information required under Item 402. However, this information may be incorporated in Form 10–K by reference from the registrant's definitive proxy statement or definitive information statement which involves the election of directors, if the definitive proxy statement or information statement is filed not later than 120 days after the end of the fiscal year covered by the Form 10–K. *See* General Instruction G.(3) to Form 10–K.

[552] 15 U.S.C. 78*l*(g).

[553] Proxy statement filing obligations only arise under section 14(a) of the Exchange Act [15 U.S.C. 78n(a)] when an issuer with a class of securities registered under section 12 of the Exchange Act [15 U.S.C. 78l] chooses to solicit proxies. Whether or not an issuer has to solicit proxies is dependent upon any requirement under its charter or bylaws or otherwise imposed by law in the state of incorporation or stock-exchange (if listed), not the federal securities laws. For example, NYSE, NYSE American, and Nasdaq require the solicitation of proxies for annual meetings of shareholders. Also, when issuers that do not solicit proxies from any or all security holders are nevertheless authorized by security holders to take a corporate action at or in connection with an annual meeting or by written consent in lieu of such meeting, they are required to file and disseminate an information statement under section 14(c) of the Exchange Act [15 U.S.C. 78n(c)].

[554] *See* Form S–1, Form S–4, Form S–11, and Form 10.

[555] *See supra* section II.M; section II.B.

[556] *See supra* section II.F.

[557] *See supra* section II.I.

disclosure is required for the subset of registrants required to provide the principal tabular disclosures, other than EGCs, that disclose this information in proxy or information statements.[558] Thus, this disclosure is not required for section 15(d) registrants or for those with securities registered under section 12(g) of the Exchange Act that do not disseminate a proxy or information statement in a given year. The pay-versus-performance disclosure requirements permit SRCs to provide scaled disclosures.[559] Finally, clawback disclosures related to a registrant's actions to recover certain erroneously awarded compensation are required for any section 12 or section 15(d) registrant that has securities listed on a U.S. exchange, including U.S.-listed FPIs and certain listed registered investment companies.[560] The check-box disclosure requirements that would be eliminated by these proposed amendments apply to all of the registrants subject to the clawback disclosure requirements with the exception of registered investment companies.[561]

Other disclosure requirements applying to all registrants that must provide the primary tables discussed above include, for example, the disclosure of director compensation,[562] narrative and quantitative disclosure regarding options granted to NEOs in close proximity to the release of material non-public information,[563] narrative disclosure of hedging policies, and, for registrants other than SRCs and EGCs, prescriptive narrative and quantitative disclosure of potential payments to NEOs upon termination or a change in control[564] and narrative disclosure of a registrant's compensation policies and practices as they relate to risk management.[565]

All section 12 and section 15(d) registrants other than FPIs and registrants that are wholly-owned subsidiaries of a reporting company[566] are also currently required to file current reports on Form 8–K under Item 5.02[567] upon the occurrence of matters including (a) the departure of directors; (b) the departure of certain officers, including, among others, any NEO; (c) the appointment of certain officers; (d) the election of new directors; (e) the commencement (or material modification) of a material compensatory plan, contract, or arrangement with a PEO, PFO, or any NEO; and (f) the calculation of salary and bonus information of an NEO that was omitted from previous Item 402 compensation disclosure in reliance on Instruction 1 to 17 CFR 229.402(c)(2)(iii) and (iv). We estimate that a total of approximately 11,053 Form 8-Ks were filed under all subsections of Item 5.02 in calendar year 2025 (including about 3,783 filings with disclosure under Item 5.02(b) regarding executive departures, about 3,665 filings with disclosure under Item 5.02(e) regarding compensation arrangements, and about 64 filings with disclosure under Item 5.02(f) regarding salary or bonus information omitted from a previous compensation disclosure).[568]

The affected registrants are also subject to requirements to disclose their annual performance outside of the Item 402 disclosure requirements, which can be relevant when evaluating executive compensation. All section 12 and section 15(d) registrants are subject to financial statement and disclosure requirements under Regulation S–X. All section 12 and section 15(d) registrants other than SRCs and FPIs are also subject to Item 201(e) of Regulation S–K, which requires the graphical disclosure of a five-year history of registrant TSR and peer group TSR.

Section 12 registrants that are not FPIs or EGCs (but including SRCs that are not EGCs) are also required to hold say-on-pay advisory votes on the compensation of the NEOs.[569] The frequency of these shareholder votes may be annual, every two years, or every three years, depending on the outcome of a binding shareholder vote on such frequency held at least every six years.[570] These registrants (section 12 registrants other than FPIs and EGCs, but including SRCs that are not EGCs) are also required, potentially, to make golden parachute disclosures and to hold say-on-golden-parachute votes. Shareholders also vote regularly in director elections at nearly all registrants other than section 15(d) registrants who have registered debt securities but not equity securities,[571] including for members of the compensation committee, and may consider compensation when making

[558] *See supra* section II.G.

[559] *See id.*

[560] *See* 17 CFR 229.402(w). We recognize that a section 15(d) reporting obligation typically is not active while a class of securities is traded on a national securities exchange because the section 13(a) reporting obligation arising from a section 12(b) registration would govern. That scenario could, however, occur if a registrant has filed a Form 25 to delist a class of securities and terminate its section 12(b) registration, and the registrant becomes obligated to file any reports that would be required under section 15(d) pending the delisting. *See* 17 CFR 240.12d2–2(d)(7).

[561] *See* Form 10–K; Form 20–F; Form 40–F. While not subject to the check-box requirements, a registered management investment company with securities listed on a U.S. exchange would be affected by the proposed elimination of Item 18(b) of Form N–CSR.

[562] *See supra* section II.L.

[563] *See supra* section II.O.3.

[564] *See supra* section II.J.

[565] *See supra* section II.O.2.

[566] *See* Instruction 1 to Item 5.02 of Form 8–K.

[567] *See* Form 8–K, Item 5.02(a) through (f).

[568] Staff reviewed filings using the Intelligize database and identified 11,967, 11,116, and 11,053 Item 5.02 Form 8–K filings in each of calendar years 2023, 2024, and 2025 respectively. The number of unique registrants making such filings in each of these years was 4,819, 4,526, and 4,469 respectively. Staff used a large language model (''LLM'') to analyze the Item 5.02(b), 5.02(e), and 5.02(f) disclosures from EDGAR in 2025. The LLM model used was OpenAI GPT–OSS–120B–1:0 with temperature set to 0. The model does not have access to the internet. We converted the filings to text and queried the LLM with the following prompt: ''Task: extract Item 5.02 structured records from the filing text. | Regulatory reasons for Item 5.02 filings include and are limited to |: a: Director resignation/removal due to disagreement/cause; | b: Departure of director or principal officer (standard/non-dispute); | c: Appointment of a new principal officer (not applicable to continuation of existing appointments); | d: Election of a new director; | e: New/amended material compensatory arrangement; | f: Determination of previously uncalculable salary/bonus. | Note: an individual being appointed as both a principal officer and a director should result in two extractions: one for 'c—appointment of a new principal officer' and one for 'd—election of a new director'. However, an existing officer being elected to a director position should not result in a new extraction for c, just for d. | Note: some filings are merely descriptions of changing compensation plans or agreements, not related to any individual, and should be labeled with reason e or f as applicable, but with null for name and role if none are specifically mentioned. | Output schema provided as (strict JSON object): | ''extractions'' | name, | role, | board_member, | reason_text, | reason_label, | date_effective, material_terms, and evidence. | Rules: Keep each extraction focused on a single person or single event. | Use null for unknown values; do not invent values. | Standardize role names where obvious (*e.g.,* CEO, CFO, Director). | Set board_member=true only when the focused individual is clearly stated to be a board member or director. | reason_text should be concise and quote-near to source wording. | evidence should be a short supporting excerpt from the filing text. | If nothing relevant is found, return an empty extractions array with filing_notes: 'No Item 5.02 content found'.'' We note that an LLM analysis can result in both false positives and false negatives, and that this analysis is stochastic in nature. Hence, re-running the same algorithm could yield different results. To assess and improve the accuracy of the results, we also conducted a manual validation of a random sample of 100 filings. This review identified five flagged items as potent errors. Two of the five flagged errors could be attributed to errors in prompting when isolating the Item 5.02 disclosures (in one instance the LLM extracted a table of contents and in another instance, the LLM extracted incorporation by reference language from Item 1.01). Of the three substantive errors, two involved 8-Ks with ambiguities in the source (*e.g.,* 8–K amendments and 8-Ks that used incorporation by reference language) and one error involved language that the LLM missed. The results reported above reflect the LLM's extraction output for the successfully processed filings with refinement using manual processing to further restrict the filings identified as containing type (b) or type (e) content to those where the focused individual was not identified to be only a board member (and not an executive officer).

[569] *See supra* section I.A.

[570] *See id.*

[571] We note that, in rare cases, holders of the registered class of equity may not have voting rights.

these voting decisions even in the absence of a say-on-pay vote.

The first five columns of Table 2 summarize how some of these existing principal requirements with respect to executive compensation disclosure currently vary across filer categories.[572] This table is a partial list for the purpose of demonstrating key differences and should not be viewed as an exhaustive list of regulatory requirements with respect to executive compensation.

Table 2. Application of Certain Baseline Disclosure and Advisory Vote Obligations by Filer Categories (Excluding Registered Investment Companies)

	FPI	EGC	SRC	Other Section 12 Registrants	Section 15(d) (only) Registrants	New NAFs
Six primary tables	No	Scaled	Scaled	Yes	Yes	Scaled
CD&A	No	No	No	Yes	Yes	No
Pay vs. performance	No	No	Scaled	Yes	No	No
Pay ratio	No	No	No	Yes	Yes	No
Clawbacks check boxes	If listed	If listed	If listed	If listed	If listed	If listed
Form 8-K re: NEOs	No	Yes	Yes	Yes	Yes	Yes
Golden parachutes	No	No	Yes	Yes	No	No
Option grant timing	No	Yes	Yes	Yes	Yes	Yes
Risk management	No	No	No	Yes	Yes	No
Say-on-pay votes	No	No	Yes	Yes	No	No

As discussed in the previous section (section IV.C.1), the 2026 Filer Status Proposing Release would define a new group of non-accelerated filers which we refer to in this economic analysis as ''new NAFs.'' The new NAFs would, based on the data presented in the 2026 Filer Status Proposing Release,[573] represent about 81 percent of registrants but only 6.5 percent of the total market public float of all registrants. The last column of Table 2 summarizes the requirements that would apply to new NAFs assuming the adoption (as proposed) of amendments in the 2026 Filer Status Proposing Release but without giving effect to the proposed amendments discussed in this release. New NAFs would be provided virtually all[574] scaled disclosure and other accommodations currently available to current NAFs, EGCs, and/or SRCs. As such, without giving effect to the amendments proposed in this release, the new NAFs would, like current SRCs and EGCs, be eligible to provide scaled disclosure for the primary tables, with two rather than six tables (a Summary Compensation Table and an Outstanding Equity Awards at Fiscal Year-End Table), two rather than three years of executive compensation information, the exclusion of any amounts associated with pensions (except when benefits are accelerated), and a more limited definition of NEOs. New NAFs would not have any CD&A, pay ratio, or pay-versus-performance disclosure requirements, and would not be required to hold say-on-pay votes. They would be subject to the clawbacks check box disclosure requirements if listed (without giving effect to the amendments proposed in this release) and would be subject to Item 5.02 Form 8–K disclosure.

3. Number and Tenure of NEOs

The current number of NEOs in a given year varies across registrants depending on, for example, the size of each registrant's executive team, the extent of transitions among its executive officers, and the definition of ''NEO'' applicable to the registrant (dependent on whether it is or is not an SRC and/or EGC). Currently, SRCs and EGCs, on

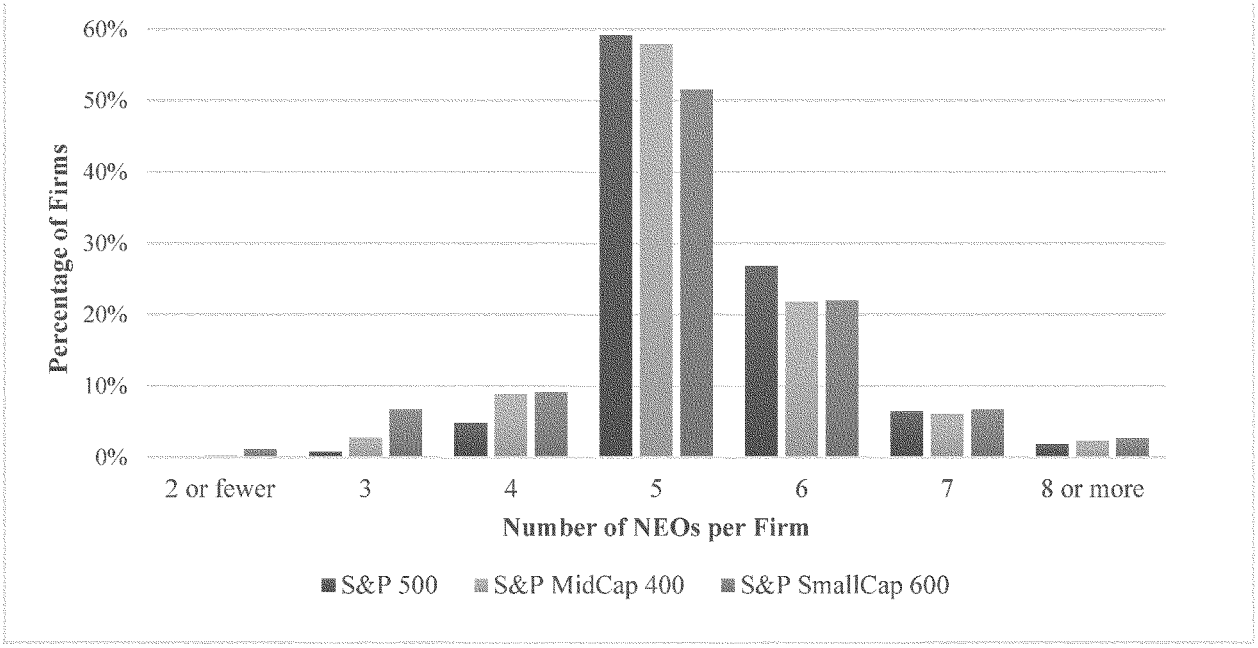
[572] A section 15(d) registrant with only registered debt and no public float would generally be able to also avail itself of the SRC accommodations presented in the SRC column. A registrant that has filed a Form 25 or Form 15 to terminate a section 12(b) or 12(g) registration remains subject to the proxy rules for 90 days thereafter. Registrants falling in this category would be subject to the same proxy requirements as section 12 registrants for that 90-day period, rather than, for example, the requirements delineated in the ''Section 15(d) (only) Registrants'' column.

[573] The data presented in the 2026 Filer Status Proposing Release is based on 2024 calendar year filings, while the registrant counts presented in this release are based on 2025 calendar year filings.

[574] *See* 2026 Filer Status Proposing Release, notes 222–227 and accompanying text (regarding the provision of confidentiality under section 6(e)(2) of the Securities Act).

average, have fewer NEOs than other registrants due to the more limited definition of NEOs applying to such registrants. Figure 1 demonstrates the current distribution of the number of NEOs across registrants of different sizes with available data.[575]

Figure 1. Number of NEOs across Registrants of Different Sizes



The mean and median number of NEOs in the full sample are 5.19 and 5, respectively. The minimum and maximum number of NEOs in the full sample are one and nine, respectively. Among the registrants with available data, 15 percent report four or fewer NEOs and 31 percent report six or more NEOs. While Figure 1 generally represents registrants that are not SRCs or EGCs,[576] in a separate analysis of a small combined sample of SRCs and EGCs for which data were readily available, we found that the majority have three NEOs.[577]

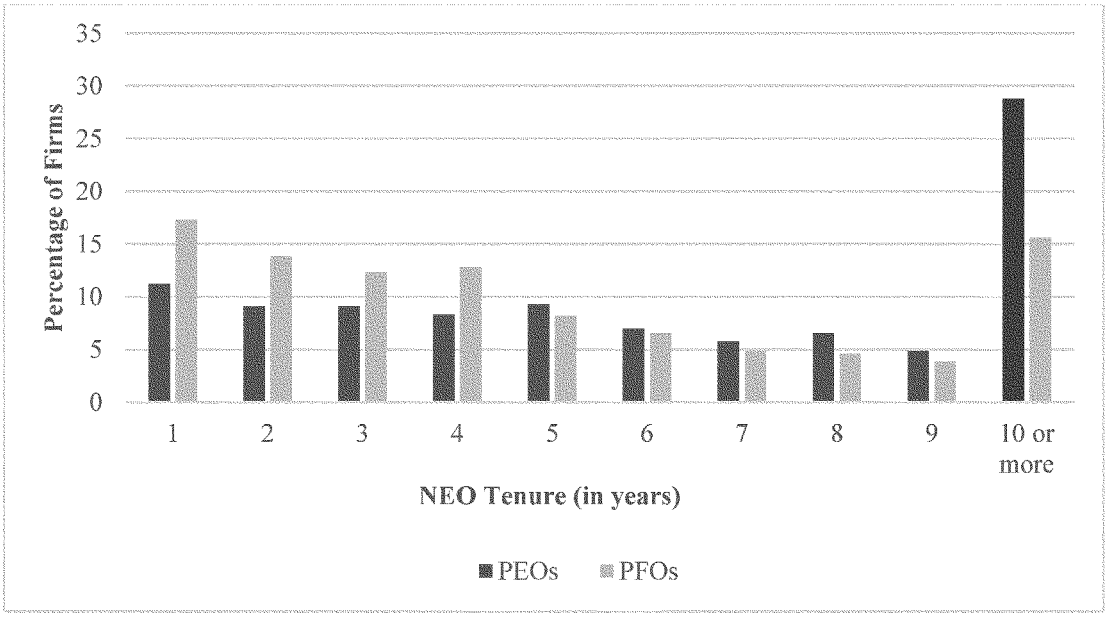
The frequency of transitions among NEOs affects the amount of individual-specific compensation history available for review by shareholders. Figure 2 demonstrates the current tenure of PEOs and PFOs at registrants with available data.

[575] These statistics are based on staff analyses of compensation data from the Standard & Poor's Execucomp (''Execucomp'') database, which in turn is sourced from company proxy statements. The statistics are thereby limited to issuers that are covered by the Execucomp database. Execucomp covers firms in the S&P Composite 1500 Index (which includes the S&P 500, S&P MidCap 400, and S&P SmallCap 600) as well as some firms that were previously removed from the index but are still trading and some requested by Execucomp clients. The presented statistics pertain to filings representing data from fiscal years ending from June 2024 to May 2025 (''proxy year 2025''). When identifying the PEO or PFO in the analyses using these data, we rely on Execucomp's identification of the CEO (for the PEO) and CFO (for the PFO). In fiscal years with multiple CEOs (or CFOs), Execucomp identifies the individual serving in that role for most of the indicated fiscal year as the CEO (or CFO).

[576] Based on staff analyses of EDGAR filings and the Execucomp data used to produce Figure 1, it appears that only five of the 1,482 registrants included in the figure are either SRCs, EGCs, or both (and all of which are in the S&P SmallCap 600 index). Removing these registrants does not markedly change the figure.

[577] This finding is based on staff analysis of EDGAR filings and data from Execucomp. Staff determined that there are 55 SRCs and seven EGCs (two of which are both SRCs and EGCs) with Execucomp data available that are, with the exception of five registrants, not presented in Figure 1 because they are not in the S&P indices for which statistics are presented.

Figure 2. Tenure of PEOs and PFOs, by Registrant Size



Based on the statistics presented in Figure 2, we expect that a three-year history of individual-specific PEO compensation should be available, in a given year, for about 80 percent of registrants, with little variation across registrants of different sizes. With respect to PFOs, such history should be available for 69 percent of registrants, with little variation across registrants of different sizes. The median tenure of PEOs in proxy year 2025 was six and a half, six, and five years at small-cap, mid-cap, and large-cap registrants respectively, while the median tenure of PFOs was consistently four years across small-cap, mid-cap, and large-cap registrants. In the same year, twelve percent of registrants in the sample experienced a transition in their PEO, and seventeen percent experienced a transition in their PFO.

4. Executive Compensation Composition

The structure of executive compensation, and how it varies across the affected registrants, also would influence the potential effects of the proposed amendments and how those effects would vary across registrants. We focus in this section on PEO compensation because it (together with PFO compensation) would be retained in the proposed revised disclosures and, based on staff experience, the structure of such compensation tends to be the most complex among the compensation contracts of the NEOs. To provide further context for this choice, Table 3 presents some statistics relating PEO and PFO compensation to other NEO compensation, by registrant size. The table is limited to the set of registrants for whom these data were readily available, which is a population of relatively larger registrants.[578]

[578] This estimate is based on staff analysis of data from Execucomp. *See supra* note 575.

Table 3. Relation of PEO and PFO Total Compensation to Other NEO Total Compensation in Proxy Year 2025, Among Registrants Covered by Execucomp

	All Registrants in Database	Registrants in S&P 500	Registrants in S&P MidCap 400	Registrants in S&P SmallCap 600
Registrants in Sample	1,776	495	395	592
% registrants where PEO is most highly compensated NEO	89%	87%	93%	90%
% registrants where PFO is second most highly compensated NEO	39%	35%	42%	39%
Among those with at least 3 NEOs:				
% of top three NEO total compensation represented by PEO total compensation	53%	52%	55%	53%

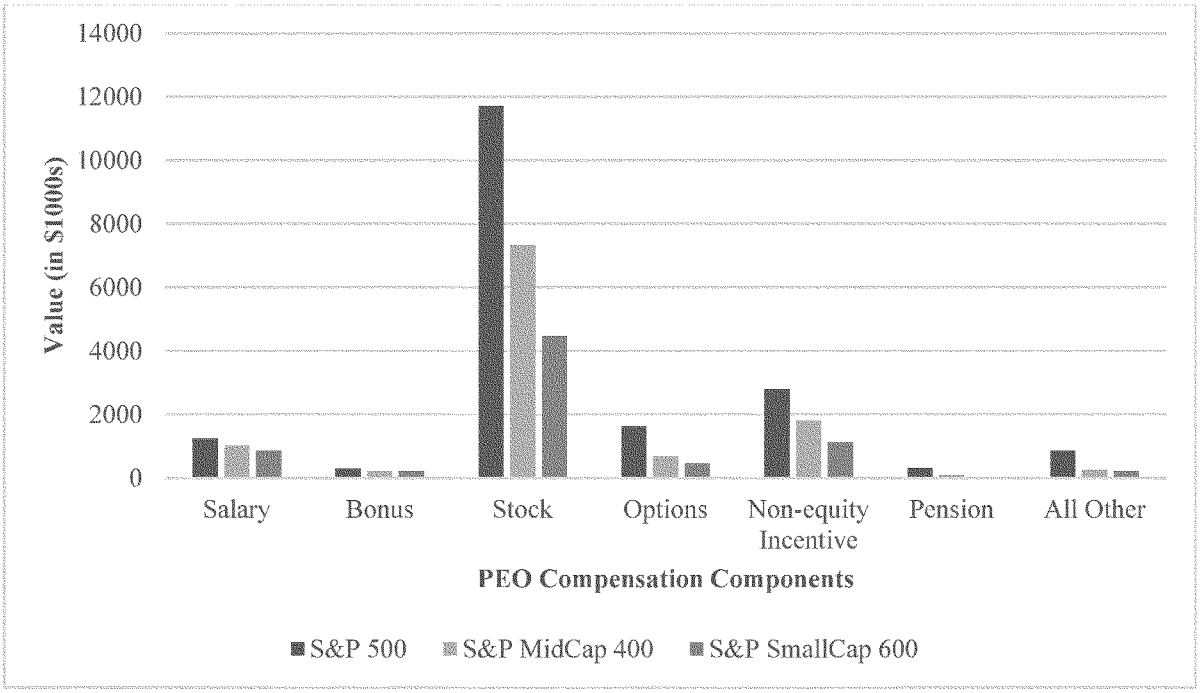
Based on the statistics presented in Table 3, the PEO is the most highly compensated NEO at 90, 93, and 87 percent of registrants among small-cap, mid-cap, and large-cap registrants respectively, while the PFO is the second most highly compensated NEO at 39, 42, and 35 percent of registrants among small-cap, mid-cap, and large-cap registrants respectively. In the full sample with available data, PFO total compensation is ranked second at 39 percent of registrants.[579] Among the remaining cases, the title of the second highest paid NEO is most often ''president'' (at 20 percent of registrants in the sample) and ''chief operating officer'' (at 9 percent).

Figure 3 presents the composition of total PEO compensation from the Summary Compensation Table across specified registrant size categories (based on index inclusion), for registrants with available data.[580]

[579] In the full sample with available data, PFO total compensation is ranked first, third, and fourth among the NEOs at 2%, 31%, and 14% of registrants, respectively.

[580] These estimates are based on staff analysis of data from Execucomp. *See supra* note 575.

Figure 3. PEO Compensation Components in Proxy Year 2025, Among Registrants Covered by Execucomp

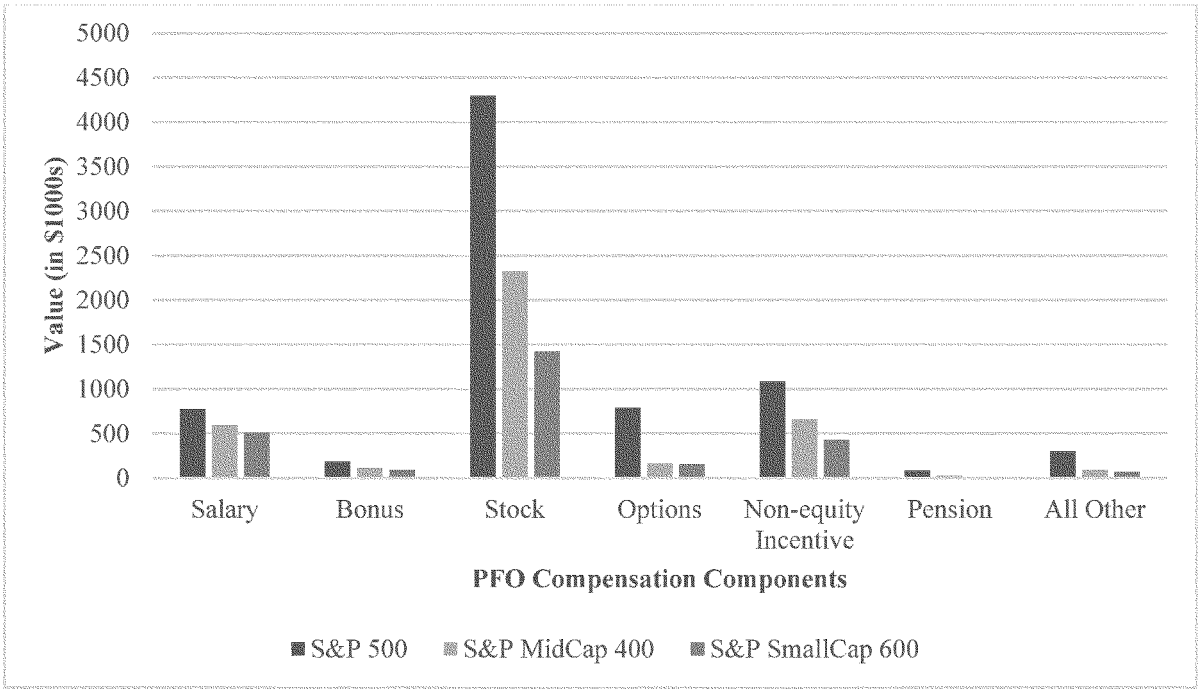


Stock awards dominate PEO compensation across all size groups in the sample of registrants with available data, representing over fifty percent of total individual PEO compensation, on average, in each category. Salary has limited variation across size categories, while the value of stock awards varies significantly by registrant size.

For comparison with the PEO data, Figure 4 presents the composition of total PFO compensation from the Summary Compensation Table across registrant size categories, for registrants with available data.[581]

[581] *See id.*

Figure 4. PFO Compensation Components in Proxy Year 2025, Among Registrants Covered by Execucomp



The structure of PFO pay is similar to that of PEOs, though in dollar terms the value of PFO compensation is, on average, lower than that of PEOs. Given the similarity of the PFO compensation composition to that of PEOs, we focus the remainder of this section on PEO compensation.

The data about PEO compensation presented thus far, like most of the other tables and figures in this section, are limited to a population of relatively larger registrants. To provide some context on executive compensation at the registrants for which detailed data are not readily available, we present some statistics on PEO total compensation (based on the Summary Compensation Table) extracted from pay-versus-performance disclosures tagged in XBRL. While this sample does not represent all the affected registrants under this proposal, it includes 3,116 registrants, as compared to 1,776 registrants covered by Figure 3.[582]

[582] These statistics are based on staff analysis of XBRL data from proxy statements extracted from EDGAR filings dated between July 1, 2024, and June 30, 2025. For the purpose of this table, staff excluded cases with more than one PEO in the same year.

Table 4. PEO Total Compensation in Proxy Year 2025, Among Registrants with Compensation Data Tagged in XBRL

	Number of Registrants	Percent of Registrants in Sample
Registrants in Sample	3,116	100%
Registrants where PEO total compensation is less than $500,000	161	5%
Registrants where PEO total compensation is between $500,001 and $1,500,000, inclusive	389	12%
Registrants where PEO total compensation is between $1,500,001 and $5,000,000, inclusive	733	24%
Registrants where PEO total compensation is between $5,000,001 and $15,000,000, inclusive	1,233	40%
Registrants where PEO total compensation is greater than $15,000,000	600	19%

Table 4 shows that, while the PEOs of about 60 percent of registrants with available data have total compensation of $5 million or greater, the remaining 40 percent have lower levels of compensation, including some with total compensation of less than $500,000. For the remainder of this section, we return to the sample of larger registrants to provide more granular analysis.

Table 5 presents further information about the use of different types of compensation elements by registrant size, among registrants with available data.[583] The dataset is limited to relatively larger registrants, and SRCs are not currently required to report pension data in their tabular compensation disclosures; the statistics on pension use below may therefore be underestimated.

[583] These estimates are based on staff analysis of data from Execucomp. *See supra* note 575.

Table 5. Prevalence of PEO Compensation Elements in Proxy Year 2025, Among Registrants Covered by Execucomp

	All Registrants in Database	Registrants in S&P 500	Registrants in S&P MidCap 400	Registrants in S&P SmallCap 600
Registrants in Sample	1,776	495	395	592
% Registrants whose PEO total compensation included the following:				
Salary	98%	99%	99%	98%
Bonus/Non-equity Incentive Awards	88%	90%	93%	89%
Stock Awards	92%	93%	94%	93%
Options	24%	38%	24%	17%
Pension	17%	27%	19%	13%
Other Compensation	97%	99%	98%	96%

Table 5 demonstrates that salary, bonuses and non-equity incentive plans, stock awards, and other compensation are each used to compensate PEOs at the vast majority of registrants, across size categories. In contrast, the use of options and pension plans is, in both cases, less prevalent generally but more common at larger than smaller registrants. Options may be granted periodically rather than annually at some registrants that use this form of compensation. Using the same data source, staff found that options were granted to the PEO in any one of proxy years 2023, 2024, or 2025 at 45 percent of large-cap registrants, 32 percent of mid-cap registrants, and 27 percent of small-cap registrants.

Table 5 does not distinguish between long-term (*i.e.,* with vesting beyond one year) and short-term non-equity incentive plans. Using a different data source, we find that 4.3 percent of registrants with available data used a long-term non-equity incentive plan to compensate a PEO at some point in the past three years.[584] Using this same data source, staff estimated that the median frequency of equity grants to PEOs is, among registrants granting these respective types of awards, two per year for stock awards and one per year for option awards.

Equity awards may be subject to vesting based on the PEO remaining in service with the registrant for a certain period of time, based on the achievement of specific performance or market conditions, or a combination of the two. Both types of equity awards deliver performance-based incentives. Equity awards that vest based on service for a period of time (*i.e.,* with only time-based vesting) deliver realized value that varies with stock price performance over the vesting period. Awards that vest based on the achievement of specific performance or market conditions (which we refer to in aggregate in this economic analysis as awards with ''performance-based vesting'')[585] deliver varying amounts of value depending on stock price performance (due to their nature as equity instruments) as well as the outcomes of the performance measures that were specified for the award.[586] Awards with time-based vesting may vest in full on a specific date (''cliff vesting'') or over multiple dates (''graded vesting''). Tables 6 and 7 present statistics on the vesting conditions in stock and option awards

[584] This statistic is based on staff analysis of data from IncentiveLab. Specifically, staff identified 129 unique firms out of 3019 (*i.e.,* 4.3%) registrants (with available data over the three-year period) using long-term cash plans at least once during fiscal years 2022, 2023, or 2024.

[585] ''Performance-based vesting'' as used in this economic analysis is, as defined above, not limited to awards with performance conditions as defined by FASB ASC Topic 718, and instead also includes awards with market conditions as defined by FASB ASC Topic 718. Our use of this term is only for purposes of this economic analysis and this term is not intended to identify, conflict with, or supersede the classification of an award for accounting purposes. We use the term performance-based vesting in this economic analysis for consistency with the academic literature, which used terms such as ''performance-vesting,'' ''performance-based vesting,'' and ''performance-based equity'' to represent these types of awards. *See, e.g.,* Bettis et al. 2018 Study, *supra* note 494; Edmans et al. 2017 Survey Paper, *supra* note 483; Pawliczek 2021 Study, *supra* note 489. We understand that similar terminology is also commonly used by practitioners to differentiate ''performance-based'' from ''time-based'' vesting or awards, without differentiating between performance conditions and market conditions. *See, e.g.,* letters from ABA; Meridian; Sullivan & Cromwell; Total Rewards.

[586] Awards with performance-based vesting typically, but not necessarily always, also deliver a number of instruments (*i.e.,* shares, units, or options) upon vesting that varies based on one or more performance or market conditions. Based on analysis of data from IncentiveLab, staff estimate that the majority (roughly 70%) of awards with performance-based vesting also deliver a variable number of instruments based on such conditions. The number of instruments underlying an equity award may also vary based on the outcome of service conditions, and there may also be factors other than vesting and the number of instruments (like the exercise price or contractual term of an award) that vary based on the outcome of service, performance, or market conditions; we refer to these later in this economic analysis as ''other such contingencies.''

to PEOs.[587] The first three rows present information about awards that vest only based on service conditions, while the following five rows present information about the rest of the awards (*i.e.,* those with performance-based vesting, with or without an additional time-based vesting period after the performance period).

Table 6. PEO Stock Award Vesting Conditions, At Registrants Covered by IncentiveLab

	All Registrants in Database	Registrants in S&P 500	Registrants in S&P MidCap 400	Registrants in S&P SmallCap 600	Registrants outside of S&P 1500
Percent with time-based vesting only	48%	38%	44%	47%	55%
Subset with cliff vesting	22%	28%	22%	18%	21%
Subset with graded vesting	78%	72%	78%	82%	79%
Percent with performance-based vesting	52%	62%	56%	53%	45%
Subset with cliff vesting	89%	89%	89%	90%	88%
Subset with graded vesting	11%	11%	11%	10%	12%
Subset with time-based vesting after end of performance period	7%	6%	7%	7%	7%
Average number of performance metrics	2.7	2.9	2.6	2.8	2.7

Table 6 shows that, of the total stock awards with time-based vesting (approximately 48 percent of stock awards), about 22 percent have cliff vesting schedules while the remainder have graded vesting.[588] The vast majority of the latter vest in annual increments. For the stock awards that vest based on achieving specific performance goals (approximately 52 percent of stock awards), the vast majority have cliff vesting schedules. Approximately seven percent of awards with performance-based vesting vest in two stages: they have an additional time-based vesting period at the end of the performance period. Among those with performance-based vesting, an average of 2.7 performance metrics were used in each award. Non-equity incentive plan awards in the same dataset, which are not reported in the table, have an average of 4.6 performance metrics per award.

[587] These statistics are based on staff analysis of data from IncentiveLab for proxy year 2025, which includes 2,585 registrants. As in the case of Execucomp, this database covers relatively larger registrants, including the S&P 1500. Their specific inclusion criteria were not available.

[588] In untabulated results, we find that the median time to complete vesting for all stock awards in this sample is three years.

Table 7. PEO Option Award Vesting Conditions, At Registrants Covered by IncentiveLab

	All Registrants in Database	Registrants in S&P 500	Registrants in S&P MidCap 400	Registrants in S&P SmallCap 600	Registrants outside of S&P 1500
Percent with time-based vesting only	88%	91%	88%	81%	88%
Subset with cliff vesting	17%	13%	5%	5%	25%
Subset with graded vesting	83%	87%	95%	95%	75%
Percent with performance-based vesting	12%	9%	12%	19%	12%
Subset with cliff vesting	91%	94%	92%	95%	88%
Subset with graded vesting	9%	6%	8%	5%	12%
Subset with time-based vesting after end of performance period	4%	5%	0%	0%	7%
Average number of performance metrics	1.9	2.1	1.3	1.5	2.2

Table 7 shows that, in contrast to stock awards, the majority of option awards (88 percent) have time-based vesting.[589] Most option awards with time-based vesting (83 percent) have graded vesting, while most with performance-based vesting (91 percent) cliff-vest, as in the case of stock awards.

Staff also considered variation in perquisites granted to PEOs across registrants. Because current disclosure requirements do not mandate separate tabular disclosure of perquisites, these data are more difficult to extract from filings. Staff therefore hand-collected perquisite information from a random sample of 100 registrants with proxy statements dated from July 1, 2024, through June 30, 2025. To generate the sample, staff used stratified random sampling in order to produce a sample that is representative of the population of registrants in terms of size (as measured by PEO total compensation). Figure 5 presents the distribution (in dollars) of reported perquisites provided to PEOs, as well as the dollar amount of reported perquisites excluding the value of security services and corporate aircraft usage,[590] across this sample of registrants.[591]

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[589] In untabulated results, we find that the median time to complete vesting for all option awards in this sample is four years.

[590] While we are proposing to rescind the Commission's prior statement of examples of items requiring disclosure as perquisites or personal benefits, including security provided at an executive's personal residence or during personal travel, under the proposal, registrants would still need to conduct an analysis on whether such benefit is integrally and directly related to the performance of the executive's duties to determine whether the benefit is a perquisite.

[591] These statistics are based on staff analysis of hand-collected perquisites data for fiscal year 2024 from a random sample of 100 registrants filing proxy statements in proxy year 2025, where random sampling was stratified by PEO total compensation (based on the Summary Compensation Table). In three cases, perquisites could not be estimated separately from the value of certain additional elements of ''other compensation''; in such cases, an upper bound estimate was used for the value of perquisites. In each of these cases, the total estimated perquisites were valued at around $50,000 or less, and dropping these three data points would not meaningfully change our analysis.

Figure 5. PEO Perquisites in Dollars, in Sample of 100 Registrants

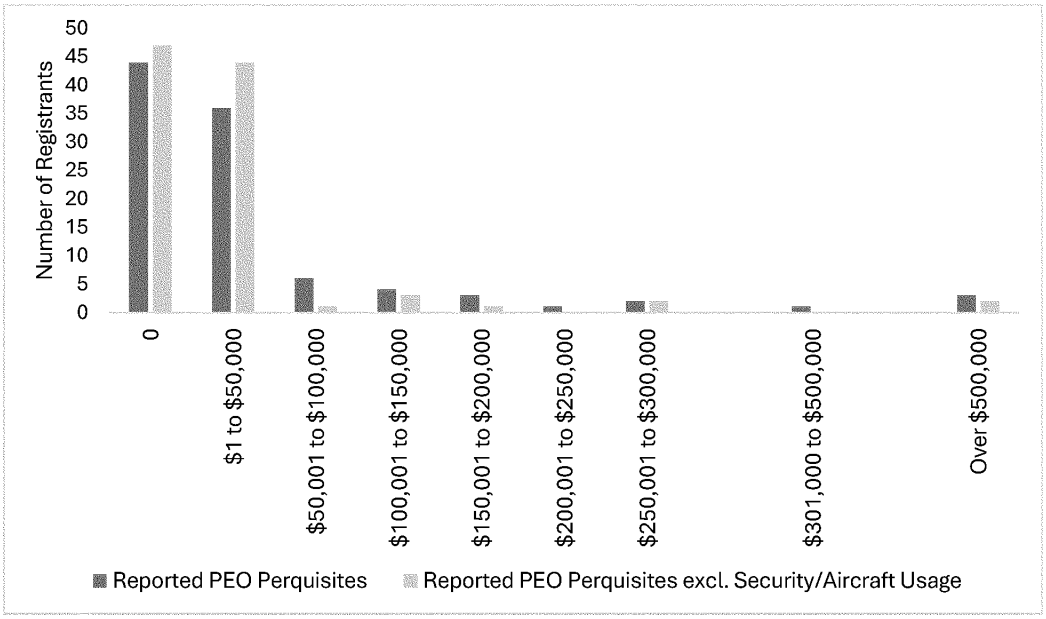


Figure 5 shows that most PEOs receive $50,000 or less in perquisites. When considering reported perquisites excluding security services and aircraft usage, the distribution shifts to the left, with even more PEOs falling in the under $50,000 categories. Commonly disclosed perquisites or personal benefits to PEOs in this sample include the usage of corporate aircraft for personal travel, security services, professional advisory services (including financial planning, tax, accounting, and legal services), ground transportation, relocation benefits, club memberships, and health and wellness benefits. Less common benefits disclosed in this sample include (among others) housing benefits, the reimbursement of children's tuition, and charitable donations.

Table 8 presents the number of registrants in this sample of 100 registrants whose PEO's reported perquisites, or reported perquisites excluding security services and aircraft usage (''Adjusted Perquisites''), met certain criteria relative to the level of total compensation (from the Summary Compensation Table) and various dollar value thresholds.[592]

[592] *See id.*

Table 8. Number of Registrants whose PEO's Perquisites or Adjusted Perquisites Meet Various Conditions, in Sample of 100 Registrants

	All	$100K or More	$150K or More	$200K or More	Over $100K and Over 10% of Salary+Bonus+ Non-Equity Incentives
Reported Perquisites Represent:					
(No Reported Perquisites)	44	0	0	0	0
Up to 2.5% of Total Compensation	43	5	3	2	1
2.5%+ to 5% of Total Compensation	9	5	4	2	2
Over 5% of Total Compensation	4	4	4	3	2
Adjusted Perquisites Represent:					
(No Adjusted Perquisites)	47	0	0	0	0
Up to 2.5% of Total Compensation	44	2	1	1	1
2.5%+ to 5% of Total Compensation	6	3	2	0	1
Over 5% of Total Compensation	3	3	3	3	1

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Table 8 demonstrates that few of the sampled registrants' PEOs had perquisites or adjusted perquisites representing over 5 percent of their total compensation. Among the three registrants whose perquisites or adjusted perquisites exceeded this level, all had perquisites or adjusted perquisites of over $150,000.

5. Director Compensation Composition

Non-employee director compensation is generally simpler in structure than executive compensation, and is rarely conditional on specific performance thresholds. For example, Figure 6 presents the composition of total non-employee director compensation from the Director Compensation Table across registrant size categories in proxy year 2025, for registrants with available data.[593]

[593] *See id.*

Figure 6. Director Compensation Components, Among Registrants Covered by Execucomp

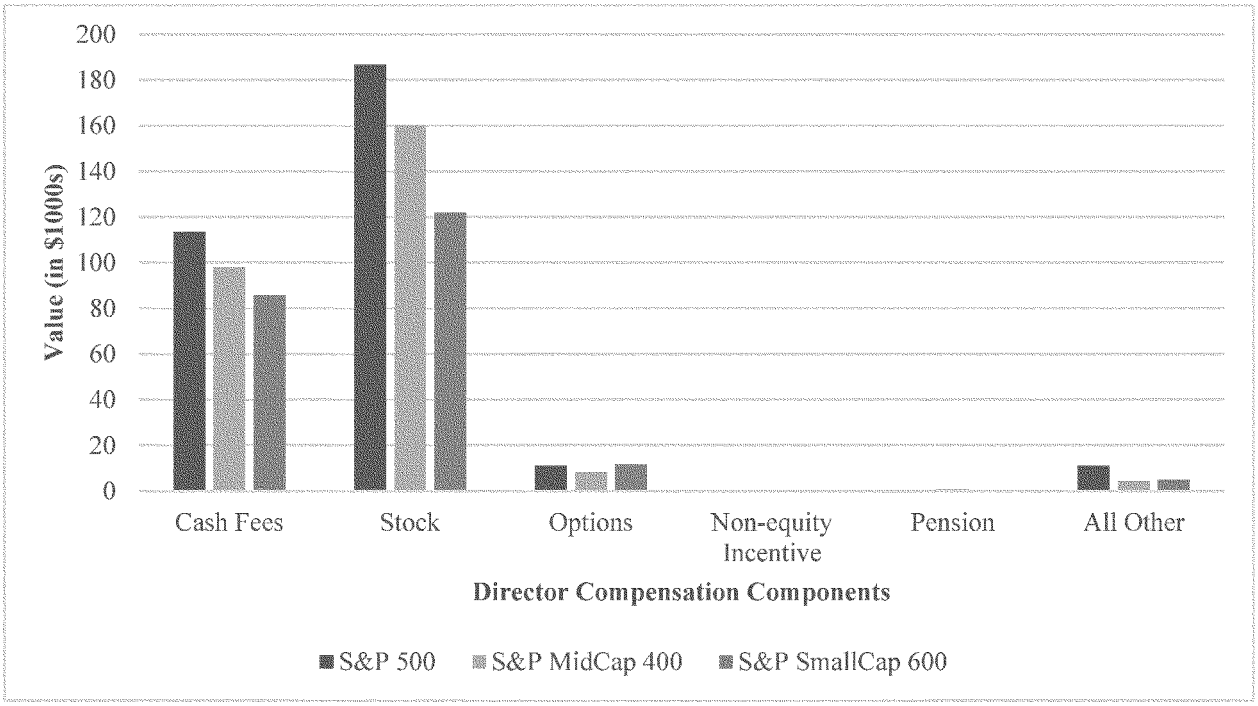


Figure 6 shows that non-employee director pay in the 2025 proxy year consisted primarily of cash fees and stock awards, which together represent, on average, ninety-four percent of the dollar value of director compensation in the sample for which data were available. Staff separately examined the fraction of registrants in this sample that granted compensation outside these two primary categories to directors, and found that eight, three, and 0.1 percent of registrants respectively reported option awards, changes in accumulated pension value or earnings on deferred compensation, or non-equity incentive awards for at least one director.[594] ''All other compensation'' to directors was reported more frequently, with thirty-four percent of registrants reporting a non-zero amount to at least one director.[595] That said, the amounts of ''all other compensation'' are small in magnitude, representing about two percent of total individual director compensation on average across the registrants with available data.

Based on practitioner studies, we understand that most non-employee director stock awards are granted without performance-based vesting and with either immediate vesting or vesting periods of one year or less.[596] One study indicates that the most commonly reported director perquisites are the reimbursement of travel expenses and director education tuition.[597] Less common director benefits disclosed include spouse travel reimbursement, access to corporate aircraft, medical and dental insurance, or discounts on company products.[598]

6. Market Practice

In this section we provide a brief overview of current practices by registrants and investors and recent market developments that are relevant to our consideration of the economic effects of the proposed amendments.

Registrants prepare executive compensation disclosures, often with the help of external advisors. For example, we understand that registrants' securities counsel may often work closely with registrant staff in preparing the proxy statement. Compensation consultants may draft, review, or otherwise provide advice on the CD&A and other compensation disclosures. Consultants, accountants, valuation experts, or other specialists may be retained to aid in producing the required tables and quantitative disclosures, particularly in constructing required valuations and making necessary computations.

In addition to the mandatory executive compensation disclosures required by Item 402, some registrants currently include voluntary disclosures that they believe may better explain their pay practices.[599] For example,

[594] *See id.*

[595] *See id.*

[596] *See. e.g.,* F.W. Cook, *2025 Director Compensation Report* (Sept. 2025), available at *https://fwcook.com/wp-content/uploads/2025/10/25-09-23_FWC_2025_Director_Comp_Final.pdf* (''Cook 2025 Report'') (analyzing director compensation at a sample of 300 registrants, split evenly across small-cap, mid-cap, and large-cap segments, and reporting that 96% of these registrants utilize one year or shorter time-based vesting, with the most common approach being one-year cliff vesting and the next most common being immediate vesting, and with immediate vesting being twice as common at large-cap registrants than the others in the sample).

[597] *See* Matteo Tonello (The Conference Board, Inc.), *Board of Director Compensation Practices in the Russell 3000 and S&P 500* (Feb. 10, 2026), Harv. L. Sch. F. on Corp. Governance Blog, available at *https://corpgov.law.harvard.edu/2026/02/10/board-of-director-compensation-practices-in-the-russell-3000-and-sp-500/.*

[598] *See id.*

[599] For example, in 2025, a compensation consulting firm found that, of 200 large public companies examined, 15% provided voluntary disclosure on the relationship between pay and performance in their executive compensation disclosure (of which 63% defined pay for this purpose as either ''realized'' or ''realizable'' pay, 27% used target pay, 10% used Summary Compensation Table total compensation, and 20% used an adjusted version of the latter, where multiple pay definitions could be used by a single registrant). *See* Meridian Compensation Partners, *2025 Corporate Governance & Incentive Design Survey* (Fall 2025), available at *https://www.meridiancp.com/app/uploads/2025/10/2025-Corporate-Governance-Incentive-Design-Survey.pdf.*

registrants may disclose measures of ''realized pay'' or ''realizable pay,'' [600] and may present trends or relations between different measures. Other registrants may present ''total direct compensation'' and/or other measures intended to demonstrate how the compensation committee views the compensation granted or earned that year. Both registrants and investors have indicated that the flexibility to include registrant voluntary disclosures can be helpful.[601] Such disclosures can allow registrants to better communicate their specific circumstances or provide context for standardized disclosures that they believe do not convey a complete picture of their compensation programs.[602] For investors, such voluntary disclosures can make it easier to understand how the board approaches its compensation decisions and programs.[603] However, the market does not seem to have coalesced around consistent definitions and formats for, or indeed the consistent inclusion of, such voluntary disclosures. Thus, while they may provide investors with useful context, the ability of investors to systematically evaluate these voluntary disclosures or to compare them to peer company disclosures may be limited.[604]

It is possible that some of these additional disclosures were introduced in connection with say-on-pay votes or in response to increased investor engagement associated with such votes.[605] To the extent that the LAF and NAF filer categories that we have proposed in the 2026 Filer Status Proposing Release are adopted, they would reduce the population of registrants required to hold such votes as that requirement would only apply to LAFs. The incentive to include these disclosures could thereby be reduced in the future, assuming the exempted registrants do not voluntarily conduct say-on-pay votes.[606]

We understand that investors currently approach the review of executive compensation disclosures in different ways. Investors often review large numbers of proxy statements and related filings over the relatively condensed proxy season every year.[607] To aid in this process, many investors, particularly institutional investors, use analyses of executive compensation disclosures produced by third parties, such as proxy advisory firms.[608] These products synthesize the information disclosed by a large number of registrants and present standardized computations, comparisons, and highlights for more efficient review.[609] Other investors undertake their own analyses based directly on registrant disclosures or information extracted from these disclosures by third-party data aggregators, or design bespoke analyses that are produced with the help of compensation consultants.[610] Recent advances in information technology may increase the feasibility of such direct review of large volumes of filings.[611]

Currently, some investors likely combine these approaches, for example, using third-party analyses to identify registrants whose executive compensation warrants further analysis, and then examining and analyzing those registrants' disclosures directly in more detail. Given the resources required for accessing third-party research and undertaking detailed quantitative computations and analysis of large numbers of proxy statements, smaller investors, particularly retail investors, are less likely to use the approaches mentioned above but may directly review executive compensation disclosures. Smaller investors, particularly those with investments in fewer registrants, are also more likely to read executive compensation disclosures linearly, whereas larger, institutional investors typically process disclosures in non-linear fashion.[612]

Investors may review executive compensation disclosures annually in advance of voting in director elections and on say-on-pay resolutions, but may

In 2021, the same firm found that 24% of the 200 large public companies examined included disclosures comparing pay and performance. *See* Meridian Compensation Partners, *2021 Corporate Governance & Incentive Design Survey* (Fall 2021), available at *https://www.meridiancp.com/app/uploads/2021/09/Meridian-2021-Governance-and-Design-Survey-2.pdf.*

[600] ''Realized pay'' and ''realizable pay'' measures are designed to provide insight into the value of compensation based on outcomes at some point in time after it is granted, though there are no standard definitions of either term or uniformly accepted approaches in how they are computed. ''Realized pay'' measures are generally intended to reflect the value that the executive receives based on performance outcomes, while ''realizable pay'' measures are generally intended to reflect a revised value of the opportunity to receive pay under outstanding awards based on performance to date.

[601] *See, e.g.,* letters from A&O Shearman; Sullivan & Cromwell; Hambly, 2025 Roundtable Transcript at 172:16–21.

[602] *See, e.g.,* letters from A&O Shearman (''[m]any companies and shareholders find that these alternative tables provide a more accurate reflection of compensation decisions with respect to the covered year''); Sullivan & Cromwell (stating that voluntary realizable or realized pay disclosures allow registrants to use ''approaches that are better tailored to their specific business models and incentive designs'').

[603] *See, e.g.,* Hambly, 2025 Roundtable Transcript at 172:16–21 (stating that ''the supplemental disclosures are often really, really helpful. Helping us look through compensation through the eyes of the board, and not through the eyes of the required disclosure often helps give us a different view into what they're thinking about pay'').

[604] *See, e.g.,* Kosmas Papadopoulos & John Roe (ISS Analytics), *Realizable Pay: Insights into Performance Alignment* (Apr. 29, 2019), Harv. L. Sch. F. on Corp. Governance Blog, available at *https://corpgov.law.harvard.edu/2019/04/29/realizable-pay-insights-into-performance-alignment/* (stating that ''[d]ifferent companies and different compensation consultants arrived at different ways of calculating and presenting these alternative [pay] measures, making it very difficult for investors to systematically use these disclosures in the analysis of pay and performance—much to the frustration of investors and companies alike'').

[605] *See, e.g.,* Lynn, 2025 Roundtable Transcript at 94:17–20 (stating that ''[i]f you go back and look at proxy statements before say on pay and after say on pay, there's a marke[d] difference in the approach that people took'').

[606] *See* 2026 Filer Status Proposing Release. At the same time, investors at registrants that would no longer be required to hold say-on-pay votes would still vote in director elections, including for compensation committee members, such that executive compensation disclosure (whether required disclosure or voluntary additional disclosure) would likely still be relevant to investor voting decisions.

[607] Based on staff experience, most annual meetings are held between April and June of a given year.

[608] Other third parties that may provide analyses of executive compensation disclosures include investment banks, via their equity research analysts, and independent research firms. *See, e.g.,* letter from CFA Institute. However, these analyses may be less detailed or less consistently available across large populations of registrants than those provided by proxy advisors.

[609] The simplicity and standardization of these analyses have also led to criticism that they are not appropriately tailored to the circumstances of different kinds of registrants. *See, e.g.,* Compensia, *The New ISS Pay-for-Performance Methodology—A Closer Look at the Gathering Storm* (June 12, 2017), available at *https://compensia.com/the-new-iss-pay-for-performance-methodology-a-closer-look-at-the-gathering-storm/.* We note that proxy advisors regularly update their analyses based on investor and registrant feedback and other factors. *See, e.g.,* Jesse T. Foley et al., *ISS and Glass Lewis Release Compensation-Related Updates For 2026 Proxy Season* (Feb. 3, 2026), available at *https://www.erisapracticecenter.com/2026/02/iss-and-glass-lewis-release-compensation-related-updates-for-2026-proxy-season/.*

[610] *See, e.g.,* California Public Employees Retirement System (''CalPERS''), *CalPERS' Executive Compensation Analysis Framework* (Apr. 2026), available at *https://www.calpers.ca.gov/docs/executive-compensation-analysis-framework.pdf* (''CalPERS Methodology'') (describing the evaluation of executive compensation by a pension fund, using bespoke analysis constructed with the help of a compensation consultant).

[611] *See, e.g.,* Jack Pitcher, *JPMorgan Cuts All Ties with Proxy Advisers in Industry First,* Wall St. J., Jan. 7, 2026, available at *https://www.wsj.com/finance/banking/jpmorgan-cuts-all-ties-with-proxy-advisers-in-industry-first-78c43d5f* (discussing one large asset manager's plans to start using an internal ''artificial-intelligence-powered platform'' to analyze proxy data).

[612] *See, e.g.,* Hambly, 2025 Roundtable Transcript at 152:2–4 and 173:5–6 (stating that he does not usually read ''front to cover . . . because I know the elements I'm looking for'' and that ''[w]e don't start with the text, and I'm sorry to tell all of you that''); Brok Romanek, *How Investors Read Proxies (In the Real World)* (June 20, 2018), TheCorporateCounsel.net Blog, available at *https://www.thecorporatecounsel.net/blog/2018/06/how-investors-read-proxies-in-the-real-world.html.*

also review these disclosures more sporadically to inform their investment decisions.[613] For example, investors may consider executive compensation when deciding whether to enter into or divest of an investment in a registrant or when monitoring their existing holdings. Investors may also more closely examine the terms of a registrant's executive compensation plans upon major corporate actions or transactions, strategic shifts, poor registrant performance, corporate scandals, or other significant developments for which the executives' incentives could provide context.

Registrants also use the data included in executive compensation disclosures to benchmark and validate their own compensation programs. We understand that compensation committee members and registrant staff involved in this process typically access this information through compensation consultants, who extract and analyze data from proxy statements as well as providing data from proprietary surveys.[614] Directors, registrant staff, and members of management may also directly review the proxy statements of peers or other registrants with similar circumstances.[615] Individual executives or management teams may also engage compensation consultants (who may use proxy statement disclosures) or directly review other registrants' proxy statements to gain insight into the overall executive labor market, to understand how their pay packages compare to those of their peers, and to prepare for compensation negotiations.[616]

Executive compensation disclosures have grown in length over at least the past two decades. While the average proxy statement in 2005 contained about 14,600 words, the average word count grew to about 25,400 words in 2015 and about 33,100 words in 2025.[617] Both investors and registrants have expressed discontent with at least some aspects of current executive compensation disclosures. While some investors have expressed criticism of the length and complexity of proxy statements,[618] many of them attribute the excess volume of disclosure to vague or boilerplate language[619] or the complexity of compensation packages themselves[620] rather than information overload or concern about the data being overly detailed.[621] Some investors have also indicated that they have experienced difficulties in finding the specific information they are looking for in proxy statements, particularly with respect to understanding the rigor of performance targets[622] and tracking a given incentive award through its lifecycle to, for example, understand how its initial structure translated into a final outcome.[623]

Representatives of registrants also have expressed criticism of the length and complexity of current disclosures,[624] but with a greater concern about the level of detail required[625] and the lengthy

[613] In a 2015 survey of 64 institutional investors (which a combined $17 trillion in assets), 59% of the investors indicated that they use information in proxy statements when making investment decisions. When asked which sections of proxy statements they read and rely on to make investment decisions, the two most highly cited areas were performance metrics used in compensation plans and the alignment of pay with performance. *See* Stanford University, RR Donnelley & Equilar, *2015 Investor Survey: Deconstructing Proxy Statements—What Matters to Investors* (Feb. 2015), available at *http://www.sec.gov/comments/4-681/4681-3.pdf* (''Stanford 2015 Investor Survey'').

[614] *See, e.g.,* Kevin J. Murphy & Tatiana Sandino, *Compensation Consultants and the Level, Composition, and Complexity of CEO Pay,* 95 Acct. Rev. 311 (2020), at 322 (stating that the most frequently reported reason by registrants in proxy statements for hiring compensation consultants was benchmarking, including identifying and understanding the pay practices employed by peer companies recruiting executives in comparable labor markets and making recommendations on competitive pay levels for executives); letters from CEC–1; McGuireWoods & Brownstein.

[615] *See, e.g.,* letter from Society for Corporate Governance (stating that some registrants responding to a survey indicated that they benefit from the ability to use current disclosures to obtain information on competitive compensation for certain executive roles without the need to rely on external consultants or other sources for market information).

[616] *See, e.g.,* letter from McGuireWoods & Brownstein (stating that ''[o]ccasionally, management teams will engage an independent compensation consultant to provide information on market trends and support executives'').

[617] These estimates are based on staff analysis of data from Wharton Research Data Services (''WRDS'') SEC Analytics Suite.

[618] *See, e.g.,* letters from Baillie Gifford; EOS; NEI; *see also* Hambly, 2025 Roundtable Transcript at 151:25–152:1 (stating that ''the complexity and the pagination has gotten out of control''); Stanford 2015 Investor Survey, *supra* note 613 (finding that 55% of the surveyed investors believed that a typical proxy statement was too long).

[619] *See, e.g.,* letters from Baillie Gifford (suggesting a reduction in boilerplate language, and stating that a CD&A ''often reads like marketing copy, burying the key drivers of pay''); EOS (indicating that current executive compensation disclosures are ''often too boilerplate in nature to reveal genuine insight or generate productive dialogue with management and at board level''); State Board Florida (stating that ''many firms focus on justifying their compensation decisions rather than providing transparent, analytical insights'').

[620] *See, e.g.,* letters from NEI (stating that the solution to lengthy and complex disclosure ''may not necessarily reside in reducing the transparency expectations for companies, but rather [in] encourag[ing] companies to simplify their compensation frameworks''); Norges Bank; *see also* Hambly, 2025 Roundtable Transcript at 152:16–19 (stating that ''[t]here is nothing in the rules and regulations that says we have to set up compensation programs that require a slide rule and an abacus to figure out [what] somebody is going to get paid'').

[621] *See, e.g.,* letters from AFREF (stating that if some disclosures are overly complex, ''the fault lies with those issuers and is no reason to decrease the amount of disclosures available to investors, none of whom have called for less information''); Better Markets (stating that investors do not ''appear to believe that they should have less information about executive compensation''); CFA Institute (stating that it has ''not found evidence of disclosure overload through [its] surveys of members'' and that it has ''not heard calls for a reduction in the length of these disclosures by [its] members or investors broadly''); Council of Institutional Investors (stating that it ''supports comprehensive (but not necessarily more complex) disclosures rather than less''); Los Angeles County Employees Retirement Association (June 23, 2025) (''LACERA''), available at *https://www.sec.gov/comments/4-855/4855-616387-1808394.pdf* (supporting comprehensive disclosures and stating that ''transparency that is not comprehensive risks creating an incentive for pay to be rewarded through benefits, perquisites, and other avenues that are detached from performance and result in 'pay padding' ''); Rees, 2025 Roundtable Transcript at 103:2–7 (stating that ''[r]egarding the level of disclosure . . . investors . . . are perfectly capable of focusing on the aspects of executive compensation that [are] most important for our analysis. No investor is asking the SEC to reduce the amount of disclosure'').

[622] *See, e.g.,* letters from Baillie Gifford; Council of Institutional Investors; Norges Bank; *see also* Bob McCormick (Council of Institutional Investors), 2025 Roundtable Transcript at 77:9–18 (stating that in the case of two registrants, where ''one grants very challenging performance metrics along with its awards, one that's very easy,'' that ''[t]hat's probably the hardest thing for investors to really understand'' and that ''the disclosure's there, but you sort of have to dig'').

[623] *See, e.g.,* letters from CFA Institute (recommending that ''information today disclosed in multiple tables, footnotes, and filings'' about the lifecycle of equity grants be merged in a single location); Norges Bank (stating that it ''find[s] that current requirements . . . mak[e] it difficult to assess the total incentive that the CEO received in any given period and how such incentives compared to the original targeted value and metrics''); *see also* Hambly, 2025 Roundtable Transcript at 171:10–23 (stating ''how do we track some of this over time? And so my biggest gripe today is, to get at that value transfer number, especially with . . . PSUs, that number doesn't have to be disclosed for about 14 months, right? . . . So I spend a lot of time trying to put this whole thing together''); John Roe (BlackRock), 2025 Roundtable Transcript at 173:21–174:15 (stating ''the summary compensation table for the short-term incentive . . . tells you how much was paid, but it doesn't tell you what was the target. . . . The short-term incentive, usually that's reported in the grants of plan-based awards table. Others aren't easy to do—it takes an awful lot of work to go through''); Adamson, 2025 Roundtable Transcript at 175:24–176:3 (stating ''I personally struggle, is this option that was exercised, what award does that go back to here? And, oh, let me see if I can find the Form 4, and I'm navigating through a haystack'').

[624] *See, e.g.,* letters from CEC–2; Davis Polk; IBC; Johnson & Johnson; McGuireWoods & Brownstein; NAM–2 (stating that ''under an ideal disclosure regime, a company's board should be able to explain its approach to incentivizing executives in plain English in five to ten pages,'' in contrast to current disclosures that ''often exceed 20 or 30 pages''); Society for Corporate Governance; Sullivan & Cromwell.

[625] *See, e.g.,* letters from A&O Shearman (stating that certain of the tabular disclosures ''tip the

clarifications and explanations some believe to be necessitated by the mandated disclosures.[626] Some registrants have also raised concerns about certain burdensome data collection and computation requirements that they do not believe to be useful to investors,[627] prescriptive requirements that do not suit varying registrant circumstances,[628] and disclosure formats or computations that they believe are internally inconsistent, inconsistent with other required computations, and/or could be misleading.[629]

7. Recent Governance Developments

We note that there have been several recent changes in the overall governance landscape that could impact the potential effects of the proposed amendments. In particular, investors have highlighted that certain forms of intervention in registrant governance, such as direct engagement,[630] shareholder proposals,[631] and certain campaigns involving notices of exempt solicitation,[632] may be becoming less accessible or less effective means of communicating their views or concerns to registrant management.[633] Different forms of corporate governance mechanisms, such as external monitoring and interventions and well-designed monetary incentives for managers, may substitute for each other to some extent in addressing the potential misalignment of interests between management and investors.[634] Thus, if certain direct interventions become less practical or effective than they were previously, investors may become even more concerned about the precise structure of executive compensation and what decisions or behavior it may incentivize on the part of management, leading them to rely to a greater degree on executive compensation disclosure than they may have in the absence of these developments.

Another recent development is increasing fragmentation of investor voting at corporate shareholder meetings.[635] Specifically, some voting authority at large institutional investors has moved from centralized stewardship teams to the individual managers of funds [636] or through voting pass-through programs to end investors in the funds.[637] Other institutional investors have reduced their reliance on traditional external proxy advisory services, and proxy advisory services themselves have introduced more customizable offerings.[638] Other innovations that have arisen may increase the voting participation of retail investors.[639] While we understand

balance'' between ''adequate disclosure'' and ''information overload'' towards the latter); Business Roundtable (referring to ''duplicative and immaterial tabular disclosures''); CEC–1 (stating that disclosures have become ''overly detailed'' and encouraging approaches that would ''make certain that investors . . . are not overloaded by an avalanche of immaterial information''); Davis Polk (stating that ''[t]he rules require disclosure far beyond what is material to investors and, as a result, clutter proxy statements with immaterial information''); IBC (criticizing a focus on the ''quantity over quality of information''); McGuireWoods & Brownstein(stating that the disclosures are ''far too voluminous and technical for even the most sophisticated investors to understand, let alone an average retail investor''); NAM–1 (stating that some of the tabular disclosures are ''not understandable or relevant to most individual and institutional investors'').

[626] *See, e.g.,* letters from Business Roundtable (stating that ''the narrative disclosure that companies often feel compelled to add on top of the required disclosures to provide a meaningful picture of their compensation results in ever lengthier and more overwhelming disclosures''); CEC–2 (stating that ''the increasing number of mandated tables and rigid definitions . . . has forced companies to provide supplementary explanations''); Sullivan & Cromwell (stating that ''registrants almost universally include non-standard tables'' to better reflect how registrants view, or how market participants evaluate, executive compensation than the mandated tables); Travelers (stating that ''companies . . . often expand their . . . disclosures to include supplemental compensation tables and accompanying narratives in an effort to correct the timing mismatch and to provide a clearer picture of executive compensation'').

[627] *See, e.g.,* letters from Axcelis; Business Roundtable; CEC–2 (describing the ''considerable'' burden involved in preparing the tabular disclosures and stating that ''these tasks are not only time-consuming but often yield disclosures that go unused by the intended audience''); McGuireWoods & Brownstein (referencing ''obtuse requirements'' that result in ''more work for human resource and accounting departments to create hypothetical calculations that do not further shareholder interests''); Society for Corporate Governance.

[628] *See, e.g.,* letters from Business Roundtable (stating that registrants ''often feel compelled to conform to rigid templates that emphasize compliance over clarity, and that leave little room for tailored explanation of how executive compensation decisions support long-term corporate strategy''); CEC–2 (stating that ''force-fitting the details of compensation into a one-size-fits-all series of mandated tables and narratives limits the ability of the company to convey the criteria used to assess the effectiveness'' of its compensation program); IBC (stating that ''[t]he one-size-fits-all approach to the disclosure requirements ignore[s] company-specific circumstances''); Society for Corporate Governance; Sullivan & Cromwell.

[629] *See, e.g.,* letters from Business Roundtable; Davis Polk (stating that ''different tables require different calculations under different accounting rules'' and that ''[t]he hodgepodge of current tabular disclosure . . . risks misleading and confusing investors by distracting from material information''); Society for Corporate Governance (stating that the disclosures ''require information to be provided in formats that are complex and at times internally inconsistent, which may cause confusion among even sophisticated investors and financial professionals'').

[630] We understand that some investors changed their engagement strategies following the staff of the Division of Corporation Finance's February 2025 release of staff guidance with respect to Schedule 13D and 13G filings. Some registrants disclosed in 2025 proxy statements that they had difficulty receiving investor feedback in that proxy season. *See, e.g.,* Subodh Mishra (ISS Stoxx), *Top Governance & Stewardship Trends for 2026,* Harv. L. Sch. F. on Corp. Governance Blog (Mar. 9, 2026), available at *https://corpgov.law.harvard.edu/2026/03/09/top-governance-stewardship-trends-for-2026/.*

[631] The number of shareholder proposals submitted to registrants dropped significantly and the number of such proposals omitted from proxy statements increased significantly in the 2025 proxy season. *See, e.g.,* Matteo Tonello (The Conference Board, Inc.), *2025 Proxy Season Review: From Escalation to Recalibration*, Harv. L. Sch. F. on Corp. Governance Blog (Sept. 15, 2025), available at *https://corpgov.law.harvard.edu/2025/09/15/2025-proxy-season-review-from-escalation-to-recalibration/.*

[632] Filings of notices of exempt solicitation decreased in the 2025 proxy season, potentially in response to revised staff guidance issued by staff of the Division of Corporation Finance in January 2025. Voluntary submissions accounted for a substantial majority of the filings. *See, e.g.,* Sullivan & Cromwell, *2025 Proxy Season Review: Part 1,* (Aug. 11, 2025), available at *https://www.sullcrom.com/SullivanCromwell/_Assets/PDFs/Memos/2025-Proxy-Season-Review-Part-1.pdf.* In light of a further staff update to a related CD&A in January 2026, which indicated that staff would object to voluntary submissions of notices of exempt solicitations, the number of such filings may drop substantially in the 2026 proxy season.

[633] *See, e.g.,* Severine Neervoort (International Corporate Governance Network), *Statement on Investor Concerns About Shareholder Rights and SEC Policy Before the SEC's Investor Advisory Committee,* Harv. L. Sch. F. on Corp. Governance Blog (Feb. 9, 2026), available at *https://corpgov.law.harvard.edu/2026/02/09/statement-on-investor-concerns-about-shareholder-rights-and-sec-policy-before-the-secs-investor-advisory-committee/;* Shareholder Rights Group, *New Securities and Exchange Commission Policy Bars Main Street Investors From Posting on Its Public Database* (Jan. 28, 2026), available at *https://www.shareholderrightsgroup.com/2026/01/new-securities-and-exchange-commission.html.*

[634] *See, e.g.,* Stuart Gillan et al., *Tradeoffs in Corporate Governance: Evidence from Board Structures and Charter Provisions,* 1 Q. J. Fin. 667 (2011) (finding that certain governance mechanisms are substitutes).

[635] *See, e.g.,* Andrey Malenko et al., *Fragmentation of Shareholder Power,* Working Paper (Mar. 2026), available at *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=6083066.*

[636] *See, e.g.,* Nathan Hermann et al., *Decentralizing Voting Power,* European Corporate Governance Institute Finance Working Paper No. 1092/2025 (Sept. 2025), available at *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5500098.*

[637] *See, e.g.,* Alon Brav et al., *The Proxy Voting Choice Revolution,* European Corporate Governance Institute Law Working Paper No. 875/2025 (Dec. 2025), available at *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5500098.*

[638] *See, e.g.,* Lillian Tsu & Shuangjun Wang, Cleary Gottlieb Steen & Hamilton LLP, *Shareholder Engagement: Is the Power of Proxy Advisors and Institutional Investors Shifting?* Harv. L. Sch. F. on Corp. Governance (Feb. 6, 2026), available at *https://corpgov.law.harvard.edu/2026/02/06/shareholder-engagement-is-the-power-of-proxy-advisors-and-institutional-investors-shifting/.*

[639] At least one application was launched within the past five years to enable retail investors to create

Continued

that the changes thus far have been modest, they may represent the early stages of a greater trend toward more decentralized voting. Such a trend may result in an increase, in comparison to the baseline, in the variety of approaches used to review disclosure and in the number of individuals separately evaluating executive compensation disclosures when making voting decisions.[640]

D. Persons Covered

The NEOs of a registrant are the group of executive officers for whom executive compensation disclosure under Item 402 is required.[641] In addition, the departure of an NEO, or the commencement or material modification of (or a material grant or award under) a material compensatory plan, contract, or arrangement with an NEO, triggers a required Form 8–K filing containing certain disclosure under Item 5.02.[642] Moreover, say-on-pay advisory votes apply to the compensation of NEOs.[643]

The current definition of NEO for registrants other than SRCs and EGCs includes a registrant's (a) PEO and PFO, including all individuals serving in either of these capacities during the last completed fiscal year, (b) three most highly compensated individuals other than the PEO and PFO who served as executive officers as of the end of the fiscal year and whose adjusted total compensation was at least $100,000, and (c) up to two additional individuals who would have been included under (b) if they had still served as executive officers at fiscal year-end. For SRCs and EGCs, the NEOs include a registrant's (a) PEO, including all individuals serving in this capacity during the last completed fiscal year, (b) two most highly compensated individuals other than the PEO who served as executive officers as of the end of the fiscal year and whose adjusted total compensation[644] was at least $100,000, and (c) up to two additional individuals who would have been included under (b) if they had still served as executive officers at fiscal year-end. Thus, the core number of NEOs is five, scaled down to three for SRCs and EGCs, but the total number of NEOs for a given registrant can range from one (in the case of an SRC/EGC with no executive officers other than the PEO with adjusted total compensation of at least $100,000) to seven (or potentially more, in cases of PEO or PFO transitions within a fiscal year) individuals.

The proposed amendments would limit the group of NEOs for which disclosure must be provided to a registrant's PEO and PFO (including individuals who served in these capacities for any part of the year).

1. Benefits

As detailed in the Baseline section (IV.C above), registrants have a median of five NEOs, with 15 percent of registrants in the sample reporting four or fewer and 31 percent of registrants with available data reporting six or more.[645] Limiting the NEO definition to individuals serving as PEO or PFO would therefore significantly reduce the number of executives for which compensation disclosure is required at most registrants. Such a reduction in the coverage of Item 402 disclosure and Form 8–K Item 5.02(b)[646] and (e) disclosure (regarding departures and compensatory plans, contracts, or arrangements, as discussed earlier in this section) would, in turn, be expected to generate significant compliance cost savings for those registrants relative to their current expenditures on such disclosures.

Most directly, reducing the number of NEOs at most registrants (by 60 percent, from five to two for the typical registrant that is not an SRC or EGC[647]) would reduce the volume of executive compensation disclosure that needs to be prepared (including the registrant's data collection and monitoring of information). The volume of some components of the disclosures, such as the individual-by-individual compensation information presented in tables, is directly proportional to the number of NEOs and would thus decrease proportionally to the reduction in that number. Narrative disclosures, such as those in the CD&A, may decrease less than proportionally with the number of NEOs if the same discussion can currently apply to multiple NEOs, but may decrease significantly at registrants where compensation design varies sufficiently across the executive roles that incremental NEOs necessitate significant additional narrative.[648] Overall, the length of most components of executive compensation disclosures would likely decrease to some extent with each fewer NEO. A smaller group of NEOs would thus be expected to significantly reduce the amount of information needed to be collected, reviewed, and presented in disclosures by registrants.

Beyond this volume-related reduction in disclosure burdens, we anticipate that limiting the NEOs to the PEO and PFO, as proposed, would also reduce burdens associated with yearly volatility in a registrant's list of NEOs. Registrants may currently expend resources on tracking, computing, and reviewing the compensation of a large group of executive officers for the purpose of identifying who among them will qualify as the three most highly

customized voting policies and more efficiently vote their shares. *See, e.g.,* Jill Fisch & Jeff Schwartz, *Corporate Democracy and the Intermediary Voting Dilemma,* 102 Tex. L. Rev. 1, 49–50 (2023). Separately, one registrant recently introduced a retail voting program allowing investors to opt in to having their shares automatically voted in line with the Board's recommendations. *See, e.g.,* Jeremiah Garvey & Seth Popick, *SEC's No-Action Relief Could Dramatically Alter Retail Voting, Law*360 (Oct. 22, 2025), available at *https://www.law360.com/articles/2400526/sec-s-no-action-relief-could-dramatically-alter-retail-voting.*

[640] Fragmentation of the voting base could also reduce the effectiveness of engagement by institutional investors, which, as discussed above, could increase the focus of investors on executive compensation as an alternative means of addressing managerial alignment with investors.

[641] *See supra* section II.B.

[642] *See* Item 5.02(b) and (e) of Form 8–K. For purposes of Item 5.02, under current Form 8–K, the term ''named executive officer'' refers to those executive officers for whom disclosure was required in the registrant's most recent filing with the Commission under the Securities Act or Exchange Act that required disclosure pursuant to Item 402(c) of Regulation S–K. *See* Instruction 4 to Item 5.02 of Form 8–K. Under the proposal, Instruction 4 to Item 5.02 of Form 8–K would be amended to update the reference from ''Item 402(c) of Regulation S–K'' to ''Item 402(b) of Regulation S–K.''

[643] *See* 17 CFR 240.14a–21(c) (Commission rules addressing shareholder approval of executive compensation, frequency of votes for approval of executive compensation, and golden parachute compensation). As discussed above, the definition of NEOs will also impact disclosures under Regulation S–K Items 403 and 404 and the filing of material contracts under Exhibit 10 to certain registration statements and periodic reports. *See supra* note 91.

[644] Adjusted total compensation in this section refers to total compensation based on all of the elements included in the Summary Compensation Table less any amounts attributable to the change in accumulated pension value or above-market earnings on deferred compensation.

[645] As discussed in section IV.C above, the registrants for which these data were readily available to us represent a subset of relatively larger registrants and exclude most SRCs and EGCs. *See supra* notes 575 and 576.

[646] As discussed below, the proportionate effect on Form 8–K Item 5.02(b) disclosure may be lower than for other affected disclosures because this disclosure requirement expressly applies to certain of the registrant's executive officers other than the PEO and PFO, whether or not they are NEOs, in addition to the PEO, PFO, and other NEOs. *See supra* note 642 (regarding the definition of NEO for purposes of Form 8–K Item 5.02).

[647] *See supra* section IV.C.3.

[648] *See, e.g.,* letters from Davis Polk (stating that ''issuers may compensate executive officers differently depending on whether they lead a business unit or a key function of the issuer, or both''); Sullivan & Cromwell (stating that disclosure of the compensation of the three highest paid executive officers other than the PEO and PFO ''needlessly contributes to the length and complexity of disclosure,'' ''particularly because executives responsible for business lines often are compensated differently from executives responsible for corporate functions'').

compensated by fiscal year-end.[649] The NEOs may vary from year to year as the various amounts and components of compensation for different executives fluctuate over time (including changes due to varying bonuses and equity awards), and ad hoc payments such as severance pay or relocation payments can cause unexpected changes in the list of NEOs. Such variation and uncertainty may increase not only the data collection and monitoring costs discussed above, but also the registrant staff time and effort required to revise the disclosures to explain in public filings the compensation of a different group of NEOs (with different roles and responsibilities) from year to year.[650] In contrast, individuals acting in the capacity of PEO or PFO are readily identifiable and have generally consistent executive roles. Limiting the NEOs to the PEO and PFO would also prevent pay distortions or additional compensation committee deliberations that could result solely because of the effect of compensation decisions on the composition of the registrant's NEOs.[651]

A smaller group of NEOs also could reduce the time that registrant staff and directors expend on outreach and investor engagement by reducing the number of executives whose pay is disclosed and subject to say-on-pay votes. However, we understand these discussions already focus primarily on PEO compensation[652] and that any such savings are therefore likely to be minimal. A smaller, more consistent group of NEOs could also likely reduce the time that registrant staff, directors, or external advisors spend informing executives that they will appear in the disclosures and discussing the disclosures with them.[653]

In addition, a smaller group of NEOs would also reduce the likelihood of triggering Form 8–K Item 5.02(b) or (e) disclosure and the accompanying time and cost expenditures. The proportionate impact is likely to be greater in the case of Item 5.02(e) disclosure of the commencement or material modification of (or a material grant or award under) a material compensatory plan, contract, or arrangement, because this disclosure requirement relates only to a registrant's NEOs as defined under Item 5.02(e). Item 5.02(b) disclosure relating to the departure of executives is required for the NEOs, but also expressly required for the registrant's PEO, president, PFO, principal accounting officer, principal operating officer, or any person performing similar functions, regardless of whether these individuals are NEOs. We estimate that registrants would, in aggregate, file about 695 fewer Form 8-Ks per year,[654] leading to additional expected compliance cost savings.

The compliance cost savings from a smaller group of NEOs may benefit shareholders to the extent that registrant staff, management and board time and resources are redirected to more productive uses. While larger and/or more sophisticated investors are likely able to readily digest the existing large volumes of disclosure, others, particularly retail investors, may benefit from the increased readability of shorter disclosures.[655]

Two commenters indicated that, based on registrant survey responses, registrants could save approximately thirty to sixty percent of the hours devoted to preparing executive compensation disclosure if the NEOs were limited to the PEO and PFO.[656] Given its significant effects on both the volume of disclosure and the number of executive officers whose compensation may need to be tracked, the proposed change in the definition of NEOs is likely to account for a large fraction of the total cost savings from the proposed amendments. However, other elements of the proposed amendments, such as the changes to the primary tabular disclosure requirements, would reduce the per-NEO burdens of producing executive compensation disclosure. Thus, the incremental impact of narrowing the scope of the NEO definition beyond the effects of the other proposed amendments may be somewhat smaller than the effects of this proposed revision considered in isolation.

The benefits of this proposed revision to the NEO definition are expected to vary across registrants based on two factors: (1) their current number of NEOs (which would drive any reduction in the volume of required disclosure); and (2) the size of the pool of executive officers whose compensation is high enough that they could potentially be classified as an NEO at the end of the fiscal year (which would drive savings due to registrants no longer tracking who might become the most highly compensated executive officers other than the PEO and PFO). Registrants currently disclosing compensation for the largest number (such as seven or more) NEOs, or those registrants with many highly paid executive officers whose similar pay levels create uncertainty about the final list of NEOs, would likely experience the greatest savings. In contrast, SRCs and EGCs, which currently typically disclose compensation for three NEOs, would generally realize more modest benefits from moving to an NEO group of only the PEO and PFO as proposed, though they may still experience substantial savings in tracking executive compensation to the extent they have a

[649] *See, e.g.,* letters from ABA (describing ''the compliance burden registrants face in determining their most highly compensated executive officers; namely, the technical requirements which often compel them to closely track throughout the fiscal year the total compensation of numerous executive officers, particularly as it involves the third most highly compensated executive officer position''); Davis Polk (citing a registrant that stated it spends ''quite a lot'' of time during the year projecting who would be an NEO); Society for Corporate Governance (stating that ''it is frequently necessary for an issuer to calculate total compensation for multiple executive officers in order to determine the NEOs that require compensation disclosure''). We understand that compensation committees are responsible for reviewing the compensation of all executive officers, such that some tracking of the compensation of these other executives is still likely to be required, but the nature of such tracking may differ from what is undertaken in anticipation of and preparation for proxy statement disclosure. In addition, to the extent that the deduction limits in 26 U.S.C. 162(m) are implicated, registrants may have to calculate compensation of executive officers for those purposes.

[650] *See, e.g.,* letter from ABA (stating that volatility in the executive officers included in the NEOs ''has raised the compliance burden for registrants that must ensure that both their narrative and tabular disclosures reflect the required information for these constant changes'').

[651] *See, e.g.,* letter from CEC–2 (stating that ''[c]ompanies may feel pressure to manage compensation levels to avoid including or excluding certain individuals as NEOs, as the public disclosure of an executive's NEO status can send unintended signals to the market about succession plans, performance, or internal dynamics''). *But see* Lennartz, 2025 Roundtable Transcript at 74:15–20 (stating that ''[t]he NEO inclusion is another area where I haven't actually seen a decision be distorted by that consideration, but there's a lot of nail biting that happens as you're going through that process'').

[652] *See, e.g.,* letters from CEC–2; Davis Polk.

[653] *See, e.g.,* Chiu, 2025 Roundtable Transcript at 192:12–18 (stating that ''the most daunting thing was, after putting the disclosure together, [she] then had to go to each executive and explain their pay to them'').

[654] *See infra* section V; *see also supra* section IV.C.2 (regarding estimates of the current number of Form 8–K filings containing disclosure responsive to Items 5.02(b) and 5.02(e)).

[655] *See, e.g.,* Brian Miller, *The Effects of Reporting Complexity on Small and Large Investor Trading,* 85 Acct. Rev. 2107 (2010) (finding that longer and less readable filings are associated with a reduction in trading activity which appears to be due to lower trading by small investors, and that such filings are also associated with a decrease in consensus among small investors).

[656] *See* letters from CEC–2 (citing a recent internal survey that found that ''limiting disclosure to the CEO/CFO would reduce hours worked by 30–50% due to reduced data collection, narrative, table publication and auditing, cost of physical publication, cost of external and internal counsel cost and leadership time to review''); Davis Polk (citing a recent internal survey in which ''multiple issuers noted that they would save approximately 50–60% of hours worked on preparing executive compensation disclosure by limiting it to the CEO and CFO'').

large number of highly paid executive officers who might qualify as NEOs by fiscal year-end under the current definition.

If the amendments proposed in the 2026 Filer Status Proposing Release are adopted, a much larger group of registrants would be subject to the same NEO definition as SRCs and EGCs and would similarly derive more modest direct benefits from the revised NEO definition. Nevertheless, the savings from eliminating the need to track the compensation of many executive officers to identify the most ''highly compensated'' could still be substantial.

2. Costs

Narrowing the NEO definition to only PEOs and PFOs, as proposed, would reduce the information available to investors about the compensation of registrants' other top executives.[657] The significance of this information loss is expected to vary across registrants depending on, among other factors, the degree to which executives other than the PEO and PFO (such as a president or chief operating officer) play a pivotal role in a registrant's strategic decisions. Registrants and investors, directly or through costs passed along by their third-party advisors, may also incur limited short-term transition costs to adapt to the new requirements.

Disclosure about executive compensation can provide information that is likely to be material to investment and voting decisions by allowing investors to, among other things, develop informed expectations about executive decision-making and registrant performance.[658] Because the PEO typically has the most direct input into a registrant's direction and strategy, disclosure that conveys an understanding about the PEO's incentives is the most likely to be material for forming these expectations. As the most senior and likely most influential executive, the PEO may also set the tone for the overall dynamic between the board and management. Thus, PEO compensation may also be an important factor in evaluating the effectiveness of boards of directors.

In practice, as indicated by the feedback from commenters, the compensation of PEOs is generally more closely monitored and scrutinized than that of other NEOs.[659] For example, some analyses used by investors in reviewing compensation disclosures focus primarily on the compensation of the PEO.[660] We therefore believe that investors generally find PEO compensation to be the most important element of executive compensation disclosure when making investment and voting decisions.

Nonetheless, there are reasons why the compensation of other key executives may also be relevant to investors' investment and voting decisions and therefore the amendment to the definition of NEO may, in some cases, result in a loss of information likely to be material to investors. For example, strategic decision-making responsibilities may be concentrated in a PEO at one registrant but dispersed across several executive officers at a different registrant. Attaining the same degree of understanding about the economic incentives that could affect key decisions might involve information about the compensation of more executive officers at the latter registrant than at the former. Information about the compensation of other executive officers would also demonstrate the similarities and differences between the compensation of the PEO and that of other executives and across the non-PEO executives, allowing investors to more fully evaluate the effectiveness of the compensation committee.[661]

Compensation information about other executive officers can also provide insight into the dynamics of a registrant's management team. For example, the differential between a PEO's compensation and that of other executives may provide insights about registrant performance that may relate to the influence of the PEO relative to the rest of the management team,[662] about expected synergies or teamwork among executives,[663] about possible PEO successors,[664] and about how competition for such succession may incentivize senior executives.[665] The design of non-PEO executive compensation can also provide information about the likelihood that these important employees will choose to stay at the registrant.[666]

Additionally, some commenters referenced investors' consideration of non-PEO compensation,[667] and some analyses used by investors also include non-PEO compensation as one of the many factors evaluated,[668] despite,

[657] Some compensation information for certain executives other than the PEO and PFO may still be required to be disclosed when they are newly appointed to one of a delineated list of roles. *See* Item 5.02(c) of Form 8–K.

[658] *See supra* section IV.B.

[659] *See, e.g.,* letters from CEC–2; Norges Bank; Rees, 2025 Roundtable Transcript at 137:8–9.

[660] *See, e.g.,* CalPERS Methodology, *supra* note 610 (describing an investor's quantitative analysis of executive compensation disclosure, which focuses on CEO pay); Institutional Shareholder Services, *United States Pay-for-Performance Mechanics: ISS' Quantitative and Qualitative Approach* (Dec. 9, 2025), available at *https://www.iss-stoxx.com/file/policy/current/americas/pay-for-performance-mechanics.pdf,* at 3–5 (''ISS Pay-for-Performance Methodology'') (describing, alongside qualitative considerations, four quantitative measures of alignment between executive pay and company performance, all of which are based on CEO pay, and stating that ''ISS primarily focuses on the CEO's pay because it sets the compensation pace at most companies''); Glass Lewis, *United States & Canada Pay-for-Performance Methodology Overview* (July 2025), available at *https://resources.glasslewis.com/hubfs/Glass%20Lewis%20Pay%20for%20Performance%202026%20Update%20-%20North%20America%20FAQs.pdf* (''Glass Lewis Pay-for-Performance Methodology'') at 1–3 (describing, alongside qualitative considerations, five quantitative analyses of pay-for-performance alignment, of which four pertain to CEO pay, and stating that the focus on CEO pay in the analyses described in the document is ''primarily a result of market norms, investor feedback, and discussion'').

[661] *See, e.g.,* letter from ABA (referencing ''investors' ability to understand differences in a registrant's compensation philosophy between its most senior leader and the rest of the executive team, as well as its attention to pay parity among its executive officers'').

[662] *See, e.g.,* Lucian Bebchuk et al., *The CEO Pay Slice,* 102 J. Fin. Econ. 199 (2011) (finding that the fraction of the aggregate compensation of the top-five executive team captured by the CEO, as a measure of the dominance of the CEO, is associated with the value, performance, and behavior of public firms).

[663] *See, e.g.,* Robert Bushman et al., *Management Team Incentive: Dispersion and Firm Performance,* 91 Acct. Rev. 21 (2016) (studying how firms incorporate synergistic interrelationships among executives into optimal incentive design, focusing on the dispersion in the pay-for-performance sensitivities across top executives).

[664] *See, e.g.,* Spenser Essman et al., *Signaling a Successor? A Theoretical and Empirical Analysis of the Executive Compensation-Chief Executive Officer Succession Relationship,* 42 Strat. Mgmt. J. 1 (2021) (finding that a lower pay disparity between the CEO and the highest paid non-CEO executive is predictive of a higher likelihood of the CEO being succeeded by an internal candidate rather than an external one).

[665] *See, e.g.,* Jayant Kale et al., *Rank-Order Tournaments and Incentive Alignment: The Effect on Firm Performance,* 64 J. Fin. 1479 (2009) (finding that tournament incentives, as measured by the pay differential between the CEO and other named executive officers, relate positively to firm performance).

[666] *See, e.g.,* Radhakrishnan Gopalan et al., *The Role of Deferred Equity Pay in Retaining Managerial Talent,* 38 Contemp. Acct. Res. 2521 (2021) (finding that executives with a greater pay duration, measured based on the weighted average of the vesting periods of different components of their pay, are less likely to leave the firm voluntarily).

[667] *See, e.g.,* letters from ABA (referring to ''investors' ability to understand differences in a registrant's compensation philosophy between its most senior leader and the rest of the executive team, as well as its attention to pay parity among its executive officers''); CFA Institute; State Board Florida (stating an interest in compensation disclosures for any executives that ''participate in strategic business decision-making'' or ''hold significant operational influence''); *see also* Rees, 2025 Roundtable Transcript at 137:8–11 (stating that ''it's true that investors by and large mostly focus on CEO pay'' but that investors also look at ''whether CEO pay is in alignment with how the rest of the C-suite is being compensated'').

[668] *See, e.g.,* CalPERS Methodology, *supra* note 610, at 5 (describing the consideration of non-CEO NEO pay in some elements of the qualitative

generally, a primary focus on PEO compensation, as noted above.

Registrants may also use compensation disclosures to obtain compensation benchmarking data.[669] The proposed amendment to the definition of NEOs could reduce the amount of public data available to compensation committees about the compensation of executive officers other than PEOs and PFOs at peer registrants or could increase the reliance of these committees on third-party survey or consultant data (potentially at an incremental cost) when designing compensation for these executives.[670] Finally, investors may also receive less information and/or less timely information about the departure of, or material contracts, plans, or arrangements with, the executive officers for whom Item 5.02(b) and (e) Form 8–K disclosure would no longer be required due to the proposed amendment to the definition of NEO.[671] While some of this information (*e.g.,* regarding executive changes) would generally be disclosed eventually by the registrant, such as in the list of executive officers in its Form 10–K,[672] or may become available through other sources (such as the registrant's website or individual executives' profiles on social media), under the proposed amendments much of the compensation-related information regarding these individuals may not be publicly available to investors and the release of information about these individuals' departures may be delayed.

Including the PFO in the proposed NEO definition partially mitigates these potential reductions in available information. For example, including the PFO may provide partial insight into executive team dynamics and how the compensation committee makes pay decisions for different executive roles. Compensation committees would also continue to have uniform benchmarking data for setting PFO compensation. The executive officers for whom compensation data would no longer be disclosed are those for whom such data are less uniformly available or comparable across registrants under the current rule, because the roles of the other NEOs (beyond PEO and PFO) may vary significantly. That said, such data can still be informative to investors under the baseline for the reasons discussed above, and the reduction in disclosure under the proposal may thereby, for some registrants, reduce the amount of information incorporated into registrant security prices and increase information asymmetries between registrant management and investors or among investors.

Transparency into executive officers' compensation may also encourage more effective compensation design for those executives, which could translate into enhanced executive performance.[673] It is therefore possible that reducing the transparency of the compensation of some highly paid executive officers by narrowing the scope of the definition of NEOs could, over time, lead to less effective incentives and thus suboptimal performance by top executives other than PEOs and PFOs. Continuing the disclosure of PEO and PFO compensation should partially mitigate this risk by maintaining transparency of the compensation packages that may set the tone for the design of other executives' compensation and maintaining scrutiny of the compensation of the PEO, who likely bears the greatest responsibility for the performance of other managers and of the registrant and who often plays a role in setting the compensation of the other, non-PEO executives.

Registrants may bear some short-term adjustment costs to update their compliance and disclosure processes. Investors may bear some short-term adjustment costs to adapt their review practices and analyses of executive compensation to a narrower definition of NEO. In both cases, these costs may be borne directly or via payments to third parties. We expect these costs to be minor relative to other adjustment costs discussed in this release because it should be relatively straightforward to identify what to remove from current disclosures or compensation analyses in connection with this proposed revision.

Like the potential benefits of the proposed revision to the definition of NEO, the potential costs of this proposed revision are expected to vary across registrants. The costs to investors may be particularly significant in the case of registrants at which one or more highly paid executive officers who are not the PEO or PFO have a significant role in many strategic decisions (which could include a president or chief operating officer), as, under the proposed amendments, those executive officers' economic incentives may no longer be fully disclosed to investors. Beyond such cases, the costs to investors are generally expected to be the greatest in the context of registrants that report five to seven (or more) NEOs under the current rule, because transparency around the compensation of top executives other than the PEO and PFO would decrease the most in such cases. In contrast, in the context of SRCs, EGCs, and other registrants currently reporting fewer NEOs, the proposed revision to the definition of NEOs would have a more limited effect on the amount of available information about executive officer compensation. If the amendments proposed in the 2026 Filer Status Proposing Release are adopted, depending on timing, a much larger group of registrants would be subject to the same NEO definition applicable to SRCs and EGCs and would thus similarly be associated with more limited costs from the proposed revision to the definition of NEO.

3. Reasonable Alternatives

We considered an alternative definition of NEO that would include either three or four executive officers, with one or more of these individuals being the most highly paid executive officers after the PEO (or PEO and PFO), as recommended by some

analysis used by this investor); ISS Pay-for-Performance Methodology, *supra* note 660, at 13 (stating that, while the focus of the analysis is generally the CEO's compensation, the qualitative factors considered in their evaluation of a registrant's compensation decisions and practices ''may also be considered for other NEO compensation''); Glass Lewis Pay-for-Performance Methodology, *supra* note 660, at 1–2 (including a test relating total granted NEO pay to financial performance alongside four other quantitative analyses of pay-for-performance alignment, of which the others pertain to CEO pay).

[669] *See supra* section IV.B.

[670] *See, e.g.,* letters from Axcelis (stating that ''the uniform and comprehensive disclosure of actual executive compensation terms . . . provides critical data for . . . decision-makers, allowing them to determine appropriate . . . compensation by referencing broad datasets of peer information''); Society for Corporate Governance (citing survey respondents who ''expressed that issuers may derive benefit from . . . the information on NEOs other than the CEO and CFO in assessing competitive compensation for those roles, without the need to rely on external consultants or other sources for market information''). *But see* letter from ABA (recommending limiting the NEOs to the PEO and two next most highly paid executive officers and arguing that ''reducing the size of the group would not . . . necessarily complicate the board's or compensation committee's decision-making by reducing insights into competitive market practices'').

[671] The security ownership of executive officers who would no longer be NEOs would also no longer be available on an individual basis under Item 403 but would be available in aggregate form jointly with other executive officers pursuant to Item 403(b). Information about the security ownership of executive officers can also be obtained from filings pursuant to section 16 (with some additional effort to trace and aggregate section 16 filings over time), though Item 403 requires additional disclosure (with respect to, for example, beneficial ownership or shares to which the persons have the right to acquire beneficial ownership) that may not be available in section 16 filings.

[672] *See* Item 10 of Form 10–K.

[673] *See, e.g.,* Bao et al. 2022 Study, *supra* note 521 (finding that firms that start disclosing CFO compensation information after it was made mandatory in 2006 thereafter experience an improvement in CFO performance relative to control firms that already disclosed CFO compensation before 2006).

commenters.[674] Such an approach would preserve more of the information currently available about the compensation of top executives, and may be particularly valuable in the case of registrants with, for example, a chief operating officer or president with significant strategic decision-making responsibilities (in light of the relative importance of the third executive to registrant performance). More generally, this approach may provide investors with a broader understanding of the registrant's overall managerial incentives, executive team dynamics, and the compensation committee's and board's compensation philosophy and relationship with the management team. It would also make more data available to compensation committees of peer registrants for the purpose of benchmarking pay. However, such an approach would not reduce compliance costs as significantly as the proposed approach. As discussed in section IV.D.1 above, identifying the most ''highly compensated'' executive officers under this alternative may require tracking the compensation of a larger group of executive officers than the group of NEOs, particularly for registrants with many highly paid executive officers whose similar pay levels create uncertainty about the final list of NEOs. This task could be simplified by, for example, requiring the determination of the most ''highly compensated'' executive officers to be based on a limited number of compensation components (such as salary and bonus). Regardless, this alternative tends to introduce at least some uncertainty and volatility into the determination of the group of NEOs due to the uncertainty and volatility in final pay levels (as is the case under the baseline), which in turn would disproportionately increase the compliance burden of adding an additional executive officer to the definition relative to the proposal. Including a most ''highly compensated'' executive officer without regard for that officer's role would also increase the likelihood that the officer's compensation design differs significantly from that of the PEO, likely expanding the extent of explanatory disclosures a registrant may feel necessary to an understanding of the individual's pay package. Further, given that the additional NEOs under this alternative would not have consistent roles or titles across all registrants, the additional information included under this alternative would be less comparable and thus somewhat more difficult to evaluate for investors than the information pertaining to the PEO and PFO as proposed.

We also considered limiting the definition of NEO to include only the PEO,[675] given the primary interest in, and scrutiny of, PEO compensation. However, as discussed in section IV.D.2 above, including the PFO provides insight into issues such as executive team dynamics and how the compensation committee tailors pay to specific roles. The PFO, who has oversight of the registrant's financial management and financial disclosure, also has a unique role at the registrant. Including the PFO provides investors with compensation information that may allow them to gauge the incentives of this key executive and, thereby, the reliability of the registrant's financial disclosures and the soundness of its financial decisions.[676]

In addition, within the proposed definition, we considered including only the individuals serving as PEO and PFO as of the end of the fiscal year, rather than all individuals who served in either capacity at some point during the fiscal year.[677] Under this alternative, the required disclosures would be further simplified and compliance costs would be further reduced in years of executive transition. This approach would also reduce the volatility in disclosed compensation caused by severance or other departure payments. However, as discussed in the Baseline section (section IV.C. above), PEO and PFO transitions are quite common: approximately twenty percent of PEOs, and thirty percent of PFOs, at registrants with readily available data had less than three years of compensation history in proxy year 2025. Limiting compensation disclosures to PEOs and PFOs serving at the end of a fiscal year, under the alternative, would therefore result in frequently incomplete years of compensation and gaps in the compensation data, making it difficult for investors to analyze pay patterns and evaluate the full cost of executive compensation, including by making it more difficult to compare disclosures across registrants and across years for the same registrant.

E. Primary Tabular Disclosure, Perquisite Disclosure, and Compensation Actually Paid Disclosure Requirements and Flexibility in the Manner of Tabular Presentation

A number of provisions in the current rule and proposed amendments pertain to the standardized quantitative data that registrants must disclose about executive compensation. Because the proposed amendments would substantially revise and reorganize the content that is disclosed in the current set of tables and narrative disclosures into a different set of tables and associated supplemental disclosures, we address all of these provisions in this section. We include consideration of the Compensation Actually Paid measure from existing pay-versus-performance disclosures in this section because it represents quantitative data about executive compensation and because the proposed amendments replace this measure with a measure from one of the new primary compensation tables, but we discuss the other pay-versus-performance disclosure requirements separately in section IV.G. below.

As discussed in the Baseline section (section IV.C. above), most section 12 and section 15(d) registrants[678] are currently required to disclose annual data about each of their NEOs' compensation in tabular format. For registrants that are not SRCs or EGCs, the executive compensation information is currently presented in six primary tables.[679] Additional disclosures are either required or delineated as items that must be included if material in footnotes and/or supplementary narrative disclosures to the tables. SRCs and EGCs are currently eligible to use a scaled version of these requirements, including only two primary tables, two rather than three years of disclosure in the Summary Compensation Table, and the exclusion of any amounts or tabular

[674] *See, e.g.,* letters from ABA; Chamber of Commerce; Equity Methods-1; Infinite Equity-2; Jones Day; McGuireWoods & Brownstein.

[675] *See, e.g.,* letter from Sullivan & Cromwell.

[676] *See, e.g.,* John Jiang et al., *CFOs and CEOs: Who Have the Most Influence on Earnings Management?* 96 J. FIN. ECON. 513 (2010) (finding that measures of earnings management are more sensitive to CFO equity incentives than to those of the CEO); Sudheer Chava & Amiyatosh Purnanandam, *CEOs versus CFOs: Incentives and Corporate Policies,* 97 J. FIN. ECON. 263 (2010) (finding that CFO equity incentives dominate those of the CEO in explaining decisions involving specialized financial judgment such as debt maturity and accrual management).

[677] *See, e.g.,* letters from Davis Polk; Society for Corporate Governance.

[678] FPIs and registered investment companies are not subject to these requirements. Externally-managed BDCs and asset-backed securities issuers also generally do not have to provide these disclosures. *See supra* section IV.C.2.

[679] These tables are the Summary Compensation Table, the Grants of Plan-Based Awards Table, the Outstanding Equity Awards at Fiscal Year-End Table, the Option Exercises and Stock Vested Table, the Pension Benefits Table, and the Nonqualified Deferred Compensation Table. For SRCs and EGCs, the required tables are limited to the Summary Compensation Table and the Outstanding Equity Awards at Fiscal Year-End Table. *See supra* section IV.C.2.

disclosures associated with pensions (except when benefits are accelerated).

A subset of the registrants required to provide the primary tabular compensation disclosures [680] are also required to provide pay-versus-performance disclosures. These disclosures include, among other things, tabular disclosure of five years of Compensation Actually Paid to the PEO and, collectively as an average, to the other NEOs. The current rule defines Compensation Actually Paid based on a computation that is intended to quantify how the value of an executive's total compensation package changed that year, including changes in the value of outstanding equity awards. Other pay-versus-performance requirements are discussed separately in section IV.G below.

The proposed amendments would condense and reorganize the information required in the current primary tabular disclosures into three new tables that would apply to all of the affected registrants. The Granted Compensation Table would present the primary elements of compensation generally at the targeted values initially granted by compensation committees or boards. The Earned Compensation Table would present the value of compensation ultimately earned by executives and provide more comprehensive coverage of the primary as well as other elements of compensation. Both of these tables would present three years of compensation data, or two years for SRCs and EGCs. The Status of Equity Awards Table would provide certain factual details about each outstanding, newly granted, or newly vested (or exercised) equity award, such as the range of shares underlying each award and the current status of each award with respect to vesting or exercise.

In addition to reorganizing certain of the information included in the current tables, the proposed new tabular disclosures would reduce the degree of detail provided, particularly about non-equity incentives, deferred compensation and perquisites, and certain other components of miscellaneous compensation, and would eliminate many currently required computations in favor of focusing on factual disclosure and computations already produced by registrants for other purposes. While the value of the primary elements of pay and certain key terms of incentive awards would be explicitly required to be disclosed, registrants would be subject to a higher dollar threshold below which perquisites need not be reported, would have additional flexibility to include some elements of miscellaneous compensation only if they are material, and would have discretion to determine what additional footnotes or other supplementary disclosure are material information necessary to an understanding of the information disclosed in the primary tabular disclosures. For example, when an amount reported in one of the proposed tables represents an aggregation of multiple individual amounts (such as multiple non-equity award payouts or various miscellaneous items), registrants would have discretion whether to identify the individual components and their values. The proposal would also eliminate the disclosure of Compensation Actually Paid and require that registrants instead use total compensation from the Earned Compensation Table in pay-versus-performance disclosures.

The proposed amendments would also give registrants more flexibility in the manner in which they present their tabular disclosures, such as by splitting a single column into multiple columns (or into a supplemental table) so long as the multiple columns (or supplemental table) are clearly labeled and in the aggregate cover all items of compensation required to be reported in that single column. A registrant would also be permitted to provide any supplemental information in any format it determines to be appropriate, including in additional columns in an existing table.

1. Comparison of Information Environment

Given the significant reorganization and revision of the quantitative executive compensation information that would be required to be disclosed under the proposed amendments, we first identify the most significant changes in the information that registrants would disclose as a result of the proposed changes to the primary tabular disclosures of executive compensation information (and the disclosure of Compensation Actually Paid) in order to facilitate the discussion of potential benefits and costs of these aspects of the proposed amendments.

The proposed amendments would generally reduce the amount of data about executive compensation that is either explicitly required or specifically suggested as possibly meriting inclusion in registrant disclosures. These reductions are expected to decrease the compliance costs associated with producing the disclosures and to enable more streamlined disclosures that registrants would have greater flexibility to tailor to their specific circumstances. The proposed amendments are also intended to better align executive compensation disclosures with the way many registrants view their compensation programs. However, they will likely result in less information being disclosed to the public than under the baseline.

Potential changes to the information environment may stem from the proposed revisions to certain bright-line standards (such as the proposed revised minimum aggregate reporting threshold for perquisites) as well as the proposed movement to more principles-based standards for other provisions. The proposed amended bright-line requirements are intended to retain the information that is most likely to be material to investors, but as they would apply consistently across registrants it is possible in some circumstances that they could result in information that is important to voting and investment decisions no longer being disclosed. There is also information required in current disclosures that would not be explicitly required under the proposal and which may be outside the scope of the proposed principles-based disclosure requirements. For example, the aggregate balances of executive pension and deferred compensation plans are reported currently but are not required under the proposal and, even if material, may not be within the scope of the materiality catch-all provisions discussed in more detail below.

Other information would no longer be explicitly required to be disclosed, or would no longer be delineated in lists of examples of potentially material items for consideration in registrant disclosures, but would still be the subject of a duty to disclose if material given a registrant's specific facts and circumstances. Some of this information may thereby still be disclosed by some registrants under the proposed principles-based disclosure requirements but may no longer be as consistently available (or as consistently presented) across registrants.

The principles-based requirements are intended to continue to require registrants to disclose material information, thereby preserving investor access to this information, but may still result in some information that is within the scope of the principles-based disclosure requirements and relevant to

[680] Among the registrants subject to the primary tabular disclosure requirements, those that are EGCs, are not subject to the proxy rules due to the absence of a section 12 registration, or do not disseminate a proxy or information statement in a given year (such as certain section 12(g) issuers) are not required to make pay-versus-performance disclosures. *See supra* section IV.C.2.

voting and investment decisions no longer being disclosed. In the next subsection, we discuss how this may happen. In the following subsections, we then discuss the potential changes that could result from the proposed amendments in three broad categories of information: information about the level of executive compensation (also known as the ''amount'' or ''quantum'' of pay), information about the performance sensitivity of such compensation, and information about other components and terms of compensation. We consider changes in information in these three categories because we understand that they are consistent with the factors that investors most commonly evaluate with respect to executive compensation.[681]

a. Sources of Potential Information Loss Under Materiality-Based Standards

The proposed amendments introduce several new materiality-based standards for the disclosures.[682] Pursuant to proposed Item 402(a)(1), the objective of Item 402 disclosures would be to provide investors with material information relevant to an assessment of the compensation of the registrant's named executive officers and directors. Pursuant to proposed Item 402(a)(5)(i), registrants would be required to disclose any material information necessary to an understanding of the information disclosed in the primary tabular disclosures, namely the proposed Earned Compensation Table, Granted Compensation Table and Status of Equity Awards Table. Also, specifically with respect to the components of pay included in the proposed Earned Compensation Table, outside of certain delineated items, registrants would be instructed to include any other compensation that the registrant determines is material (or otherwise elects to disclose).[683]

As discussed in the previous section, the scope of these materiality-based disclosure standards would not encompass all of the information that is required to be disclosed in current Item 402 disclosures. Nevertheless, we expect that these materiality-based disclosure provisions—including one applying broadly to information material to an understanding of the information disclosed in the primary tabular disclosures and one applying specifically to the inclusion of dollar values of material compensation to the NEOs—would preserve the disclosure of material information that falls within these categories. At the same time, there are several factors, discussed in the following paragraphs, that may result in investors having access to a reduced amount of relevant information when making their investment and voting decisions.

First, the materiality determinations would be made at the registrant level, but investors often consider information about compensation practices in the broader market when evaluating and making decisions about a particular registrant.[684] For example, when evaluating whether the performance conditions applied to a PEO's non-equity incentive award appear appropriate, investors may consider how these conditions compare to the performance conditions attached to non-equity incentive awards of peer PEOs. Under the proposed amendments, an element of compensation that is disclosed by all registrants under the baseline might be disclosed, for instance, by one registrant, because it is material given that registrant's circumstances, but might not be disclosed by other registrants, because it is not material based on their own facts and circumstances. While all of these registrants would be properly disclosing material information, investors may have less context with which to precisely evaluate the first registrant's disclosures than they would under the baseline.

Second, materiality determinations are fact-specific for a given time. Item 402 compensation disclosures are generally made annually, and the underlying facts may change at a time when there is not a present duty to disclose or update information about an executive's compensation and monetary incentives. In contrast, investors evaluate registrants and make decisions throughout the year, the materiality of information may change at any point during the year.[685] For example, at a company that has not historically paid dividends, it may not be material whether or not the PEO is entitled to dividends on unearned equity; but if the company newly begins paying dividends during the year, factors that could help investors to better understand the context and ramifications of this corporate action may become more important to their investment or voting decisions. Under the baseline, information about (for example) certain terms of incentive awards or certain components of compensation is generally disclosed by all registrants regardless of materiality. Under the proposed amendments, if this information (such as whether the PEO is entitled to dividends on unearned equity, or any specific terms of non-equity incentive awards) is not material at the time that a registrant's annual compensation disclosure is made, the information might not be available to investors if it becomes material thereafter.

Third, there may be information in current executive compensation disclosures that is important to investment or voting decisions that registrants deem to be immaterial.[686]

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[681] *See, e.g.,* LACERA (stating that it is ''imperative that SEC guidance require disclosure of . . . the total quantum of pay and the mechanisms through which pay is realized'' and describing some of these mechanisms, such as the timelines and range of pay outcomes that depend on performance); NEI (organizing the information about executive compensation that it considers to be material into three categories: the ''[q]uantum of executive pay,'' ''[d]egree of pay alignment with performance,'' and ''[c]ompensation framework disclosures''). Academic research on executive compensation also tends to categorize the features of compensation as the level, performance sensitivity, and other elements of pay structure. *See, e.g.,* Edmans et al. 2017 Survey Paper, *supra* note 483.

[682] This section is focused on the primary tabular disclosures. There are additional proposed materiality standards that would apply specifically to other elements of the disclosures, such as director compensation and certain components of NEO golden parachute payments and benefits. *See, e.g., infra* sections IV.I and IV.L.2.

[683] *See* proposed Item 402(b)(2)(viii)(I).

[684] Academic research demonstrates that peer disclosures play a role in the evaluation of a particular registrant's disclosure. *See, e.g.,* Nemit Shroff et al., *When Does the Peer Information Environment Matter?* 64 J. ACCT. ECON. 183 (2017); Christian Leuz & Peter D. Wysocki, *The Economics of Disclosure and Financial Reporting Regulation: Evidence and Suggestions for Future Research,* 54 J. ACCT. RES. 525 (2016); Anat R. Admati & Paul Pfleiderer, *Forcing Firms to Talk: Financial Disclosure Regulation and Externalities,* 13 REV. FIN. STUD. 479 (2000).

[685] *See, e.g.,* Michael Dambra et al., *Disclosure, Materiality Thresholds, and the Cost of Capital: Evidence from Federal Open Market Committee Announcements,* 70 MGMT. SCI. 8322 (2024) (finding evidence consistent with changes in the cost of capital, based on unexpected changes in the target federal funds rate, affecting registrants' materiality thresholds).

[686] Researchers have identified situations in other contexts in which the stock market appeared to react to the disclosure of information that registrants initially deemed to be immaterial. *See, e.g.,* Preeti Choudhary et al., *Immaterial Error Corrections and Financial Reporting Reliability,* 38 CONTEMP. ACCT. RES. 2423 (2021) (''Choudhary et al. 2021 Study'') (finding a modest negative stock market reaction to the disclosure of restatements that were deemed immaterial, with a greater reaction for the misstatements that decreased net income or that involved multiple issues); Judson Caskey et al., *Noncompliance With SEC Regulations: Evidence from Timely Loan Disclosures,* 64 J. ACCT. ECON. 183 (2017) (finding that, even after controlling for loan size as a percentage of assets, registrants are less likely to disclose a loan contract pursuant to a materiality determination if it bears a less favorable interest rate, and that registrants not immediately disclosing these loans have short-term stock market outperformance that later reverses into longer-term stock market underperformance relative to registrants that disclose the loans, as the

The materiality of executive compensation depends on multiple complex factors. For example, a small quantum of pay, which could look immaterial by typical quantitative standards, may still be material because of the outsize effects executive actions (and, by extension, their incentives) can have on registrant performance.[687] There is thus a risk that information in current disclosures that appears to be immaterial but may, in fact, be material to investor decisions may not be disclosed under the proposal.

While materiality-based standards may increase the likelihood of the loss of important information relative to what would be available under a more prescriptive disclosure standard, they also have benefits, including reducing the risk of immaterial disclosures. The potential loss of information under the proposal may be partially mitigated by investor expectations for more detailed information, as expressed through their voting support or direct engagement with registrants, and the development of market practices or norms for disclosure. It is also possible that some registrants respond to the proposed principles-based requirements with an over-disclosure of information beyond what is material in order to limit the risk of omitting material information, thus reducing any information loss relative to the baseline.[688]

In summary, while the proposed amendments are intended to retain the disclosure of the information about executive compensation that is most likely to be material, some reduction in information will nevertheless result. In characterizing the effects of the proposed amendments on the information available to investors in the following subsections we therefore identify some of the information that may no longer be available (or consistently available) to investors even though we believe that aspects of the proposal would mitigate the loss of material information.

b. Information About the Level of Executive Compensation

In this and the following two sections, we focus on characterizing the potential change in the information that would be available in the primary tabular executive compensation disclosures as a result of the proposed amendments. We defer our discussion of the benefits and costs of the identified changes in information environment, as well as the format in which the information is presented, to sections IV.E.2 and IV.E.3 below.

Information about the level[689] of executive compensation would continue to be available to investors under the proposed amendments, but may not be as precise as currently disclosed information. Any such difference in precision relative to the information available under the baseline is expected to be modest in most cases but could be more significant under some circumstances. The potential reduction in the precision of estimates of the level of pay would stem in many cases from detailed elements of the proposed amendments. We describe these fine distinctions in this section to clearly identify the difference in information that would be available under the proposal as compared to the baseline.

Effects on the precision of estimates of the level of pay would also vary depending on the specific measure relied on by a given investor. Measures of the level of executive compensation used by investors currently vary but often begin with the compensation disclosed in the Summary Compensation Table.[690] Some may directly use the total compensation from this table,[691] some may revalue certain components but otherwise closely track this total compensation measure,[692] and some may adjust the year in which certain awards are included[693] or drop some of the components included in this table in the process of constructing their measures.[694]

Because the Earned Compensation Table and Granted Compensation Table together encompass, to a large extent, the components of the Summary Compensation Table, we expect that investors and other market participants would continue to be able to use the proposed tables to construct measures of the level of executive compensation. For example, the total from the Granted Compensation Table would provide one measure of ''total direct compensation''[695] that could be used to evaluate the level of pay. Under some circumstances, this measure may be a more up-to-date measure of the level of pay granted than the measures that are available today. In particular, given the proposed flexibility to allow registrants to include, in a given year's granted compensation, equity awards that were granted early in the following year in recognition of that previous year's performance, information about equity awards made soon after the fiscal year end could be made available to investors earlier than under the current rule.

More directly replicating other measures in use today would be possible with varying degrees of precision depending on the specifics of the desired measure and the extent to which registrants provide additional context to the required tables. For example, to reconstruct a measure similar to Summary Compensation Table total compensation, one could take all of the individual components of the Earned Compensation Table other than the values for stock and option awards and substitute the values of these awards from the Granted

information flows into stock prices in the longer term).

[687] *See, e.g.,* Alison Mackey, *The Effect of CEOs on Firm Performance,* 29 STRAT. MGMT. J. 1357 (2008).

[688] We acknowledge that registrants may be less likely to increase the transparency of their executives' pay beyond what is required than they would be to increase other corporate disclosures in the face of these kinds of factors. *See, e.g.,* Attila Balogh et al., *Does Stakeholder Outrage Determine Executive Pay?,* 15 REV. CORP. FIN. Stud. 227 (2026) (discussing managerial incentives to camouflage their pay and providing related evidence).

[689] As discussed above, we use the term ''level'' of compensation to represent the amount of such compensation, also known as the ''quantum'' of pay or pay ''opportunity.'' *See supra* section II.

[690] *See, e.g.,* McCormick, 2025 Roundtable at 77:5–8 (stating that ''when investors are looking at the overall disclosure . . . . [t]hey start with the summary comp table''); Hambly, 2025 Roundtable at 170:21 through 171:2 (stating that ''one of the things as an investor I'm trying to understand is, what is the value transfer opportunity the board is making for this individual? . . . And so . . . I use the summary comp table, I use the [Form 4] disclosures to try to say, okay, what was the stuff we just paid?'').

[691] *See, e.g.,* letter from NEI (stating that total compensation from the Summary Compensation table is one among multiple factors considered when evaluating the ''quantum of executive pay'').

[692] *See, e.g.,* Institutional Shareholder Services, *ISS United States Executive Compensation Policies: Frequently Asked Questions* (updated Dec. 9, 2025), available at *https://www.iss-stoxx.com/file/policy/current/americas/us-compensation-policies-faq.pdf* (''ISS Compensation FAQ'') at 7 (stating that the ''total compensation'' included in ISS reports and related to peer ''total compensation'' matches what is disclosed in the Summary Compensation Table, with a substitution of annual salary for any part-year salary and potential substitution of ISS-computed valuations of stock and options for those included in the table).

[693] *See, e.g.,* letter from Johnson & Johnson; *id.* at 22 (stating that ISS may consider adjusted total compensation—reflecting equity in the year of performance it was intended to reward rather than the following year, in which it was technically granted—as part of its qualitative analysis).

[694] *See, e.g.,* Glass Lewis Pay-for-Performance Methodology, *supra* note 660, at 3 (stating that its definition of total compensation excludes any cash severance or changes in pension value).

[695] *See, e.g.,* letter from Infinite Equity-3 (defining total target direct compensation as the sum of target salary, target bonus and non-equity incentive awards, and target equity awards, and indicating that this measure ''is often used as a primary point of reference for Boards and their compensation consultants when benchmarking and making pay decisions'').

Compensation Table.[696] The resulting measure would differ from the Summary Compensation Table total compensation measure in three respects: (i) it would value equity grants with performance-based vesting[697] or with other such contingencies[698] differently, (ii) it would include pension service costs rather than the change in the actuarial present value of accumulated pension benefits; and (iii) it would exclude certain perquisites below the proposed threshold and may exclude other miscellaneous compensation that is deemed immaterial.

Regarding the first of these points, equity awards appearing in the Summary Compensation Table are currently valued at fair value computed in accordance with FASB ASC Topic 718.[699] For any awards that are subject to performance conditions, the grant date fair value reported in the Summary Compensation Table is based upon the probable outcome of such conditions. For awards with market conditions, the estimate of grant date fair value is based on valuation techniques which incorporate the likelihood of achieving the market conditions into the award's fair value.[700] The proposed amendments would require stock and option awards with performance-based vesting or other such contingencies to be included in the Granted Compensation Table at their fair value under the assumption that the award's target outcome will be achieved. For awards with only service conditions that affect whether or not an award vests, there should be no difference in the valuations. Awards with service conditions that affect factors other than whether or not an award vests (such as, for example, an exercise price that varies with years of service) are generally rare, and the degree to which the value reported for such awards they would differ under the proposed amendments would depend on the nature of the service condition and how the award is structured. For awards with performance conditions, we understand that the proposed and baseline valuation approaches should generally give similar results because the target outcome is usually closely aligned with the probable outcome.[701] That said, it is possible that registrants could respond to the proposed amendments by setting target outcomes that differ more significantly from probable outcomes than in current practice, which could introduce greater imprecision into the reported valuations. For awards with market conditions, the current and proposed valuations may differ significantly. Because reasonable techniques for valuing the effects of market conditions currently exist and account for all of the possible outcomes of an award, we expect that the simpler approach of assuming the target outcome is achieved would generally provide a less precise estimate of award value than the values disclosed currently.

The second difference delineated above should reduce the volatility in reported pay caused by the change in value of all previously accumulated pension benefits with changes in interest rates and other actuarial assumptions. This reduction in reported pay volatility would only affect registrants whose NEOs receive pension benefits, which are a minority of registrants among which larger registrants are disproportionately represented.[702] While we understand that pension plans are more prevalent among larger registrants, the inclusion of pension service costs even for SRCs and EGCs, which are not currently required to disclose pension-related compensation, should increase the precision with which investors can measure the level of executive compensation for any EGCs and SRCs that provide pension benefits to their NEOs.[703] That said, the proposed change in the treatment of pensions would obscure the effects on pension benefits of any unexpected increases in pay,[704] which are not reflected in computations of pension service costs.

With respect to the third point of difference listed above, if compensation practices were to remain unchanged, the exclusion of perquisites below the proposed threshold would reduce the precision with which investors can measure the level of executive compensation to a modest degree. Table 8 of the Baseline section (section IV.C) above demonstrates the degree to which different levels of PEO perquisites reported today (as a percentage of Summary Compensation Table total compensation), based on a random sample of 100 registrants, would be reported under the proposed reporting threshold of $150,000 (in the third column of the table). As demonstrated in this table, the proposed threshold would result in the vast majority of perquisites that total no more than 2.5 percent of total compensation no longer

[696] To more closely approximate Summary Compensation Table total compensation, one could further add back, to the extent applicable, any compensation related to director services recorded elsewhere in the proxy statement under the proposed amendments.

[697] As discussed above, for the purpose of this economic analysis, we define performance-based vesting to include both performance and market conditions that affect vesting. *See supra* note 585. We estimate that about 52% of stock awards and 12% of option awards granted in a given year are subject to performance-based vesting. *See supra* Tables 6 and 7. Awards with any performance condition or market condition would be valued differently (for the purposes of the tabular compensation disclosures) under the proposed amendments as compared to the baseline.

[698] ''Other such contingencies'' include factors other than vesting (like the exercise price, conversion ratio, or contractual term of an award) that vary based on the outcomes of service, performance, or market conditions; but not, for example, a fixed exercise price (upon which any eventual payout is contingent but which itself is a fixed contractual term). We understand that awards that do not have performance-based vesting but have ''other such contingencies'' are rare.

[699] *See* Instruction 3 to 17 CFR 229.402(c)(2)(v) and (vi).

[700] For example, market conditions may be valued using a lattice model or Monte Carlo simulation.

[701] We understand that the probable outcome of awards with performance conditions at the grant date is typically the target outcome, such that the valuation of these awards under the proposal and the baseline should not differ. In some cases, we understand that the probable and target values may differ due to slightly different assumptions being used by the compensation committee and for accounting purposes, which could lead to a somewhat less accurate estimate of the value transferred on the grant date (but a more accurate estimate of the board's intentions) being reported under the proposed amendments. *See, e.g.,* Takis Makridis et al., *Top 10 Equity Compensation Issues for 2025,* Equity Methods Blog Post (Feb. 2025), available at *https://www.equitymethods.com/articles/top-10-equity-compensation-issues-for-2025/* (stating that ''[m]any budgets or long-range plans comprise a few scenarios based on different states of nature or sets of assumptions. One of these scenarios—typically, the one considered most probable—will likely be used for setting the goals on a PSU'' and that ''the accounting team will begin accruing expense based on what they understand to be the probable outcome of the performance condition. If they're making that assumption from a different budget, they won't be expensing at target'').

[702] We estimate that about 17% of registrants with available data reported pension plans for their PEO in proxy year 2025, including about 27% of registrants in the S&P 500 Large-Cap Index, compared to about 13% of registrants in the S&P 600 Small-Cap Index. *See supra* section IV.C.4. Companies that grant executive pensions also differ from other registrants along other dimensions. *See, e.g.,* Brian Cadman & Linda Vincent, *The Role of Defined Benefit Pension Plans in Executive Compensation,* 24 Eur. Acct. Rev. 779 (2015) (finding that registrants whose CEOs have defined benefit pension plans are significantly larger in terms of sales and assets, are more highly levered, have lower stock price volatility, and have lower free cash flows than registrants whose CEOs do not have such plans; and that the electrical, gas, and sanitary services industry and the commercial banking industry have a significantly higher percentage of registrants with CEO pension plans than other industries).

[703] While data on pension usage by these registrants is unavailable due to this disclosure accommodation, we understand that pensions are rarely used by smaller companies. *See supra* section IV.C.4.

[704] Researchers have found that such increases prior to pension plan freezes or lump sum pension payouts may be used to opportunistically increase compensation. *See* Irina Stefanescu et al., *Pay Me Now (and Later): Pension Benefit Manipulation Before Plan Freezes and Executive Retirement,* 127 J. Fin. Econ. 152 (2018).

being disclosed. It would also result in some perquisites totaling over 2.5 percent but less than 5 percent of total compensation no longer being disclosed, introducing somewhat more noise into measures of the level of executive compensation at registrants that make heavier use of perquisites.[705]

If the use of perquisites were to expand as a result of reduced scrutiny, such that our random sample is not representative of expected practices, the proposed disclosure threshold could introduce a larger amount of noise into measures of the level of executive compensation, particularly at smaller registrants. As demonstrated in Table 4 of the Baseline section (section IV.C) above, we estimate that about five percent of registrants currently pay their PEOs $500,000 or less in total compensation. For such registrants, the proposed threshold could result in perquisites representing 30 percent or more of a PEO's compensation not being disclosed.

The proposed miscellaneous category of compensation may also introduce a small degree of imprecision into measures of the level of pay given that what items (beyond the delineated list of items) are material and therefore included in this category may vary across registrants. We expect any resulting noise to be minor, but it may be difficult for investors or third parties to make adjustments to enhance comparability because specific information about the components of miscellaneous compensation received (and thus what is either included or excluded) may not be available.

Under the proposed amendments, the ability to construct the alternative measures of the level of pay currently in use that involve revaluing equity awards under alternative assumptions or removing certain components of compensation would depend on the extent to which registrants disclose all of the terms of equity awards necessary for such computations and identify the amounts of each of the components of compensation that would be deducted.

[705] Our sample of 100 registrants is not sufficiently large to reliably characterize the types of registrants that make heavier use of perquisites. Research on which registrants make greater use of perquisites has had mixed results. *See, e.g.,* Angela Andrews et al., *Corporate Governance and Executive Perquisites,* 16 Rev. Acct. Fin. 21 (2017) (finding that registrants with weak corporate governance are more likely to award perquisites to executives); Raghuram G. Rajan & Julie Wulf, *Are Perks Purely Managerial Excess?* 79 J. Fin. Econ. 1 (2006) (finding that at least some perks appear to be more likely to be used when there is greater potential for such perks to contribute to improved managerial productivity).

c. Information About the Performance Sensitivity of Compensation

Equity awards, non-equity incentive awards, and certain bonuses deliver varying amounts of value to NEOs depending on registrant and/or NEO performance. While other components of pay tend to vary less with performance,[706] the amount of pay delivered through these other components can also fluctuate in a way that can serve to either enhance or partially offset these performance incentives.

Current executive compensation disclosures include information about the *ex ante* contingencies that affect future compensation payouts, information about outstanding equity awards and how the expected value of these ''in flight'' awards has changed, and information about the *ex post* value eventually realized by the NEOs from all of the elements of their compensation. The ''in flight'' and *ex post* values cannot be perfectly constructed based on the disclosure about *ex ante* compensation structure because, for example, specific performance thresholds are often not disclosed [707] and incremental compensation decisions made while awards are outstanding may affect the total amount of compensation that is eventually realized. The progress toward outcomes reflected in ''in flight'' valuations and the actual *ex post* outcomes provide insight into the rigor of performance goals and how the board's compensation decisions during a given performance period may have magnified, dampened, or otherwise modified the executive's monetary incentives. Under the proposed amendments, we believe that most of the information about *ex ante* incentives and *ex post* outcomes would still be disclosed in some form, while disclosure about ''in flight'' values would be limited.

Regarding the *ex ante* contingencies that affect future payouts, the primary terms that are set in advance to provide direct performance incentives and establish the horizon of these incentives are (with varying applicability depending on the award): vesting schedules; performance or market conditions (or service conditions affecting factors other than vesting), including the associated formula or range of payouts and performance period; and option exercise prices and expiration dates. Registrants (including SRCs and EGCs) are currently required to disclose option exercise prices and expiration dates in tabular format; [708] equity vesting schedules in footnote disclosures; [709] and non-equity incentive award vesting schedules and performance-based conditions (whether for equity or non-equity awards) in narrative disclosures.[710] Registrants other than SRCs and EGCs are also currently required to disclose the range of potential payouts of newly-granted incentive awards in the Grants of Plan-Based Awards Table.

Under the proposed amendments, the range of potential payouts under equity awards and the exercise prices of any option awards would be reported in the proposed Status of Equity Awards Table, while all of the other primary *ex ante* equity award terms other than option expiration date would be explicitly required to be disclosed pursuant to proposed Item 402(d)(3), but could be provided in footnotes, narrative, or tabular disclosure at the registrant's election. Option expiration dates would be disclosed to the extent material given a registrant's facts and circumstances.[711] Under both the

[706] *See, e.g.,* Edmans et al. 2017 Survey Paper, *supra* note 483, at 410 (presenting evidence that ''the vast majority of executive incentives stem from revaluations of stock and option holdings, rather than changes in annual pay''); Kevin J. Murphy, *Executive Compensation: Where We Are, and How We Got There,* in: George M. Constantinides et al. (eds.), 2 Handbook Econ Fin 211 (2013) at 234 (stating that studies show that virtually all of the sensitivity of pay to corporate performance for the typical CEO is attributable to the direct link between stock price performance and the CEO's portfolio of stock and options).

[707] *See, e.g.,* letter from Cravath (stating that ''[i]t is our experience that it has become commonplace for issuers to withhold disclosure of performance-related measures at the outset of any award and to disclose them only for the time period when the award is earned (backward-looking disclosure rather than forward-looking disclosure)'').

[708] Option exercise prices and expiration dates are reported in the Outstanding Equity Awards at Fiscal Year-End Table. For registrants other than SRCs and EGCs, option exercise prices are also reported in the Grants of Plan-Based Awards Table.

[709] Equity vesting schedules are required to be reported in footnotes to the Outstanding Equity Awards at Fiscal Year-End Table.

[710] Registrants other than SRCs and EGCs are required to disclose (in narrative disclosure to the Summary Compensation Table and Grants of Plan Based Awards Table) the material terms of any award disclosed in the Grants of Plan Based Awards Table, which are specified to include ''a general description of the formula or criteria to be applied in determining the amounts payable, and the vesting schedule'' as well as ''any performance-based conditions, and any other material conditions, that are applicable to the award.'' SRCs and EGCs are required to disclose (in narrative disclosure to the Summary Compensation Table) the ''material terms of each grant'' and the ''material terms of any non-equity incentive plan award made to a named executive officer during the last completed fiscal year, including a general description of the formula or criteria to be applied in determining the amounts payable and vesting schedule.''

[711] We understand that there is currently very little variation in option expiration dates, and that

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current rule and the proposed amendments, registrants are not required to disclose specific target levels or goals that affect compensation outcomes if doing so would result in competitive harm to the registrant.

The current rule requires disclosures about outstanding equity awards in the Outstanding Equity Awards at Fiscal Year-End Table, with, for registrants other than SRCs and EGCs, additional information in the Grants of Plan-Based Awards Table. Current disclosures also provide information about the updated value of ''in flight'' equity awards in two places. For equity awards with performance-based vesting, all registrants are required to compute and report in the Outstanding Equity Awards at Fiscal Year-End Table a number of shares or units as well as an estimated dollar payout value based on either the actual achievement of performance goals (for awards that have been earned but not yet vested) or how actual performance to-date compares to upcoming performance goals (for unearned, unvested awards).[712] More broadly, in the computation of Compensation Actually Paid for the purpose of pay-versus-performance disclosures, registrants other than EGCs (and those not filing proxy or information statements)[713] are required to calculate and include (and separately identify) the updated fair value of all new equity awards as of the end of the fiscal year and the change in fair value relative to the prior fiscal year-end of any outstanding equity awards through the end of the fiscal year (or, in both cases, as of their vesting date, if earlier). These computations are provided for the PEO and, as an average, for the other NEOs as a group. The measure of compensation actually paid in these disclosures can be used directly as an aggregate measure of ''realizable pay'' reflecting these ''in flight'' values.

The proposed amendments would not require any ''in flight'' valuations of incentive awards. However, the proposed Status of Equity Awards Table would provide an overview of all of an NEO's equity awards, including those granted in previous years that are still ''in flight'' as well as those newly granted, newly vested, or newly exercised or expired. Investors or their advisors may be able to construct approximate estimates of the value of ''in flight'' awards, as some do currently,[714] with the potential precision of such estimates depending on the extent to which registrants disclose all of the terms and performance goals necessary to compute a precise fair value for such awards. The greatest sources of imprecision in these estimates relative to registrant-produced estimates are likely to be (i) a lack of access to the specific performance goals underlying awards[715] and therefore how performance is tracking relative to those goals[716] and (ii) any simplifications used by investors or third parties to make these computations for a large number of registrants.[717]

The current rule also requires the disclosure of certain *ex post* realized amounts of pay based on actual performance outcomes. As in the case of measures of the level of pay, measures of realized pay in use by investors and third parties differ in what components they include and how they value them (particularly with respect to whether they consider options at vesting or at exercise).[718] Currently, in the case of salary, bonuses, non-equity incentive payouts, and items categorized in ''all other compensation'' (such as perquisites and registrant contributions to deferred compensation plans), the realized amounts are reported in the Summary Compensation Table for all registrants and can be included or excluded based on the particular definition of realized pay being used. With respect to equity, depending on the definition of realized pay, the realized amounts can be obtained directly from the Option Exercises and Stock Vested Table or can be constructed based on the award terms disclosed in other tables or narrative.[719]

options generally expire in ten years from the grant date. *See supra* section IV.C.

[712] The number of shares or units and the associated market or payout value for awards for which performance-based vesting conditions have not yet been satisfied are to be computed based on achieving threshold performance goals, except that if the previous fiscal year's performance has exceeded the threshold, the disclosure shall be based on the next higher performance measure (target or maximum) that exceeds the previous fiscal year's performance. If the award provides only for a single estimated payout, that amount should be reported. If the target amount is not determinable, registrants must provide a representative amount based on the previous fiscal year's performance. *See* 17 CFR 229.402(f)(2); Instruction 3 to 17 CFR 229.402(f)(2) (for registrants that are not SRCs or EGCs); 17 CFR 229.402(p)(2); Instruction 3 to 17 CFR 229.402(p)(2) (for SRCs and EGCs).

[713] *See supra* note 680.

[714] *See, e.g.,* CalPERS Methodology, *supra* note 610 (describing one investor's focus on realizable pay and its realizable pay methodology); ISS Compensation FAQ, *supra* note 692, at 12–13 (describing the calculation of ''realizable pay'' produced by one proxy advisory service); *see also* letter from Axcelis (stating that ''if an investor wanted to engage in the calculations required by Regulation S–K Item 402(v), the investor has access to all the factual information needed to undertake that exercise'').

[715] While proposed Item 402(d)(3) would require registrants to disclose the material terms of any performance, market, and/or service conditions with respect to each equity award reported in the Status of Equity Awards Table, registrants would, as under the current rule, be permitted to omit target levels with respect to specific quantitative or qualitative performance-related factors the disclosure of which would result in competitive harm for the registrant. We understand that specific performance goals are currently not disclosed by registrants in many cases. *See infra* note 794.

[716] Academic researchers have found that ''in flight'' valuations provided by registrants contain information that does not seem to be otherwise known to investors, particularly with respect to updated values for the estimated payouts of equity awards with performance-based vesting. *See, e.g.,* Mary Ellen Carter & Andrea Pawliczek, *Extracting Information from Compensation Actually Paid: Stock Price Effects vs. Other Signals,* Working Paper (Dec. 30, 2025), available at *https://ssrn.com/abstract=4531025* (extracting the part of compensation actually paid that can be explained by publicly-available information, and finding that the remaining, unexplained variation in this measure, which the authors state is likely to reflect information like changes in registrant expectations about future performance share payouts, is associated with future operating and stock performance); C. Edward Fee et al., *Hidden Gems: Do Market Participants Respond to Performance Expectations Revealed in Compensation Disclosures?,* 75 J. Acct. Econ. 101509 (2023) at 101509 (finding that the information provided in the updated numbers of unearned shares in the Outstanding Equity Awards at Fiscal Year-End Table ''is not captured by other information channels'' available to investors and is associated with future registrant accounting and stock performance); *see also* ISS Compensation FAQ, *supra* note 691, at 12 (indicating that, in its calculation of ''realizable pay,'' all outstanding awards with performance-based vesting are simply valued at target).

[717] *See, e.g.,* ISS Compensation FAQ, *supra* note 692, at 12 (indicating that, in its calculation of ''realizable pay,'' all outstanding awards with performance-based vesting are simply valued at target).

[718] *See, e.g.,* Glass Lewis, *United States & Canada Pay-for-Performance Methodology Overview* (Feb. 2025), available at *https://resources.glasslewis.com/hubfs/PDF%20File%20Links/Pay%20for%20Performance%20Methodology%20-%20North%20America.pdf,* at 2 (stating that ''Realized CEO Pay is the sum of actual cash payouts, exercised options and SARs, and vested full value awards. . . . We exclude severance, change in pension value/non-qualified deferred compensation and director fees. Base salary, short-term incentives, and other payments and benefits are recorded in respect to the fiscal year for which they were earned''); Robin Ferracone & Jack Zwingli, *Pay Definitions: What Works Best in Pay for Performance Analysis* (Nov. 2012), available at *https://farient.com/wp-content/uploads/2012/11/20121101-Farient-Advisors-Pay-Definitions-White-Paper.pdf,* at 9 (stating that realized pay includes salary, bonus, non-equity incentive plan payouts, pension change/deferred compensation, all other compensation, options valued upon exercise, and stock valued upon vesting); Equilar, *Resources* (accessed Aug. 2026), available at *https://www.equilar.com/resources.html* (stating that ''[r]ealized pay comprises base salary, bonuses, any stock or options that vested only during the fiscal year, and the value of 'all other compensation' '').

[719] The values of stock when vested and options when exercised are available in the Options Exercised and Stock Vested Table. To compute the fair value of options at their vesting date instead, the exercise price, expiration date, and vesting schedule can be obtained from the disclosures of *ex ante* terms discussed above, with potential

For SRCs and EGCs, which are not required to include the Options Exercises and Stock Vested Table, information about the realized value on option or stock grants can be derived based on information in Form 4 disclosures with potential reference to Item 402 disclosures to compute realized equity values under the desired definition.[720]

The proposed amendments would make one measure of realized pay—the total presented in the proposed Earned Compensation Table—directly accessible for all of the affected registrants. The measure would be similar to one that can currently be constructed relatively easily for registrants other than SRCs and EGCs,[721] but not so easily for SRCs and EGCs.[722] The ability of investors or third parties to construct alternative measures of realized pay that involve valuing options upon vesting or removing certain components of compensation would depend on the extent to which registrants disclose all of the terms of equity awards necessary for such computations and separately identify and quantify each of the components of compensation.

d. Information About Other Components and Terms of Compensation

Beyond the information about the level of pay and the primary performance incentives provided by equity and non-equity awards, there are details about a number of other components of compensation and about other terms of incentive awards that are currently required to be disclosed and that investors may evaluate today. Examples of some of these other compensation components and terms are provided throughout this subsection. While information about some of these factors would still be required to be reported by registrants if it is material information necessary to an understanding of the information disclosed in the tables pursuant to proposed Item 402(a)(5)(i), and may be reported voluntarily in additional cases, the proposed amendments are expected to result in reduced disclosure about at least some of these compensation components and terms by some registrants.

For registrants other than SRCs and EGCs, current disclosures provide significant detail about the balances of and annual changes in NEO retirement plans in the Pension Benefits Table and Nonqualified Deferred Compensation Table. Because these tables would be eliminated under the proposed amendments, information about the NEOs' present value of accumulated benefits in any pension plans and aggregate balance in any non-qualified deferred compensation plans may no longer be disclosed.[723] Similarly, actual payments and distributions under any of these plans to NEOs who already qualify to receive such amounts, as well as years in service and any contributions made by NEOs themselves, might not be disclosed. SRCs and EGCs are not currently required to provide the tables specific to retirement benefits but are required to disclose the material terms of each plan that provides for the payment of retirement benefits; these disclosures might also not be provided under the proposed amendments. While pension service costs and prior service costs, employer contributions to defined contribution or other deferred compensation plans, and any above-market or preferential earnings on non-qualified deferred compensation plans would be included in dollar terms in the aggregate in the Miscellaneous Compensation Received column of the proposed Earned Compensation Table, they may no longer be separately identified.

Beyond these retirement-related amounts, other elements of the current ''other compensation'' category that could be included in the proposed ''miscellaneous'' category may also be less likely to be separately identified than under the current rule. Currently, registrants other than SRCs and EGCs are required to identify and quantify any item that is not a perquisite whose value exceeds $10,000, while SRCs and EGCs are required to identify and quantify any item of ''other compensation'' to the extent material, where identification of an item is not considered material if it does not exceed the greater of $25,000 or 10 percent of all items of a given type.[724] Under the proposed amendments, while an aggregate amount of miscellaneous compensation to an NEO would be disclosed, it may be unclear to what extent, for example, the miscellaneous compensation consists of tax gross-ups, retirement contributions, a discount for purchases of the registrant's securities, or another item included in the miscellaneous category. It also may be unclear which elements the registrant has included (because they are material or because the registrant otherwise elects to include them) versus which have been excluded as immaterial.

Current disclosures also include significant detail specific to perquisites. For registrants other than SRCs and EGCs, if the total value of perquisites to an NEO exceeds $10,000, these registrants must identify each perquisite by type (regardless of its amount, but without quantification). All registrants, including SRCs and EGCs,[725] generally

reference to the Outstanding Equity Awards at Fiscal Year-End Table or Form 4 disclosures to confirm the extent to which options subject to performance-based vesting have been earned. The fair value of options at their vesting date is also embedded in the computation of compensation actually paid but may be difficult to extract from this number depending on how many other components are included in the computation and how much detail a registrant provides about the calculation of compensation actually paid.

[720] For these registrants, the value of stock at vesting for awards with time-based vesting may be identified in Form 4 or, if the stock was reported in Form 4 at the grant date, can be identified based on market data and the vesting schedule which is reported among the *ex ante* award terms whose disclosure is discussed above. The value of performance-based stock when vested should generally be computable based on Form 4 and market price data, unless there is an additional time-based vesting period after the end of the performance period, in which case the vesting details in Item 402 disclosure may have to be referenced as in the case of stock awards with only time-based vesting. The value of options when exercised should be computable from Form 4 disclosures of the exercise event and market price data. To compute the fair value of options at their vesting date instead, the same data sources can be used as in the case of other registrants as noted above. *See supra* note 719. The value of stock at vesting and the fair value of options at their vesting date are also embedded in the computation of compensation actually paid for those registrants that are required to produce pay-versus-performance disclosures, but may be difficult to extract from this number depending on how many other components are included in the computation and how much detail a registrant provides about the calculation of compensation actually paid.

[721] The compensation in the proposed Earned Compensation Table could be replicated using current disclosures of these registrants by using the Summary Compensation Table amounts for all non-equity items and the Options Exercised and Stock Vested Table for equity items.

[722] The compensation in the proposed Earned Compensation Table can be replicated using current disclosures of SRCs and EGCs by using the Summary Compensation Table amounts for all non-equity items. For equity items, the value of stock at vesting and options at exercise can be obtained using information in Form 4 disclosures with potential reference to Item 402 disclosures. *See supra* note 720.

[723] We estimate that about 17% of registrants report a pension plan (in the Pension Benefits Table) and about 42% report a non-qualified deferred compensation plan (in the Non-Qualified Deferred Compensation Table) for their PEO in proxy year 2025 filings. Among these registrants reporting such plans, the median reported total pension balance for the PEO was $2.6 million (with a 99th percentile of $47 million) and the median reported total balance in non-qualified deferred compensation was $2.3 million (with a 99th percentile of $75 million). These estimates are based on staff analysis of data from Execucomp. *See supra* note 575.

[724] *See* Instruction 4 to 17 CFR 229.402(c)(2)(ix); 17 CFR 229.402(o)(7).

[725] While other registrants are required to quantify these perquisites pursuant to an

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also quantify the value of each perquisite that exceeds the greater of $25,000 or 10 percent of the NEO's total perquisites in footnote disclosure. Given the proposed higher threshold for disclosing perquisites and no longer requiring individual perquisites to be identified or quantified, we expect that most of these details would no longer be disclosed under the proposed amendments. Further, the proposed changes in interpretive guidance to determine whether an item is a perquisite would give registrants greater flexibility to identify certain benefits as not constituting perquisites. Additionally, the proposed changes to perquisites would specifically rescind a prior Commission statement that security services provided at an executive's personal residence or during personal travel are always perquisites. These changes may result in reduced disclosure of certain items, such as the provision of security services, relative to what is currently reported.

Registrants (including SRCs and EGCs) are also currently required to disclose the material terms of all incentive awards with respect to NEOs, which the current rule defines to include certain delineated terms beyond those pertaining directly to the performance contingencies and horizons discussed in the previous subsection. For example, these delineated terms include any tandem features [726] and whether dividends will be paid on stock awards, and if so, the applicable dividend rate and whether that rate is preferential. Registrants might not disclose all such terms of incentive awards in Item 402 disclosures under the proposed amendments. It is possible that some of these terms may be disclosed in relation to compensatory plans, contracts or arrangements and material grants thereunder filed pursuant to the current reporting requirements under Item 5.02 of Form 8–K.[727]

2. Benefits

The proposed amendments to the tabular disclosures and associated footnotes and narrative disclosures are expected to reduce compliance costs, make certain information more readily available to the users of disclosure, and reduce the risk of certain distortions in executive compensation due solely to the nature of current disclosure requirements.

The primary sources of compliance cost savings would be a reduction in the need to track and collect certain data, the elimination of certain complex computations, and a reduced volume of disclosure that would have to be produced and reviewed.

With respect to tracking and data collection, the proposed amendments would introduce a new *de minimis* tracking exclusion below which registrants would not be required to track perquisites. Several commenters indicated that the tracking, recordkeeping, and analysis of even very minor potential perquisites imposed significant burdens on registrants.[728] The proposed *de minimis* tracking exclusion would align with the threshold used to identify fringe benefits for tax purposes, and should thus limit the need to track small benefits beyond what would already have to be tracked for these other purposes.[729] The *de minimis* tracking exclusion would thereby reduce burdens on a registrant's internal time and resources and could reduce the costs of consulting outside advisors to analyze, even for very minor benefits, whether they are perquisites. The revised interpretive guidance with respect to identifying perquisites could also reduce the items that must be tracked (to the extent that registrants determine certain items are not properly categorized as perquisites) and could, in some circumstances, further align which benefits must be tracked with benefits that would, regardless, be tracked for tax purposes. The proposed amendments would also require items of miscellaneous compensation that are not specifically delineated in proposed Item 402(b)(2)(vii) to be included only if material (or if the registrant otherwise opts to include them), in contrast to the current requirement to include all other compensation regardless of amount, which may reduce the need to track other immaterial forms of compensation.

The proposed amendments would also eliminate the need for registrants to perform certain complex computations that we understand are not used for any other purpose beyond compensation disclosures. For example, the calculation of Compensation Actually Paid for the purpose of pay-versus-performance disclosures has been cited as a particularly burdensome element of the current requirements.[730] Commenters particularly highlighted the burdens of revaluing equity awards every year and at every vesting date [731] and tracking accrued dividends,[732] and noted that many registrants must rely on external consultants to construct the measure.[733] While some commenters

instruction specific to perquisites, SRCs and EGCs are required to separately identify and quantify a perquisite under the instruction with respect to any item currently categorized as ''other compensation.'' As stated above, the latter instruction requires identification and quantification of an item to the extent material, where identification of an item is not considered material if it does not exceed the greater of $25,000 or 10% of all items of a given type (in this case, of total perquisites).

[726] A tandem grant of two instruments, such as an option and an accompanying stock appreciation right, may be used to give an executive more flexibility as to how to exercise an award (*e.g.,* for cash as opposed to for equity); we understand that one of the awards is typically cancelled if the other is exercised.

[727] *See, e.g.,* Item 5.02(c) and (e) of Form 8–K.

[728] *See, e.g.,* letters from Davis Polk (citing the survey response of one issuer as stating that if ''issuers would not have to track de minimis amounts of perquisites toward the aggregate threshold, their time burden of compliance would decrease by 40% of hours worked''); McGuireWoods & Brownstein (stating that ''companies devote significant time and effort to tracking, analyzing and recordkeeping of potential perquisites that appear to have little to no value to investors,'' and giving the example of a bag of items such as a water bottle and pullover received at a corporate event that would require ''company personnel to have to (1) inventory such ''swag bag'', (2) input such items into a tracker, and (3) later analyze (often with the help of executive compensation lawyers) whether such items may be perquisites''); Society for Corporate Governance; Travelers.

[729] We acknowledge that the definitions of perquisites and fringe benefits do not perfectly overlap but increasing the alignment of the *de minimis* threshold should nonetheless reduce the degree of tracking required.

[730] *See, e.g.,* letters from Axcelis; CEC–2; Davis Polk; McGuireWoods & Brownstein; NAM–2; Society for Corporate Governance (citing an internal member survey indicating that ''[o]ne quarter of survey respondents (26%) reported that they spend between twenty-five to seventy-five thousand dollars annually for outside advisors to prepare pay versus performance disclosures, and nearly 10% of respondents (9.5%) reported that they spend more than seventy-five thousand dollars annually on outside advisors to prepare pay versus performance disclosures; and [n]early 40% of respondents spend approximately 21 to 60 hours annually in connection with their pay versus performance disclosures, and 14% of respondents stated that they spend more than 60 hours annually on pay versus performance disclosures'').

[731] *See, e.g.,* letters from Axcelis (stating that ''[t]he calculation of the annual 'Equity Award Adjustment' amount requires, typically, at least 15 single date valuation determinations for each executive officer . . . . Large spreadsheets and many hours of data input are required''); Davis Polk (stating that the required revaluations of equity are ''burdensome to issuers, particularly those that grant options and particularly if they have a frequent vesting schedule, which is the case for many tech, fintech and life sciences issuers''); NYSE; Travelers.

[732] *See, e.g.,* letters from NYSE; Pay Governance, LLC (Apr. 27, 2026), available at *https://www.sec.gov/comments/4-855/4855-763667-2344554.pdf.*

[733] *See, e.g.,* letters from Davis Polk; Johnson & Johnson (stating that ''[t]he current fair value approach requires us to use costly vendors to conduct complex simulations to value our outstanding performance share units that are based on relative total shareholder return''); McGuireWoods & Brownstein (stating that the ''numerous adjustments require a significant amount of time and attention to perform, such that most companies we work with are forced to

indicated that costs have come down since the initial years of the disclosure,[734] this computational burden still represents an incremental cost on registrants other than EGCs (and other registrants that do not file a proxy or information statement in a given year), and removing the requirement to make this computation should result in meaningful cost savings.

Other complex computations that would be eliminated by the proposed amendments currently apply to a broader group of registrants. Specifically, several commenters stated that producing the Outstanding Equity Awards Table, which is required in executive compensation disclosure for all registrants and requires a different set of equity award valuations than any other table, is burdensome.[735] The most complex computations required in this table are likely those involving the determination of the number of shares or units and the dollar payout value of outstanding awards with performance-based vesting based on how the performance goals compare to recent performance. Such computations would no longer be required under the proposed amendments; the proposed Status of Equity Awards Table would instead present only factual information about equity awards and whether they have vested or been exercised. The proposed interpretive guidance with respect to the identification of perquisites and the elimination of the requirement that perquisites must be valued on the basis of the aggregate incremental cost to the registrant could also reduce the computational burden on registrants. In particular, the need to undertake complicated calculations could be reduced to the extent that (i) registrants determine that certain items which required complex computations to derive the value to be reported in compensation disclosure were not properly categorized as perquisites (given their specific circumstances) and/or (ii) the greater flexibility in how perquisites are valued allows registrants to use simpler computations than they do currently or to rely on computations already produced for tax or other purposes.[736]

The proposed amendments with respect to the primary tabular compensation disclosures are also expected to significantly reduce the volume of disclosure that must be prepared and reviewed by registrant staff, the board and, often, external advisors. Registrants other than SRCs and EGCs are currently required to include six primary tables, each of which is often associated with detailed footnotes and/or narrative disclosure and is time-consuming to produce.[737] Under the proposal, only three primary tables would be required of all registrants. Additional reductions in the volume of disclosures may result depending on how registrants use the flexibility afforded to them. For example, the proposed tabular disclosures would have no explicit footnote requirements, which may allow registrants to condense disclosures and limit duplication of any material information that is required to supplement the data in the tables. Also, to the extent that the proposed tables are substitutes, or close substitutes, for some disclosures that registrants currently provide on a voluntary basis to supplement the mandated disclosures, registrants may reduce the extent of supplementary disclosures they provide. Overall, the proposed amendments to the primary tabular disclosures are expected to substantially reduce the volume of disclosures (via the number of tables, the length of accompanying narrative and footnotes, and potentially the extent of voluntary supplemental disclosures) and thereby reduce the time and resources required to produce and review the disclosures.[738]

Certain aspects of the proposed amendments to the tabular and associated disclosures would also provide investors with more ready access to certain information. For example, investors would have more direct access to a target-based measure of the level of the primary components of pay in the proposed Granted Compensation Table. In some cases, this measure may be something that investors could easily construct based on existing disclosures, but in other cases, it could provide access to compensation values that investors currently may have difficulty estimating. Specifically, to the extent that registrants include information about performance-stock units granted soon after the end of the fiscal year, the total column in the proposed Granted Compensation Table may provide a more up-to-date picture of the level of granted pay than can often be gleaned from current disclosures.[739] To the extent that some SRCs and EGCs provide pension benefits to their NEOs, the proposed amendments would also allow for the construction of a more consistent measure of the comprehensive level of compensation for such issuers relative both to larger issuers that award and currently report pensions and to SRCs and EGCs that do not provide pensions.

With respect to the performance sensitivity of pay, while the proposed amendments would not require any valuations of ''in flight'' equity awards, the proposed Status of Equity Awards Table would provide a single, more uniform (given that it would apply to all registrants) source of award-by-award information about the status of all new, in flight, and recently vested or expired awards.[740] Because this information is

outsource the actual calculations to compensation consulting firms''); NAM–2; NYSE; Travelers (stating that ''because of the complexity of the rules, and due to resource constraints, many companies have outsourced the computational work required to produce the necessary CAP calculations to external vendors, imposing meaningful and arguably unnecessary expense'').

[734] *See, e.g.,* letters from Equity Methods-1 (stating that after the initial disclosures, ''standardization and automation significantly reduced complexity and costs''); Farient-2 (stating that ''[w]ith the machinery of calculating CAP now in place and the need for a good alignment measure, it would be a step backwards to change the definition or remove the data, which is relatively easy to update going forward'').

[735] *See, e.g.,* letters from Davis Polk; McGuireWoods & Brownstein; Society for Corporate Governance.

[736] *See, e.g.,* letters from Jones Day; Meridian.

[737] *See, e.g.,* letter from CEC–2 (stating that ''the administrative burden of producing these tables is considerable. Each table requires precise calculations, detailed footnotes, and extensive coordination between HR, legal, finance, and external advisors. Companies must ensure consistency across multiple data sources, reconcile fair value assumptions with financial statement inputs, and provide explanatory disclosures if inconsistencies or interpretive ambiguities arise'').

[738] Some commenters noted that improved systems and technological capabilities have reduced the costs of producing current disclosures. *See, e.g.,* letters from CFA Institute; Equity Methods-1. We acknowledge that some of these costs may have come down over time but continue to believe that the proposed amendments to the tabular and associated disclosures would be associated with compliance cost savings, particularly with respect to processes that are less automated, such as the inputting of minor perquisites into a tracking system or the review of large volumes of disclosure by the board, or that require the use of external advisors, such as complex computations.

[739] *See, e.g.,* letter from LACERA (stating that they ''encourage the SEC to facilitate disclosures that provide timely and consistent disclosures of equity grants awarded to senior executives'' and that while ''Form 4 requires timely disclosure of option grants, disclosures do not currently require reporting of PSUs until the completion of vesting''); Hambly, 2025 Roundtable Transcript at 171:11–19 (stating that his ''biggest gripe today is, to get at that value transfer number, especially with . . . PSUs, that number doesn't have to be disclosed for about 14 months, right? You don't have to do a Form 4. Very few people do a press release about that one. And it's not in the proxy statement I'm reading of the most recent grant; that'll come next year's proxy statement'').

[740] As discussed above in this subsection, to the extent that registrants opt to include information beyond the end of the fiscal year, the proposed Status of Equity Awards Table may also provide more up-to-date information about the outcomes of equity awards with performance-based vesting than

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spread across multiple tables in current compensation disclosures and is sometimes aggregated across awards of the same type, the proposed table may reduce search costs for investors seeking to track the status of particular awards or to understand how the actual and potential outcomes of awards granted in recent years layer together to provide performance and retention incentives.[741] The proposed tabular disclosures would also provide more direct access to a measure of *ex post* realized compensation, in the total column of the proposed Earned Compensation Table. For investors interested in evaluating how the board's design of executive compensation granted some years in the past translated into pay outcomes based on actual performance,[742] this proposed table would likely make the inputs required to perform this analysis more accessible, particularly in the case of SRCs and EGCs.[743]

The reduced volume of disclosures and additional flexibility afforded to registrants to tailor their primary tabular and associated disclosures under the more principles-based approach of the proposed amendments could also increase the efficiency with which some investors review the disclosures. By allowing registrants to split the prescribed columns or tables to more clearly present their specific compensation programs, to focus any supplementary disclosure to the tables on material information, and to format these supplementary disclosures in the way they believe to be most effective, the proposed amendments may allow investors reading disclosures linearly to more readily understand registrants' unique compensation programs.

The proposed amendments to the primary tabular and associated disclosures may also reduce the risk of certain distortions in board and/or compensation committee decision-making. In particular, registrants' decisions to provide their NEOs with certain benefits or services may be influenced by considerations of the impact of such decisions on executive compensation disclosure.[744] Separately, the increased complexity of calculating Compensation Actually Paid for pay-versus-performance disclosure when awards have frequent (such as monthly or quarterly) vesting schedules may discourage such vesting schedules solely because of the associated computational burden.[745] The proposed revised interpretive guidance regarding the identification of perquisites and the proposed elimination of the requirement to compute the current measure of Compensation Actually Paid would reduce the risk of such distortions or, even in the absence of actual distortions, would enable boards and/or compensation committees to focus on more substantive considerations when making these decisions.

The benefits of the proposed amendments to the primary tabular and associated disclosures are expected to vary across registrants. Specifically, any compliance cost savings are likely to be lower for SRCs and EGCs given that they are not currently required to include many of the tables and associated disclosures that would no longer be required under the proposed amendments. If the proposed amendments in the 2026 Filer Status Proposing Release are adopted as proposed, a larger subset of registrants (*i.e.,* NAFs) would be subject to all of the accommodations currently available to SRCs or EGCs. Under those circumstances, the compliance costs savings attributable to the proposed amendments to the tabular and associated disclosures would be lower than they would be with the current filer status framework in place. At the same time, investors may benefit more from the proposed amendments to the primary tabular and associated disclosures in the context of SRCs and EGCs (or, if the 2026 Filer Status Proposing Release are adopted as proposed, the broader group of NAFs) than in the case of other registrants, given the increased accessibility and comparability of the information in the proposed Earned Compensation Table relative to similar information in these registrants' current disclosures.[746]

The proposed narrowing the scope of NEOs would also directly reduce the degree of perquisite tracking, the number of computations, and the volume of disclosure produced in the tabular and associated disclosures. Thus, when considered in combination with that proposed change, the incremental compliance cost savings of the proposed amendments to the tabular and associated disclosures would be lower than when considered independently.

current executive compensation disclosures. This may reduce search costs for investors who would otherwise seek this information earlier in Form 4 disclosures.

[741] *See, e.g.,* letter from Norges Bank (stating that ''current requirements emphasize detailed information at the time of grant but provide limited standardized disclosure about vesting outcomes and how performance criteria were actually evaluated, making it difficult to assess the total incentive that the CEO received in any given period and how such incentives compared to the original targeted value and metrics. A simple format tracking each award through its lifecycle, such as a table or chart, could provide investors with useful information about how compensation programs function in practice''); McCormick, 2025 Roundtable Transcript at 77:13–22 (explaining that investors may seek to understand ''how often are . . . grants being actually paid'' and that investors look for ''the disclosure . . . that it was either not paid, or only paid at 80 percent, or something like that''); Mueller, 2025 Roundtable Transcript at 177:7–13 (stating that the current tabular disclosures are ''repetitious but incomplete, right? And so—because they're reporting—you have the outstanding equity awards table that has options on a grant-by-grant basis, but RSUs are not required to be on a grant-by grant basis, and then . . . in the option exercise table, it doesn't necessarily tie that back to which options got exercised'').

[742] *See, e.g.,* Carolyn Cross (Vanguard, Inc.), Vanguard Portfolio Management: Proxy Voting Policy for U.S. Portfolio Companies, Harv. L. F. on Corp. Governance Blog (Feb. 26, 2026), available at *https://corpgov.law.harvard.edu/2026/02/26/vanguard-portfolio-management-proxy-voting-policy-for-u-s-portfolio-companies/* (stating that one large asset manager mainly assesses the alignment of pay and performance ''through alignment of incentive targets with strategy set by the company and analysis of three-year total shareholder return and realized pay over the same period versus a relevant set of peer companies'').

[743] As discussed in section IV.E.1.c above, identifying the realized amounts for equity grants may currently be slightly more involved in the case of SRCs and EGCs, which are not required to include the Options Exercised and Stock Vested Table.

[744] *See, e.g.,* letters from Baker & McKenzie LLP (May 7, 2026), available at *https://www.sec.gov/comments/4-855/4855-771227-2361274.pdf* (stating that ''treating personal security as a perquisite can deter or delay companies from providing needed protection or can pressure companies to reduce coverage—an outcome we have seen repeatedly in practice''); Davis Polk; McGuireWoods & Brownstein (stating that they ''worry that in today's environment, companies are not providing benefits deemed perquisites under current regulations that would greatly enhance the safety of executives and thereby protect and promote shareholder value''); Society for Corporate Governance (stating that ''the current disclosure requirement, where the cost of executive security is reported as part of an executive's compensation, is a factor that boards of directors or board committees evaluate when reviewing and approving such arrangements, weighing unnecessarily on the exercise of their business judgment''). We understand that there has been an increased focus on executive security in recent years, which may increase the value to registrants of greater perceived discretion in their decisions in this area. *See* Shane Heitzman et al., *Corporate Executive Protection,* U.S.C. Marshall School of Business Research Paper (Jan. 7, 2026), available at *https://ssrn.com/abstract=5044075,* at 6 (finding that the fraction of registrants in the S&P 500 that reported benefits provided to their CEOs for off-the-job security increased in recent years, from 31.0% in 2014 to 46.4% in 2024).

[745] *See* letter from NYSE (stating that ''[t]he potential frequency of a complex valuation has been distorting executive compensation disclosure decisions to the extent that some issuers (including pre-initial public offering companies) consider changing their vesting schedules to try to lessen the burden of the PvP disclosure requirement'').

[746] As discussed earlier in this subsection, the Earned Compensation Table may make information about equity award outcomes easier to access in the case of SRCs and EGCs (which are not currently required to include the Option Exercises and Stock Vested Table) and the inclusion of pension service costs (and prior service costs) in the Earned Compensation Table for all registrants would make the disclosures of SRCs and EGCs more comparable to those of other registrants.

3. Costs

The proposed amendments to the primary tabular and associated disclosures are expected to result in short-term adjustment costs for multiple parties, ongoing search and analysis costs for investors, a reduction in the precision with which executive compensation is evaluated (and thus an increased risk of suboptimal investment and voting decisions), costs to registrants in determining materiality and tailoring disclosures, and a risk of distortions in compensation structures.

Registrants and investors, either directly or through third parties (such as compensation consultants, proxy advisors, and executive compensation data aggregators), are expected to experience short-term adjustment costs in adapting to the proposed primary tabular and associated disclosures. The proposed amendments represent a significant overhaul of the executive compensation disclosures with which these parties have developed experience—in many cases, over the past two decades.[747] As a result, these parties may all have to revise their technological systems, internal processes, and contracts with other parties to adapt to a new set of disclosures, all of which may entail costs. For registrants, making materiality determinations and deciding how best to tailor disclosures may require extra effort in the first year of compliance with new disclosure requirements. Registrants may also expend some resources to engage with investors, other registrants, and third parties, including external advisors and trade groups, to develop market practices and norms relating to some of the more principles-based elements of the proposed amendments. For investors and other users of executive compensation disclosure, in the short term, comparisons across years may be more likely to span the current and proposed new disclosure regimes and may thus be complicated by the changes in data and presentation format. Similarly, comparisons across registrants may be complicated in the short term by differences in the interpretation and application of the rules across registrants, until the development of market practices and norms relating to varied compensation features and structures in the proposed tables.

For the investors and other users of executive compensation disclosure, more condensed and principles-based disclosures may entail ongoing incremental search and analysis costs to find, organize, and evaluate material information.[748] Specifically, investors, other registrants, and third parties (such as compensation consultants and proxy advisors) may bear increased search costs to the extent that information that they currently have experience finding in relatively consistent locations (whether in tables, footnotes, or narrative) would be inconsistently available under the proposed amendments or presented in different formats and locations by different registrants, which is a risk of any principles-based disclosure requirement. Sections V.E.1.b, c, and d above identify information about the level of pay, its performance sensitivity, and other factors with respect to executive compensation that may be used currently by investors or other registrants (directly or via compensation consultants or proxy advisors) that may be less readily or less consistently available under the proposed amendments.

For example, the proposed amendments do not prescribe how or where in the disclosure (and at what level of detail or aggregation) information about certain terms of incentive awards should be reported, so the time required to locate, understand, and organize this information may be greater than in the case of current disclosures. Also, the proposed Status of Equity Awards Table would, like the current Grants of Plan-Based Awards Table, include certain terms of newly granted equity awards, but, unlike the current table, would not be required to include information about non-equity incentive awards. Depending on where the material terms of these awards are disclosed it may therefore take additional time to understand the nature of non-equity incentive awards.[749] The flexibility afforded to registrants under the proposal to split columns or tables may further increase the variation in location of similar information across filings of different registrants and thus entail additional search costs. These search costs may be partially mitigated, over time, by the potential development of any market practices or norms (or investor requests) that increase the consistency of the inclusion and location of information in disclosures.

Elements of the proposed amendments that condense the disclosures could also contribute to search costs. For example, under the current rule, the Options Exercised and Stock Vested Table can currently be used to identify options that have been exercised or stock that has vested in this fiscal year. Under the proposed disclosures, identifying these amounts would require comparing items in the proposed Status of Equity Awards Table to the similar table in the previous year's disclosure. Sections V.E.1.b, c, and d above also identify information that may excluded from a particular registrant's executive compensation disclosures under the proposal but may be included in other filings (such as a Form 4 or an Item 5.02 8–K); users of executive compensation disclosure who seek such information would also bear search costs to access and review these additional disclosures.[750]

The proposed amendments could also increase the resources users of disclosures expend on analyzing the information in the disclosures, particularly to the extent they seek measures or analyses reflecting the ''in flight'' valuations of outstanding awards to get a more real-time and comprehensive sense of how compensation is tracking performance than possible using *ex post* realized pay.[751] As discussed in section IV.E.1.c

[747] *See, e.g.,* letter from CFA Institute (stating that ''[p]rofessional investors have been working with [executive compensation] disclosures from many companies for twenty years . . . . The features (and shortcomings) of the current disclosure rulebook are well known''); Rees, 2025 Roundtable Transcript at 103:14–16 (stating that ''changes to the summary compensation table presentation are particularly problematic. We've been relying on this table presentation since 2006''); Hambly, 2025 Roundtable Transcript at 173:7–9 (stating that ''[t]he current system of disclosure is flawed, but it's what we have, and we've learned to operate within it'').

[748] *See, e.g.,* letter from Compensia (stating that the Commission should consider ''costs borne by investors to capture, organize, and assess the information to be disclosed, much of which will intentionally and necessarily vary among issuers under [a] 'principles-based' disclosure regime'').

[749] We estimate that about 81% of registrants reported paying non-equity incentive compensation to their PEO in the most recent year reported in proxy year 2025 filings. This estimate is based on staff analysis of data from Execucomp. *See supra* note 575.

[750] For example, the Outstanding Equity Awards at Fiscal Year-End Table currently presents shares that are earned based on performance-based vesting conditions separately from those that are unearned, even if they have not yet vested. Because the proposed Status of Equity Awards Table would report changes in the status of such awards only when they fully vest, investors seeking this information under the proposed amendments may have to separately search for it in Form 4 disclosures. As reported in Table 6 in the Baseline section above, we estimate that about 7% of performance-based stock awards have an additional time-based vesting period after the performance period. As discussed in section IV.E.1.c above, the interpretation of the data in the current Outstanding Equity Awards at Fiscal Year-End Table may be limited due to the aggregation of multiple awards in the same row.

[751] *See, e.g.,* letter from Equity Methods-1 (stating that ''[t]he problem with showing only realized pay is that it is extremely backward-looking and can create an illusion of clarity insofar as it ignores the much larger batch of in-flight awards that are progressing toward a vesting event''); Aiyesha Dey et al., *Pay Versus Performance and Investor Voting*

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above, the proposed disclosures would no longer require such valuations and would thus reduce access to registrant-computed values, though some investors or third parties already produce their own related estimates.[752] To the extent that additional investors begin to construct such estimates or rely more heavily on third parties for such analysis if the proposed amendments are adopted, those investors may bear direct or indirect costs of such computations.[753] The costs of analysis may also increase for investors or third parties who rely on measures of the level of pay or realized pay outcomes other than those that can be directly extracted from the proposed disclosures, to the extent that these measures are more readily constructed based on current disclosures, as discussed in section IV.E.1.c above.

The proposed amendments to the primary tabular and associated disclosures would also result in less detailed and comprehensive information about executive compensation being available to investors. Some of the information that may no longer be disclosed or that may be less consistently or readily available under the proposed amendments to the primary tabular and associated disclosures may be of little consequence. For example, some of this information may be highly granular and thus unlikely to be material, such as the individual identification of extremely low-value perquisites. But other information that may be unavailable or less consistently available under the proposed amendments may, particularly when considered in aggregate, reduce the precision of investor evaluations of executive compensation and thus introduce noise into decisions that are made in reliance on information about executive compensation.[754]

Specifically, as discussed in sections V.E.1.b, c, and d above, the reduction of certain details in the mandated disclosures under the proposed amendments may result in somewhat less precise estimates of the level and performance sensitivity of executive compensation and a reduced availability of information about more secondary components and terms of compensation. The increased search and analytical costs noted above could also lead some investors or their advisors to use more simplified computations or heuristics to limit such costs even when more precise evaluations are possible, further increasing the potential noise in investors' evaluation of executive compensation.[755] The principles-based approach to certain elements of the disclosures and the focus on materiality in the context of a specific registrant may also reduce the precision of comparative analyses, whether across time or across registrants.[756]

To the extent the proposed amendments result in a lower degree of precision in the evaluation of executive compensation, some noise may be introduced into both investment and voting decisions.[757] Based on the evaluation of informational effects presented in section IV.E.1.b above, the potential reduced precision in measures of the level of pay is expected to be modest in most cases.[758] However, the precision of such measures may be more significantly affected in the case of smaller registrants, who tend to pay lower levels of executive compensation because any given dollar amount of undisclosed compensation represents a larger share of total pay at such registrants.[759] The noise that could be introduced into investors' evaluation of the primary performance incentives stemming from NEO compensation, including any noise introduced by an imprecise understanding about how changes in the level of pay over time either enhance or dampen these incentives, is similarly expected to be modest based on the assessment in sections V.E.1.b and c above. That said, even a small degree of imprecision in understanding executive incentives may have greater implications than a comparable degree of imprecision in understanding the level of pay.[760] To

Decisions, Working Paper (June 30, 2026), available at *https://ssrn.com/abstract=5017414* (''Dey et al. 2026 Study'') (finding evidence consistent with the hypothesis that the disclosure of Compensation Actually Paid decreased information processing costs for some investors, such as by demonstrating that this measure was more associated with voting outcomes in cases where there were more complex pay packages, longer pay disclosures, or a higher emphasis on performance-based compensation, all of which could make it more difficult for investors to produce similar analysis on their own).

[752] These estimates are likely to be less precise than registrants' own valuations. *See supra* notes 716 and 717 and associated text; *see also* letter from Pennant (May 8, 2026), available at *https://www.sec.gov/comments/4-855/4855-771627-2362154.pdf* (describing the data that had to be extracted from different sources to construct a measure like Compensation Actually Paid prior to the pay-versus-performance disclosure requirements, and stating that ''performing this extraction consistently across thousands of issuers required either large analyst teams or costly bespoke data vendors'' and that ''[t]he result was that some organizations with larger dedicated stewardship and governance organizations attempted it, while many other investors defaulted to the proxy advisors' [Summary Compensation Table]-based models'').

[753] Some commenters indicated that investors do not seem to rely on the information in current Pay-versus-Performance disclosures, which may imply that they would not bear costs to seek similar computations elsewhere. *See, e.g.,* letters from Business Roundtable; Davis Polk; NAM–2. However, others stated that it is a useful disclosure for investors. *See, e.g.,* letters from AFL–CIO et al.; AFREF; Better Markets; Council of Institutional Investors. Also, there is some evidence that the measure of compensation actually paid is used at least to some extent in making voting decisions. *See, e.g.,* Dey et al. 2026 Study, supra note 751 (finding that reported PEO compensation actually paid is associated with say-on-pay voting support, and providing supportive evidence of a causal relation between the measure and voting decisions by demonstrating that a similar linkage does not hold in the prior year, for which compensation actually paid was eventually reported but not made available at the time of that year's vote); Glass Lewis Pay-for-Performance Methodology, *supra* note 660, at 2–3 (describing, as part of the pay-for-performance assessment provided by a proxy advisory service, a test using reported compensation actually paid that it began using in proxy year 2026).

[754] *See, e.g.,* letters from CFA Institute (stating that ''overhauling the disclosures to eliminate or materially change their tenor and direction comes with a large price tag, whereby the costs of preparing this information inside companies with precision is transferred to investors across the capital markets who will be making less precise estimates with incomplete information''); Compensia (stating that ''revisions or reforms that sacrifice the quality or availability of decision-necessary data will almost certainly have the unintended impact of increasing ecosystem costs that are ultimately borne by shareholders'').

[755] *See, e.g.,* David Hirshleifer & Siew Hong Teoh, *Limited Attention, Information Disclosure, and Financial Reporting,* 36 J. Acct. & Econ. 337 (2003) (developing a theoretical model where investors have limited attention and processing power and showing that, with partially attentive investors, the means of presenting information may have an impact on stock price reactions, mis-valuation, long-run abnormal returns, and corporate decisions).

[756] *See, e.g.,* letters from CFA Institute (stating that ''disclosures are not read in a vacuum . . . investors pay close attention to changes in amounts, pay structures, and disclosures from period to period and differences between peer companies''); Equity Methods-1 (stating that ''while we are generally in favor of a principles-based approach that affords leeway in structure, we believe investors benefit most when they can draw comparisons across firms (cross-sectionally) as well as over time for any given firm (longitudinally)''); State Board Florida (stating that ''inconsistency makes it difficult for investors to analyze and compare compensation practices effectively'').

[757] See section IV.B above for a discussion of why information about executive compensation may be relevant to investment and voting decisions. *See also* letters from AFL–CIO et al.; CFA Institute; LACERA; NEI.

[758] As discussed in section IV.E.1.b above, the potential sources of reduced precision include the proposed change in the valuation methodology for equity grants, the amount of information that would be disclosed about pensions and other deferred compensation, and the amount of information that would be disclosed about perquisites and miscellaneous compensation.

[759] *See, e.g., supra* Figure 3 and Table 4. As discussed in section IV.E.1.b above, for PEOs receiving $500,000 or less in total compensation, and assuming an expanded use of perquisites, the proposed amendments could potentially result in a significant percentage of PEO compensation being obscured.

[760] *See, e.g.,* letters from CFA Institute (stating that ''incentives can significantly impact managers'

the extent that information about pension balances and entitlements to dividends is less likely to be disclosed under the proposed amendments (after considering disclosures pursuant to the proposed materiality-based provisions as well as any voluntary disclosures as discussed in section IV.E.1.d above) investors may also have a weaker understanding of how these monetary factors could contribute to an executive's decision-making.[761] Reduced information about the components of miscellaneous compensation or of perquisites, also discussed in section IV.E.1.d, could prevent investors from distinguishing the provision of benefits that support the productivity of executives from those that may signal governance concerns.[762] Each of these potential sources of noise in an investor's evaluation of executive compensation may contribute to investment or voting decisions that deviate somewhat from the decisions that would be made based on more precise information, particularly when all of the potential sources of imprecision are considered in the aggregate.

Registrants may also bear ongoing incremental costs under the proposal, including costs to evaluate materiality to determine what information to include or exclude from disclosures under the proposed, more principles-based, tabular and associated disclosure requirements. For example, registrants would have to determine, based on a materiality assessment, what items to include in the miscellaneous compensation category of the proposed Earned Compensation Table besides those that are explicitly delineated, whether to identify and quantify the individual components that are aggregated in any given category of compensation, what amount of detail to provide with respect to the terms of incentive awards, and what other supplemental disclosure may be required. As discussed in section IV.E.1(a) above, such assessments may be quite complex. Determining the scope of disclosure that is material may require the consultation of external advisors, and certain factors may require reassessment each year as the registrant's facts and circumstances change. In addition, to the extent that some registrants may disclose more than what is strictly material to reduce the risk of omitting material information, some of the anticipated savings discussed in the previous section from reducing the volume of disclosure may be mitigated. Similarly, determining how best to tailor disclosures may entail varying degrees of annual (or periodic) reconsideration of which elements to highlight, whether to use the flexibility to split columns or tables, or whether there is a more effective way of presenting the information that supplements the tabular disclosures.

Costs may also be associated with any distortions in compensation structures that result from the proposed amendments to the tabular and associated disclosures. For example, the proposed amendments would decrease the level of transparency around perquisites and retirement plans and could thus contribute to greater use of such forms of compensation.[763] Creating a salient threshold for the disclosure of perquisites could also unintentionally encourage an aggregate use of perquisites closer to this level.[764] The proposed amendments would also treat equity and non-equity incentive awards somewhat differently. While the proposed Status of Equity Awards Table would highlight, for example, the performance period and final vesting date, range of possible outcomes, and actual outcome (upon vesting or exercise), on an award-by-award basis for all equity incentive awards, registrants would have flexibility in disclosing any material terms and material award-level outcomes for non-equity incentive awards. To the extent that this disclosure is less comprehensive or less prominent than that for equity awards, such lower transparency could result in an increased use of non-equity incentive awards.[765] The proposed Granted Compensation Table would also require equity with market conditions to be valued assuming the target outcome is achieved while options (whose payout outcomes also vary based on market outcomes) would continue to be valued using techniques that take into account all of their possible outcomes. This differential treatment could distort decisions about what type of equity to award executives. Any distortions in compensation structures that may arise in response to the proposed amendments could result in costs to shareholders to the extent that pay structures provide suboptimal performance incentives or levels of pay for executive officers.

The costs of the proposed amendments to the primary tabular and associated disclosures are expected to vary across registrants. Specifically, any adverse effects on investor access to information are likely to be smaller with respect to SRCs and EGCs given that they are not currently required to include many of the tables and associated disclosures that would no longer be required under the proposed amendments. If the proposed amendments in the 2026 Filer Status Proposing Release are adopted, a larger subset of registrants would receive all the accommodations currently available to SRCs or EGCs. The costs attributable to changes to investor access to information under the proposed amendments to the tabular and associated disclosures would thereby be lower than if those rules are not adopted.

The proposed narrowing in the definition of NEOs would also directly

priorities and, by extension, companies' long-term performance''); Farient-1 (stating that ''[u]nreasonable pay quantum can cost shareholders millions of dollars [but] [w]eak alignment can cost shareholders billions through short-term or myopic decisions driven by perverse incentives''); Norges Bank (stating that ''[h]ow a company's management team is incentivized and rewarded has significant influence over their decision-making and financial performance over time'').

[761] As discussed above, high pension and deferred compensation balances have been associated with the degree of managerial risk-taking, while entitlements to dividends have been associated with registrant payout policy. *See supra* section IV.B.

[762] *See, e.g.,* letters from AFL–CIO et al. (stating that ''[h]igh levels of perquisites, while the dollar amounts may not be material, can indicate a power imbalance between senior executives and boards of directors''); LACERA (stating that ''enhanced disclosure of tax gross-ups [and other benefits] enabled investors to scrutinize such pay provisions and led to the subsequent reduction in market practice of firms providing these pay padding mechanisms''); State Board Florida (stating that ''excessive or poorly justified perks can signal governance concerns when they appear excessive, unaligned with performance, or poorly justified'' and that ''[a] lack of clear rationale for perks undermines investor confidence in board oversight''); *see also supra* section IV.B.

[763] *See supra* note 529 and the associated text; *see also* letters from CFA Institute (stating that ''reducing disclosure for the sake of lowering administrative costs opens the door for abuse''); LACERA (stating that ''[t]ransparency that is not comprehensive risks creating an incentive for pay to be rewarded through benefits, perquisites, and other avenues that are detached from performance and result in 'pay padding'); Meridian (stating, in the context of the potential exclusion of certain retirement-related costs from the Summary Compensation Table, that the Commission could ''require the absolute dollar amount to be included elsewhere in the compensation disclosures to discourage companies from using retirement plans more aggressively to 'hide' compensation'').

[764] *See, e.g.,* Murphy & Jensen 2018 Study, *supra* note 523, at 208 (discussing the introduction of tax penalties on golden parachutes representing over three times base pay and stating that ''[a]pparently compensation committees and executives took the regulation as effectively endorsing . . . the payments of three times average compensation (which quickly became the standard)'').

[765] *See supra* note 529 and associated text; *see also* letter from LACERA (stating, in the context of the treatment of performance stock units as compared to restricted stock units, that ''[e]quitable treatment . . . avoids creating an unintended incentive for companies to favor grants that require less timely disclosure'').

reduce the information to be provided in the tabular and associated disclosures. While investors are often most focused on PEO pay,[766] to the extent that a larger group of NEOs would be associated with, for example, higher levels of the search and analysis costs discussed in this section, the incremental costs of the proposed amendments to the tabular and associated disclosures would be somewhat lower when considered in combination with the proposed NEO definition than when considered independently.

4. Reasonable Alternatives

We considered several alternative approaches to the primary tabular disclosures of executive compensation data.

For example, we considered additional prescriptive requirements to disclose certain factual information about the terms of incentive awards in a standardized format. The proposed Status of Equity Awards Table includes some terms of equity awards, such as the final vesting date and range of potential payouts. We could require additional columns or footnotes to the proposed tables, or even an additional table, for example, to present additional terms of equity awards (such as performance-based vesting conditions, vesting schedules, and/or option expiration dates) or to present the terms of non-equity awards (such as the final vesting date, vesting schedule, range of potential payouts, and/or performance-based vesting conditions). As discussed in the Broad Economic Considerations section (section IV.B. above), an *ex ante* understanding of the basic monetary incentives of NEOs (*e.g.,* how their compensation varies with stock price, volatility in stock price, and non-market performance metrics, as well as the horizon of these incentives) is important to developing expectations as to how the NEOs and registrants may perform. Prescriptive requirements to disclose all of the award terms that drive this performance sensitivity in a specified format could reduce investor search costs if the information would otherwise be presented in more variable formats and would ensure that this information is consistently available across registrants for comparative purposes. That said, the proposed amendments would require registrants to provide any material information necessary to an understanding of the information disclosed in the primary tabular disclosures and would provide greater flexibility as to how the information is presented.[767] Not prescribing a presentation method could allow market practices or norms to develop under which this information may be presented in a more efficient manner than what we might consider prescribing.

We also considered alternatives to the proposed perquisites disclosure threshold. For example, we considered higher or lower dollar thresholds. Some commenters suggested a flat threshold of $50,000 [768] or $100,000.[769] Table 8 in the Baseline section above demonstrates (in its second and third columns) that a threshold of $100,000 or the proposed level of $150,000 would likely result in the vast majority of reported perquisites that currently represent five percent or more of total compensation being disclosed.[770] But, in contrast to the proposed threshold, a lower threshold would be more likely to capture perquisites representing lower percentages of total compensation.[771] A higher threshold than proposed (such as the $200,000 threshold presented in column four of Table 8) would be more likely to exclude perquisites from the disclosure even if they represent five percent or more of total compensation.

We also considered percentage thresholds or dual dollar and percentage thresholds for the disclosure of perquisites. For example, we could require that perquisites be disclosed if they exceeded the greater of $100,000 or 10 percent of the total of salary and bonuses (including all non-equity incentive payouts), as reported in the fifth column of Table 8. Such a threshold could be more permissive in terms of not requiring the disclosure of some low levels of perquisites. However, a percentage threshold based on salary and bonuses (as under the disclosure requirements adopted in 1992), would result in a threshold that would vary across NEOs with similar levels of compensation but different degrees of reliance on equity versus non-equity pay, and could encourage greater use of non-equity incentives. A flat threshold rather than a percentage or combined dollar and percentage threshold also reduces the risk of obscuring larger amounts of pay and introducing more noise in measured total compensation, particularly if the usage of perquisites were to increase in response to the proposed amendments.[772] Another alternative would be to require a dual dollar and percentage threshold with a ''lesser of'' rather than ''greater of'' approach. Such a threshold would have similar benefits as a dollar threshold at companies with higher levels of NEO compensation while also requiring the disclosure of perquisites that represent a larger fraction of compensation at registrants with lower levels of NEO compensation relative to the $150,000 threshold.[773] However, a two-pronged threshold would be more complex than the proposed threshold.

Given the proposed flexibility in the methodology used to value perquisites, we considered requiring registrants to disclose the methodology used. Such disclosure could allow investors to better understand how to interpret any reported perquisite amounts or factors that may impact the comparability of the perquisite disclosures across different registrants. However, given that the proposed amendments do not require that perquisite amounts be separately identified (except to the extent material per proposed Item 402(a)(5)(i)), the incremental value of methodology disclosure to investors may be limited in many cases. We expect that some registrants may disclose such methodologies on a voluntary basis or pursuant to the materiality standards of Item 402(a)(1) and Item 402(a)(5)(i).

We further considered whether to revise the current guidance indicating that an item is not a perquisite if it is generally available on a non-discriminatory basis to all employees of the registrant to instead reference whether the item is generally available on a non-discriminatory basis to all executive officers. Such an approach could result in additional compliance cost savings by further limiting the scope of benefits that would need to be tracked and reported for executive compensation disclosure purposes.

[766] *See supra* section IV.D.

[767] *See supra* section II.E.1.

[768] *See* letters from Compensation Advisory Partners; CEC–1; McGuireWoods & Brownstein.

[769] *See* letters from ABA; Business Roundtable; Cooley; Meridian; NAM–2; NYSE.

[770] In the sample of 100 registrants presented in Table 8, in all of the cases in which PEO perquisites represented over 5% of total compensation the level of perquisites exceeded both $100,000 and $150,000.

[771] In the sample of 100 registrants presented in Table 8, among PEO perquisites that represented less than either 5% or 2.5% of total compensation, a higher number exceeded a $100,000 threshold than those that exceeded a $150,000 threshold.

[772] For example, in the sample of 100 registrants presented in Table 8, in all of the cases in which PEO perquisites represented over 5% of total compensation, these perquisites would also exceed a flat threshold of $150,000, whereas only half (or fewer when considering the adjusted measure of perquisites) of these would be disclosed under a threshold of the greater of $100,000 or 10% of salary and bonuses.

[773] For example, many smaller registrants pay $500,000 or less in total compensation to their PEO, of which $150,000 in potential perquisites would represent 30% or more of total compensation.

However, the alternative approach could also reduce the amount of information available to investors to assess executive benefits. Assuming that perquisite granting practices remain unchanged, we already expect that a very small percentage of registrants would report perquisites under the proposed amendments.[774]

With respect to the data required to be presented in the proposed Earned Compensation Table and proposed Granted Compensation Table, we considered requiring that registrants provide a breakdown of any items presented in the aggregate in the tables. For example, if multiple annual bonuses or equity grants were made in the same year, the values attributable to each would be required to be identified in a footnote. Similarly, under this alternative approach, registrants would be required to identify individual components of the Miscellaneous Compensation Received column of the Earned Compensation Table, potentially subject to some minimum threshold as under the current requirements for the ''all other compensation'' column of the Summary Compensation Table.[775] This approach would allow investors and their advisors, as well as other registrants, more complete access to individual components of pay so that they can, for example, make adjustments (within their own analyses) for comparability, construct alternative measures that are more suited to their methods of evaluating executive compensation, or more precisely benchmark individual components of pay. Given the flexibility available to registrants under the proposal to exclude components of pay that are not material or to present certain items of pay in an alternate year if (consistent with the proposed requirements) they believe it to be more appropriate given their award schedule, identifying the individual components of pay could allow users of the disclosure to better understand what is included or excluded in any given column in a given year. Identifying the individual components of pay could also allow investors to better understand specific components of pay, like a retention bonus, that could skew their evaluation if not differentiable from other components of pay. On the other hand, not requiring such breakdowns would give registrants more flexibility and may encourage more concise disclosure. Under the proposal, registrants would nonetheless be required to provide these breakdowns to the extent they constitute material information relevant to an assessment of NEO compensation.

F. Compensation Discussion and Analysis

Certain registrants are required to provide a CD&A discussing the compensation granted to, earned by, or paid to the NEOs. The current stated purpose of the CD&A is ''to provide investors material information that is necessary to an understanding of the registrant's compensation policies and decisions regarding the NEOs,'' which can reduce information asymmetries between registrants and investors about how the registrant approaches its executive compensation program. Currently, the rules include seven required topics to be covered in CD&As, as well as a list of fifteen example topics that may be material for inclusion depending on a registrant's facts and circumstances.[776] CD&A disclosure is required of all registrants required to provide Item 402 disclosures[777] other than SRCs and EGCs.

The proposed amendments would simplify the requirements of the CD&A and take a more principles-based approach by reducing the number of required topics to three and eliminating the non-exhaustive list of example topics.

1. Benefits

The proposed revisions to the requirements for CD&As are expected to reduce the costs of preparing and reviewing these disclosures and to encourage more succinct, tailored disclosure. We understand that CD&A disclosures are often the lengthiest component of current executive compensation disclosures.[778] Both investors[779] and registrants[780] have identified content included in current CD&As that is not helpful to registrants in communicating, or to investors in understanding, a registrant's compensation policies and decisions. We expect that the proposed amendments would facilitate the reduction of this type of CD&A content, although the degree of streamlining and simplification would depend in part on registrants' choices and approaches to drafting.

Specifically, the proposed reduction in the number of required topics and elimination of the non-exhaustive examples of potential topics may allow registrants to reduce the inclusion of boilerplate, repetitive, or superfluous content to the extent that it was merely being included to ensure a response to some or all of these potential topics despite such topics having been already sufficiently covered or not being material in the context of their compensation programs. While the cost of preparing such disclosures may be relatively modest, given that boilerplate-type disclosures can likely be modeled after the prior year or other registrants' proxy disclosures, they may unnecessarily add to the volume of disclosure that must be reviewed by multiple parties. It is possible that reducing the length of CD&As could also reduce the production of introductory proxy summary sections by registrants, if the resulting volume of disclosure is more digestible without a summary.

We recognize that there can be elements of narrative disclosures that are not susceptible to rapid change, in that norms, other statutory or regulatory requirements, investor and stakeholder expectations, and liability concerns can create outside pressures to continue to produce longer disclosures.[781] However,

[774] *See supra* Table 8.

[775] Currently, registrants are required to identify to the extent material any item included under ''All Other Compensation,'' where identification of an item shall not be considered material if it does not exceed the greater of $25,000 or 10% of all items included in one of the specified categories of compensation required to be included in this column.

[776] See section II.F above for a complete list of these topics.

[777] These registrants include all section 12 and section 15(d) registrants that are not registered investment companies, FPIs, or either asset-backed securities issuers or externally-managed BDCs which do not have executive officers. *See supra* section IV.C.2.

[778] *See, e.g.,* letters from Baillie Gifford (stating that ''CD&A averages 25–30 pages''); Chamber of Commerce; Society for Corporate Governance (citing 2021 data from Equilar, Inc., indicating that CD&As in their sample averaged nearly 10,000 words, or approximately 15 pages in 10-point font); *see also* Schustereder, 2025 Roundtable Transcript at 100:2 (stating that the CD&A for his registrant is about 35 pages in length today).

[779] *See, e.g.,* Hambly, 2025 Roundtable Transcript at 152:2–15 (stating that, in one example CD&A he reviewed that day, he ''saw the same graphic twice in the 40 pages . . . [and] the same paragraph three times in the 40 pages'' and that with ''most . . . proxies [he] could cut 25 percent off with a good copy editor''); McCauley, 2025 Roundtable Transcript at 106:17–107:3 (stating that, with respect to CD&As, ''volume is not the problem'' but that ''[q]uality is the deficiency in many investors' minds'' and that ''the generic boilerplate legalese is really not helping anybody'').

[780] *See, e.g.,* letters from Chamber of Commerce (stating that the ''CD&A provided by most companies is laden with technical jargon and information that is immaterial to investors''); Society for Corporate Governance (stating that ''overly broad and redundant'' rule text pertaining to CD&As has a ''tendency to produce unwieldy disclosure'').

[781] *See, e.g.,* letters from ABA (stating that the length of CD&As results from the scope of their functionality, which has extended to include providing a supporting statement for the say-on-pay

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given the other significant changes proposed to executive compensation disclosure in this release, we anticipate that registrants (in their disclosure choices) and market participants (in their engagement with registrants) may be more likely in this context to take the opportunity to establish new approaches and develop new expectations of what structure and content is optimal for CD&A disclosure. We therefore believe that reducing the perceived need to provide some of these disclosures would result in compliance cost savings. Given that CD&A disclosures are often the lengthiest component of executive compensation disclosures, and that the time and effort required to review the disclosures likely increase with their length and involve multiple parties (including, often, legal counsel, compensation consultants, and directors), even a partial reduction in the size of CD&A disclosures could generate meaningful aggregate savings across the population of affected registrants.

Investors may benefit from the proposed revisions to CD&A disclosures to the extent that these revisions result in disclosures that are more focused on information that is likely to be material. In particular, more focused disclosures may make it easier for investors to find the parts of the disclosures that matter to them [782] and to more efficiently distinguish between disclosure of compelling compensation policies and potential attempts to obfuscate less ideal pay practices.[783] Investors may also benefit from any new insights provided by registrants in response to the revised disclosure topic requiring the objectives of the compensation program to be disclosed in relation to the registrant's corporate strategy. As discussed above, the implications of compensation programs for the registrant's strategic priorities and executive decision-making in relation to those priorities are likely among the most value-relevant information that can be extracted from executive compensation disclosures.[784] Consistent with this view, the relation between compensation design and corporate strategy has been identified as an important consideration by registrants [785] and investors.[786] While some registrants may currently address strategic considerations in the CD&A when discussing the objectives of their compensation programs, it is unclear to what extent current CD&As are consistently effective in addressing this topic beyond discussing more universal objectives of compensation programs.[787] Explicitly requiring that the objectives of the compensation program be discussed in the context of corporate strategy may thus encourage registrants to better tailor these disclosures and allow investors to more effectively evaluate compensation programs.

The benefits of the proposed revisions to the rules governing CD&As may interact with those of the proposed amendments to the definition of NEO. By reducing the number of NEOs whose compensation must be discussed in the CD&A, the proposed revision to the definition of NEO may already reduce the volume of CD&A disclosures, thereby reducing the incremental benefit from reduced volume that could result from the proposed revision to the required and example topics for the CD&A.

The benefits of the proposed revisions to the CD&A topics are also expected to vary across registrants. Because EGCs and SRCs are exempt from CD&A disclosure requirements, they (and their investors) would not experience any incremental benefits. For other registrants required to provide Item 402 disclosures that must include a CD&A, the degree of benefits would vary based on the current extent of potentially extraneous disclosure in their CD&As and the extent to which they streamline these CD&As in response to the enhanced flexibility. If the proposed amendments in the 2026 Filer Status Proposing Release are adopted, a smaller group of registrants (representing about 20 percent of registrants but over 93 percent of the total market public float) would be subject to CD&A disclosure requirements, which would reduce the scope of benefits of the proposed amendments with respect to CD&As.[788] That said, the reduction in these benefits would be expected to be proportionately lower than the change in the number of affected registrants, because the large companies that would remain subject to the CD&A requirements likely have longer and more complex CD&A disclosures currently (and thus a greater opportunity to streamline these disclosures), on average, than other registrants.[789]

2. Costs

We expect that the proposed amendments to CD&A requirements could generate short-term adjustment costs for the registrants required to provide CD&As. There may also be some short-term adjustment costs for investors, as well as costs associated with potential reductions in the information disclosed in CD&As. The potential costs to investors are likely to be at least partially mitigated because the proposal would consolidate and

vote, addressing proxy advisor expectations, and addressing an audience of a variety of stakeholders including ''employees, the media, customers, suppliers and vendors, creditors, governmental entities, and the general public''); Compensia (stating that ''numerous factors have contributed to the perceived 'bloat''' in CD&As, including the influence of proxy advisory firms, the complexity of executive compensation design, the shift in equity awards from stock options to performance-based stock or unit awards, the enactment of say-on-pay votes, technological advances, and increasingly diversified investor voting policies); Society for Corporate Governance (stating that ''litigation trends, proxy advisory firm standards, and investor questions further . . . [increase] the length and complexity of the disclosures'').

[782] *See, e.g.,* letters from IBC (stating that ''for investors, these disclosures are buried in volumes of regulatory compliance text though they describe critical decisions''); Pearl Meyer (stating that ''critical information—such as sign-on awards, one-time grants, or significant changes to pay structure—often remains scattered throughout the document or relegated to the back of the CD&A''); State Board Florida (stating that ''[a] primary issue encountered by investors regarding executive compensation disclosure is the difficulty in navigation and comparability'').

[783] *See, e.g.,* Indrarini Laksmana et al., *Compensation Discussion and Analysis (CD&A): Readability and Management Obfuscation,* 31 J. Acct. Pub. Pol. 185 (2012) (finding that registrants with CEO pay exceeding the level that the researchers could attribute to the economic determinants of compensation had a more difficult to read CD&A).

[784] *See supra* section IV.B.

[785] *See, e.g.,* Fortt, 2025 Roundtable Transcript at 184:13–17 (stating that ''most boards that I've worked with, at least, over the course of my career, how they think about executive compensation is really as a tool of corporate strategy, and a strategic implementation''); Lennartz, 2025 Roundtable Transcript at 84:10–13 (stating that ''it's incumbent upon companies to demonstrate how their compensation programs align with the business strategy and ultimately shareholder interest'').

[786] *See, e.g.,* letter from Council of Institutional Investors (stating that ''[e]valuating board-level compensation decisions requires that shareowners have complete and thorough information about,'' among other things, ''the relationship between compensation decisions and the company's business objectives'').

[787] *See, e.g.,* Chiu, 2025 Roundtable Transcript at 175:7:11 (stating that ''issuers continue to say that we pay to recruit, retain, motivate, incentivize, even though maybe we could just have a template, and everybody says check, and we could maybe spare everybody at least 10 pages of that''); Stanford 2015 Investor Survey, *supra* note 613, at 14 and 16 (in which investors indicated in open-ended responses that they seek additional information on, among other things, the ''link between the pay structure, where the company wants to go, and how it will get there,'' ''[h]ow the executive compensation is tied to long-term company strategy,'' and ''[m]ore narrative on how the company's governance is informed by its strategic goals'').

[788] *See* 2026 Filer Status Proposing Release.

[789] *See, e.g.,* Jieqiong Gao et al., *On the Informational Effectiveness of the Compensation Discussion and Analysis (CD&A): Evidence From Textual Features,* 41 J. Acct. Aud. Fin. 1281 (2026) at 1303 (finding, in Table 5, that registrant size, as measured by the log of total assets, is a statistically significant predictor of CD&A length and a measure of CD&A readability).

simplify the required topics such that the topics that would be deleted could be adequately covered (to the extent material) by the discussions of the topics that would continue to be required. That said, the magnitude of the costs to both registrants and investors will depend on how registrants exercise their increased discretion in revising the disclosures.

Registrants may bear some short-term costs to remove unnecessary CD&A content and to decide how to respond to the required topic that we are proposing to amend to relate the objectives of the compensation program to the registrant's corporate strategy, if they do not already fully address this matter in their current disclosures. Once a registrant decides how to address this revised topic, we expect material ongoing incremental costs of preparing and including disclosure responsive to this topic to be limited outside of years where the compensation program or corporate strategy changes markedly, as the disclosure is otherwise likely to be similar from year to year.

The potential costs to investors from the proposed amendments to the CD&A requirements depend on how registrants would use their expanded discretion in developing revised disclosures. To the extent that only boilerplate and repetitive information would be omitted, any costs to investors would be minimal, short-term, and limited to adjusting review processes to reflect more focused CD&As. If, instead, CD&A disclosures are revised to remove some information that is currently either directly considered by investors as a factor in their decisions or provides context that increases the efficiency or accuracy with which investors evaluate other executive compensation disclosures, then investors may bear additional costs to evaluate executive compensation in the absence of this information and their investment and voting decisions may be based on less complete information. Some of the CD&A content that investors have highlighted as particularly valuable include the overview of how senior executives are compensated and how boards make compensation decisions,[790] discussions about long-term incentive awards,[791] and voluntarily provided quantitative analyses (such as of realized or realizable pay).[792] We do not expect that the proposed amendments are likely to significantly change the provision of these disclosures.

One topic that many investors have expressed is important to them but which would be removed from the example topics suggested for CD&As is represented by the Item 402(b)(2)(vi) and (vii) examples regarding how specific forms of compensation are structured and implemented to reflect performance, as well as related Instruction 4 regarding the disclosure of target levels with respect to specific quantitative or qualitative performance-related factors.[793] As discussed in the Broad Economic Considerations section (section IV.B. above), performance metrics and the rigor of targets can affect investor expectations about executive and registrant performance. However, we understand that specific target levels are currently not disclosed in CD&As in many cases, based on concerns about potential competitive harm and in reliance on Instruction 4.[794] Where such targets are currently disclosed, we expect they would continue to be disclosed given investor expectations.

Another example topic that would no longer be enumerated, and that some investors have indicated is important to them, is the disclosure pursuant to Item 402(b)(2)(xiv) of any peer groups used in benchmarking executive compensation, including the specific component companies of such peer groups.[795] As discussed in the Broad Economic Considerations section (section IV.B. above), the labor market for executives plays a significant role in the appropriate level of pay and strength of incentives. Peer group disclosures provide insight into the labor market specific to the executive officers of a particular registrant.[796] However, there has long been skepticism of registrant peer selection,[797] and it is unclear whether disclosure of peer groups has helped to limit the risk that certain registrants could be included in a peer group in order to justify higher pay rather than to provide an unbiased measure of compensation in the most comparable external positions.[798] We expect that many of the investors that have access to third party analyses (or invest at a scale that justifies expending the resources to undertake their own analyses) will have alternate sources for understanding the executive labor market even if fewer registrants disclose the components of their peer groups under the proposed amendments.[799] That said, other investors, particularly retail investors and smaller institutional investors, may lose access to peer group information and thus have somewhat less context with which to evaluate the rest of the executive compensation disclosures.[800]

The potential costs for registrants and for investors associated with the

[790] *See, e.g.,* letters from AFL–CIO et al.; CFA Institute (specifying that ''[a] key driver that investors have sought from the CD&A is the added benefit of transparency about potential conflicts of interest''); Council of Institutional Investors.

[791] *See, e.g.,* Stanford 2015 Investor Survey, *supra* note 613, at 8 (in which ''the CD&A discussion of long-term incentives or equity awards'' was among the top three responses to the question, ''[w]hat three sections of a company's proxy are you most likely to look at first?'').

[792] *See, e.g.,* Hambly, 2025 Roundtable Transcript at 172:16–173.

[793] *See, e.g.,* letters from AFREF; Baillie Gifford; CFA Institute; Council of Institutional Investors; Erste; LACERA; NEI; State Board Florida; *see also* Stanford 2015 Investor Survey, *supra* note 613 (presenting survey results indicating that sections discussing ''pay for performance alignment'' and ''performance metrics'' are two of the top three cited sections both when the surveyed investors are asked which sections of the proxy they read and rely on to make voting decisions and when they are asked a similar question about their investment decisions).

[794] *See, e.g.,* Margaret Engel et al., Compensation Advisory Partners, *Current State of Forward Goal Disclosure in Long-Term Incentive Plans,* (Apr. 16, 2025), available at *https://www.capartners.com/cap-thinking/current-state-of-forward-goal-disclosure-in-long-term-incentive-plans/* (stating that, in a review of the proxy statements of the 100 largest U.S. publicly-traded companies, based on revenues, they found that ''only 30% of companies with absolute performance metrics in the long-term incentive plan disclose forward-looking goals''); letter from Cravath (stating that ''it has become commonplace for issuers to withhold disclosure of performance-related measures at the outset of any award and to disclose them only for the time period when the award is earned'').

[795] *See, e.g.,* letters from Baillie Gifford; LACERA; NEI.

[796] *See, e.g.,* Ray Rui Gao & Yifei Lu, *Aggregated Compensation Peer Group Disclosure and Managerial Labor Market Competition: A Network Analysis,* 64 J. Acct. Res. 831 (2026).

[797] *See, e.g.,* Michael Faulkender & Jun Yang, *Inside the Black Box: The Role and Composition of Compensation Peer Groups,* 96 J. Fin. Econ. 257 (2010).

[798] *See, e.g.,* Michael Faulkender and Jun Yang, *Is Disclosure an Effective Cleansing Mechanism? The Dynamics of Compensation Peer Benchmarking,* 26 Rev. Fin. Stud. 806 (2013).

[799] For example, proxy advisory services generally identify and present their own peer groups to allow their clients to evaluate compensation in the context of the labor market. While we understand that these firms use a registrant's self-selected compensation peer group as an input in developing their own peer groups, we expect that they could develop a reasonable peer group (though it may differ materially from a registrant-identified peer group) even in the absence of this information. *See* Institutional Shareholder Services, *Peer Group Selection Methodology and Issuer Submission Process: Frequently Asked Questions,* (Dec. 9, 2025), available at *https://www.issgovernance.com/file/policy/active/americas/US-Peer-Group-FAQ.pdf;* Glass Lewis Pay-for-Performance Methodology, supra note 660, at 6. Investors may also be able to identify reasonable peer registrants by considering registrants that have similar characteristics, such as a comparable market capitalization and related industry, to that of the registrant in question.

[800] As technology improves, it is possible that lower-cost information sources about peer groups may be available to more investors. For example, research has demonstrated that generative AI tools can be used to identify product-market peers (though these are not the same as compensation peers). *See* Yi Cao et al., *Can Generative AI Help Identify Peer Firms?,* 30 Rev. Acct. Stud. 3344 (2025).

proposed revisions to CD&A requirements are expected to vary based on the characteristics of registrants. Specifically, SRCs and EGCs are not subject to CD&A disclosure requirements, so they (and their investors) are not expected to be impacted by these costs. For other registrants, the costs would depend on how they react to the proposed amendments. The greatest costs are likely to be associated with those registrants that respond to the increased flexibility by making significant changes to their CD&A disclosures, which would involve greater short-term adjustment costs for both registrants and investors and which could, depending on what type of disclosure is removed in these revisions, result in reduced information being available to investors. It is possible that the increased flexibility to no longer make certain disclosures could be disproportionately exercised by registrants whose pay practices may be viewed less favorably by the market. Any such effect could reduce the informativeness of CD&A disclosures as a result of the proposed amendments, irrespective of the intent of the changes made by registrants to their disclosures.

If the amendments proposed in the 2026 Filer Status Proposing Release are adopted, a more limited subset of registrants would be subject to CD&A disclosure requirements, thus limiting the scope of any costs of the proposed amendments with respect to these disclosures.

3. Reasonable Alternatives

As an alternative to the proposed amendments to CD&A requirements, we could amend the rule to replace all of the current required topics and example topics with a fully principles-based requirement that registrants discuss any material information necessary to an understanding of the registrant's compensation policies and decisions regarding the NEOs. This approach would maximize flexibility to registrants and could result in even more focused, tailored disclosure. However, this approach could be more burdensome for registrants, who may need to spend a significant additional amount of time determining the scope of information to disclose in the absence of any required items for the disclosure. This approach could also lead to over disclosure (reducing the size of any potential reductions in disclosure volume and compliance cost savings), if, in the absence of guidance, registrants produce excess disclosures in order to reduce the risk of missing any potentially material topics. The resulting disclosures could also be less efficient for investors to process, if different registrants interpret the scope of the CD&A very differently.

We could, alternatively, retain a select number of example topics from the current rule (with the same or revised language) targeted at more consistently retaining disclosures in which investors have shown the greatest interest. However, such an approach would reduce registrant flexibility and increase the risk of boilerplate disclosures and could reduce the extent to which CD&As are shortened and streamlined to focus on material information.

G. Pay-Versus-Performance Disclosure Requirements

A subset of the registrants required to provide the primary tabular compensation disclosures [801] are also required to provide pay-versus-performance disclosures presenting five years of Compensation Actually Paid,[802] total compensation from the Summary Compensation Table, and the annual outcomes of four performance measures (namely, the TSR of the registrant, TSR of a peer group, net income, and a Company-Selected Measure) in a prescribed tabular format. The tabular disclosure must include the two compensation measures for both the PEO and, collectively on an average basis, the non-PEO NEOs, and is required to be accompanied by detailed footnotes demonstrating how Compensation Actually Paid was derived from total compensation from the Summary Compensation Table and providing (or cross-referencing) equity valuation assumptions. Under a principles-based requirement, the registrants subject to pay-versus-performance disclosure requirements are also currently required to describe the relationship between Compensation Actually Paid (for the PEO and, collectively on an average basis, the other NEOs) and each of the three registrant performance measures in the tabular disclosures (where the description of the relationship with the TSR of the registrant must include a comparison of the registrant's TSR to the reported peer group TSR). The pay-versus-performance disclosures are also required to include a table listing the names of the three to seven ''most important'' financial performance measures that are used to link Compensation Actually Paid to performance (the Tabular List). SRCs are subject to a scaled version of these requirements with three years of disclosures, fewer quantified performance measures, no peer group disclosure, no Tabular List, and the exclusion of amounts associated with pension plans in the computation of Compensation Actually Paid.[803]

These requirements are proposed to be amended to reflect a more simplified requirement to relate the PEO's and PFO's total compensation from the Earned Compensation Table to registrant TSR over the past three years, with no prescriptive tabular elements or mandated formats.

1. Benefits

The proposed amendments to the pay-versus-performance requirements are expected to reduce compliance costs, provide registrants with greater flexibility in their disclosures of how their executive compensation relates to performance, and simplify compensation disclosures.

The greatest compliance costs savings from these amendments are expected to result from the elimination of the disclosure of the Compensation Actually Paid measure. As discussed previously in section IV.E, this computation is often quite complex and has been associated with significant burdens, though these computational costs may have decreased since the initial years of disclosure.[804]

The proposed amendments to the pay-versus-performance disclosure requirements are also expected to reduce costs by reducing the volume of disclosure that must be prepared and reviewed by registrant staff, directors, and external advisors such as legal counsel and compensation consultants. The current pay-versus-performance disclosures require two tables and very extensive footnotes reconciling computations and providing valuation assumptions, all of which would no longer be required. Based on staff experience, eliminating these footnotes alone would typically reduce pay-versus-performance disclosure by a full page. Replacing the disclosure comparing two compensation measures to each of three performance measures, as well as a comparison of TSR to peer

[801] Among the registrants subject to the primary tabular disclosure requirements, those that are not EGCs or do not disseminate a proxy or information statement in a given year (such as certain section 12(g) registrants and, in general, section 15(d) registrants which are not also section 12 registrants) are required to make pay-versus-performance disclosures. *See supra* section II.E.

[802] As discussed in section IV.E above, the current rule defines Compensation Actually Paid in a given year based on a computation that is intended to quantify how the value of an executive's total compensation package changed that year, including changes in the value of outstanding equity awards.

[803] *See* 17 CFR 229.402(v)(8).

[804] *See supra* notes 733 and 734 and associated text.

TSR—that is, a narrative or graphical description of seven total relationships—with a description of two relationships (namely, for each of the PEO and PFO, between the executive officer's total earned compensation and the registrant's TSR) should also significantly reduce the volume of disclosure that must be produced.

While the current requirements have principles-based elements, they are also quite prescriptive. By reducing the prescribed elements of the current requirements, such as by eliminating the required tables and the required inclusion of multiple compensation and performance measures, the proposed amendments provide registrants with greater flexibility to tailor their disclosure to more effectively communicate how their executive compensation relates to their performance. Under the proposal, some registrants may voluntarily continue to include performance measures other than TSR in the pay-versus-performance disclosure or to provide voluntary supplemental disclosures with other compensation measures (such as Compensation Actually Paid or realizable pay), while others may produce simpler disclosures.

The simplification of the pay-versus-performance requirements and associated reduction in disclosure volume may benefit some investors, such as retail investors, who may read disclosures linearly. Given that some of the currently prescribed disclosures (such as narratives comparing compensation to net income regardless of whether a registrant is profitable or ties compensation to any measures of profitability) may not be particularly relevant for a given registrant, removing some of this disclosure may also reduce the likelihood that less sophisticated investors are confused by some of the disclosure.

The proposed pay-versus-performance disclosures would provide somewhat different information than current disclosures, because of their focus on *ex post* rather than in flight compensation values. The inputs into such an analysis are relatively easier to construct from other executive compensation disclosures because more complete information is available under the current rule (and would become even more readily available under the proposal) for equity awards that have vested or been exercised than for those that are still in flight. The proposed pay-versus-performance disclosures are therefore not anticipated to provide significant additional information beyond the other proposed disclosures, but, if registrants use their flexibility to present this information effectively, it may help investors to more easily evaluate whether ultimate pay outcomes align with registrant performance than would be possible otherwise.

As discussed above, the benefits of the proposed amendments to pay-versus-performance disclosures are likely to vary across investors of different types, with investors that read executive compensation linearly benefiting the most from any simplification of the disclosures. The benefits of the proposed amendments are also expected to vary across registrants. EGCs and certain other registrants (such as section 15(d) registrants)[805] are not currently subject to these requirements and thus would not be affected by the proposed changes. Among other registrants, those with the most complex equity compensation structures (particularly those that use option compensation and that have frequent vesting, such as monthly vesting schedules) likely incur the greatest burdens in computing Compensation Actually Paid currently and are thus likely to experience the greatest compliance cost savings as a result of the proposed amendments to the pay-versus-performance requirements. Registrants that voluntarily continue to disclose Compensation Actually Paid or similar measures or that voluntarily continue to include and explain multiple performance measures in their pay-versus-performance disclosures may experience lower compliance cost savings than other registrants.

The proposed narrowing of the scope of NEOs would also directly reduce the number of computations required to produce the current pay-versus-performance disclosures and simplify the required descriptions of relationships between pay and performance. Under the proposed definition of NEO, the current pay-versus-performance requirements would no longer require computing Compensation Actually Paid for multiple non-PEO NEOs and then taking the average, as the only non-PEO NEO would be the PFO. The relationship of the Compensation Actually Paid of the PFO with the registrant performance measures may be easier to describe than that of the average Compensation Actually Paid across multiple NEOs, given that the latter would reflect changes in the composition of the NEOs over time as well as factors such as registrant performance. Thus, when considered in combination with the proposed amendment to the definition of NEO, the incremental compliance cost savings and degree of disclosure simplification expected to result from the proposed amendments to the pay-versus-performance requirements would be lower than when considered independently.

If the amendments in the 2026 Filer Status Proposing Release are adopted as proposed, a much smaller group of registrants (*i.e.,* LAFs, to the extent they disseminate proxy or information statements) would be subject to pay-versus-performance disclosure requirements, which would reduce the incremental benefits of the proposed amendments to these requirements relative to what they would be with the current filer status framework in place.

2. Costs

The proposed amendments to the pay-versus-performance requirements may make it somewhat more difficult for investors to evaluate the sensitivity of executive compensation to registrant performance, which may result in increased analytical costs for some investors (either directly or through third parties) and increased noise in investment and voting decisions. Registrants may also bear some short-term adjustment costs to determine how to present the disclosure given the proposed flexibility in format and change in content of the pay-versus-performance disclosures.

The elimination of the disclosure of the Compensation Actually Paid measure would represent a loss of some information, and particularly of readily available analysis, for investors. As discussed above in section IV.E, this computation provides insight into how the value of an executive's overall compensation package changes from year to year (including for awards that are ''in flight''), allowing investors to relate registrant performance with concurrent changes in the value of compensation.[806] While investors and

[805] Pay-versus-performance disclosure is only required in proxy or information statements that involve Item 8 of Schedule 14A (the item that requires all Item 402 disclosure). Thus, this disclosure is not required of, for example, section 15(d) registrants or for those with securities registered under section 12(g) of the Exchange Act that do not disseminate a proxy or information statement in a given year. *See supra* section IV.C.2.

[806] In contrast, the proposed Earned Compensation Table would include the value of stock awards at vesting and option awards at exercise. These values are generally affected by registrant performance over the full period from the grant date until vesting (or exercise). Given the typical time to total vesting of three years for stock awards and typical expiration date of ten years for option awards, the total compensation in the Earned Compensation Table for a given fiscal year may often reflect registrant performance over the

Continued

third parties can construct estimates of Compensation Actually Paid or similar ''realizable pay'' measures based on other disclosed information, these estimates would lack the precision of registrant-constructed measures,[807] and may result in duplicative analytical effort by multiple parties. Investors with fewer resources to allocate towards evaluating executive compensation disclosures may lose access to any such measure. These factors may reduce the accuracy of investors' understanding of the sensitivity of executive compensation to performance and, at times, may lead some investors to make different investment or voting decisions than they would with more precise information.[808] To the extent that some registrants voluntarily continue to disclose Compensation Actually Paid, realizable pay, or similar measures, these effects on the precision with which investors evaluate executive compensation may be mitigated at such registrants.

The proposed elimination of prescribed tabular disclosures for the purpose of pay-versus-performance disclosure may make it harder for investors to extract the underlying information for the purpose of comparative analysis. This cost may be mitigated by the proposed simplification of the disclosures, in that there is less such information that could be extracted and such information (such as registrant TSR) can be collected from other readily available sources.

Much of the other information that would no longer be required in the proposed pay-versus-performance disclosures may be of only minor consequence. For example, some of this information, such as the values of net income and peer cumulative TSR or the list of company-selected additional financial performance metrics, would generally remain available in other registrant disclosures or other readily available sources.[809] Other information that may no longer be reported may be irrelevant, such as narratives comparing compensation actually paid to net income at registrants that are not profitable and do not link compensation to net income. That said, removing this information from pay-versus-performance disclosures could, in some cases, increase the time that investors spend referring to other disclosures or other sources in order to interpret the pay-versus-performance disclosure, or could lead some investors to overlook important context about the broader performance or pay-for-performance programs of a registrant when evaluating the pay-versus-performance disclosure.[810]

Registrants required to provide pay-versus-performance disclosure may bear some short term adjustment costs to transition to the proposed amendments. While the proposed requirements would be substantially more limited than current requirements, they would retain the same flexibility in presentation format for the description of the relationship between pay and performance as the current requirements. Registrants may initially need to reconsider the best way to present the pay-versus-performance disclosure given the proposed shift in focus of these disclosures from Compensation Actually Paid to a measure of realized pay (Total Compensation Earned from the Earned Compensation Table) and the different nature of the relationship of each of these pay measures with registrant TSR.

The costs of the proposed amendments to the pay-versus-performance disclosure requirements are expected to vary across investors. As discussed above, investors who do not have access to third party analyses, have fewer analytical resources, or are less adept at interpreting current disclosures on their own may be the most likely to have a less precise understanding of how pay relates to performance under the proposal than under the current requirements. In contrast, investors who do have access to third party analyses or who undertake their own detailed analyses of executive compensation disclosures are the most likely to bear increased analytical burdens as a result of the proposal.

The costs of the proposed amendments to the pay-versus-performance requirements are also expected to vary across registrants. EGCs and certain other registrants (such as section 15(d) registrants)[811] are not currently subject to the pay-versus-performance requirements, so investors would not bear costs with respect to these registrants (and these registrants would bear no transition costs). Among other registrants, the information in current pay-versus-performance disclosures would be the hardest to replicate by investors or third parties for the registrants with the most complex equity compensation structures or those that would not disclose specific performance targets and thresholds in performance or market conditions applied to their awards under the proposal. The proposed amendments would thereby be the most likely to result in increased analytical burdens for investors and increased imprecision in the understanding of how NEO pay relates to performance at these registrants.

The proposed narrowing of the scope of NEOs would also directly affect the scope of the current pay-versus-performance disclosures. However, given the significant investor focus on PEO compensation and the difficulties in interpreting the average compensation actually paid to a group of NEOs, we do not expect the incremental costs of the proposed amendments to the pay-versus-performance requirements to be significantly different when considered in combination with the proposed definition of NEO than when considered independently.

Should the amendments in the 2026 Filer Status Proposing Release be adopted as proposed, the incremental costs associated with the proposed amendments to the pay-versus-performance requirements would be

previous three years (considering only stock awards) or up to ten years (when also considering option awards). *See supra* section IV.C.4.

[807] *See supra* notes 715–717 and associated text.

[808] *See supra* note 753.

[809] Specifically, net income is disclosed in registrant financial statements and a measure of peer TSR can be constructed for an alternate peer group using readily available market data, while the names of financial performance metrics used to link Compensation Actually Paid with registrant performance would typically be included in executive compensation disclosures about performance and/or market conditions applicable to equity incentive awards under the proposed amendments. Performance metrics used only to determine the outcome of non-equity incentive awards or only to determine the amount of a discretionary bonus but that are not referenced in supplemental disclosures to the proposed principal tabular disclosures or discussed under the proposed CD&A requirements (in response to the requirement to discuss the ''material elements of compensation and how those amounts are determined'') may no longer be listed elsewhere in disclosures, but in such cases are not expected to be material.

[810] For example, relying solely on TSR to evaluate registrant and executive performance could provide an incomplete picture of such performance in certain situations, such as when expected outperformance is already reflected in the starting stock price, when a stock is thinly traded, when market dynamics cause stock returns to become particularly disconnected from fundamental performance, or when executive performance is best measured by other financial performance metrics. The current required disclosure of TSR of a peer group and of additional financial performance measures (both quantitatively and in the Tabular List) may help to address these concerns by providing additional context and broadening the picture of registrant performance and pay-for-performance programs presented in the disclosure. Under the proposal, registrants will retain the flexibility to include any additional measures or context that they feel necessary to clearly describe the relationship of their executive compensation with registrant performance. However, they may be less likely to provide such context when it highlights a potential disconnect of pay with performance than when it supports a strong relationship between pay and performance.

[811] *See supra* note 805.

reduced. In that scenario, the pay-versus-performance requirements, and thus the effects of any changes to these requirements, would be limited to LAFs that disseminate proxy or information statements, a smaller group of registrants than the group subject to these requirements under the baseline.

3. Reasonable Alternatives

As an alternative to the proposed amendments, we could retain the disclosure of Compensation Actually Paid and use this measure rather than total compensation from the Earned Compensation Table in the pay-versus-performance requirements, while eliminating the prescriptive tables, footnotes, and other compensation and performance measures included in the current disclosures. This approach may provide investors with clearer and more timely insights into how executive compensation varies with registrant performance. However, given that the construction of the Compensation Actually Paid measure represents a large share of the burdens of the current requirements, this approach would provide very limited compliance cost savings for registrants relative to the baseline.

Another alternative would be to propose a more fully principles-based pay-versus-performance disclosure requirement, under which registrants would be required to provide a clear description of the relationship between executive compensation and registrant performance, without specific measures of compensation and performance being prescribed for this purpose. Such an approach would increase the flexibility of registrants to tailor the disclosure to their specific compensation structures, but may make it more difficult for investors to evaluate the disclosures by increasing the variation in the nature and content of the disclosures across registrants.

We also considered using our exemptive authority to eliminate pay-versus-performance disclosure requirements in the context of the PFO's compensation. Limiting the pay-versus-performance disclosure to the PEO would further reduce compliance costs while continuing to provide the disclosure for the executive officer whose pay is most scrutinized by investors.[812] However, given the simplified pay-versus-performance requirements under the proposed amendments, the incremental costs of providing this disclosure are expected to be modest, and investors may benefit from disclosures highlighting how the PFO's eventual pay outcomes have aligned with registrant performance, both to better understand the PFO's compensation structure and to understand how the alignment of such pay outcomes with performance may differ for other senior executives as compared to the PEO.

H. Pay Ratio Disclosure Requirements

Each registrant subject to the pay ratio disclosure requirements currently must disclose, each year, the ratio between the annual compensation of its PEO and that of its median employee identified in accordance with the rule. This pay ratio must be computed using total compensation based on all elements included in such total in the Summary Compensation Table. The median employee is to be identified based on the distribution of compensation across all of the registrant's full- and part-time, seasonal, and temporary U.S. and non-U.S. employees. A data privacy exemption permits registrants to exclude any individual employed in a foreign jurisdiction in which the data privacy laws or regulations are such that the registrant is unable to obtain or process the required information without violating those laws or regulations. A *de minimis* exception is also available in that registrants whose non-U.S. employees represent five percent or less of their total U.S. and non-U.S. employees may exclude those employees from the computation. This disclosure is not required of SRCs or EGCs, but is required of all other registrants that must make Item 402 disclosures.[813]

The proposed amendments would simplify the computation of this ratio by limiting the population used to identify the median employee to full-time, U.S.-based employees, excluding seasonal and temporary employees, and changing the definition of total compensation used in the ratio to that reflecting the total from the proposed Granted Compensation Table (which contains fewer elements than the Summary Compensation Table). Under the proposed amendments, registrants would be required to determine the median employee once every five years (as compared to three years under the baseline). The proposed amendments would also remove certain requirements to make disclosures about the selection process for the median employee (such as requirements to disclose the compensation measure used and the date chosen for identifying the median employee).[814]

1. Benefits

Limiting the population from which the median employee is drawn to full-time, U.S.-based employees, excluding seasonal and temporary employees, is expected to significantly reduce the costs of preparing pay ratio disclosures relative to the compliance costs of producing these disclosures under the current rule.[815]

In particular, excluding non-U.S. based employees from this computation would eliminate the need to, for example, test whether the *de minimis* exemption applies, make foreign exchange computations, integrate data from the potentially different payroll systems often used to track compensation for employees in disparate foreign locations, and comply with the potentially complex requirements of local data privacy laws when integrating such data.[816] Commenters have highlighted the inclusion of employees in foreign jurisdictions in the determination of the median employee as a source of significant compliance costs.[817] For example, when the pay ratio rule was first proposed, commenters submitted

[812] *See supra* section IV.D.

[813] These registrants include all section 12 and section 15(d) registrants that are not registered investment companies, FPIs, either asset-backed securities issuers or externally-managed BDCs which do not have executive officers, and, for purposes of Form 10–K, certain wholly-owned subsidiaries of a reporting company. *See supra* section IV.C.2.

[814] The proposed amendments would also simplify and streamline the instructions and requirements in the rule text regarding the identification of the median employee, including in relation to the use of estimates, but we do not expect this revision to have meaningful economic effects because the change in text is not intended to change the flexibilities afforded to registrants in this process. *See supra* section II.I.3.

[815] At the time of adoption, the Commission estimated the ongoing cost of producing pay ratio disclosures each year after the initial year of disclosure to be about 40% of the estimated $368,159 in average first year compliance costs per registrant, or, on average, about $147,264 each year for each affected registrant. The ongoing cost for a registrant with foreign operations was estimated to be about 1.9 times the cost for an average affected registrant. These estimates reflected the Commission's consideration of comments, including reports of survey data, regarding the expected costs of compliance. *See* 2015 Pay Ratio Adopting Release. We are not aware of more recent estimates of the cost of these disclosures.

[816] The costs savings from these sources may be more limited for registrants who currently rely on the data privacy exemption or *de minimis* exemption to exclude some or all non-U.S. employees from their current computations.

[817] *See, e.g.,* letters from Axcelis; Business Roundtable; Compensia; Meridian; *see also* 2015 Pay Ratio Adopting Release at 50158 (stating that ''[s]ome commenters indicated that the most important driver for the compliance costs of the required disclosure is the presence of foreign operations and the complexity of dealing with, or the need to create compatible employee data and payroll systems that track the compensation of employees of such foreign operations'').

the results of a survey of registrants that indicated that requiring only U.S. employees to be used when estimating the pay ratio would decrease the costs of the disclosure on average by 40 percent.[818]

Excluding part-time, seasonal, or temporary employees from the computation of the pay ratio is expected to provide additional cost savings by reducing the number of employees whose compensation data must be integrated to identify the median employee. Such a change could also reduce the likelihood that registrants feel the need to provide supplementary narrative disclosures explaining that their pay ratio may be skewed due to the inclusion of employee compensation that is not on a full-time basis.[819] The survey results submitted to the comment file when the pay ratio rule was first proposed indicated that requiring only full-time employees, excluding seasonal and temporary employees, to be used when estimating the pay ratio would decrease the costs of the disclosure on average by 11 percent.[820] These savings are smaller in magnitude than those associated with excluding foreign workers, and the two estimates should not be treated as fully additive given potential overlap in the underlying cost drivers.

Because wages outside of the U.S. and unadjusted part-time, temporary, and seasonal pay are likely to be lower on average than full-time, annual U.S.-based wages, excluding these employees from the median calculation is likely to raise the reported median employee wage for registrants with such employees, thereby lowering the reported pay ratio. To the extent that the inclusion of part-time, temporary, seasonal, and non-U.S. employees—without time-equivalent or purchasing-power-parity[821] adjustments—currently inflates reported ratios, the revised computation may produce a ratio that more accurately represents the compensation structure of a registrant's domestic full-time workforce. Research indicates that higher reported pay ratios can be associated with less favorable investor,[822] employee,[823] and public[824] perceptions. If the current ratio overstates a registrant's pay disparity, correcting this may reduce perceptions that are not warranted by the registrant's actual compensation practices.

Requiring that the median employee be determined once every five years instead of once every three years should further reduce the compliance costs borne by registrants to produce pay ratio disclosure. In particular, identifying the median employee may be the most burdensome aspect of producing the disclosure given the large compensation datasets and the various processing steps that may be required. Reducing the frequency of this process should therefore reduce compliance costs.

With regard to benefits to investors, to the extent the proposed amendments reduce registrant costs, these savings may ultimately benefit the shareholders of the affected registrants. Investors may also benefit from more comparable pay ratio disclosures under the proposal. Registrants take varying approaches to foreign operations and fluctuating labor needs, with some outsourcing these labor needs to other entities while others directly employ non-U.S. and/or part-time, seasonal, or temporary workers. Some may employ such part-time, seasonal, or temporary workers at consolidated subsidiaries while others do so through unconsolidated subsidiaries (whose employees are not included in pay ratio computations). These differences in approaches to fulfilling similar labor needs can lead to variation in pay ratios that does not reflect true differences in underlying labor costs. Further, because the current rule does not permit the compensation of a part-time employee to be converted to a full-time equivalent or seasonal or temporary worker pay to be annualized, including their pay in comparison to the full-time, annual compensation of a PEO can artificially inflate pay ratios.[825]

Amending the definition of total compensation to be used in the ratio to reflect the definition used in the proposed Granted Compensation Table could result in further cost savings for some registrants. In particular, to the extent that a registrant's median employee receives benefits or miscellaneous compensation that would otherwise be included in a total compensation measure based on the Summary Compensation Table (but not in a measure based on the proposed Granted Compensation Table)—such as participation in a registrant pension plan or registrant contributions to a defined contribution plan—the registrant's computation of the median employee's total compensation may be simplified under the proposed amendments because these components would not be required to be included under the proposal.

Eliminating requirements to make supplementary disclosures related to the selection process for the median employee may lead to additional cost savings by reducing the volume of necessary disclosure that must be prepared, reviewed, and included in registrants' filings. Relative to the expected savings from excluding non-U.S. based employees and part-time, temporary, and seasonal workers from the computations, these savings are expected to be more marginal.

The benefits of the proposed revisions to the pay ratio disclosure requirements are expected to vary across registrants. Because EGCs and SRCs are exempt from the pay ratio disclosure requirements, they would not experience any incremental benefits. For other registrants required to provide Item 402 disclosures, those expected to benefit the most from the proposed revisions are the registrants with significant foreign operations, particularly those with employees in a large number of different countries or whose employees are otherwise tracked in many separate payroll systems. Registrants in industries that are more likely to employ part-time, temporary, or seasonal workers, such as retail or agricultural industries, are also likely to experience greater savings (and potential positive reputational effects from lower reported pay ratios) than other registrants. Finally, those with broad-based retirement plans or other employee benefits that are included in the Summary Compensation Table definition of total compensation but omitted from the proposed Granted Compensation Table may benefit from simpler computations of median employee compensation.[826]

[818] *See* 2015 Pay Ratio Adopting Release at 50158.

[819] For example, registrants may provide a supplementary ratio that reflects full-time equivalent adjustments to the pay of part-time workers, given that Instruction 5 to Item 402(u) prohibits full-time equivalent adjustments for any employee in the required pay ratio disclosure. A study of the initial pay ratio disclosures found that 14% of registrants reported a supplementary ratio, though these may have been included for a range of reasons. *See* Sun-Moon Jung et al., *Why Do Firms Utilize the Flexibility Allowed in CEO-Employee Pay Ratio Disclosure? Evidence from Dodd-Frank Act Section 953 (b),* 35 Acct. Horiz. 83 (2021).

[820] *See* 2015 Pay Ratio Adopting Release at 50158.

[821] Purchasing power parity is a measure of the relative buying power of different currencies based on the price of the same basket of goods in different countries.

[822] *See* Yihui Pan et al., *Do Equity Markets Care about Income Inequality? Evidence from Pay Ratio Disclosure,* 77 J. Fin. 1371 (2022) (''Pan et al. 2022 Study'').

[823] *See* Audra Boone et al., *The Saliency of the CEO Pay Ratio,* 28 Rev. Fin. 1059 (2024).

[824] *See* Wonjae Chang et al., *Does Sensationalism Affect Executive Compensation? Evidence from Pay Ratio Disclosure Reform,* 61 J. Acct. Res. 187 (2023).

[825] *See* R. Pozen and K. Qadeer, *The Fix for Misleading 'CEO Pay Ratios,'* Wall. St. J. (Mar. 19, 2018), available at *https://www.wsj.com/articles/the-fix-for-misleading-ceo-pay-ratios-1521497476.*

[826] These registrants could, however, end up disclosing higher pay ratios under the proposed rules because retirement or other benefits may represent a larger share of total compensation for

In addition, if the amendments proposed in the 2026 Filer Status Proposing Release are adopted, a much smaller group of registrants would be subject to pay ratio disclosure requirements, which would reduce the overall incremental benefits of the proposed amendments to these requirements. However, we note that the large registrants that would continue to be subject to pay ratio disclosure requirements are the most likely to be multinational, with employees in a large number of countries, and may thus individually benefit the most from the proposed amendments.

2. Costs

The proposed amendments to the pay ratio disclosure requirements are expected to reduce the amount of underlying information summarized in registrant pay ratios. However, given our understanding of how these ratios are currently used, as discussed below, we do not expect significant adverse effects on investors' ability to use and interpret pay ratios relative to the baseline.

While there is some indication that pay ratios are not relied on by investors to the same extent as many other executive compensation disclosures,[827] researchers have found evidence that at least some investors seem to consider pay ratio information when making voting[828] and investment[829] decisions. Investors have expressed that pay ratio disclosures can provide information relevant to understanding a registrant's human capital management and associated risks.[830]

For these uses, we expect a pay ratio limited to U.S., full-time employees, excluding seasonal and temporary employees, to suffice for most investors. In fact, as discussed in the context of benefits above, this proposed revision could make the ratio more easily interpretable. That said, the exclusion of part-time, seasonal, and temporary workers, as well as the use of a less comprehensive compensation measure in the ratio, may add new sources of imprecision into the ratios, in that the proposed ratios would reflect less complete information than current ratios. Requiring that the median employee be determined once every five years instead of once every three years (and eliminating the instruction explicitly requiring registrants to update the median employee sooner under certain circumstances)[831] may introduce a further source of imprecision into the ratio, by increasing the likelihood that the median employee reflected in the disclosure is an outdated reflection of the registrant's current workforce. However, pay ratios already reflect a number of factors that complicate cross-registrant comparisons, such as differences in industry and business type; in the degree of vertical integration; in the reliance on contract and outsourced workers; and in corporate structure with respect to ownership and consolidation.[832] We therefore do not expect the incremental imprecision that could result from simplifying the ratio to be significant relative to the baseline level of imprecision in the ratio due to existing factors.

The proposed amendments would also remove certain requirements to make disclosures about the selection process for the median employee. There is evidence that some registrants may use their discretion in how the median employee is identified to lower their reported pay ratios.[833] The proposed amendments could make it more difficult for investors to identify such behavior, complicating investors' interpretation of the disclosures. However, at least some of the elements of discretion, included in both the current and proposed rule, such as the choice of a date for identifying the median employee, may be less consequential in the context of the proposed amendments, where, for example, temporary and seasonal employees are excluded. Further, as discussed above, the structural imprecision inherent in pay ratio disclosures (arising from workforce composition and other factors) means that any additional variation caused by the application of this discretion may not significantly affect investors' ability to interpret pay ratios.

While we expect limited costs of the proposed revisions to pay ratio disclosures, the potential costs are expected to vary across investors depending on how they use pay ratio disclosures and will vary across registrants based on their characteristics. Specifically, SRC and EGCs are not subject to pay ratio disclosure requirements and thus they and their investors bear none of these incremental costs. The greatest costs may be associated with registrants in any industries with significant reliance on part-time, seasonal, or temporary workers, or with registrants with variation in employee compensation structure among otherwise similar registrants, which could make it more

the median employee than for the PEO, such that removing them from the compensation measure increases the ratio of PEO to median employee compensation.

[827] *See, e.g.,* letters from Farient-1 (stating that ''we rarely see this measure questioned, used, or referenced by proxy advisors or investors''); NAM–1 (stating that pay ratio disclosures ''are not relevant or used by most investors (aside for a handful of labor activists) in their proxy voting decisions''); Society for Corporate Governance (reporting based on a survey of their members that ''nearly 80% of the respondents had never been asked about their pay ratio disclosure in shareholder engagement meetings in the past three years''); *see also* Institutional Shareholder Services, *U.S. Executive Compensation Policies FAQ* (Dec. 9, 2025), available at *https://www.issgovernance.com/file/policy/latest/americas/US-Executive-Compensation-Policies-FAQ.pdf,* at 25 (stating that ''[t]he CEO pay ratio . . . does not affect [ISS's] say-on-pay or director vote recommendations''); Glass Lewis, *2026 Benchmark Policy Guidelines—United States* (Dec. 2025), available at *https://resources.glasslewis.com/hubfs/2026%20Guidelines/Benchmark/Benchmark%20Policy%20Guidelines%202026%20-%20United%20States.pdf,* at 64 (stating that ''[w]hile the pay ratio has the potential to provide additional insight when assessing a company's pay practices, at this time it is not a determinative factor in the Benchmark Policy's voting recommendations'').

[828] *See* Steven Crawford et al., *Mind the Gap: CEO–Employee Pay Ratios and Shareholder Say-on-Pay Votes,* 48 J. Bus. Fin. Acct. 308 (2021) (finding that, in the first year of pay ratio disclosure in the U.S., and among registrants in the S&P 1500, the rate of votes against say-on-pay resolutions is significantly higher for registrants disclosing pay ratios in the top decile).

[829] *See* Pan et al. 2022 Study, *supra* note 822 (finding that firms disclosing higher pay ratios experience significantly lower abnormal announcement returns to the first-time disclosure of pay ratios in the U.S., and that during the year of such disclosure, relative to other investors, inequality-averse investors rebalanced their portfolios away from stocks with high pay ratios).

[830] *See, e.g.,* letters from AFREF; AFL–CIO et al.; CFA Institute; Public Citizen; *see also* Hambly, 2025 Roundtable Transcript at 186:14–187:4 (stating that the pay ratio disclosures are ''driving some really interesting engagements'' with registrants about ''that bottom 50% of the people that work for them,'' and explaining that they are interested in the pay of these workers ''because when I go into a business, I'm probably interacting with a lower wage worker, and if we're going to drive value over time, those—that's the face of your companies'').

[831] Current Instruction 2 to 17 CFR 229.402(u) specifies that a registrant is required to identify its median employee only once every three years ''*provided that,* during a registrant's last completed fiscal year there has been no change in its employee population or employee compensation arrangements that it reasonably believes would result in a significant change to its pay ratio disclosure.''

[832] *See* 2015 Pay Ratio Adopting Release at 50132.

[833] *See, e.g.,* Zinat Alam et al., *Discretion in Pay Ratio Estimation,* 173 J. Bank. Fin. 107416 (2025) (finding that, after controlling for factors that could explain the complexity of a registrant's estimation approach to pay ratio disclosure, the use of more complex approaches is associated with producing lower pay ratios, particularly for registrants headquartered in states where aversion to income inequality is expected to be greater or when their executive compensation has recently drawn shareholder attention).

difficult for investors to identify outliers based on the revised disclosures. If the amendments proposed in the 2026 Filer Status Proposing Release are adopted, a more limited subset of registrants would be subject to pay ratio disclosure requirements, thus limiting the scope of any costs of the proposed amendments.

3. Reasonable Alternatives

As an alternative to limiting the population used to identify the median employee to full-time, U.S.-based employees, excluding seasonal and temporary employees, we could limit the population to all U.S.-based employees regardless of employment status (*i.e.,* including part-time, seasonal, or temporary workers) and permit registrants to convert their pay to full-time, annual equivalents in the pay ratio computations. This approach could lead to somewhat more comparable pay ratios across registrants with respect to domestic workforces. However, including these workers and allowing annualization and full-time equivalent computations would likely increase costs for registrants relative to the proposal, because of the greater number of employees whose compensation data must be integrated to identify the median employee and because the registrant may need to perform annualization and full-time-equivalent computations for large numbers of employees. Alternatively, we could include only full-time employees, excluding seasonal and temporary workers, but include non-U.S.-based employees. Under this alternative, we could, for example, expand the *de minimis* exemption provided in the current rule (such as to 10 or 25 percent) and permit purchasing-power-parity adjustments for non-U.S. based employees. Including non-U.S. workers for registrants at which these employees constitute a larger fraction of the workforce, but allowing adjustments to factor in variations in wages across countries, may increase comparability of these registrants' pay ratios with those of registrants that meet similar labor needs using primarily U.S. employees. However, as discussed above, commenters have highlighted integrating foreign and domestic compensation systems for this purpose to be a significant source of compliance costs,[834] and some of these costs may be borne even by registrants that are able to avail of an expanded *de minimis* exemption because of the need to determine whether the *de minimis* threshold is met. Separately, the extent to which either of these alternatives (including additional types of domestic employees or including foreign employees) would improve the comparability of pay ratios across registrants would be limited by the substantial existing imprecision in pay ratios arising from other sources, as discussed in section IV.H.2 above.

We also considered using the annual total compensation calculation methodology from the proposed Earned Compensation Table (rather than from the Granted Compensation Table, as proposed) for purposes of the pay ratio disclosure. The Earned Compensation Table provides a more comprehensive measure of compensation, including components that are not reflected in the Granted Compensation Table (such as retirement benefits and perquisites), and could thus enhance comparability of pay ratio disclosures across registrants that rely to a different degree on, for example, retirement or other benefits to compensate their PEO. However, as in the case of the currently required Summary Compensation Table methodology as discussed above, computing a measure based on Earned Compensation Table methodology for the median employee may be more burdensome than computing the measure as proposed. Further, as in the case of the other alternatives discussed above, the extent to which this alternative would improve the comparability of pay ratios across registrants would be limited by the substantial existing imprecision in pay ratios arising from other sources.

I. Compensation of Directors

Registrants are currently required to provide tabular disclosure regarding the compensation of directors for the last completed fiscal year in a Director Compensation Table that largely mirrors the Summary Compensation Table, with cash fees instead of salaries in the first column of the table. The Director Compensation Table does not include a bonus column, but includes stock awards, option awards, non-equity incentive plan compensation, change in pension value [835] and nonqualified deferred compensation earnings,[836] and all other compensation columns that parallel the columns in the Summary Compensation Table. The delineated list of items to be included in ''all other compensation'' in the Director Compensation Table includes some items in the equivalent category in the Summary Compensation Table (such as perquisites, tax gross-ups, and contributions to defined benefit retirement plans) but also includes items that are specific to the director context (such as consulting fees and costs associated with director legacy programs). In all cases, the tabular disclosure is required to be accompanied by a narrative description of any material factors necessary to an understanding of the director compensation disclosed in the table.

The proposed amendments would continue to require certain qualitative and quantitative disclosure of the material compensation of directors, including disclosure of compensation at the individual director level, but would eliminate (1) mandatory disclosure of certain specified categories of compensation (such as retirement contributions, tax gross-ups, consulting fees, and costs associated with director legacy programs) regardless of materiality and (2) prescriptive tabular presentation requirements, in favor of a more principles-based approach. The proposed amendments would also change the focus of disclosure with respect to equity awards at the individual director level from the grant date fair value reported in the current Director Compensation Table to a combination of disclosure of the value of any earned (*i.e.,* vested or exercised) equity and the size and material terms of any outstanding equity awards. In addition, registrants would be required to describe the material aspects of the director compensation program in general (*i.e.,* not in the context of individual named directors), including quantification of cash and equity retainers for different roles. Registrants would also be required to disclose any material information necessary to an understanding of the information otherwise disclosed. Further, unlike the current rule, the proposed amendments would require that registrants include compensation to NEOs for any services they provide as directors in the director compensation disclosure and require that registrants exclude that compensation from the executive compensation tables.

1. Benefits

The proposed amendments to the director compensation disclosure requirements are expected to reduce repetitive disclosures and the costs of preparing disclosures. It is also possible

[834] *See supra* notes 817 and 818.

[835] As in the case of the Summary Compensation Table, SRCs and EGCs are required to include a similar table as other registrants but are not required to include information about pension plans.

[836] As discussed in section IV.C.5 above, staff found that eight, three, and 0.1% of registrants respectively reported option awards, changes in accumulated pension value or earnings on deferred compensation, or non-equity incentive awards for at least one director in the 2025 proxy year.

that the proposed principles-based requirements could increase the information available to investors about how directors are compensated.

As discussed in the Baseline section above, the structure of director pay is generally simpler than that of executive pay. Registrants often describe this structure, such as the level of annual director fees and how these base fees are augmented by additional fees for board leadership positions or committee service as well as how stock grants are sized, in narrative and supplemental tabular disclosures. This information, as well as information about other items of director compensation, is then also summarized at the director level in the Director Compensation Table. The proposed amendments, by not prescribing a presentation format, may allow registrants to more succinctly describe the material aspects and quantified elements of the compensation of directors. By requiring the disclosure of any amounts of NEO compensation that are attributable to service on the board in this section alone, and not in the tabular disclosures of executive compensation, the proposed amendments may also reduce any duplicative explanations of the director pay structure that may currently be made in the executive compensation disclosures.

Reducing any redundant disclosures should reduce, to a modest extent, the costs of preparing director compensation disclosures as well as the overall length of disclosures and thus the cost of disclosure review by registrant staff, outside advisors, and the board. To the extent that some of the elements of compensation included in the current tabular disclosures are not material in the context of a particular registrant or a particular director, there may be additional savings associated with no longer tracking and/or reporting these elements. Consistent with these expectations, some commenters stated that the current tabular disclosure requirement is costly and suggested that narrative disclosure of material information about director compensation would be less burdensome to produce.[837]

Finally, researchers have raised concerns that directors may receive certain benefits as a result of their board position that are not currently disclosed as compensation.[838] To the extent that there are material director benefits that are not encompassed by the current disclosure requirements, the proposed more principles-based approach to the disclosure of director compensation, together with the materiality standards applied in proposed Item 402(k) and the objective put forth in proposed Item 402(a)(1), could potentially result in increased information being disclosed, to the benefit of investors, about how individuals are compensated for their service as directors.

2. Costs

The proposed amendments to the director compensation disclosure requirements may, because of the transition to a different disclosure framework with more principles-based standards and presentation flexibility, generate some new (primarily short-term) costs for registrants to evaluate materiality and decide how to present their disclosures and may increase search costs for the users of disclosure. The proposed amendments may also reduce the amount of information available to investors (and registrants) for the purpose of evaluating (and benchmarking) director pay.

The proposed requirements rely on registrants to identify the material aspects of their compensation of directors in order to define the scope of the disclosure beyond the minimum required quantified elements (such as any cash and equity retainers for board, committee, chairmanship, and other director services). Registrants may need to expend some effort to determine what factors to disclose, and they may choose to consult with outside advisors to assist them in making this determination. We expect that the relatively simple structure of director compensation should simplify this task in most cases, but the materiality determinations may be more complicated for those with relatively more complex director compensation, such as those with directors receiving pay in the current ''all other compensation'' category.[839]

Given that the proposed amendments would not mandate a specific disclosure format, registrants would also have to decide how to present the information, and they may potentially consult with outside advisors to assist them. Additional costs may be associated with engaging with investors, other registrants, external advisors, and trade groups to develop market practices or norms for presenting the disclosures. That said, while there may be some ongoing costs associated with evaluating the materiality of various elements as the directors and their circumstances or the director compensation program as a whole change over time, most of the costs associated with determining the content and presentation format for the disclosures should be limited after the initial years of experience with the proposed amendments.

To the extent that registrants respond to the proposed amendments by employing a wide range of alternative presentation formats, or by relying on narrative rather than organized tabular presentations, or by excluding some information currently in the disclosures but that can be computed[840] or found in other filings or locations,[841] the search and analysis costs expended by investors, peer registrants, and/or third parties such as compensation consultants and proxy advisors to understand, extract, and compare director compensation information across registrants may be increased.[842]

As discussed in section IV.E.1.a above, there are various reasons why a principles-based disclosure standard may result in investors being less informed despite registrants disclosing all material information. For example, there may be elements of such compensation that are not material to some registrants and thus may appropriately not be disclosed under the proposed amendments, resulting in less consistent peer information to judge the reasonable level of these elements at other registrants. While we expect that the materiality standard, together with concern about litigation risks, should limit the loss of information about director compensation, we note that researchers have found that even modest variation in their compensation

[837] *See* letters from ABA (stating that the Director Compensation Table ''involves a time-consuming and expensive compliance undertaking for registrants'' and recommending that any required disclosure of director compensation be limited to a narrative disclosure requirement); Davis Polk (stating that the Director Compensation Table is ''superfluous and unnecessarily costly'' and that ''any material information concerning directors can be sufficiently covered by narrative disclosure'').

[838] *See, e.g.,* Ye Cai et al., *Paying by Donating: Corporate Donations Affiliated with Independent Directors,* 34 Rev. Fin. Stud. 618 (2021) (finding, in a sample of S&P 500 firms over ten years, that about one-fourth of the firm-years included a corporate donation to a charity affiliated with one or more of the board's independent directors, that the size of such donations typically exceeded the annual director compensation, and that such donations were associated with 9.4% higher CEO compensation and a lower likelihood of the CEO being replaced for poor performance).

[839] As discussed in the Baseline section above, about 34% of registrants with available data had at least one director with non-zero ''other compensation'' in proxy year 2025.

[840] For example, while the proposed rule would not explicitly require the disclosure of the total compensation received by, or the grant date fair value of equity awarded to, a particular director, these could be estimated based on other elements that would be explicitly required to be disclosed.

[841] For example, information about director compensation may be included in a stock incentive plan included as an exhibit to a registrant's annual report or in an Item 5.02 Form 8–K disclosure.

[842] See section IV.B above for a discussion of the uses of this information.

may impact director behavior.[843] It is therefore possible that the proposed amendments may result in an increase in the imprecision of investors' understanding of director compensation at some registrants, introducing some noise into investment and voting decisions.

3. Reasonable Alternatives

As an alternative to the proposed amendments, we considered retaining more prescriptive presentation requirements. For example, we could have designed a new Director Compensation Table with simplified requirements and columns to reflect factors that are currently commonly disclosed in narrative or supplemental tables (such as separate columns for base director fees and fees associated with board leadership or committee positions). Relative to the proposed approach, a prescriptive tabular disclosure requirement would reduce the need for registrants to decide how to present their disclosures and would make the data more readily extractable and comparable for investors, peer registrants, and third parties. However, a revised tabular disclosure could still result in duplicative disclosure to the extent that it does not fully align with how registrants prefer to describe their director pay practices. Under the proposed approach, it is possible that market norms for director compensation disclosure may develop to provide similar benefits to this alternative without lengthier or repetitive disclosure.

We also considered requiring program-level disclosure about the material aspects of director compensation while no longer requiring director compensation disclosure on an individual, director-by-director basis. Requiring only program-level disclosure could further reduce the volume of director compensation disclosure that would have to be produced and reviewed. However, given potential variation across directors in elements of compensation outside of the basic retainers and potential differences in equity exposure due, for example, to when different directors joined the board, director-level compensation information may be material to investors in assessing director incentives.

The proposed amendments would require quantitative disclosure of the value of any earned equity (*i.e.,* vested stock or exercised options) and the size and material terms of any outstanding equity awards as of the end of the fiscal year. Alternatively, we could instead require the disclosure of the grant date fair value of equity (and the material terms of any grants). It is possible that investors may be most directly interested in the grant date fair value and material terms of equity when it is initially awarded to a director given that this amount and these terms may be most relevant to an understanding of the performance sensitivity of awarded compensation and thus the director's *ex ante* incentives—such as their degree of ''skin in the game.'' [844] While grant date fair values could be computed (and material terms of grants could likely be identified) based on the proposed disclosure of the material aspects of the director compensation program in general, obtaining this information may involve more search and analysis costs for investors and other users of the disclosure than if it is directly disclosed (as under the current rule).

Requiring the disclosure of information about granted rather than earned and outstanding equity may also enhance comparability by resulting in more equivalent disclosure for director compensation structures that have similar economic implications. For example, disclosure of granted equity would result in similar disclosure for stock awards that cliff-vest in one year (and are thus earned after a year) and stock awards that vest immediately (and are thus earned immediately) but that are subject to a holding requirement, which have similar economic implications (in that the stock cannot be sold for at least a year after it is granted) and are both common structures for director equity.[845] That said, the proposed approach to director compensation disclosure may be more consistent with the proposed approach for executive compensation disclosure in that the proposed requirements for director-level disclosure would require similar information to what would be disclosed for each NEO in the proposed Earned Compensation Table and Status of Equity Awards Table.

We also considered not requiring the disclosure of outstanding equity awards for directors. Given the very short duration of most non-executive director equity awards (which generally vest in one year or less than a year, including a large fraction that vest immediately),[846] many directors are likely to have no outstanding unvested equity at fiscal year-end, and most are likely to have no overlapping grants that are outstanding at the same time. Further, given that directors are usually subject to equity ownership requirements and director holdings often increase over time until they achieve a minimum retention requirement,[847] investors may be more interested in the total amount of equity subject to such holding requirements rather than the extent of unvested equity at fiscal year-end. However, the proposed requirement to disclose outstanding equity awards may supplement the proposed requirement to disclose earned equity compensation to provide a more complete picture of director equity awards across directors and registrants.

J. Scaled Disclosure

Currently, SRCs and EGCs may elect to provide executive compensation disclosure that is generally subject to scaled disclosure accommodations. For example, among many other accommodations, as discussed above,[848] SRCs and EGCs typically have three rather than five NEOs, have two rather than six required tables under the primary tabular disclosure requirements, may include fewer years of data in certain prescribed tables, and are not currently required to include a CD&A or pay-ratio disclosure. SRCs and EGCs may also provide only a narrative description of the material terms of retirement plans and of potential payments and benefits to an NEO in the case of certain termination and change-in-control events, in contrast to the more detailed and prescribed disclosures on these topics currently required of other registrants.

Some aspects of the proposed amendments (such as the proposed, more narrow NEO definition or the proposed streamlined tabular disclosure requirements) would apply more limited disclosure requirements to all registrants, thereby reducing the extent of differences between the requirements that apply to SRCs and EGCs and all other registrants. Other aspects of the proposed amendments would maintain current accommodations for SRCs and EGCs, such as the exemptions for these registrants from CD&A and pay ratio disclosures. The proposed amendments would also eliminate the current Item 402(q)(1) narrative disclosure requirement (with respect to retirement plans) that applies to these registrants.

[843] *See* Renee B. Adams & Daniel Ferreira, *Do Directors Perform for Pay?* 46 J. Acct. Econ. 154 (2008) (studying director meeting fees and finding that director meeting attendance can be affected by even small monetary rewards).

[844] *See supra* section IV.B.

[845] *See, e.g.,* Cook 2025 Report, *supra* note 596.

[846] *See id.*

[847] *See id.*

[848] *See supra* section II.M.

1. Benefits

Because compliance costs generally do not scale perfectly with size, in that they have some fixed cost components, the same disclosure requirement can result in disproportionate burdens on smaller companies. While the proposed amendments would reduce and streamline the extent of disclosure required by all registrants, they would also maintain a scaled disclosure regime for SRCs and EGCs. As under the baseline, the continuing accommodations would help to limit the disproportionate burden that disclosure requirements can otherwise place on smaller registrants.

Maintaining scaled disclosure accommodations for SRCs and EGCs may help to support the potential capital formation benefits of the proposed amendments. In particular, these smaller and younger registrants may be more likely than other registrants to face constraints in their financial or managerial resources and may thus be more likely to redirect any additional compliance cost savings towards strategic planning or capital investment.

The nature of the proposed revised requirements for SRCs and EGCs may also benefit investors. While these registrants would remain eligible to elect scaled requirements, they would, in contrast to the current requirements, produce the same set of tabular disclosures (though with two rather than three years of data where applicable) with the same content (including with respect to pensions) as other registrants. These more consistent disclosures may facilitate investors' review and comparison of the disclosures across registrants of different types. The proposed disclosures would also make certain information about SRCs and EGCs, particularly with respect to stock vesting or option exercises, more accessible than under current rule.

If the proposed amendments in the 2026 Filer Status Proposing Release are adopted, SRCs would no longer be subject to the pay-versus-performance requirements or golden parachute disclosure (and voting) requirements. Further, the proposed exemption from Item 402(q)(1) (*i.e.,* narrative disclosure about retirement plans) and other executive compensation disclosure accommodations would be extended to all new NAFs, a much larger group of filers (with a broader range of individual characteristics) than current SRCs and EGCs. While the larger registrants among the new NAFs might not benefit as significantly from accommodations as current SRCs and EGCs (because they are less likely to face the same resource constraints as these smaller registrants) they may also benefit from incremental compliance cost savings and investors would benefit from more consistent disclosures than would be available if the new NAFs avail themselves of the accommodations under current executive compensation disclosure rules.

2. Costs

The proposed amendments, by applying more consistent tabular disclosure requirements across all registrants, may generate some incremental compliance costs for SRCs and EGCs. In particular, these registrants would newly have to reflect in the proposed Earned Compensation Table stock that vested or options that were exercised. They would also have to include, in this table, the service costs and prior service costs associated with pension plans. However, we expect the collection of this information to impose minimal costs because equity outcomes are likely tracked for other purposes and pension service costs are reported for accounting purposes. Also, the proposed amendments would eliminate the current Item 402(q)(1) narrative disclosure requirement pertaining to pension and other retirement compensation, which would reduce other compliance costs for these registrants.

For investors, the proposed elimination of the current Item 402(q)(1) narrative disclosure requirement with respect to retirement plans would reduce the amount of information available with which to assess the overall monetary incentives of NEOs at SRCs and EGCs. As discussed in section IV.B above, pensions and deferred compensation can affect, for example, the likelihood that managers will be more or less conservative in their strategic choices.

If the proposed amendments in the 2026 Filer Status Proposing Release are adopted, SRCs would no longer be subject to the pay-versus-performance requirements and the golden parachute disclosure (and voting) requirements. Further, the proposed elimination of Item 402(q)(1) disclosure would be extended to all new NAFs, likely increasing any costs to investors of somewhat less detailed information about the pensions and other retirement compensation of NEOs of these registrants.

3. Reasonable Alternatives

As an alternative to the proposed accommodations for SRCs and EGCs, we considered expanding these accommodations. For example, we could allow these issuers to exclude the Status of Equity Awards Table or to provide disclosure only for the PEO rather than both the PEO and PFO. Further accommodations could reduce the volume of disclosures produced by SRCs and EGCs and provide additional compliance cost savings for these registrants, which could be directed toward other purposes.

However, the proposed Status of Equity Awards Table would require the disclosure of factual information, with no incremental computations, and should not be overly burdensome to produce. Similarly, we expect that the proposed disclosure of the PFO's compensation, given the proposed simplified requirements and that the PFO is easily identifiable, would require limited tracking, data collection, or computation for SRCs and EGCs beyond what we expect is produced for other purposes (though it would still contribute to the overall volume of disclosure that would need to be produced). On the other hand, as discussed in sections IV.D and IV.E above, these disclosures may be material to investors' understanding of the executive compensation structures at these registrants.

K. Structured Data

As discussed in section II.C.5, the proposed amendments would require LAFs, and permit all other registrants, to tag the information disclosed within the proposed Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table in Inline XBRL. As proposed, registrants would not be required to tag any footnotes to the tabular disclosures or the narrative disclosures made under Item 402. The proposed amendments would remove the requirement to tag pay-versus-performance disclosures and compensation recovery disclosures in Inline XBRL.[849]

1. Benefits

The proposed amendments requiring LAFs, and permitting all other registrants, to tag certain tabular disclosures in Inline XBRL would largely augment the benefits discussed above in section IV.E.2, namely by reducing compliance costs by removing certain existing XBRL tagging requirements and allowing the tagging of any tabular executive compensation disclosure to remain optional for non-LAFs and by making certain LAF executive compensation disclosures

[849] *See supra* section II.C.5.

more readily available to investors and other users of executive compensation disclosure.

With regard to reducing compliance costs, non-LAFs that do not elect to tag the information disclosed within the proposed Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table in Inline XBRL would benefit from reduced compliance costs as they would no longer be required to tag, to the extent applicable, disclosures related to pay-versus-performance (402(v)) or actions to recover erroneously awarded compensation (402(w)) in their proxy statements or other reports.

The tagging of disclosures in Inline XBRL by LAFs and by non-LAFs that would choose to do so under the proposed rule would make compensation information more accessible to users and investors and increase disclosure processing efficiency.[850] Research indicates that XBRL requirements have led to benefits for individual companies, investors and the market as a whole, by reducing information asymmetry,[851] improving stock price informativeness of public disclosures,[852] enhancing market competition,[853] increasing liquidity,[854] decreasing cost of capital,[855] improving the accuracy of financial analysis,[856] and enhancing artificial intelligence (also known as ''super intelligence'') [857] capabilities.[858] While those observations are specific to operating company financial statement disclosures, and not proxy statement executive compensation disclosures, they indicate that the proposed Inline XBRL requirements would likely provide investors with increased insight into executive compensation information disclosed in the proposed tables. A number of commenters stated that tagging the summary compensation information would improve investor and data provider access to executive compensation data, enabling investors to better analyze the data, compare disclosures across registrants and enhance transparency.[859] Others suggested that tagging executive compensation data could reduce reliance on proxy advisor services, or reduce the expense of collecting such data by data providers.[860] These benefits, however, may be limited because only the proposed main tables will be tagged, and some analysis of executive compensation data may require context that is contained within the narrative disclosures or footnotes to the tables.

Under the proposed Inline XBRL tagging requirements, non-LAFs may elect to tag certain tabular disclosures. However, it is unclear how many would choose to do so, and, as a result, the overall impact on users of executive compensation disclosures, due to not requiring non-LAFs to tag these disclosures, is uncertain. For example, investors could still benefit from the transparency and improved access to information that would be provided by the proposed structuring requirements to the extent LAF compensation data are more commonly analyzed by investors, or to the extent that executive compensation information for non-LAFs that would choose to tag their disclosures could be benchmarked to LAFs for comparison purposes.

On the other hand, some of the benefits to investors and other data users from the proposed structuring requirements may be offset to the extent they would still rely on proxy advisor services or other data providers to obtain compensation data for non-LAFs who do not elect to tag the primary tabular disclosures.

2. Costs

LAFs, and other registrants who elect to tag the proposed primary tables in Inline XBRL, could incur increased compliance costs. However, we believe these costs would be modest since registrants are subject to Inline XBRL tagging requirements for many other disclosures and have experience tagging proxy statements for pay-versus-performance disclosures and compensation recovery disclosures. Such costs would be mitigated by the removal of the existing Inline XBRL tagging requirements for pay-versus-performance disclosures and compensation recovery disclosures. Further, because the proposed amendments streamline and reduce the overall disclosure volume,[861] and the proposal regarding Inline XBRL do not require LAFs and other electing registrants, to tag narrative or footnote disclosures, the overall costs for Inline XBRL tagging under the proposal could be reduced in the aggregate to the extent that it is simpler or less costly for registrants or their third-party vendors to tag the proposed primary tabular disclosures as compared to the existing pay-versus-performance or compensation recovery disclosures.

The proposed amendments to remove the requirement to tag pay-versus-performance and compensation recovery disclosures would result in investors receiving fewer tagged

[850] *See supra* section IV.E.2; U.S. Sec. & Exch. Comm'n, *Semi-Annual Report to Congress Regarding Public and Internal Use of Machine-Readable Data for Corporate Disclosures* (Dec. 2025), available at *https://www.sec.gov/files/fdtareport-1-2026.pdf.*

[851] *See, e.g.,* Xin Luo et al., *Initial Evidence on the Market Impact of the iXBRL Adoption,* 37 Acct. Horizons 143 (2023).

[852] *See, e.g.,* Yuyun Huang et al., *Information Processing Costs and Stock Price Informativeness: Evidence from the XBRL Mandate,* 46 Austl. J. Mgmt. 110 (2021); Ju-Chun Yen & Tawei Wang, *The Association Between XBRL Adoption and Market Reactions to Earnings Surprises,* 29 J. Info. Sys. 51 (2015); Yi Dong et al., *Does Information-Processing Cost Affect Firm-Specific Information Acquisition? Evidence from XBRL Adoption,* 51 J. Fin. & Quant. Analysis 435 (2016); Yanan Zhang et al., *XBRL Adoption and Expected Crash Risk,* 38 J. Acct. & Pub. Pol'y 31 (2019); Jap Efendi et al., *Do XBRL Filings Enhance Informational Efficiency? Early Evidence from Post-earnings Announcement Drift,* 67 J. Bus. Rsch. 1099 (2014).

[853] *See, e.g.,* Bing Li et al., *The Impact of XBRL Adoption on Local Bias: Evidence from Mandated US Filers,* 39 J. Acct. & Pub. Pol'y 6 (2020).

[854] *See, e.g.,* Wafa Sassi et al., *The Impact of Mandatory Adoption of XBRL on Firm's Stock Liquidity: A CrossCountry Study,* 19 J. Fin. Reporting & Acct. 299 (2021).

[855] *See* Chae-Won Ra & Ho-Young Lee, *XBRL Adoption, Information Asymmetry, Cost of Capital, and Reporting Lags,* 10 iBusiness 93 (2018); Syou-Ching Lai et al., *XBRL Adoption and Cost of Debt, Int'l. J. Acct. & Info. Mgmt.* 199 (2015); Tienshih Hsieh & Jean C. Bedard, *Impact of XBRL on Voluntary Adopters' Financial Reporting Quality and Cost of Equity Capital,* 15 J. Emerging Tech. Acct. 45 (2018); Marcin Jaskowski & Daniel Rettl, *Information Acquisition Costs and Credit Spreads,* 149 J. Banking Fin. 106775 (2023).

[856] *See, e.g.,* Andrew J. Felo et al., *Can XBRL Detailed Tagging of Footnotes Improve Financial Analysts' Information Environment?,* 28 Int'l. J. Acct. Info. Sys. 45 (2018); Marcus Kirk et al., *From Print to Practice: XBRL Extension Use and Analyst Forecast Properties* (Aug. 18, 2016), available at *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2826159;* Chunhui Liu et al., *XBRL's Impact on Analyst Forecast Behavior: An Empirical Study,* 33 J. Acct. & Pub. Pol'y 69 (2014). *But see* Sherwood Lane Lambert et al., *Analysts' Forecasts Timeliness and Accuracy Post-XBRL,* 27 Int'l J. Acct. & Info. Mgmt. 151 (2019).

[857] *See* Executive Order 14434.

[858] *See, e.g.,* Marcelo Farr et al., *Can AI Be Trusted with Financial Data?* (Sept. 15, 2025), available at *https://ssrn.com/abstract=5316518; see also* Revathy Ramanan, *Why Structured Data and Definitions Vastly Outperform Unstructured PDFs in LLM Analysis,* XBRL (Dec. 19, 2024), available at *https://www.xbrl.org/why-structured-data-and-definitions-vastly-outperform-unstructured-pdfs-in-llm-analysis/.*

[859] *See supra* note 184.

[860] *See* letter from XBRL US (recommending making tabular disclosures machine-readable, which would allow automatic extraction of data by data providers and make it less costly and more timely to investment clients); Rees, 2025 Roundtable Transcript at 104 (stating that issuers who want to reduce investor dependence on proxy advisors should support requiring compensation disclosure in a machine-readable format so investors can conduct their own economic analysis); *see also* letter from Equity Methods-1 (recommending structured data for compensation disclosures, which combined with other recommendations would ''empower investors to apply their own models and make independent assessments versus having to rely on black-box models procured by third-party proxy advisory (or other firms)'').

[861] *See supra* section II.C.5.

disclosures and would increase the burden on investors for analyzing or processing them.[862] However, we expect the costs of this reduced tagged disclosure to be modest because the proposed amendments would include tagged information that makes up a substantial portion of the proposed executive compensation disclosure overall and is generally of greatest relevance to investors.[863]

3. Reasonable Alternatives

As an alternative to the proposed requirement for LAFs to tag the information disclosed in the proposed Earned Compensation Table, Granted Compensation Table, and Status of Equity Awards Table in Inline XBRL, we could require all registrants to tag these tables in Inline XBRL. We also could have required LAFs or all registrants to block text tag or detail tag any footnotes to the tabular disclosures or other narrative disclosures made under proposed Item 402. Relative to the proposed approach, these approaches would have made executive compensation data more readily accessible to investors and increased disclosure processing efficiency. However, a broader tagging requirement would have increased compliance costs for registrants, particularly for SRCs, if the requirement applied to them. Further, because the proposed requirement replaces the existing tagging requirements with tagged information that makes up a substantial portion of the proposed executive compensation disclosure overall, any incremental benefit to investors for tagging additional compensation disclosures could be limited given such disclosures are largely being simplified and streamlined under the proposal.

L. Other Proposed Amendments

In this subsection we discuss the costs and benefits of the proposed amendments that have not already been discussed in the preceding subsections.

1. Disclosure on Actions To Recover Erroneously Awarded Compensation

Clawback disclosures related to a registrant's actions to recover certain erroneously awarded compensation from executive officers (not limited to the NEOs) are required for any section 12 or section 15(d) registrant that has securities listed on a national securities exchange, including U.S.-listed FPIs and certain listed registered investment companies.[864] Some of these disclosures are triggered if the registrant was required to prepare a restatement at any time during or after the last completed fiscal year. Specifically, these requirements include (i) the disclosure of certain information if the restatement required the recovery of erroneously awarded compensation and (ii) the disclosure of certain information if the registrant concluded that the restatement *did not* require recovery of erroneously awarded compensation.[865] Registrants other than registered investment companies are also currently required to indicate, in two check-boxes on the cover pages of Forms 10–K, 20–F, and 40–F, (1) whether the financial statements in the filing reflect the correction of an error to previously issued financial statements (regardless of whether such correction was required or voluntary) and (2) whether any such error corrections are restatements that required a recovery analysis under the registrant's clawback policy.[866]

The proposed amendments would eliminate the disclosure requirements that apply when the registrant concludes that a restatement *did not* require recovery of erroneously awarded compensation (*i.e.,* Item 402(w)(2) and the corresponding elements of Forms 20–F, 40–F, and N–CSR) and would eliminate the check-box requirements that flag for investors whether the filing reflects restatements and whether a recovery analysis was required. The rule would still require registrants to disclose an action to recover erroneously awarded executive compensation stemming from an accounting restatement, including information where an amount was determined to be recoverable but recovery would be impracticable. The proposed amendments would, however, remove the current requirement that amounts determined to be recoverable but for which recovery would be impracticable be separately disclosed for each current and former NEO and all other current and former executive officers as a group.

The proposed amendments to the disclosure requirements associated with clawbacks may generate limited compliance cost savings and contribute to more streamlined disclosure. More importantly, such elimination would reduce the likelihood that the need to check the first box even in the case of restatements that are not required may cause registrants to avoid voluntarily making and reporting these restatements. Reducing any incentive to avoid voluntary restatements could decrease the likelihood of less reliable financial statements and larger restatements in the future.

The removal of the check-boxes and the disclosures currently required when a registrant concludes that a restatement did not require the recovery of compensation would reduce, somewhat, the transparency around restatements and the application of clawback policies. Specifically, the disclosures that would be eliminated may currently make it easier for investors to identify when a ''little r'' restatement has been made (given that such restatements, unlike ''big R'' restatements, do not trigger Item 4.02 Form 8–K disclosure) [867] and facilitate investor monitoring of how clawback policies are applied in practice by flagging situations when it was concluded that recovery was not required. However, it is unclear whether investors are relying on these disclosures, and, in staff's experience, the narrative disclosures that the requirements have elicited are typically boilerplate and generally provide little information. Removing the current requirement that amounts determined to be recoverable but for which recovery would be impracticable be separately disclosed for each current and former NEO and for all current and former executive officers as a group may also reduce the granularity of the information available to investors to monitor how registrants are applying clawback policies in practice, but it is not clear whether, or to what extent, this level of detail is relied upon by investors.

Under the proposal, ''little r'' restatements could still be identified by comparing current to previously issued

[862] *See* 2022 Pay-versus-Performance Adopting Release at 55172 (discussing benefits of Inline XBRL tagging for pay-versus-performance disclosures); 2022 Clawback Adopting Release at 73124 (discussing benefits of Inline XBRL tagging for clawback disclosures).

[863] *See supra* section II.C.5.

[864] *See supra* note 560.

[865] These requirements are contained in 17 CFR 229.402(w)(1) and 17 CFR 229.402(w)(2) respectively for affected registrants other than registered management investment companies, and in Items 18(a) and 18(b) of Form N–CSR respectively for the latter.

[866] A practitioner analysis of registrant filings found that 235 and 90 registrants checked the first and second boxes respectively in 2025. Of these, eight involved an actual clawback of compensation with an additional four having a clawback analysis that was still in process. *See* Olga Usvyatsky, *SEC Compensation Recovery Rule: Restatements and Related Clawbacks, Quarterly Update # 4,* Deep Quarry Substack Blog (Mar. 5, 2026), available at *https://deepquarry.substack.com/p/sec-compensation-recovery-rule-restatements-1ed.*

[867] Researchers have raised concerns that some issuers may not be making appropriate materiality determinations for errors identified in that certain ''little r'' restatements may have been more appropriately categorized as ''big R'' restatements. *See, e.g.,* Choudhary et al. 2021 Study, *supra* note 686. Greater transparency into ''little r'' restatements could thus better inform investors about the reliability of a registrant's financial statements.

financial statements (though with greater search costs than may be possible using the current checkboxes), and the application of clawback policies could be monitored to some extent based on the disclosure requirements that are proposed to be retained that apply when registrants conclude that the recovery of compensation is required.[868] We therefore expect that the costs to investors of eliminating these disclosures should be at least partially mitigated by the continued availability of these other sources of information.

2. Potential Payments and Benefits Upon Termination or Change-in-Control and Golden Parachute Compensation

Registrants required to provide the primary tabular executive compensation disclosures, other than SRCs and EGCs, are also required under current Item 402(j) to disclose any payments and benefits that an NEO is contracted to receive in various potential termination or change in control scenarios.[869] Current Item 402(j) requires registrants to (i) describe and explain the circumstances that would trigger payments or the provision of benefits; (ii) describe and quantify the estimated payments and benefits that would be provided in each circumstance; (iii) describe and explain how the amounts provided are determined; (iv) describe and explain any material conditions or obligations applicable to the receipt of payments or benefits; and (v) describe any other material factors regarding each such arrangement.[870] In practice, many registrants address these requirements with a combination of narrative disclosure and tabular disclosure. SRCs and EGCs are not required to provide these disclosures under current Item 402(j) but are instead required, under current Item 402(q)(2), to provide narrative disclosure of the material terms of any arrangements providing for payments to an NEO in any termination or change of control situation.[871]

All of these registrants, other than EGCs (but including SRCs), are separately required under current Item 402(t) to provide tabular and narrative disclosure about golden parachute arrangements in connection with certain actual transactions (such as acquisitions, mergers, going-private transactions, and tender offers) when such transactions are the subject of a shareholder vote or are otherwise disclosed subject to Item 14 of Schedule 14A.[872] The tabular element of the disclosure includes columns separately identifying the aggregated dollar value of the cash, equity, pension or non-qualified deferred compensation, perquisites or benefits, tax reimbursement, and ''other'' components of golden parachute compensation.[873] The disclosures may be required of acquirers or targets and must include information about any golden parachute arrangements that NEOs of either entity have with either the acquirer or target (that is, not just about arrangements that the registrant has with its own NEOs). We estimate that 165 registrants, of which about 27 percent were SRCs, made such disclosures in 2025.[874] Under certain circumstances, these registrants are also required to conduct a non-binding shareholder advisory vote to approve the golden parachute compensation.[875]

The proposed rule would replace current Item 402(j)'s prescriptive quantitative and qualitative requirements for registrants other than SRCs and EGCs to disclose potential payments and benefits to each NEO in various termination and change-in-control scenarios with a principles-based requirement (under proposed Item 402(i)) to disclose the material terms of written and unwritten arrangements related to such payments (similar to the requirements under current Item 402(q)(2) for SRCs and EGCs).[876] At the same time, the proposal would replace the similar narrative disclosure requirement (current Item 402(q)(2)) for SRCs and EGCs with a requirement that these registrants instead comply with similar proposed Item 402(i), like other registrants.[877] Separately, proposed Item 402(j) would revise the golden parachute disclosure requirements (current Item 402(t)) to apply a materiality standard to both the quantitative and qualitative disclosures and to streamline the disclosure (by combining several columns in the tabular disclosure into a broader miscellaneous column and by replacing the required footnote and narrative disclosures with a principles-based narrative requirement).[878]

These proposed amendments are expected to reduce the compliance costs associated with the disclosures of potential payments upon various termination and change in control events and of golden parachutes in the context of specific transactions. Most significantly, the proposed amendments would reduce the computations required to produce these disclosures. In particular, registrants would no longer have to undertake complex quantifications of different types of payments under a range of hypothetical circumstances,[879] or to make

[868] While the proposed amendments would not provide full transparency into the situations that trigger consideration of a clawback in the absence of a determination that recovery is required, investors could continue to monitor such situations in the context of PEO and PFO compensation by using information about restatements and about the performance conditions that apply to NEO incentive awards.

[869] The covered circumstances include, without limitation, resignation, severance, retirement or a constructive termination of an NEO; a change in control of the registrant; or a change in the NEO's responsibilities.

[870] 17 CFR 229.402(j).

[871] 17 CFR 229.402(q)(2).

[872] Item 402(t) disclosures are required in proxy or consent solicitations relating to such transactions and/or in information statements relating to such transactions filed pursuant to Regulation 14C; proxy or consent solicitations that do not contain merger proposals but require disclosure of information under Item 14 of Schedule 14A; registration statements on Forms S–4 and F–4 containing disclosure relating to mergers and similar transactions; going private transactions on Schedule 13E–3; and third-party tender offers on Schedule TO and Schedule 14D–9 solicitation/recommendation statements. *See* 2011 Say-on-Pay Adopting Release.

[873] Academic researchers have found that, on average, approximately 42% (of the total reported dollar value) of reported golden parachute payments is cash, while about 48% is in the form of equity, 2% represents tax reimbursements, and the remaining 8% falls into the other categories. *See* Stuart L. Gillan & Nga Q. Nguyen, *What Influences Shareholder Votes on Golden Parachute Payments?,* 37 **J. APP. CORP. FIN.** 77 (2025) (''Gillan & Nguyen 2025 Study'').

[874] This estimate is based on staff review of registrant filings using Intelligize as well as filer status data based on staff review of EDGAR filings.

[875] A say-on-golden-parachute vote is not required in every circumstance or for all arrangements for which golden parachute disclosure is required. Such votes are required when shareholders are asked to approve an acquisition, merger, consolidation, or proposed sale or other disposition of all or substantially all assets, unless Item 402(t) disclosure of the same arrangements was previously made and subjected to a broader say-on-pay vote. *See* 2011 Say-on-Pay Adopting Release.

[876] *See supra* section II.J. We are also proposing a new instruction that would permit omission of this disclosure if the registrant has fulfilled the requirements of the rule in a filing made under Item 5.02 of Form 8–K. We are also proposing that, in contrast to current 17 CFR 229.402(j) but consistent with current 17 CFR 229.402(c)(2)(ix)(D) (''All other compensation'' column of the Summary Compensation Table), a change in the NEO's responsibilities would be treated as an example of constructive termination, rather than as a separate prong of circumstances covered by proposed Item 402(i). We are proposing this change for consistency between how the termination and change-in-control scenarios are described in proposed Item 402(b)(2)(vii)(E) (Miscellaneous Compensation Received column of the proposed Earned Compensation Table) and proposed Item 402(i). This proposed change in the language describing the covered scenarios is not intended to change the scope of circumstances covered by proposed Item 402(i) relative to that covered by current Item 402(j).

[877] *See supra* sections II.J and II.M.

[878] *See supra* section II.K.

[879] *See* letters from McGuireWoods & Brownstein (stating that current Item 402(j) requires ''companies to perform extensive calculations'' and that producing the associated disclosures involves ''hours of internal and external resources''); Meridian (stating that Item 402(j) disclosures ''can

computations associated with immaterial amounts for inclusion in golden parachute disclosures. The increased flexibility afforded to registrants under the proposed amendments with respect to determining material information to be included and in what format to present this information under both proposed Item 402(i) and (j) (outside of the prescribed cash and equity columns of the golden parachutes table) may also contribute to a reduction in the overall length of disclosures.[880]

As discussed in section IV.B above, information about severance plans and golden parachutes can provide investors with a more complete understanding about executive incentives (including in the context of current or future potential transactions) and expected registrant performance.[881] Investors who therefore seek to extract and compare executives' pre-contracted payments in case of termination or a change in control may bear increased search costs under the proposal given that the content and format of the disclosures is likely to vary more across registrants than under the current, more prescriptive requirements. Search costs would increase further to the extent that registrants rely on the proposed instruction to omit the disclosure of such pre-contracted payments if equivalent disclosure has been made under Item 5.02 of Form 8–K, in that investors would have to search additional filings to obtain this information. Investors may also bear increased analytical costs to compute quantitative amounts no longer calculated and reported by registrants. Investors seeking to understand the detailed terms and components of golden parachutes disclosed in the context of a specific transaction may also bear greater search costs to find and extract information (to the extent it continues to be disclosed) that is now required consistently in a prescribed location (such as the required footnotes identifying payments associated with single-trigger versus double-trigger arrangements or quantifying each separate form of compensation included in the reported totals).[882]

Under the more principles-based proposed amendments, investors may also have a less precise understanding of severance, golden parachute, and other termination and change of control arrangements than under the current rule.[883] This reduced precision in the available information about such arrangements—and thus of executive incentives—may introduce noise into investors' investment and voting decisions, including when they are evaluating and voting on potential transactions or making say-on-golden-parachute votes.

Both the costs and benefits of the proposed replacement of current Items 402(j), (t), and (q)(2) with proposed Items 402(i) and (j) would depend on how registrants use the flexibility afforded to them and thus how the information available to investors, and the format of this information, changes in response to the more principles-based requirements. The effects would also vary across registrants based on their filer status. SRCs and EGCs are not subject to current Item 402(j) but are instead subject to current Item 402(q)(2); given the similarity of their current requirements under this item (which is proposed to be eliminated) and proposed Item 402(i) (to which they are proposed to be subject) we do not anticipate significant effects from this proposed change for these registrants.[884] EGCs are not required to make golden parachute disclosures under current Item 402(t) and would not be subject to proposed Item 402(j) which would replace it and would thus not be affected by this proposed change.

If the proposed amendments in the 2026 Filer Status Proposing Release were to be adopted, SRCs would (like EGCs) no longer be subject to current Item 402(t) golden parachute disclosures (or say-on-golden-parachute votes). In that case, the proposed amendments to the golden parachute requirements in this release would result in no incremental costs or benefits with respect to SRCs (and all NAFs). Further, the number of registrants eligible to use scaled disclosures (*i.e.,* new NAFs) would be significantly increased and thus the incremental effects of the proposed amendments to current Item 402(j) (which would not apply to new NAFs) would be more limited.

3. Policies and Practices Related to Grant of Equity Awards Close in Time To Release of Material Nonpublic Information—Item 402(x)

All registrants required to provide the tabular compensation disclosures discussed in section IV.E above are also subject to Item 402(x), which requires them to disclose certain information about the timing of option grants.[885] In narrative form, registrants are required to discuss any policies and practices on the timing of awards of options in relation to the disclosure of material nonpublic information. If a registrant makes any option awards to NEOs in the period beginning four business days before, and ending one business day after, the filing (or furnishing) of a periodic or current report (with a limited exception) that discloses material nonpublic information, they must also disclose certain quantitative information in tabular format. The required table includes certain terms of the award and the percentage change in market price of the underlying securities from one trading day prior to one trading day following the disclosure of material nonpublic information.

The proposed amendments would eliminate these requirements. This proposed change may be associated with modest compliance cost savings relative to the total expenditures on producing compensation disclosure. In particular, the reported policies and practices may not change significantly from year to year, thus requiring only modest preparation costs after the first year of compliance, and we understand that companies are rarely required to

be burdensome for a company to prepare, particularly (i) in the first year in which an NEO qualifies as an NEO and (ii) if a company must calculate whether excise tax payments would have been made using theoretical year-end values'').

[880] The increased flexibility afforded to registrants under proposed Item 402(i) may also result in some short-term adjustment costs for registrants as they reconsider the content and presentation format for these annual disclosures under the proposed amendments.

[881] *See supra* note 502 and associated text.

[882] Academic researchers have found that the presence of single-trigger arrangements and the inclusion of tax reimbursements are both individually associated with say-on-golden-parachute voting outcomes, which may suggest that some investors seek information on these terms. *See* Gillan & Nguyen 2025 Study, *supra* note 873.

[883] *See, e.g.,* Cadman et al. 2016 Study, *supra* note 502, at 765–766 (stating that registrant disclosures about severance pay prior to 2006 ''consisted of a statement as to whether a severance agreement exists and a narrative description of the material payments due upon CEO termination'' and finding that ''estimates of contracted severance pay based on [these] disclosures were, on average, 59% lower than the true amount''). *See* section IV.E.1.a above for a discussion of how investors may lose access to meaningful information under a principles-based standard even when registrants are required to disclose material information.

[884] Current 17 CFR 229.402(q)(2) lists a slightly narrower group of circumstances for which arrangements must be disclosed, in that, in contrast to current 17 CFR 229.402(j) and proposed Item 402(i), information about payments in the case of a change in the executive's responsibilities is required only in connection with a change in control, but not otherwise (such as in case of an executive's demotion outside of a change in control). Proposed Item 402(i) may thereby slightly enhance investors' understanding of arrangements associated with a change in an executive's responsibilities at SRCs and EGCs while slightly increasing the costs of compliance to these registrants.

[885] *See supra* section II.O.3.

include the tabular disclosures [886] and that these disclosures do not impose significant data collection or computational burdens. Still, these elements contribute to the time required to produce and review disclosures,[887] and eliminating them would reduce the length of disclosure. Eliminating the tabular disclosure requirement may also increase registrant flexibility in the timing of their option grants, given that registrants may feel unduly constrained to avoid the appearance of ''spring-loading'' or ''bullet-dodging'' even when no such intention exists and there are legitimate reasons to time grants close to the release of material nonpublic information.[888]

The direct costs of the elimination of Item 402(x) are expected to be limited, given that the quantitative information presented in the tabular disclosures would still be available or possible to estimate from other sources.[889] While some commenters indicated that the narrative disclosures are duplicative of other disclosure requirements,[890] we note that, under the proposed amendments, the CD&A would no longer explicitly require a discussion of how the determination is made as to when awards are granted. Regardless, it is unclear whether investors have found these narrative disclosures to be material, and we expect that registrants subject to CD&A requirements would continue to disclose related policies and practices to the extent material. The indirect costs of eliminating the disclosure may be more significant than the direct costs, to the extent that the disclosure discourages grant practices that may obscure the transfer of value to executives or dampen their implied performance incentives.[891] However, it is unclear whether Item 402(x) actually allows investors to distinguish opportunistic timing of grants or news from legitimate timing and compensation decisions.[892] Also, option compensation is now used by a minority of registrants,[893] mitigating any costs (though also limiting the benefits) of eliminating the disclosure.

4. Compensation Policies and Practices Related to the Registrant's Risk Management—Item 402(s)

Under the current Item 402(s), to the extent that risks arising from a registrant's compensation policies and practices for its employees (including non-executive officers) are reasonably likely to have a material adverse effect on the registrant, the registrant is required to discuss its policies and practices as they relate to risk management practices and risk-taking incentives. The proposed amendments would eliminate this requirement for all registrants.

While the preparation of this disclosure may not be as resource-intensive as other executive compensation requirements, registrants must still devote time and effort to assess whether their compensation policies and practices create risks that could have a material adverse effect, draft or update narrative disclosures, and review these disclosures with internal stakeholders and external advisors. Removing the requirement would reduce the time and resources spent on these activities. Given the reported policies and practices may not change significantly from year to year, thus requiring only modest preparation costs after the first year of compliance, removing Item 402(s) is expected to yield modest compliance cost savings relative to the total expenditures on producing compensation disclosure. The proposed changes may also reduce boilerplate or repetitive disclosure to the extent that other disclosure requirements (*e.g.,* Item 105 of Regulation S–K) already require discussion of material risks.

The direct costs of information loss from the elimination of Item 402(s) are expected to be limited, given that to the extent that a registrant's compensation policies and practices create risks that are reasonably likely to have a material adverse effect, the disclosure of such risks would generally continue to be required, if material, pursuant to other disclosure requirements.[894] There may be indirect costs of eliminating the Item 402(s) disclosure requirement in that registrants may be likely to more thoroughly consider the risk management effects of their compensation decisions (including in the context of employees other than the PEO and PFO) when there is an explicit disclosure requirement pertaining to compensation-related risks than otherwise. However, the risk of such indirect effects may be limited given the degree of overlap with other disclosure requirements described above.[895]

5. Timing of Executive Compensation Disclosure in Registration Statements

Under current rules, it can be difficult to file a ''long form'' registration statement (*i.e.,* Forms S–1, S–4, S–11, 10, and N–2) after the end of the fiscal year but before the annual executive compensation disclosure would typically be made because these forms require Item 402 disclosure that covers the fiscal year ended prior to the filing. In contrast, when using a ''short form'' registration statement, like Form S–3, a filer has up to 120 days after the end of the fiscal year to prepare and file executive compensation information. The proposed amendments would extend comparable flexibility for providing Item 402 disclosure for the last completed fiscal year to registration statements on Forms S–1, S–4, S–11, 10, and N–2.

Specifically, the proposal would permit registrants to file these registration statements without Item 402 disclosure for the last completed fiscal year so long as the registrant files the Item 402 information within (at the latest) a 120-day period following fiscal year-end.[896] Under the proposal, if this maximum 120-day period would end before the date of effectiveness, the registrant must pre-effectively amend the registration statement to include the Item 402 disclosure for the last completed fiscal year.

[886] *See, e.g.,* Morgan Lewis, *Public Companies Faced Added Disclosure Scrutiny During this Proxy Season* (August 2025), available at *https://www.morganlewis.com/pubs/2025/08/public-companies-faced-added-disclosure-scrutiny-during-this-proxy-season* (stating, based on their evaluation of disclosures during the 2025 proxy season, the first year that calendar-year filers were required to include Item 402(x) disclosure in their proxy statements, that ''most companies did not need to include the tabular disclosure component of Item 402(x)'').

[887] Several commenters stated that the 17 CFR 229.402(x) disclosures are burdensome. *See* letters from Cooley; NAM–1; Society for Corporate Governance.

[888] *See, e.g.,* letters from Davis Polk; Society for Corporate Governance.

[889] The grant date, number of underlying securities, and exercise price of options would be disclosed in the proposed Status of Equity Awards Table. The grant date fair value of options may be disclosed in the Granted Compensation Table or, if aggregated with other grants and not separately broken out, may be estimated based on the disclosed terms of the options. The date of release of material nonpublic information and stock price movements in the days surrounding such release can generally be determined based on public filings and broadly available market data.

[890] *See. e.g.,* letters from Business Roundtable; Cooley.

[891] Academic research provides evidence of strategic timing of option grants or news releases around the time of option grants that have the effect of decreasing the option exercise price, which increases the value of option compensation and the likelihood of a positive eventual option payoff. *See* 2022 Insider Trading Arrangements Adopting Release, notes 525–528 and 531; *see also* letter from A&O Shearman (stating that the Item 402(x) tabular disclosure ''is rarely required . . . but rather serves as a deterrent against poor option timing practices'').

[892] *See, e.g.,* letters from Davis Polk; Society for Corporate Governance.

[893] Table 4 in section IV.C indicates that 24% of registrants with available data granted options to their PEO based on disclosures for proxy year 2025.

[894] *See supra* section II.O.2.

[895] *See id.*

[896] *See supra* section II.P.

Allowing a maximum 120-day window for Item 402 updates may prevent offerings [897] from being delayed when certain amounts in executive compensation disclosures are not yet determinable. Thus, the proposal would limit rule-related constraints on registrant's securities offering timetables, potentially reducing frictions in the offering process, such as a reliance on specialized advisors for rushed computations or the risk of congestion in offering schedules (and thus higher demand and higher costs for advisors and underwriters and potentially lower attention from investors) prior to common fiscal year-ends or 120 days after such year-ends. By reducing the need to delay offerings solely to finalize Item 402 computations, the proposal should lower direct and indirect issuance costs for registrants and expand scheduling flexibility for underwriters, potentially benefiting smaller issuers and time-sensitive transactions.

Deferring Item 402 disclosure until later in the maximum 120-day window could introduce temporary information gaps for investors reviewing the initial registration statement during the period prior to the filing of the Item 402 information, potentially affecting pricing and demand in select offerings. However, registrants and investors will be able to determine the potential staleness of executive compensation information before making their offering and investment decisions and can make informed choices in light of this consideration. Also, the proposed requirement to pre-effectively amend the registration statement when the maximum 120-day deadline will occur before the effective date is expected to limit the duration of such delays in the availability of information.[898]

On May 19, 2026, the Commission proposed, among other things, to make Form S–3 available to significantly more registrants.[899] If that proposal is adopted, a more limited group of registrants may be subject to the timing constraints discussed in this subsection because some registrants would newly be able to use Form S–3 (which is not subject to these constraints) rather than relying on long form registration statements. In this case, the proposed amendments with respect to the timing of executive compensation disclosure in registration statements may have more limited costs and benefits.

M. Monetized Benefits and Costs

In this section, we present estimates of the aggregate initial and ongoing monetized benefits and costs. These totals include only benefits and costs that are monetized in this release and thus do not encompass all of the proposed rule's benefits and costs.[900] For example, we were not able to quantify costs to investors, including any short-term adjustment costs or any ongoing search and analysis costs, beyond current costs borne by investors, that could result from the proposed amendments.[901]

1. Estimates and Monetization of Compliance Costs and Cost Savings

The analysis above discusses the ongoing compliance cost savings that are anticipated to be associated with proposed amendments.[902] The preceding analysis also discusses transition or short-term adjustment costs that registrants may bear to adapt to certain of the proposed amendments, which represent initial implementation costs for registrants.[903] This section discusses the estimates of these initial compliance costs and ongoing compliance cost savings. For estimation purposes, these costs and savings are attributed to the burden per response for Forms 10–K and N–CSR and Schedules 14A and 14C, and to a reduction in the number of responses per year for Form 8–K.[904] We request comment on all aspects of the methodology and assumptions used and estimates obtained in this section.[905]

We present our estimates of the initial implementation costs in Table 9. These estimates are based on a number of assumptions, including an assumption that registrants will incur initial implementation costs to adjust to some aspects of the proposed amendments,[906] but no initial implementation costs (separate from the ongoing compliance costs) with respect to certain other elements of the proposed amendments, including, among others, those associated with the golden parachutes disclosures under proposed Item 402(j) and those affecting Forms 8–K and N–CSR.

We expect that each affected registrant will incur initial implementation costs once. For estimation purposes, we ascribe initial implementation costs to each response on the various affected forms and schedules, before later computing a per registrant average. To aggregate the initial implementation costs across registrants, we also assume that registrants affected by the proposed amendments would incur these initial implementation costs immediately upon effectiveness of the proposed amendments, if adopted as proposed, even though we acknowledge that some of these costs would likely be incurred over the course of the first year or in other early years after effectiveness (*e.g.,* for registrants subject to pay-versus-performance disclosures who do not disseminate a proxy or information statement in the first year after effectiveness of the proposed rules).

In Table 9 we estimate that registrants would incur approximately $527 million in aggregate costs to implement those elements of the proposed amendments whose burdens we attribute to Form 10–K.[907] In deriving this estimate, we assume that registrants would spend 125 hours on average to transition to the proposed disclosure requirements, including, for example, to make materiality determinations where necessary to identify the content to be disclosed, to tailor the content and format of the disclosures given their individual circumstances, to engage with other parties regarding potential market practices or norms for the revised disclosures, and to revise their processes, such as revising technological systems, internal

[897] Some registration statements are not accompanied by offerings, such as a Form 10 filed in the context of a direct listing or to meet OTC quotation requirements. We refer to ''offerings'' for simplicity, but other such registration statements are subject to similar current timing constraints and would have similar costs and benefits from the proposed timing flexibility as those discussed in the context of offerings in this section.

[898] The proposed amendments would also eliminate the provision of Item 402 that provides registrants with extra time to disclose salary and bonuses that are not yet calculable if they provide the disclosure in an Item 5.02(f) 8–K (and therefore to also eliminate Item 5.02(f) of Form 8–K) because the proposed amendments with respect to the timing of executive compensation disclosure in registration statements would render this provision unnecessary. We do not expect incremental economic effects, beyond the effects discussed in this section, to be associated with these elements of the proposed amendments.

[899] *See Registered Offering Reform,* Release No. 33–11418 (May 19, 2026) [91 FR 31022 (May 26, 2026)].

[900] *See supra* notes 473 and 477.

[901] *See, e.g., supra* section IV.A (summarizing uncertainties with respect to the potential effects on investors).

[902] *See supra* sections IV.D.2, IV.E.3, IV.F.2, IV.G.2, IV.H.2, IV.I.2, IV.J.2, IV.K.2, and IV.L.

[903] *See supra* sections IV.D.2, IV.E.3, IV.F.2, IV.G.2, IV.I.2, IV.K.2, and IV.L.2.

[904] *See infra* section V.B.

[905] *See infra* section IV.O.

[906] The aspects of the proposed amendments for which we estimate initial implementation costs are those for which we have identified short-term transition or adjustment costs for registrants in the discussions of costs and benefits pertaining to the various aspects of the proposed amendments above. *See supra* note 903.

[907] *See* PRA Table 1, *infra* section V.B (summarizing the elements of the proposed amendments whose burdens or reduction in burdens we attribute to different forms and schedules).

processes, and contracts.[908] In Table 9, we estimate that registrants would incur approximately $26 million in aggregate costs to implement the proposed amendments to the pay-versus-performance disclosure requirements. In deriving this estimate, we assume that registrants would spend 10 hours on average to transition to the proposed disclosure requirements, which we believe would primarily be spent deciding how to tailor the content and format of the disclosures given their individual circumstances and whether to supplement with additional disclosure.[909]

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Table 9. Estimated and Monetized Initial Implementation Costs (2026 Dollars)

Proposed Amendment Summary[i]	Form	Estimated Burden Hours per Affected Response for Initial Implementation[ii] (A)	Monetized Initial Implementation Costs per Affected Response (B) =(A)×$625[iii]	Estimated Number of Affected Annual Responses[iv] (C)	Aggregate Monetized Initial Implementation Costs (rounded) (D) = (B)×(C)
Revising Item 402 disclosure requirements	Form 10-K	125	$78,125	6,740	$527 Million
Revising NEO definition	Form 8-K	0	0	n/a	0
Revising pay-versus-performance disclosure requirements	Schedule 14A	10	$6,250	3,935	$24.6 Million
	Schedule 14C	10	$6,250	231	$1.4 Million
Revising golden parachute disclosure requirements	Schedule 14A	0	0	n/a	0
	Schedule 14C	0	0	n/a	0
Removing a disclosure item[v]	Form N-CSR	0	0	n/a	0
Total					$553 Million
Average per registrant subject to Item 402 (i.e., excluding Form N-CSR), assuming number of registrants equals number of 10-K responses					$82,000

[i] *See* PRA Table 1 for more detail on the elements of the proposed amendments whose burdens (or reduction in burdens) we attribute to each form/schedule

[ii] These burden hours are estimates of the internal and external hours that would be involved in the short-term transition and adjustment activities discussed in this section.

[iii] The rate of $625 per hour is a blended hourly rate of our current estimate of the hourly rate for each of four occupations: lawyers ($774), accountants and auditors ($330), financial managers ($730), and general and operations managers ($656). This blended hourly rate assumes that lawyers will account for 50 percent of the time spent on compliance activities; accountants and auditors, 30 percent; financial managers, 10 percent; and general and operations managers, 10 percent. This also reflects both internal and external hourly costs. We expect that the types of individuals, the rates for those individuals, and the proportion of each individual's contributions would vary among registrants and could differ depending on which specific form a registrant is completing. Nonetheless, for purposes of this economic analysis, we believe the $625 per hour rate is a reasonable estimate of the hourly cost of completing the required forms. To calculate the occupational hourly rates used in this release, the Commission uses the May 2025 occupational mean hourly wage data from the Occupational Employment and Wage Statistics (OEWS) program of the Bureau of Labor Statistics (BLS) for "Securities, Commodity Contracts, and Other Financial Investments and Related Activities" (NAICS 523). *See Occupational Employment and Wage Statistics*, U.S. Bureau of Labor Statistics, available at https://www.bls.gov/oes/; *see also Standard Occupational Classification*, U.S. Bureau of Labor Statistics, available at https://www.bls.gov/soc/ (describing occupational classification system used by BLS); Exec. Off. of the President, Off. of Mgmt. & Budget, North American Industry Classification System (2022), available at https://www.census.gov/naics/reference files tools/2022 NAICS Manual.pdf (describing the industry classification system used by BLS and other agencies). The mean hourly wage for each occupation is multiplied by an employment cost index (ECI) factor of 1.0227, calculated as one plus the percentage change in the seasonally adjusted ECI for wages and salaries of private industry workers from the second quarter of 2025 (ECI=173.563), which contains the May 2025 OEWS reference period, to the first quarter of 2026 (ECI=177.498), which is the date of the most recently available ECI observations when the occupational hourly rates used in this release were calculated. *See Employment Cost Index*, U.S. Bureau of Labor Statistics, Seasonal Data 2001-Present, available at https://www.bls.gov/eci/tables.htm. The adjusted mean hourly wage is then multiplied by a nonwage cost adjustment factor of 5.734, which accounts for nonwage costs borne by employers, such as bonuses, benefits, and overhead. This factor is calculated as the average, over 2016-2025, of the ratio of the Bureau of Economic Analysis's gross output for NAICS 523 to total wages across all occupations for NAICS 523 in the OEWS data. *See Gross Output by Industry*, U.S. Bureau of Economic Analysis, available at https://www.bea.gov/data/industries/gross-output-by-industry; *Occupational Employment and Wage Statistics*, U.S. Bureau of Labor Statistics, available at https://www.bls.gov/oes/. For example, the $774 occupational hourly rate for lawyers is calculated as $131.91 × 1.0227 × 5.734, or approximately $774 (where $131.91 is the May 2025 mean hourly wage for lawyers in NAICS 523). The final product is the occupational hourly rate. *See generally* Updated Methodology for Calculating Occupational Hourly Rates (Dec. 19, 2025), available at https://www.sec.gov/files/method-occupational-hourly-rates.pdf.

[iv] *See* section V, PRA Table 2 "Number of Affected Annual Responses."

[v] Removing the disclosure item that requires registered management investment companies subject to the requirements of Rule 10D-1 to provide the same disclosure required by Item 402(w)(2) of Regulation S-K.

Table 10 presents the annual compliance cost savings for registrants, based on the estimates in section V below. The estimates in section V reflect the average expected compliance cost savings across the first three years of effectiveness of the proposed amendments, net of any initial implementation costs. For the purposes of this section, we have separately estimated the initial implementation costs (in Table 9) and thus can also separate the ongoing compliance costs savings excluding the reduction resulting from these initial implementation costs. The necessary computation to separate these initial costs and ongoing savings are presented in Table 10. Specifically, the table starts with the three-year average reduction in burdens (reflecting both ongoing savings and the initial costs) from PRA Table 2, monetizes the burden hours to obtain an estimate of the net dollar savings per response, and multiplies that by three to obtain the total net burden reduction over this three-year period. The table then adds back the estimated monetized burden for initial implementation of the proposed amendments from Table 9 to compute the total gross reduction in burdens (not reduced by initial implementation costs) in column (F) of Table 10 and divides this by three to present the annual reduction in burdens in column (G) of Table 10.

[908] *See supra* sections IV.D.2, IV.E.3, IV.F.2, IV.I.2, IV.K.2, and IV.L.2.

[909] *See supra* section IV.G.2.

Table 10. Monetized Cost Savings Per Response (2026 Dollars)

Proposed Amendment	Form	Net Burden Hour Reduction per Affected Response[i] (A)	Net Cost Burden Reduction per Affected Response[ii] (B)	Monetized Net Cost Savings Per Response (C) = $625[iii]x(A) +(B)	Monetized 3-Year Total Net Cost Savings (D) = 3x(C)	Monetized Initial Implementation Costs per Affected Response (E)[iv]	Monetized 3-Year Total Gross Cost Savings (F) = (D)+ (E)	Monetized Ongoing Annual Cost Savings per Affected Response (rounded) (G) = (F)/3
Revising Item 402 disclosure requirements	Form 10-K	254.28	$50,166	$209,091	$627,272	$78,125	$705,397	$235,000
Revising NEO definition	Form 8-K	6.31[v]	$843	$4,787	$14,360	$0	$14,360	$4,800
Revising pay-versus-performance disclosure requirements	Schedule 14A	13.28	$2,655	$10,955	$32,865	$6,250	$39,115	$13,000
	Schedule 14C	13.28	$2,655	$10,955	$32,865	$6,250	$39,115	$13,000
Revising golden parachute disclosure requirements	Schedule 14A	1	$1,800	$2,425	$7,275	$0	$7,275	$2,400
	Schedule 14C	1	$1,800	$2,425	$7,275	$0	$7,275	$2,400
Removing a disclosure item[vi]	Form N-CSR	8	$1,188	$6,188	$18,564	$0	$18,564	$6,200

[i] *See* section V, PRA Table 2, column "Burden Hour Decrease Per Affected Response." These burden hour reductions are based on a number of assumptions. *See* section V, PRA Tables 1 and 2. For example, for Form 10-K it is assumed that 30% of the current burdens for Form 10-K are attributable to Item 402 and that the proposed amendments would reduce the burden attributable to Item 402 by approximately 50%. *See* section V, PRA Table 1 at footnote (i). These are key assumptions underlying the cost savings estimates.

[ii] *See* section V, PRA Table 2, column "Cost Burden Decrease Per Affected Response." These external cost reductions are based on a number of assumptions. *See* section V, PRA Tables 1 and 2. For example, for Form 10-K it is assumed that 30% of the current external cost burdens for Form 10-K are attributable to Item 402 and that the proposed amendments would reduce the burden attributable to Item 402 by approximately 50%. *See* section V, PRA Table 1 at footnote (i). These are key assumptions underlying the cost savings estimates.

[iii] *See* Table 9 at note iii.

[iv] *See* Table 9 Column (B).

[v] *See* section V, PRA Table 2 at footnote (i).

[vi] Removing a disclosure item that requires registered management investment companies subject to the requirements of Rule 10D-1 to provide the same disclosure required by Item 402(w)(2) of Regulation S-K.

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Table 11 begins with the annual ongoing cost savings from Table 10, aggregates them across responses, and computes an average estimate of these savings per year per registrant. We estimate that the proposed amendments would result in aggregate annual cost savings of approximately $1.64 billion.

Table 11. Ongoing Annual Compliance Cost Savings in Aggregate and Per Registrant (2026 dollars)

Proposed Amendment	Form	Estimated Ongoing Annual Cost Savings per Response[i] (A)	Estimated Number of Responses[ii] (B)	Estimated Aggregate Ongoing Annual Cost Savings (C)=(A)×(B)
Revising Item 402 disclosure requirements	Form 10-K	$235,000	6,740	$1.58 Billion
Revising NEO definition	Form 8-K	$4,800	695	$3.34 Million
Revising pay-versus-performance disclosure requirements	Schedule 14A	$13,000	3,935	$51.2 Million
	Schedule 14C	$13,000	231	$3.00 Million
Revising golden parachute disclosure requirements	Schedule 14A	$2,400	153	$367,000
	Schedule 14C	$2,400	12	$28,800
Removing a disclosure item	Form N-CSR	$6,200	1	$6,200
Total				$ 1.64 Billion
Average per registrant subject to Item 402 (i.e., excluding Form N-CSR row), assuming number of registrants equals number of 10-K responses				$244,000

[i] *See* Table 10 at column (G)

[ii] See section V, PRA Table 2 "Number of Affected Annual Responses."

As presented in Table 11, our monetized estimate of the compliance cost savings for the proposed amendments is approximately $244,000 per year per registrant, on average across registrants. The cost savings are expected to be driven by three key factors. First, reducing the scope of the disclosures as proposed—particularly with respect to the scope of named executive officers, the employees included in the pay ratio determinations, and certain *de minimis* perquisites—would reduce registrants' need to undertake data collection and tracking. Second, the proposed amendments would eliminate current requirements to make certain complex computations such as valuations of outstanding equity awards (after grant but prior to vesting or exercise) for the purpose of the disclosures. Finally, the overall lower total volume of required disclosures (including proposed reductions in the number of tables as well as the extent of narratives and footnotes) should reduce the burdens involved in registrant staff, board, and external advisor review of the disclosures. The compliance cost savings are expected to vary across registrants, as discussed in the following section.

2. Initial and Annual Aggregate Monetized Benefits and Costs

We summarize our estimates of aggregate annual monetized benefits and costs in Table 12.[910] The figures in this table summarize the analysis presented in Tables 9, 10 and 11. These estimates represent averages, and we recognize that the burdens will likely vary among individual registrants based on a number of factors, including the structure and complexity of their executive compensation program; their current status and relief currently available to them; and their existing service providers and costs associated with them. These estimates are also dependent on their underlying assumptions, which are laid out in the tables above and the text describing the tables. Registrants' implementation costs and ongoing cost savings would depend on their filing status, and would both generally be expected to be lower for registrants that are permitted to provide scaled executive compensation disclosures (*i.e.,* SRCs and EGCs currently) than for other registrants required to provide executive compensation disclosures.[911] As such, the aggregate implementation cost estimates and ongoing cost saving estimates for the proposed amendments would be lower if the Commission adopts the amendments in the 2026 Filer Status Proposing Release because the disclosure accommodations available under the baseline would be extended to a larger number of the affected registrants.

Table 12. Aggregate Annual Monetized Benefits and Costs Estimates (millions of 2026 dollars)

Aggregated Monetized Effects	Initial Effects	Year 1 through Year 10
Benefits	$0	$1,640
Costs	$553	$0

3. Present Values and Annualized Values of Aggregate Monetized Benefits and Costs

Consistent with the requirements of Executive Order 12866, the Commission reports estimated total monetized benefits and costs for all affected entities in two additional ways specified in OMB Circular A–4.[912] These two presentations address the fact that the benefits and costs of the proposed rule accrue at different points in time, and that benefits and costs realized sooner are generally more valuable than those realized later.[913]

We report (1) the present values of expected benefits and costs that are monetized in our economic analysis, aggregated across all affected entities over a 10-year time horizon starting in 2026, and (2) the annualized values over the same time horizon, derived from the present values. This time horizon represents the period over which the principal benefits and costs that are monetized in the Economic Analysis are expected to accrue.[914] The present values and annualized values account for the timing of benefits and costs through discounting, which is a procedure that accounts for the time value of money.[915]

Table 13 provides the present discounted values of the aggregate annual monetized annual benefits and costs shown in Table 12. The analysis uses annual real discount rates of three percent and seven percent over a 10-year time horizon, starting in 2026. We estimate that the present value of total monetized benefits is about $14.2 billion using a three percent discount rate and about $11.9 billion using a seven percent discount rate. The estimate of the present value of the

[910] *See* Table 13 below for the present value of monetized benefits and costs over 10 years.

[911] *See supra* sections IV.D.2, IV.E.3, IV.F.2, IV.G.2, IV.H.2, IV.J.2, IV.K.2, and IV.L.

[912] *See* E.O. No. 12866 (Sept. 30, 1993) [58 FR 51735, 51741 (Oct. 4, 1993)] (requiring agencies to provide an analysis of benefits, costs, and regulatory alternatives to OIRA for significant regulatory actions); OMB, Circular A–4, at 31–34, 45 (Sept. 17, 2003) (providing guidance to agencies regarding compliance with E.O. 12866); *see also* E.O. No. 14215 (Feb. 18, 2025) [90 FR 10447, 10448 (Feb. 24, 2025)] (requiring all Federal agencies, including the Securities and Exchange Commission, to comply with E.O. No. 12866). In addition, E.O. 14192 requires agencies to provide their best approximation of the total costs or savings associated with each new regulation or repealed regulation consistent with the analyses required by E.O. 12866. *See* E.O. No. 14192 (Jan. 31, 2025) [90 FR 9065, 9066 (Feb. 6, 2025)].

[913] *See* Circular A–4, at 32.

[914] *See id.* at 31 (stating that ''[t]he ending point should be far enough in the future to encompass all the significant benefits and costs likely to result from the rule''). For the purposes of this analysis, we assume the effective date of the proposal, as well as the start year for the analysis's time horizon, is the present year.

[915] *See id.* at 32 (''The Rationale for Discounting'') and 45 (''Treatment of Benefits and Costs over Time''); *see also* OIRA, Regulatory Impact Analysis: A Primer, at 11 (Aug. 15, 2011), available at *https://www.reginfo.gov/public/jsp/Utilities/circular-a-4_regulatory-impact-analysis-a-primer.pdf* (''To provide an accurate assessment of benefits and costs that occur at different points in time or over different time horizons, an agency should use discounting. Agencies should provide benefit and cost estimates using both 3 percent and 7 percent annual discount rates expressed as a present value as well as annualized.''); Harvey S. Rosen & Ted Gayer, Public Finance 151 (8th ed. 2008) (defining present value as ''the value today of a given amount of money to be paid or received in the future'').

initial implementation costs is $553 million because that is assumed to be incurred without a delay.

Table 13. Present Value of Monetized Benefits and Costs over 10 years from 2026 to 2035 (millions of 2026 dollars)[a]

Estimated Effects[b]	3% real discount rate	7% real discount rate
Benefits	$14,200	$11,900
Costs	$553	$553

[a] This Table includes only benefits and costs that are monetized. As discussed in this economic analysis, there are other benefits and costs that we are not able to monetize.

[b] For each discount rate, the present value calculations are based on these assumptions: (i) all one-time monetized costs are incurred immediately and not discounted; (ii) all recurring annual monetized benefits and costs begin to accrue in the first year in which affected entities rely on the proposed rule; (iii) recurring monetized benefits and costs occur in a steady stream. We use a mid-year discount rate.

Table 14 reports annualized aggregate monetized benefits and costs using real discount rates of 3 percent and 7 percent over a 10-year horizon.[916] The lump sum present values of aggregate monetized benefits and costs reported in Table 13 are converted in Table 14 into a constant stream of annualized benefits and costs over a 10-year time horizon, starting in 2026.[917] Annualized benefits and costs may differ from the sum of recurring monetized annual benefits and costs discussed earlier in this Economic Analysis because they incorporate the timing of benefits and costs through discounting, and combine one-time and recurring benefits and costs.[918] We estimate that the annualized total monetized benefits are about $1.64 billion per year using a three percent discount rate and about $1.64 billion per year using a seven percent discount rate.

Table 14. Annualized Monetized Benefits and Costs over 10 years from 2026 to 2035 (millions of 2026 dollars)[a]

Estimated Effects[b]	3% real discount rate	7% real discount rate
Benefits	$1,640	$1,640
Costs	$63.9	$76.1

[a] This Table includes only benefits and costs that are monetized. As discussed in this economic analysis, there are other benefits and costs that we are not able to monetize.

[b] For each discount rate, the annualized values are calculated by dividing the corresponding present values in Table 13 by the sum of discount factors over the time horizon. The discount factor in year t of the time horizon is equal to $1/(1 + \text{discount rate})^{(t-0.5)}$.

N. Effects on Efficiency, Competition, and Capital Formation

While the preceding sections of this economic analysis focused on the detailed effects of the proposed amendments on the affected parties, in this section we consider the broader market-level effects on efficiency, competition, and capital formation.

[916] This approach is consistent with the recommended treatment of benefits and costs over time in Circular A–4. *See id.* at 45 (''You should present annualized benefits and costs using real discount rates of 3 and 7 percent'').

[917] For each discount rate, the annualized monetized benefits (costs, respectively) in Table 14 represent the constant annual stream of benefits (costs, respectively) whose present value over the time horizon equates the corresponding present value in Table 13. See note b, Table 14, for additional calculation details.

[918] The annualized benefits and costs present these values over the 10-year time horizon, starting in the present year.

The proposed amendments, in aggregate, are expected to significantly reduce the compliance costs required to produce executive compensation disclosures, relative to the current burdens on registrants associated with these disclosures. The resulting savings of cash flow as well as registrant staff, board, and management time and attention may facilitate capital formation by redirecting these resources from compliance efforts toward other, more productive uses.[919] In particular, for companies that face financing constraints or limited managerial capacity, such savings may be redirected to strategic planning or capital investments that would not otherwise have been undertaken.[920] In other cases, the savings may be returned to shareholders, who may direct them to other investment opportunities. A reduced disclosure burden on reporting issuers could also be a positive factor in encouraging additional companies to raise capital through registered securities offerings or to become or remain a public company,[921] which may also enhance capital formation.[922] There is also a possibility that reduced transparency with respect to executive and director compensation could increase the cost of capital for reporting companies or reduce trust in markets, which could have offsetting effects on capital formation.[923]

The proposed amendments would be expected to generate some short-term inefficiencies due to the adjustment costs that would be borne by registrants and investors (directly and/or via third parties) to adapt to the significant proposed changes (such as by designing new disclosures or revising disclosure review practices) relative to the current executive compensation disclosure requirements, as discussed above.[924] The potential inefficiencies would also include, for investors, any time and resources that may be expended to express to registrants their requests for disclosure and, for registrants, to engage with investors and potentially work with external advisors and other entities, including trade groups, to develop market practices and norms relating to some of the more principles-based elements of the proposed amendments.[925] Beyond these short-term adjustment costs, the effects of the proposed amendments on efficiency depend on the extent to which the proposal would affect investor search and analysis costs, would reduce the precision with which investors can evaluate executive compensation, and/or would contribute to distortions in compensation programs relative to the compensation design that would be optimal for shareholder value maximization.[926]

In particular, for investors that review large numbers of executive compensation disclosures, the more principles-based approach of the proposed amendments may increase search and analysis costs (borne either directly or via third parties such as proxy advisors and data aggregators) by reducing the consistency of format, location, and inclusion of certain information. The proposed amendments would afford registrants substantial discretion with respect to, for example, what information about director compensation and about potential payments to executives upon termination is material and how to report it;[927] what amounts of executive compensation beyond the types that are explicitly delineated are material and must thus be included;[928] how to format the required tabular disclosures;[929] what supplementary information is necessary or appropriate to understand the tabular disclosures;[930] where to present and how to format any such supplementary information as well as the performance, market and service conditions of equity awards;[931] what specific topics should be covered in CD&As;[932] and, broadly, what information is material to an assessment of the registrant's executive and director compensation.[933]

To the extent that the flexibility afforded to registrants would result in significant variation in the format, organization, and content of disclosures across registrants (or across time for the same registrant), investors (directly or via third parties) may require more time and resources than they expend today to identify, understand, extract, and compare information about executive compensation. Registrants (directly or via third parties) may also bear increased search costs in their benchmarking exercises. Certain other aspects of the proposed amendments that may help to condense the disclosures may, at the same time, increase the likelihood that some of the users of disclosures would need to refer

[919] It is also possible that the reduced transparency of certain elements of executive compensation under the proposal could contribute to higher compensation being paid (such as in the form of higher perquisites), which could offset the compliance costs savings.

[920] *See, e.g.,* Jonathan Lewellen & Katharina Lewellen, *Investment and Cash Flow: New Evidence,* 51 J. Fin. Quant. Analys. 1135 (2016) (finding that increases in cash flow are associated with additional investment for those firms that are the most likely to be financially constrained).

[921] Studies have found that costs associated with mandated reporting may affect companies' going public decision. For example, there is some evidence of favorable effects of EGC accommodations on IPO activity. *See, e.g.,* Michael Dambra et al., *The JOBS Act and IPO Volume: Evidence that Disclosure Costs Affect the IPO Decision,* 116 J. Fin. Econ. 121 (2015). There is also evidence suggesting that costs associated with the Sarbanes-Oxley Act regulations encouraged companies to exit U.S. public stock markets. *See, e.g.,* Christian Leuz et al., *Why do Firms Go Dark? Causes and Economic Consequences of Voluntary SEC Deregistrations,* 45 J. Acct. Econ. 181 (2008) at 181 (finding that ''many firms go dark due to poor future prospects, distress and increased compliance costs after SOX''). While savings associated with the proposed amendments, if adopted, might be one factor in a company's decision to go public (or to stay public), we also acknowledge that non-regulatory factors may play a more significant role in driving initial public offering activity. *See, e.g.,* Michael Ewens et al., *Regulatory Costs of Being Public: Evidence from Bunching Estimation,* 153 J. Fin. Econ. 103775 (2024) (estimating that regulatory costs may explain about 7% of the decline in the likelihood of initial public offerings after 2000, and stating that non-regulatory factors, such as abundant private equity financing, changing economies of scale and scope, and changing acquisition behavior, are likely to have played a more important role); Xiaohui Gao et al., *Where Have All the IPOs Gone?* 48 J. Fin. Quant. Analys. 1663 (2013) (documenting various patterns in initial public offering activity, small firm profitability, mergers and acquisitions activity, and other trends that the authors find to be inconsistent with a regulatory costs explanation for the decline in initial public offerings after 2000 but consistent with increases in the importance of economies of scope over time).

[922] An increase in the number of companies who access public capital markets could increase capital formation to the extent it facilitates the raising of more capital than would be available to these issuers outside of public markets and the investment of such capital toward productive uses. Access to public markets may facilitate the raising of more capital due, for example, to an enhancement of investor protections and a broadening of the investor base.

[923] *See, e.g.,* Douglas Diamond & Robert Verrecchia, *Disclosure, Liquidity, and the Cost of Capital,* 46(4) J. of Fin. 1325 (1991); David Easley & Maureen O'Hara, *Information and the Cost of Capital,* 59(4) J. of Fin. 1553 (2004); Luigi Guiso et al., *Trusting the Stock Market,* 63 J. Fin. 2557 (2008); letters from AFL–CIO et al. (stating that ''changes to the . . . executive compensation disclosure rules would also harm capital formation, as investors will respond to less transparency on executive compensation by withholding their capital''); CFA Institute (stating that ''[t]he rulebook as it exists today addresses problems and scandals that led to substantial investor losses'' and that the ''[r]emoval of large swaths of disclosures would be a self-inflicted wound to investor confidence in US capital markets''); Public Citizen (stating that changes to executive compensation disclosure requirements would ''subtract from capital formation, as investors might know less about the efficiency of corporate funds shaping incentives and withhold their capital'').

[924] *See, e.g., supra* sections IV.E.3, IV.F.2, and IV.I.2.

[925] *See id.*

[926] *See id.*

[927] *See supra* sections II.L and II.J.

[928] *See supra* sections II.C.1 and II.K.

[929] *See supra* section II.E.2.

[930] *See supra* section II.E.1.

[931] *See supra* sections II.C.3 and II.E.1.

[932] *See supra* section II.F.

[933] *See supra* section II.A.

to other filings to access information that is currently contained in a single filing, further increasing potential search costs.[934]

In other ways, search costs may be reduced by the proposed amendments. In particular, the proposed Status of Equity Awards Table may make it easier to assess the complete set of equity awards that have been newly granted, remain outstanding, or have newly vested or been exercised, on an award-by-award basis. Today, this information is spread across multiple tables and presented at different levels of aggregation. For example, for SRCs and EGCs, some of this information (regarding the final outcomes of awards) may have to be accessed in different filings, as these registrants are not currently required to include an Option Exercises and Stock Vested Table. To the extent that registrants use the flexibility afforded to them to include information about grants or award outcomes that occurred after the end of the last completed fiscal year in the proposed Status of Equity Awards Table, such up-to-date information may also become easier to access without referring to other filings. The proposed requirement that LAFs tag the proposed primary tabular disclosures in Inline XBRL may also reduce the costs of extracting information from the disclosures of this subset of registrants.

The net effect on investor search costs, and thus the efficiency of the process by which investors and the market as a whole digest the disclosures, would likely depend on how registrants would use the flexibility afforded to them and whether the potential increases or decreases in search costs are associated with the information that is most frequently sought and most resource-intensive to find.

The proposed amendments may also increase the costs of analysis for some investors (either directly or via third parties). Current disclosures include certain registrant-computed measures of the value of in flight awards, both in the Outstanding Equity Awards at Fiscal Year-End Table (for all registrants) and in more detailed form in the disclosure of Compensation Actually Paid (for registrants required to provide pay-versus-performance disclosures). Removing the requirement that registrants compute these measures may increase analytical burdens on investors (directly or via third parties) who use such computations to evaluate how compensation is tracking performance over time.[935] For those registrants required to include a CD&A, the disclosure of, for example, compensation peer groups would no longer be explicitly required. To the extent that some such registrants would no longer disclose peer groups, investors and/or third parties may bear greater analytical burdens to identify appropriate peers against which to judge the appropriateness of a registrant's executive compensation design without input from the registrant. Inefficiencies may result from these analytical burdens in that there may be an increased risk of duplicative analytical effort by investors and/or third parties.

Any increased search and analytical burdens are likely to be borne primarily by those investors who most actively review executive compensation disclosures in detail and allocate the greatest resources to such review, which are likely institutional investors and larger investors.[936] Other investors, such as retail investors or smaller investors for whom it is not possible or cost-effective to allocate significant resources to such review, would be less likely to bear such costs but would, in the absence of taking on such search and analysis, be more likely to have less information and analysis available when making investment and voting decisions. Given recent governance changes that increase the delegation of voting to the end holders of securities,[937] the role of this group of investors may become more important to voting outcomes in the future, which may exacerbate any effects of reduced access to information and analysis. That said, these investors may be the most likely to read executive compensation disclosure linearly. As such, these investors are also the most likely to benefit from the expected reduction in the volume of disclosure; while they may have less detailed information and analysis at their disposal, they may find the information that remains easier to digest than current disclosures. Given the limited time and resources these investors allocate to reviewing executive compensation disclosures, the cost of their review is unlikely to change meaningfully. However, information asymmetries about executive compensation between investors of different types could either increase or decrease or remain unchanged depending on the extent to which the more principles-based approach would result in information being more readily understood by retail and smaller investors, offsetting the increased asymmetries that may arise from differences in the degree of additional search and analysis undertaken.

The proposed amendments would reduce the detail and comprehensiveness of executive compensation disclosure and may thus lead, overall, to a less precise evaluation (by even the investors with more significant experience or resources for disclosure review) of the appropriateness of the level of pay and of the full set of monetary incentives provided to executive officers.[938] For example, the proposed amendments are expected to reduce the amount of detailed information available about certain terms of incentive awards (including information about the rigor of performance goals that, in some cases, is currently only available via in flight estimates provided by registrants), certain miscellaneous components of pay (including perquisites and retirement benefits), and potential payments upon termination. The proposed amendments are expected to reduce the comprehensiveness of information about, for example, the compensation of a larger group of executive officers, all amounts of compensation paid to NEOs (however small), and director compensation. Any increase in search and analysis costs could further increase the imprecision of investor evaluations to the extent that some investors would be unwilling to bear additional costs to more closely approach the current precision with which they understand executive compensation.[939]

Any such reduced precision in investors' understanding of the executive compensation at registrants may introduce noise into their voting and investment decisions, in that these decisions may be more likely to vary

[934] For example, the proposed amendments would require reference to the proposed Status of Equity Awards Table from the prior year to identify, in the current year's table, stock that vested or options that were exercised in the most recently completed fiscal year; would require reference to Form 4 disclosures to identify the number of earned shares at the end of the performance period of a stock award with performance-based vesting plus an additional time-based vesting period; and may require reference to Forms 8–K or exhibits to other filings for certain terms of termination agreements and equity awards. *See supra* section IV.E.1.

[935] For evidence that investors and third parties are using the provided computations currently, see note 753 above.

[936] These investors may have clients that include retail and smaller investors, who may thereby indirectly bear some of these costs.

[937] *See supra* section IV.C.7.

[938] As discussed in the more detailed discussion of economic costs and benefits of the individual provisions of the proposed amendments, materiality considerations and voluntary disclosures may reduce the amount of information loss under the proposal as compared to the baseline, but some information is still expected to be lost. *See supra* sections IV.D through IV.J and IV.L.

[939] *See supra* note 755.

from the decisions that would be made with more detailed and comprehensive information. Such noise may reduce allocative efficiency in the capital market, in that investors' ability to direct capital to its most productive uses may be negatively affected by a diminished ability to reliably evaluate different investment alternatives. A reduction in the detail and comprehensiveness of executive compensation would also be expected to reduce the amount of information incorporated into stock prices, and thus the informational efficiency of markets. Noise in voting decisions may reduce productive efficiency, in that less informed voting outcomes in director elections, say-on-pay votes, votes on equity incentive plans, and other relevant votes may result in less optimal board composition, compensation design, and other registrant-level decisions than otherwise, which could affect the performance and productivity of registrants.

The proposed amendments may also affect compensation design because of the influence disclosure considerations can have on compensation decisions. Some aspects of the proposed amendments reduce factors that could contribute currently to distortions in compensation design (such as in the consideration of whether to provide personal security services to executives or whether to pay a bonus that could change the composition of the NEOs). However, other aspects of the proposed amendments may contribute to new potential distortions, through reduced transparency of some elements (such as perquisites, non-equity incentive pay, retirement benefits, and termination pay) relative to the transparency of other elements of compensation or through differences in how similar awards may be valued (in the case of options versus stock with market conditions). Any distortions associated with disclosure considerations rather than shareholder value optimization may reduce the optimality of executive compensation design and thereby affect the productive efficiency of registrants.

The potential effects of the proposed amendments on efficiency and capital formation may be influenced by other concurrent changes in market practices and regulation. On one hand, other regulatory initiatives to reduce disclosure burdens may, together with the proposed amendments, result in aggregate compliance cost savings that are more likely to have meaningful impacts on capital formation and the decision of companies to go (or stay) public. On the other hand, these initiatives, in totality, may also be more likely to reduce transparency to an extent that there may be offsetting effects on the cost of capital and overall trust in public markets. Market and regulatory environment changes around other governance mechanisms, as discussed in section IV.C.7 above, may also increase the relative importance of executive compensation information to investors' voting and investment decisions and may thus exacerbate the effects of any noise that would be introduced into these decisions as a result of the more condensed and less detailed disclosures that would result from the proposed amendments. A recent trend towards more fragmented shareholder voting, also discussed in section IV.C.7 above, may result in an increase in the number of individuals separately evaluating executive compensation disclosures and in the variety of approaches used for such evaluations. Such a trend could increase the costs associated with a reduction in registrant-provided computations or in the accessibility of certain information, while also increasing the potential benefits of a reduced volume of disclosure given the more limited resources these investors may expend in reviewing the disclosure.

We anticipate limited competitive effects of the proposed amendments on registrants. Because compliance costs generally do not scale perfectly with size, in that they have some fixed cost components, the same disclosure requirement can result in disproportionate burdens on smaller companies. The scaled accommodations currently available to SRCs and EGCs may encourage competition by reducing the risks of such disproportionate burdens. Some aspects of the proposed amendments (such as the proposed NEO definition or the proposed tabular disclosure requirements) would reduce the extent of differences between the requirements that apply to SRCs and EGCs and all other registrants by applying more limited disclosure requirements to all registrants. However, the proposed amendments would also maintain an exemption for SRCs and EGCs from some of the disclosure requirements under the proposal that we expect to be relatively more costly to produce, such as CD&A and pay ratio disclosures. The proposed amendments would thereby maintain a scaled disclosure regime for SRCs and EGCs (or for NAFs, if the proposed amendments in the 2026 Filer Status Proposing Release are adopted) and are thus not expected to meaningfully affect competition among registrants on the whole.

O. Request for Comment

132. What compliance cost savings would be realized by registrants under the proposed amendments? What costs, including transition costs and ongoing costs, would registrants incur under the proposed amendments? Please provide any data or estimates regarding the costs of compliance under the current rules and the anticipated costs of compliance under the proposal, such as (in both cases) preparing the disclosures, including registrant staff and director time; the fees of legal counsel, compensation consultants, or other external advisors; costs for XBRL data tagging; and other costs associated with preparing the disclosures. Where possible, please associate any potential compliance cost savings with the specific elements of the proposed amendments that facilitate such savings.

133. To what extent would the principles-based elements of the proposed amendments benefit registrants and/or investors by facilitating the tailoring of registrants' executive compensation disclosures? To what extent would the principles-based elements result in additional costs to evaluate materiality and design tailored disclosure formats? Would the principles-based elements of the proposed amendments increase or decrease the use of, or degree of reliance on, external advisors, including compensation consultants?

134. Would the disclosures under the proposed amendments facilitate investors' evaluation of a registrant's executive compensation practices? How does the information that would be provided in the proposed tabular disclosures align with the measures and metrics that investors focus on or view as material in making investment and voting decisions? Is the total compensation measure that would be included in the Granted Compensation Table a measure of total compensation that investors would use directly, or would they make adjustments to evaluate the level of an NEO's pay? Would investors be able to directly use the total compensation measure from the proposed Earned Compensation Table as a measure of realized pay or would they make adjustments to evaluate compensation outcomes and practices? How would they use these two proposed measures, or the quantitative elements in the Granted Compensation Table and Earned Compensation Table, in their analyses?

135. Are there additional values or measures that should be required to be disclosed under Commission executive compensation disclosure rules in

tabular format or in footnotes because they are material to investors? To what extent do investors require separate identification of the individual items that would be aggregated in columns of the proposed tabular disclosures (such as the individual grant date fair value of each equity award, or the individual components of miscellaneous compensation) to evaluate executive compensation? How do investors use such information in making investment and voting decisions?

136. Is all of the executive compensation information that is material to investors in the context of larger companies also material in the context of SRCs and EGCs (or new NAFs, as defined in the 2026 Filer Status Proposing Release)? If not, how so?

137. How would the proposed amendments affect investors' costs to review and evaluate executive compensation disclosures, relative to their costs under the current rule? In what ways would search costs and analysis costs decrease for investors? In what ways would these costs increase? How would the costs vary across different types of investors? Please provide any data or estimates regarding the costs to investors of reviewing current executive and director compensation disclosures and the anticipated costs of reviewing the proposed revised disclosures, including individual or institutional staff time; any costs associated with extracting and analyzing data, including producing any required computations; the fees of third parties, including data aggregators or proxy advisors; and other costs associated with reviewing and analyzing the disclosures. Where possible, please associate any potential increases in costs with the specific elements of the proposed amendments that would result in such costs.

138. What adjustment costs would investors experience in the initial year after the effectiveness or compliance date of the proposed amendments? How would such costs vary across different types of investors? Please provide any data or estimates regarding such costs, linking any such transition costs with the specific elements of the proposed amendments that would result in such costs.

139. Given the overall objective of a more principles-based approach to executive compensation disclosure, would there be any costs to investors of the overall potential reduction in information? Specifically, we are proposing to consolidate the primary tabular disclosures into three new tables. What would be the costs to investors, if any, of the reduction in information in the tabular disclosures?

140. Would executive compensation levels or structures be likely to change as a result of the proposed amendments? How so? For example, would the use of non-equity incentive awards be likely to change? Would the level of perquisites or retirement benefits provided to executives be likely to change?

141. Would different types of investors (*e.g.,* institutional investors, financial intermediaries acting on behalf of investors, or retail investors) be differentially affected by the proposed amendments? How so?

142. Are the monetized estimates and underlying assumptions in section IV.M appropriate? Why or why not? Is the estimate of initial compliance costs a reasonable reflection of the potential transition costs to registrants? Are there additional costs or benefits that can be reasonably estimated? Please provide any data or analysis that could inform the monetization of costs and benefits.

143. Do investors and other market participants have any reliance interests in the current executive compensation disclosure rules? If so, please describe.

144. What would be the effects of the proposed amendments on efficiency, competition, capital formation, and investor protection?

V. Paperwork Reduction Act

A. Summary of the Collections of Information

Certain provisions of our rules, forms, and schedules that would be affected by the proposed amendments contain ''collection of information'' requirements within the meaning of the Paperwork Reduction Act (''PRA'').[940] We are submitting the proposed amendments to the OMB for review and approval in accordance with the PRA and its implementing regulations.[941] The hours and cost associated with preparing, filing, and sending the forms and schedules and retaining records constitute paperwork burdens imposed by each collection of information.[942] An agency may not conduct or sponsor, and a person is not required to comply with, a collection of information requirement unless it displays a currently valid OMB control number. The titles for the affected collections of information are:

- Form 10–K (OMB Control No. 3235–0063);
- Form 8–K (OMB Control No. 3235–0060);
- Regulation 14A and Schedule 14A (OMB Control No. 3235–0059);
- Regulation 14C and Schedule 14C (OMB Control No. 3235–0057); and
- Form N–CSR (OMB Control No. 3235–0570).

The forms and schedules listed above were adopted under the Exchange Act, and Form N–CSR was adopted under the Investment Company Act. Responses to these collections of information are mandatory. Responses are not kept confidential, and there is no mandatory retention period for the information disclosed.

A description of the proposed amendments, including the need for the information and its proposed use, as well as a description of the likely respondents and a discussion of the potential economic effects of the proposed amendments, can be found in sections II and IV above.

For purposes of the PRA analysis, the paperwork burden is generally allocated between burden hours, which reflect the portion of the burden that is performed by a registrant internally, and costs, which typically reflect the cost of outside professionals retained by the registrant in connection with the information collection. The estimates in the PRA analysis represent the average burden for all registrants, both large and small. In deriving our estimates, we recognize that the burdens will likely vary among individual registrants based on a number of factors, including the size and complexity of their businesses. These estimates include the time and the cost of preparing and reviewing disclosure, filing documents, and retaining records. We believe that some registrants will experience costs in excess of this average and some registrants will experience less than the average costs. The estimates also reflect the average expected compliance cost savings across the first three years of effectiveness of the proposed amendments, though these savings may be reduced in, for example, the first year of effectiveness (due to short-term transition costs) and greater in the later years. For purposes of the PRA analysis, the burden estimates are presented on a net basis, reflecting the offsetting effect of estimated cost savings against estimated information collection costs of the proposed amendments. Our methodologies for deriving these estimates are discussed in section V.B below.

[940] 44 U.S.C. 3501 *et seq.*

[941] *See* 44 U.S.C. 3507(d); 5 CFR 1320.11.

[942] The paperwork burdens for Regulation S–K and Regulation S–T are imposed through the forms, schedules, and reports that are subject to the requirements in these regulations and are reflected in the analysis of those documents.

B. Estimated Paperwork Burden Effects of the Proposed Amendments

The following PRA Table 1 summarizes the estimated effects of the proposed amendments on the paperwork burdens associated with the affected forms and schedules.

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PRA Table 1. Estimated Paperwork Burden Effects of the Proposed Amendments		
Proposed Amendments	**Affected Forms / Schedules**	**Estimated Effects**
Revising Item 402 disclosure requirements, including: • Reducing the number of NEOs; • Reducing the number of required tables; • Simplifying various other requirements, including with respect to CD&A, pay ratio, clawbacks, and perquisites; and • Eliminating various other requirements, including with respect to quantification of potential payments upon termination or change-in-control, compensation policies and practices related to risk management, and policies and practices related to grant of equity awards close in time to release of material non-public information.	Form 10-K	Decrease of 254.28 burden hours and $50,165.82 in costs per response[(i)] No change in number of annual responses
Revising NEO definition, thereby reducing the number of situations where a Form 8-K filing would be required under Item 5.02(b) and (e) of Form 8-K.	Form 8-K	No change in burden hours or costs per response Decrease of 695 Form 8-K filings per year[(ii)]
Revising pay-versus-performance disclosure requirements, including substantially streamlining the requirements.	Schedule 14A, Schedule 14C	Decrease of 13.28 burden hours and $2,655.07 in costs per response[(iii)] No change in number of annual responses
Revising golden parachute disclosure requirements, including simplifying the tabular requirements.	Schedule 14A, Schedule 14C	Decrease of 1.00 burden hour and $1,800.00 in costs per response[(iv)] No change in number of annual responses
Removing the disclosure item that requires registered management investment companies subject to the requirements of Rule 10D-1 to provide the same disclosure required by Item 402(w)(2) of Regulation S-K.	Form N-CSR	Decrease of 8 burden hours and $1,188 in costs per response[(v)] No change in number of annual responses

(i) The current OMB inventory for Form 10-K reflects, on average, approximately 1,695.20 burden hours and $334,438.81 in costs per response (which we calculate based on the current Form 10-K OMB inventory of 6,740 total responses annually, 11,425,648 total burden hours annually, and $2,254,117,579 total cost burden annually). We estimate that approximately 30% of the current burdens for Form 10-K are attributable to Item 402 and that the proposed amendments would reduce the burden attributable to Item 402 by approximately 50%. Accordingly, we estimate that the proposed amendments would decrease the burden per response by approximately 254.28 burden hours (30% of 1,695.20 hours multiplied by 50%) and $50,165.82 in costs (30% of $334,438.81 multiplied by 50%). In deriving our estimates, we considered, among other things, the length and complexity of Item 402 disclosures as compared to other annual report and proxy statement disclosures and the fact that the proposed amendments would reduce the number of NEOs and required tables typically by greater than 50%.

(ii) The current OMB inventory for Form 8-K reflects total annual responses of 70,760. We estimate that the proposed amendments would decrease the number of Form 8-K filings by approximately 695. In deriving our estimates, we considered, among other things, the number of Forms 8-K that were filed in 2025 that responded to Item 5.02(b) and (e) and the fact that the proposed amendments would reduce the number of NEOs.

(iii) The Commission estimated in 2022 that Item 402(v) would impose, on average, approximately 17.70 burden hours and $2,360.06 in costs per response. *See* 2022 Pay-versus-Performance Adopting Release at 55190. We are adjusting these cost estimates by a factor of 1.5 to reflect the Commission's determination, subsequent to the 2022 Pay-versus-

Performance Adopting Release estimates, to update for inflation the OMB cost inventory for its collections of information. *See* 2022 Clawback Adopting Release at 73133. When applied to the cost burden for Item 402(v), this results in an updated cost of approximately $3,540.09 per response. We estimate that the proposed amendments would reduce the burden attributable to pay-versus-performance disclosures by approximately 75%. Accordingly, we estimate that the proposed amendments would decrease the burden per response by approximately 13.28 burden hours (17.70 hours multiplied by 75%) and $2,655.07 ($3,540.09 multiplied by 75%) in costs. In deriving our estimates, we considered, among other things, the fact that the proposed amendments would substantially streamline the pay-versus-performance disclosure requirements (e.g., eliminating the requirement to present in a specified tabular format and eliminating the requirement to calculate a separate compensation actually paid figure) and would exempt a broader range of registrants (i.e., SRCs) from the requirement entirely.

(iv) The Commission estimated in 2011 that Item 402(t) would impose, on average, approximately 5.00 burden hours and $6,000.00 in costs per response. *See* 2011 Say-on-Pay Adopting Release at 6035-36. We are adjusting these cost estimates by a factor of 1.5 to reflect the Commission's determination, subsequent to the 2011 Say-on-Pay Adopting Release estimates, to update for inflation the OMB cost inventory for its collections of information. *See* 2022 Clawback Adopting Release at 73133. When applied to the cost burden for Item 402(t), this results in an updated cost of approximately $9,000.00 per response. We estimate that the proposed amendments would reduce the burden attributable to golden parachute disclosures by approximately 20%. Accordingly, we estimate that the proposed amendments would decrease the burden per response by approximately 1.00 burden hour (5.00 hours multiplied by 20%) and $1,800.00 in costs ($9,000.00 multiplied by 20%). In deriving our estimates, we considered, among other things, the fact that the proposed amendments would simplify the tabular requirements, including by reducing the number of required columns.

(v) The Commission estimated in 2022 that Item 18 of Form N-CSR would impose, on average, approximately 25 burden hours and $3,600 in costs per response. *See* 2022 Clawback Adopting Release at 73134. We estimate that the proposed amendments would reduce the burden attributable to Item 18 of Form N-CSR disclosures by 33%. Accordingly, we estimate that the proposed amendments would decrease the burden per response by approximately 8 burden hours (as rounded) (25 hours multiplied by 33%) and $1,188 ($3,600 multiplied by 33%) in costs. In deriving our estimates, we considered, among other things, the fact that the proposed amendments would eliminate certain disclosure, as well as the tagging of that disclosure in XBRL format, currently required by Item 18(b) of Form N-CSR.

For PRA purposes, the Item 402 paperwork burden generally is reflected in the OMB inventory for the Form 10–K collection of information notwithstanding the fact that, as a practical matter, registrants must also include the disclosures required by Item 402 in their annual proxy or information statement on Schedule 14A or Schedule 14C and often incorporate by reference such disclosures into their annual report on Form 10–K. We recognize that Item 402 information is required by collections of information beyond Form 10–K and that, as a result, there also may be incremental reductions in burdens for additional collections of information as a result of the proposed amendments not reflected in our estimates.[943] We have not taken separate reductions in burdens for such collections as typically the disclosures provided in response to such collections duplicate (or incorporate by reference) what is provided in response to Form 10–K. We believe this approach reflects the overall effect of the proposed amendments and also errs on the side of being conservative by avoiding overstating the reductions in burdens.[944]

C. Incremental and Aggregate Burden and Cost Estimates

The following PRA Table 2 summarizes the estimated number of affected annual responses and the estimated aggregate change in burden hours and costs as result of the proposed amendments.

[943] Such collections of information include: Form S–1 (OMB Control No. 3235–0065); Form S–4 (OMB Control No. 3235–0324); Form S–11 (OMB Control No. 3235–0067); Form 10 (OMB Control No. 3235–0064); and Form N–2 (OMB Control No. 3235–0026).

[944] We also recognize that there may be an incremental reduction in burden not separately reflected in our estimates under Item 10 of Schedule 14A due to the reduction in the number of NEOs under the proposed amendments. *See* Item 10(a)(2)(ii)(A) of Schedule 14A (requiring tabular disclosures for each NEO under Item 402). We have not reflected a separate reduction in burden in this respect given that executive officers as a group are required to be covered under Item 10 of Schedule 14A and to take a conservative position with respect to reductions in burdens. *See* Item 10(a)(2)(ii)(B) of Schedule 14A (requiring tabular disclosures for all executive officers as a group).

PRA Table 2. Estimated Number of Affected Responses and Incremental Burden Hour and Cost Burden Decreases						
Affected Forms / Schedules	Decrease in Annual Responses (from PRA Table 1)	Number of Affected Annual Responses	Burden Hour Decrease Per Affected Response (from PRA Table 1)	Cost Burden Decrease Per Affected Response (from PRA Table 1)	Decrease in Burden Hours	Decrease in Cost Burden
	(a)	*(b)*	*(c)*	*(d)*	*(e) = (b) x (c)*	*(f) = (b) x (d)*
Form 10-K	N/A	6,740	254.28	$50,165.82	1,713,847	$338,117,627
Form 8-K	695	695	N/A	N/A	4,385[(i)]	$585,816[(i)]
Schedule 14A	N/A	3,935 / 153[(ii)]	13.28 / 1.00	$2,655.07 / $1,800.00	52,410[(iii)]	$10,723,100[(iv)]
Schedule 14C	N/A	231 / 12[(ii)]	13.28 / 1.00	$2,655.07 / $1,800.00	3,080 [(v)]	$634,921[(vi)]
Form N-CSR	N/A	1	8	$1,188	8	$1,188[(vii)]

(i) For purposes of calculating the decrease in burden hours and decrease in cost burden for Form 8-K, the number of affected responses in column (b) has been multiplied by, in the case of column (e), the average burden hours per response currently reflected in the OMB inventory for Form 8-K (i.e., approximately 6.31 hours per response, which we calculate based on the current Form 8-K OMB inventory of 70,760 total responses annually and 446,650 total burden hours annually) and, in the case of column (f), the average cost burden per response currently reflected in the OMB inventory for Form 8-K (i.e., approximately $842.90 in costs per response, which we calculate based on the current Form 8-K OMB inventory of 70,760 total responses annually and $59,643,418 total cost burden annually).

(ii) The first number reflects the estimated number of affected responses with respect to the proposed pay-versus-performance amendments and is based on the number of registrants that are currently subject to the pay-versus-performance requirements and the ratio of the number of annual responses reflected in the OMB inventory for Schedule 14A as compared to Schedule 14C. The second number reflects the estimated number of affected responses with respect to the proposed golden parachute amendments and is based on the number of Schedules 14A or Schedules 14C that were filed in 2025 that included golden parachute disclosures.

(iii) The decrease in burden hours for Schedule 14A is the sum of the burden hour decreases for the proposed pay-versus-performance amendments and the proposed golden parachute amendments (i.e., (3,935*13.28) + (153*1.00)).

(iv) The decrease in cost burden for Schedule 14A is the sum of the cost burden decreases for the proposed pay-versus-performance amendments and the proposed golden parachute amendments (i.e., (3,935*$2,655.07) + (153*$1,800.00)).

(v) The decrease in burden hours for Schedule 14C is the sum of the burden hour decreases for the proposed pay-versus-performance amendments and the proposed golden parachute amendments (i.e., (231*13.28) + (12*1.00)).

(vi) The decrease in cost burden for Schedule 14C is the sum of the cost burden decreases for the proposed pay-versus-performance amendments and the proposed golden parachute amendments (i.e., (231*$2,655.07) − (12*$1,800.00)).

(vii) *See supra* PRA Table 1.

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The following PRA Table 3 summarizes the current and requested paperwork burdens and calculates the changes to affected information collections' estimated responses and total burdens under the proposed amendments.

PRA Table 3. Changes in Paperwork Burdens under the Proposed Amendments									
Form / Schedule	Current Burden (from OMB inventory)			Program Change (from PRA Table 2)			Revised Burden		
	Current Annual Reponses	Current Burden Hours	Current Cost Burden	Decrease in Annual Responses	Decrease in Burden Hours	Decrease in Cost Burden	Annual Responses	Burden Hours	Cost Burden
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g) = (a) − (d)*	*(h) = (b) − (e)*	*(i) = (c) − (f)*
Form 10-K	6,740	11,425,648	$2,254,117,579	N/A	1,713,847	$338,117,627	6,740	9,711,801	$1,915,999,952
Form 8-K	70,760	446,650	$59,643,418	695	4,385	$585,816	70,065	442,265	$59,057,602
Schedule 14A	6,043	816,349	$163,269,774	N/A	52,410	$10,723,100	6,043	763,939	$152,546,674
Schedule 14C	354	39,756	$7,951,194	N/A	3,080	$634,921	354	36,676	$7,316,273
Form N-CSR	26,104	202,306	$5,455,736	N/A	8	$1,188	26,104	202,298	$5,454,548

D. Request for Comment

Pursuant to 44 U.S.C. 3506(c)(2)(B), we request comment in order to:

- Evaluate whether the proposed changes to the collections of information are necessary for the proper performance of the functions of the Commission, including whether the information will have practical utility;
- Evaluate the accuracy of our estimates of the change in burden hours and cost burden that would result from adoption of the proposed amendments;
- Determine whether there are ways to enhance the quality, utility, and clarity of the information to be collected;
- Evaluate whether there are ways to minimize the burden of the collections of information on those who respond, including through the use of automated collection techniques or other forms of information technology; and
- Evaluate whether the proposed amendments would have any effects on any other collection of information not previously identified in this section.

Any member of the public may direct to us any comments concerning the accuracy of these burden estimates and any suggestions for reducing these burdens. Persons submitting comments on the collection of information requirements should direct them to the OMB Desk Officer for the U.S. Securities and Exchange Commission, *MBX.OMB.OIRA.SEC_desk_officer@omb.eop.gov,* and should send a copy to Vanessa A. Countryman, Secretary, U.S. Securities and Exchange Commission, using any of the methods in the **ADDRESSES** section, with reference to File No. S7–2026–39. Requests for materials submitted to OMB by the Commission with regard to the collection of information should be in writing, should refer to File No. S7–2026–39, and should be submitted to the U.S. Securities and Exchange Commission, Office of FOIA Services, 100 F Street NE, Washington, DC 20549–2736. OMB is required to make a decision concerning the collections of information between 30 and 60 days after publication of this release. Consequently, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication.

VI. Initial Regulatory Flexibility Act Analysis

When an agency issues a rulemaking proposal, the RFA [945] requires the agency to prepare and make available for public comment an IRFA that describes the impact of the proposed rule on small entities.[946] This IRFA relates to the proposed amendments to rules and forms described in section II above.

A. Reasons for, and Objectives of, the Proposed Action

The proposed amendments are intended to make the Commission's executive compensation disclosure requirements more principles-based and the disclosures clearer, more concise, and less complex. In addition, the proposed amendments are intended to reduce compliance burdens for registrants and focus the disclosure on information that is likely to be material to investors. To this end, the proposed amendments would primarily (1) consolidate the main tabular disclosure requirements of Item 402 into three new tables, (2) reduce the number of NEOs for whom executive compensation disclosure is required from five or more to two in most circumstances, (3) provide registrants more flexibility in identifying and reporting perquisites, (4) make compensation disclosure generally, including the CD&A, more principles-based, (5) narrow the required scope of pay-versus-performance, pay ratio and clawbacks disclosures, (6) eliminate prescriptive requirements to disclose potential payments and benefits to an NEO in various termination or change-in-control scenarios, making them more principles-based, (7) simplify and make more principles-based the existing golden parachute compensation disclosure, (8) eliminate mandatory tabular disclosure for director compensation, and (9) extend the period of time available to registrants for providing Item 402 disclosure regarding the last completed fiscal year in registration statements that require Item 402 information. A discussion of the proposed amendments, including a high-level tabular comparison of certain elements of the proposal to current requirements, is set forth in section II above. We discuss the economic impact and potential alternatives to the amendments in section IV, the estimated compliance costs and burdens of the amendments under the PRA in section V, and the present values and annualized values of monetized benefits and costs in section IV.M, above.

B. Legal Basis

The amendments contained in this release are proposed under the authority set forth in: sections 3(b), 6, 7, 10, 19(a), and 28 of the Securities Act; sections 3(b), 9, 10D, 10(b), 12, 13, 14, 14A, 15(d), 16, 20A, 21A, 23(a), and 36 of the Exchange Act; sections 8, 20(a), 24(a), 30, and 38 of the Investment Company Act; section 211 of the Investment Advisers Act; [947] sections 3(a), 306(a), and 406 of the Sarbanes-Oxley Act of 2002; sections 102, 103, and 107 of the Jumpstart Our Business Startups Act; [948] sections 951, 953(a), 953(b), and 954 of the Dodd-Frank Wall Street Reform and Consumer Protection Act; and 5 U.S.C. 601.

C. Small Entities Subject to the Proposed Amendments

The proposed amendments to Item 402 and the related forms, rules, and schedules under the Securities Act, the Exchange Act and Investment Company Act would apply to registrants that are small entities, either as issuers or as investment companies. The RFA defines ''small entity'' to mean ''small business,'' ''small organization,'' or ''small governmental jurisdiction.'' [949] For purposes of the Regulatory Flexibility Act, currently under our rules, an issuer, other than an investment company, is a ''small business'' or ''small organization'' if it had total assets of $5 million or less on the last day of its most recent fiscal year and is engaged or proposing to engage in an offering of securities that does not exceed $5 million.[950] An investment company, including a BDC or face-amount certificate company that is a registrant under the Securities Act or the Exchange Act, is considered to be a small entity if it, together with other investment companies in the same group of related investment companies, has net assets of $50 million or less as of the end of its most recent fiscal year.[951] We estimate that, based on calendar year 2025 data, there were 678 issuers, 5 BDCs, and 62 open-end or closed-end management investment companies (''funds'') [952] that may be considered small entities under the current rules' definitions that would be subject to the proposed amendments.[953]

D. Projected Reporting, Recordkeeping, and Other Compliance Requirements

We expect the proposed amendments to reduce burdens associated with preparing executive compensation disclosure for *all* registrants. The proposed amendments should result in savings for registrants, by reducing both the time spent and the financial expense of preparing required disclosure under Item 402, which would benefit smaller companies.

The proposed amendments would substantially change the executive compensation disclosure requirements for *all* companies that file reports under the Exchange Act, offer securities for sale under the Securities Act, or register a class of securities under section 12(b) or section 12(g) of the Exchange Act on Form 10.

Additionally, smaller registrants, including ''small entities,'' would continue to be exempt from certain existing disclosure requirements. Specifically, smaller registrants are not currently required to provide disclosure related to CD&A, pay ratio, and compensation policies and practices related to risk management.[954] The proposed amendments would continue these accommodations, to the extent these requirements are being retained for other registrants.[955]

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[945] 5 U.S.C. 601 *et seq.*

[946] 5 U.S.C. 603(a).

[947] 15 U.S.C. 80b–1 *et seq.*

[948] Public Law 112–106, 126 Stat. 306 (2012).

[949] 5 U.S.C. 601(6).

[950] *See* 17 CFR 240.0–10(a); *see also* 17 CFR 230.157 (providing that an issuer, other than an investment company, is a ''small business'' or ''small organization'' if it had $5 million or less in total assets on the last day of its most recent fiscal year). In the 2026 Filer Status Proposing Release the Commission proposed to update the rules that define ''small entity'' under the RFA. As discussed in section II.E above, we are proposing to revise to $35 million the current $5 million threshold in our small business and small organization definitions for issuers for purposes of the RFA under the Securities Act and Exchange Act. We encourage commenters to review that proposal to determine whether it might affect their comments on this IRFA.

[951] *See* 17 CFR 270.0–10(a).

[952] These estimates are based on staff analysis of issuers potentially subject to the proposed amendments during calendar year 2025. This analysis is based on data from Morningstar Direct and data reported to the Commission for the quarter-end time period.

[953] The Commission also has a pending proposal addressing the definition under the Investment Company Act of small organization and small business for purposes of the RFA. *See Amendments to the ''Small Business'' and ''Small Organization'' Definitions for Investment Companies and Investment Advisers for Purposes of the Regulatory Flexibility Act,* Release No. IC–35864 (Jan. 7, 2026) [91 FR 1107 (Jan. 12, 2026)]. We encourage commenters to review that proposal to determine whether it might affect their comments on this IRFA.

[954] See section II.M above for a more detailed discuss of the scaling and other accommodations available currently and under the proposed rules for SRCs and EGCs, which would include small entities.

[955] SRCs and EGCs, including those that are small entities, are currently not required to comply with 17 CFR 229.402(s) (narrative disclosure of compensation policies and practices as they relate to risk management). *See* 17 CFR 229.402(m). Under

E. Duplicative, Overlapping, or Conflicting Federal Rules

We do not expect the proposed rules, if adopted, to duplicate, overlap, or conflict with other rules.

F. Significant Alternatives

The RFA directs us to consider alternatives that would accomplish our stated objectives, while minimizing any significant adverse impact on small entities. In connection with the proposed amendments, we considered the following alternatives:

- Establishing different compliance or reporting requirements or timetables that take into account the resources available to small entities;
- Clarifying, consolidating, or simplifying compliance and reporting requirements under the rules for small entities;
- Using performance rather than design standards; and
- Exempting small entities from all or part of the requirements.

As noted, we expect that all or nearly all small entities would be permitted to take advantage of any existing accommodations, to the extent retained in the proposed rule, that allow smaller registrants to provide reduced disclosure in certain areas as compared to other registrants or to be exempt from certain disclosure requirements. The proposed rules would continue to exempt small registrants from substantially the same executive compensation disclosure requirements from which they are exempt under the current rules, as discussed in more detail in section II.M above. In addition, as with all registrants, under the proposal small entities would only be required to provide disclosure for their PEO and PFO, which for SRCs and EGCs is a reduction from the current requirement to provide the PEO, PFO, and next most highly paid executive officer.

With regard to the non-scaled portions of the proposed rule, we believe that the expected benefits of the proposed amendments, including a more principles-based approach and greater flexibility in regard to certain provisions, will accrue to all registrants, including small entities. These expected benefits would result from, among other things:

- Requiring registrants to determine and disclose compensation information only for the PEO and PFO, instead of three or more executives (for small entities);
- A consolidated, more streamlined approach to tabular disclosure of executive compensation;
- Eliminating mandatory tabular disclosure for director compensation;
- Eliminating required disclosure related to grants of certain equity awards close in time to the release of material nonpublic information; and
- Simplifying disclosure requirements related to a registrant's action to recover erroneously awarded compensation.

After taking into account transition costs, we do not expect that the requirements included in the proposed amendments would increase burdens on any registrants, including small entities. We do not anticipate that small entities would experience any significant adverse impact from the proposal.

We have used both performance standards and design standards in connection with the proposed amendments. Where performance standards supported the goals of the proposed rule amendments, we sought to provide registrants with flexible, principles-based opportunities to meet related disclosure requirements. Where necessary or appropriate to achieving the goals of the proposed rule amendments to elicit specific information, we included design standards, requiring more prescriptive content and/or format to promote clarity and comparability. We believe that, in those areas where we have used design standards, the objectives of the proposed rules are unlikely to be met using performance standards. In these instances, we do not believe that small entities would be disproportionately affected by the proposed prescriptive requirements, some of which they are already complying with under the current rule.

We did consider several alternatives to certain provisions of the proposed rules, which we discuss in detail in section IV above. Some of these alternatives include:

- Reducing the NEOs covered to only the PEO (section IV.D.3). Because the elimination of the PFO may not significantly reduce costs, while the information loss to investors could be significant, we are not proposing this alternative.
- Requiring alternative presentations for the primary tabular disclosures, such as additional prescriptive requirements to disclose certain factual information about the terms of incentive awards in a standardized form or further delineation of Miscellaneous Compensation Received items (section IV.E.4). Because such additional prescriptive measures would likely increase costs, and not prescribing a presentation method could allow market practices or norms or company-specific approaches to develop under which this information may be presented in a more efficient manner, we are not proposing these alternatives.

The proposed amendments are intended to make the executive compensation disclosure requirements more principles-based, reduce compliance burdens for registrants, and focus the disclosure on information that is likely to be material to investors. We expect that the proposed amendments will generate compliance cost savings for registrants generally, including small entities. As indicated above, the proposed amendments include or retain a number of scaled disclosure accommodations for small entities, which encompass different compliance or reporting requirements, simplified compliance and reporting requirements, and certain exemptions.

Request for Comment

We encourage the submission of comments with respect to any aspect of this IRFA. In particular, we request comments regarding:

- The number of small entities that may be affected by the proposed amendments;
- The existence or nature of the potential impact of the proposed amendments on small entities discussed in the analysis;
- Whether and to what extent the proposed new accommodations related to golden parachute disclosure, pay-versus-performance disclosure and narrative disclosures relating to required tables would benefit small entities;
- Whether and to what extent the proposed continuation of existing exemptions from CD&A and pay ratio disclosure and, for small entities that are EGCs, pay-versus-performance and golden parachute compensation disclosure, would continue to benefit small entities;
- Whether and to what extent the proposed amendments aimed at reducing burdens for all registrants, including providing executive compensation disclosure for only two NEOs and eliminating required tabular disclosure for director compensation and narrative and tabular disclosure requirements related to grants of equity awards close in time to the release of material nonpublic information, would benefit small entities;
- Whether additional accommodations should be made available to small entities;
- Whether there are modifications to the proposed amendments that could

the proposal, the requirements contained in 17 CFR 229.402(s) would be eliminated for all registrants.

further lower the burden on small entities; and

• How to quantify the impact of the proposed amendments.

Commenters are asked to describe the nature of any impact and provide empirical data (or quantitative estimates) supporting the extent of the impact. Comments will be considered in the preparation of the Final Regulatory Flexibility Analysis, if the proposed amendments are adopted, and will be placed in the same public file as comments on the proposed amendments themselves.

VII. Congressional Review Act

For purposes of Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act),[956] the Commission must seek OMB's determination as to whether a final regulation constitutes a ''major rule.'' Under the Congressional Review Act, a rule is considered ''major'' where, if adopted, it results in or is likely to result in:

• An annual effect on the economy of $100 million or more;

• A major increase in costs or prices for consumers or individual industries; or

• Significant adverse effects on competition, investment, or innovation.[957]

To help inform OMB's determination as to whether any final rule that results from the proposal would be a ''major rule,'' the Commission solicits comment and data on:

• The potential effect on the U.S. economy on an annual basis;

• Any potential increase in costs or prices for consumers or individual industries; and

• Any potential effect on competition, investment, or innovation.

Commenters are requested to provide empirical data and other factual support for their views to the extent possible to inform OMB's determination regarding whether any final rule following this proposal is likely to be a ''major rule'' for the purposes of the Congressional Review Act.

Statutory Authority

The proposed amendments contained in this release are being proposed under the authority set forth in: sections 3(b), 6, 7, 10, 19(a), and 28 of the Securities Act; sections 3(b), 9, 10D, 10(b), 12, 13, 14, 14A, 15(d), 16, 20A, 21A, 23(a), and 36 of the Exchange Act; sections 8, 20(a), 24(a), 30, and 38 of the Investment Company Act; section 211 of the Investment Advisers Act; sections 3(a), 306(a), and 406 of the Sarbanes-Oxley Act of 2002; sections 102, 103, and 107 of the Jumpstart Our Business Startups Act; sections 951, 953(a), 953(b), and 954 of the Dodd-Frank Wall Street Reform and Consumer Protection Act; and 5 U.S.C. 601.

List of Subjects in 17 CFR Parts 229, 232, 239, 240, 249, and 274

Reporting and recordkeeping requirements, Securities, Investment companies, Administrative practice and procedure, Electronic filing.

Text of Proposed Amendments

For the reasons set forth in the preamble, the Commission is proposing to amend title 17, chapter II of the Code of Federal Regulations as follows:

PART 229—STANDARD INSTRUCTIONS FOR FILING FORMS UNDER SECURITIES ACT OF 1933, SECURITIES EXCHANGE ACT OF 1934 AND ENERGY POLICY AND CONSERVATION ACT OF 1975—REGULATION S–K

■ 1. The authority citation for part 229 continues to read as follows:

Authority: 15 U.S.C. 77e, 77f, 77g, 77h, 77j, 77k, 77s, 77z–2, 77z–3, 77aa(25), 77aa(26), 77ddd, 77eee, 77ggg, 77hhh, 77iii, 77jjj, 77nnn, 77sss, 78c, 78i, 78j, 78j–3, 78l, 78m, 78n, 78n–1, 78o, 78u–5, 78w, 78ll, 78mm, 80a–8, 80a–9, 80a–20, 80a–29, 80a–30, 80a–31(c), 80a–37, 80a–38(a), 80a–39, 80b–11 and 7201 *et seq.;* 18 U.S.C. 1350; sec. 953(b), Pub. L. 111–203, 124 Stat. 1904 (2010); and sec. 102(c), Pub. L. 112–106, 126 Stat. 310 (2012).

■ 2. Amend § 229.201 by revising Instruction 2 to the *Instructions to paragraph (d)* to read as follows:

§ 229.201 (Item 201) Market price of and dividends on the registrant's common equity and related stockholder matters.

* * * * *

Instructions to paragraph (d).

* * * * *

■ 2. For purposes of this paragraph, an ''individual compensation arrangement'' includes, but is not limited to, the following: a written compensation contract within the meaning of ''employee benefit plan'' under § 230.405 of this chapter and a plan (whether or not set forth in any formal document) applicable to one person as provided under Item 402(a)(7) of Regulation S–K (§ 229.402(a)(7)).

* * * * *

■ 3. Revise and republish § 229.402 to read as follows:

§ 229.402 (Item 402) Executive compensation.

(a) *General.*

(1) *Objective.* The objective of this Item is to provide investors with material information relevant to an assessment of the compensation of the registrant's named executive officers and directors. This Item requires clear, concise, and understandable disclosure of the compensation granted to, earned by, or paid to the named executive officers designated under paragraph (a)(2) of this Item and the directors covered by paragraph (k) of this Item for all services rendered in all capacities to the registrant and its subsidiaries.

Instruction to Item 402(a)(1). The registrant may provide any information not explicitly called for by this Item that is relevant to this objective in any format it determines to be appropriate, including in a supplemental table, in additional columns in an existing table, in footnotes to the tabular disclosures, or in supplemental narrative disclosures.

(2) *Persons covered.* Disclosure must be provided pursuant to this Item for each of the following (each a ''named executive officer'' and collectively ''named executive officers''):

(i) All individuals serving as the registrant's principal executive officer or acting in a similar capacity during the last completed fiscal year (''PEO''); and

(ii) All individuals serving as the registrant's principal financial officer or acting in a similar capacity during the last completed fiscal year (''PFO'').

(3) *Information required.* If a named executive officer served as the registrant's principal executive officer or principal financial officer or acted in a similar capacity during any part of a fiscal year with respect to which information is required, provide information for all of that person's compensation for the full fiscal year.

(4) *Recovered compensation.* If any amount has been recovered pursuant to the compensation recovery policy required by the listing standards adopted pursuant to 17 CFR 240.10D–1, identify and quantify the recovered amount and reduce the amount reported in the tables required under this Item by the recovered amount.

(5) *Certain matters with respect to presentation.*

(i) *Information necessary to an understanding of the tables.* The registrant must disclose any material information necessary to an understanding of the information disclosed in the tables required by paragraph (b) (Earned Compensation Table), (c) (Granted Compensation

[956] *See* 5 U.S.C. chapter 8.

[957] *See* 5 U.S.C. 804(2) (defining ''major rule'').

Table), and (d) (Status of Equity Awards Table) of this Item.

Instruction to Item 402(a)(5)(i). The registrant may disclose this information in any format it determines to be appropriate, including in a supplemental table, in additional columns in an existing table, in footnotes to the tabular disclosures, or in supplemental narrative disclosures.

(ii) *Flexibility in the manner of tabular presentation.* The registrant has flexibility in the manner of presentation of the tables required under this Item, as follows:

(A) *Omission of table or column.* A table or column may be omitted if no compensation granted to, earned by, or paid to any of the named executive officers is required to be reported in that table or column in any fiscal year covered by that table or column; and

(B) *Splitting columns.* A registrant may split a single column into multiple columns (or into a supplemental table) so long as the multiple columns (or supplemental table) are clearly labeled and in aggregate cover all items of compensation required to be reported in such single column.

(iii) *Compensation in a currency other than U.S. dollars.* If an amount required to be reported in U.S. dollars was granted to, earned by, or paid to a named executive officer or director in a currency other than U.S. dollars, report such amount in U.S. dollars and disclose, by a footnote to the table or otherwise, the rate and methodology used to convert the amount to U.S. dollars.

(6) *Treatment of specific types of issuers.*

(i) *Smaller reporting companies.* A registrant that qualifies as a ''smaller reporting company'' as defined by Item 10(f) (§ 229.10(f)(1)) may comply with this Item by providing the information required by:

(A) Paragraph (a) of this Item (General);

(B) Paragraph (b) of this Item (Earned Compensation Table) for each of its last two completed fiscal years;

(C) Paragraph (c) of this Item (Granted Compensation Table) for each of its last two completed fiscal years;

(D) Paragraph (d) of this Item (Status of Equity Awards Table);

(E) Paragraph (f) of this Item (Pay-versus-performance);

(F) Paragraph (g) of this Item (Disclosure of a registrant's action to recover erroneously awarded compensation);

(G) Paragraph (i) of this Item (Potential payments upon termination or change-in control);

(H) Paragraph (j) of this Item (Golden parachute compensation); and

(I) Paragraph (k) of this Item (Compensation of directors).

(ii) *Emerging growth companies.* A registrant that is an ''emerging growth company'' as defined in Rule 405 under the Securities Act (§ 230.405 of this chapter) or Rule 12b–2 under the Exchange Act (§ 240.12b–2 of this chapter), may comply with this Item by providing the information required by:

(A) Paragraph (a) of this Item (General);

(B) Paragraph (b) of this Item (Earned Compensation Table) for each of its last two completed fiscal years;

(C) Paragraph (c) of this Item (Granted Compensation Table) for each of its last two completed fiscal years;

(D) Paragraph (d) of this Item (Status of Equity Awards Table);

(E) Paragraph (g) of this Item (Disclosure of a registrant's action to recover erroneously awarded compensation);

(F) Paragraph (i) of this Item (Potential payments upon termination or change-in control); and

(G) Paragraph (k) of this Item (Compensation of directors).

(iii) *Foreign private issuers.* A foreign private issuer will be deemed to comply with this Item if it provides the information required by Items 6.B, 6.E.2, and 6.F of Form 20–F (17 CFR 249.220f), with more detailed information provided if otherwise made publicly available or required to be disclosed by the issuer's home jurisdiction or a market in which its securities are listed or traded, or paragraph (19) of General Instruction B of Form 40–F (17 CFR 249.240f), as applicable.

(7) *Definitions.* For purposes of this Item, the following definitions apply, unless the context otherwise requires:

Closing market price means the price at which the registrant's security was last sold in the principal market for such security as of the date for which the closing market price is determined.

Equity means stock and/or options, or similar instruments.

Equity incentive plan means an incentive plan or portion of an incentive plan under which awards are granted that fall within the scope of FASB ASC Topic 718, *Compensation—Stock Compensation.*

Grant date means the grant date determined for financial statement reporting purposes pursuant to FASB ASC Topic 718.

Incentive plan means any plan providing compensation intended to serve as incentive for performance to occur over a specified period, whether such performance is measured by reference to financial performance of the registrant or an affiliate, the registrant's stock price, or any other performance measure.

Non-equity incentive plan means an incentive plan or portion of an incentive plan that is not an equity incentive plan.

Option means an instrument such as a stock option, stock appreciation right, or similar instrument with option-like features.

Plan includes, but is not limited to, a plan, contract, authorization, or arrangement, whether or not set forth in any formal document, pursuant to which cash, securities, similar instruments, or any other property may be received. A plan may be applicable to one person. Registrants may omit information regarding group life, health, hospitalization, medical reimbursement, or disability plans that do not discriminate in scope, terms, or operation in favor of executive officers or directors of the registrant and that are available generally to all salaried employees.

Stock means instruments such as common stock, restricted stock, restricted stock units, phantom stock, phantom stock units, stock equivalent units, or any similar instruments that do not have option-like features.

Stock appreciation rights or SARs means SARs payable in cash or stock, including SARs payable in cash or stock at the election of the registrant or a named executive officer.

(8) *Newly reporting companies.* Information with respect to fiscal years prior to the last completed fiscal year will not be required if the registrant was not a reporting company pursuant to section 13(a) or 15(d) of the Exchange Act (15 U.S.C. 78m(a) or 78o(d)) at any time during that fiscal year, except that the registrant will be required to provide information for any such year if that information previously was required to be provided in response to a Commission filing requirement.

(b) *Earned Compensation Table.*

(1) *General.* Provide the information specified in paragraph (b)(2) of this Item, concerning the compensation earned by the named executive officers for each of the registrant's last three completed fiscal years, in an Earned Compensation Table in the following tabular format:

EARNED COMPENSATION TABLE

Name and position	Year	Salary earned ($)	Non-equity awards earned ($)	Equity awards		Miscellaneous compensation received ($)	Total compensation earned ($)
				Stock awards vested ($)	Option awards exercised ($)		
(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g)*	*(h)*
[PEO]							
[PFO]							

(2) Include in the Earned Compensation Table:

(i) The name and principal position of the named executive officer (column (a));

(ii) The fiscal year covered (column (b));

(iii) The dollar value of base salary (cash and non-cash) earned by the named executive officer during the fiscal year covered (column (c));

(iv) The aggregate dollar value of non-equity awards (including annual cash bonuses, *ad hoc* cash bonuses, such as signing and retention bonuses, and non-equity incentive plan awards) earned by the named executive officer during the fiscal year covered and all earnings on any outstanding awards under non-equity incentive plans (column (d));

Instruction 1 to Item 402(b)(2)(iii) and (iv). Include in the Salary Earned column (column (c)) or Non-Equity Awards Earned column (column (d)) any amount of salary or non-equity awards forgone at the election of a named executive officer under which stock, equity-based, or other forms of non-cash compensation instead have been received by the named executive officer.

Instruction 2 to Item 402(b)(2)(iii) and (iv). Report amounts when earned (including when an amount is earned for a single year under an award with a multi-year performance period).

(v) The aggregate dollar value realized upon vesting of stock (computed by multiplying the number of shares of stock or units by the closing market price of the underlying shares or units on the vesting date), or upon the transfer of a stock award for value (column (e));

(vi) The aggregate dollar value realized upon exercise of options (computed by multiplying the total number of securities underlying the options by the difference between the closing market price of the underlying securities on the exercise date and the exercise or base price of the options), or upon the transfer of an option award for value (column (f));

Instruction to Item 402(b)(2)(v) and (vi). Include the value of any related payment or other consideration provided (or to be provided) by the registrant to or on behalf of a named executive officer, including payment of the exercise price or related taxes, in the Miscellaneous Compensation Received column (column (g)).

(vii) Miscellaneous compensation earned or otherwise received during the covered fiscal year that the registrant could not properly report in any other column of the Earned Compensation Table (column (g)), as follows:

(A) Perquisites and other personal benefits, unless the aggregate total value of such compensation for a named executive officer is less than $150,000;

Instruction to Item 402(b)(2)(vii)(A). To determine if perquisites and personal benefits exceed the perquisites aggregate reporting threshold, the registrant may exclude from the calculation any individual perquisite or personal benefit that is a *de minimis* fringe benefit under section 132(a)(4) of the Internal Revenue Code (26 U.S.C. 132(a)(4)), or any successor provision.

(B) All ''gross-ups'' or other amounts reimbursed during the fiscal year for the payment of taxes, including any reimbursements of taxes owed with respect to perquisites or other personal benefits;

(C) For any security of the registrant or its subsidiaries purchased from the registrant or its subsidiaries (through deferral of salary or bonus, or otherwise) at a discount from the market price of such security at the date of purchase, unless that discount is available generally, either to all security holders or to all salaried employees of the registrant, the compensation cost, if any, computed in accordance with FASB ASC Topic 718;

(D) For any exercises of options where the registrant paid the exercise or base price or related taxes, or provided any other consideration with respect to the option exercise to or on behalf of the named executive officer, the value of those payments;

(E) The amount paid or accrued to any named executive officer pursuant to a plan or arrangement in connection with:

(*1*) Any termination of such named executive officer's employment with the registrant and its subsidiaries, including without limitation through resignation, severance, retirement, or constructive termination (including a change in responsibilities); or

(*2*) A change in control of the registrant.

(F) Registrant contributions or other allocations to vested and unvested defined contribution plans and nonqualified deferred compensation plans, and any above-market or preferential earnings on compensation that is deferred on a basis that is not tax-qualified, including earnings on nonqualified defined contribution plans;

Instruction to Item 402(b)(2)(vii)(F). Interest on deferred compensation is above-market only if the rate of interest exceeds 120 percent of the applicable federal long-term rate, with compounding (as prescribed under section 1274(d) of the Internal Revenue Code (26 U.S.C. 1274(d))) at the rate that corresponds most closely to the rate under the registrant's plan at the time the interest rate or formula is set. In the event of a discretionary reset of the interest rate, the requisite calculation must be made on the basis of the interest rate at the time of such reset, rather than when originally established. Only the above-market portion of the interest must be included. If the applicable interest rates vary depending upon conditions such as a minimum period of continued service, the reported amount should be calculated assuming satisfaction of all conditions to receiving interest at the highest rate. Dividends (and dividend equivalents) on deferred compensation denominated in the registrant's stock are preferential only if earned at a rate higher than dividends on the registrant's common stock. Only the preferential portion of the dividends or equivalents must be included.

(G) For any plan that provides for the payment of retirement benefits or benefits that will be paid primarily following retirement, including but not

limited to tax-qualified defined benefit plans and supplemental executive retirement plans, but excluding tax-qualified defined contribution plans and nonqualified defined contribution plans, the aggregate of:

(*1*) Service costs, calculated as the actuarial present value of each named executive officer's benefit under all such plans attributable to services rendered during the covered fiscal year, and

(*2*) Prior service costs, calculated as the entire cost of benefits granted (or credit for benefits reduced) in a plan amendment (or initiation) during the covered fiscal year that are attributed by the benefit formula to services rendered in periods prior to the amendment;

Instruction to Item 402(b)(2)(vii)(G). For purposes of the amount(s) reported pursuant to paragraph (b)(2)(vii)(G), the registrant must use the same methodology as used for the registrant's financial statements under generally accepted accounting principles.

(H) The dollar value of any insurance premiums paid by, or on behalf of, the registrant during the covered fiscal year with respect to life insurance for the benefit of a named executive officer;

(I) The dollar value of any dividends or other earnings paid on outstanding stock or option awards; and

(J) The dollar value of any other compensation earned by or paid to the named executive officer for or during the fiscal year that the registrant determines is material or otherwise elects to disclose.

(viii) The sum of all amounts reported in columns (c) through (g) (column (h)).

Instruction to Item 402(b)(2). Any amounts deferred, whether pursuant to a plan established under section 401(k) of the Internal Revenue Code (26 U.S.C. 401(k)), or otherwise, must be included in the appropriate column for the fiscal year in which earned.

(3) A registrant that is a large accelerated filer (as defined in § 240.12b–2 of this chapter) must provide, and all other registrants are permitted to provide, the disclosure required under paragraph (b)(2) of this section in an Interactive Data File as required by 17 CFR 232.405 (Rule 405 of Regulation S–T) in accordance with the EDGAR Filer Manual (referenced in § 232.301 of this chapter).

Instruction 1 to Item 402(b)(3). Information or disclosures provided in a footnote to the Earned Compensation Table are not required to be provided in an Interactive Data File.

(c) *Granted Compensation Table.*

(1) Provide the information specified in paragraph (c)(2) of this Item, concerning the compensation granted to the named executive officers for each of the registrant's last three completed fiscal years, in a Granted Compensation Table in the following tabular format:

GRANTED COMPENSATION TABLE

Name and position	Year	Annualized salary ($)	Non-equity awards granted ($)	Equity awards		Total compensation granted ($)
				Stock awards granted ($)	Option awards granted ($)	
(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g)*
[PEO]						
[PFO]						

(2) Include in the Granted Compensation Table:

(i) The name and principal position of the named executive officer (column (a));

(ii) The fiscal year covered (column (b));

(iii) The annualized dollar value of base salary for the named executive officer as of the last day of the fiscal year covered (column (c));

(iv) The aggregate target dollar value of non-equity awards (including annual cash bonuses and *ad hoc* cash bonuses, such as signing and retention bonuses) and the aggregate target dollar value of payouts pursuant to awards under non-equity incentive plans granted to the named executive officer during the fiscal year covered (column (d));

Instruction 1 to Item 402(c)(2)(iv). The aggregate target dollar value of a non-equity award is reportable in the fiscal year during which the award was granted; *provided, however,* that if a non-equity award was earned in a fiscal year prior to the grant year, such award must be reported in that prior fiscal year (*e.g.,* an annual bonus not granted until the first quarter of the fiscal year immediately following the last completed fiscal year but earned in the last completed fiscal year must be reported in the last completed fiscal year).

Instruction 2 to Item 402(c)(2)(iv). For non-equity awards with multiple potential outcomes (*e.g.,* minimum, target, and maximum), the target outcome is the achievement of the target outlined in the award at the 100 percent level. For non-equity awards that have a binary outcome (*i.e.,* awards that are either fully earned or not earned at all), the target outcome is that the award criteria are met and the award is fully earned.

(v) For awards of stock granted during the covered fiscal year, the aggregate grant date fair value computed in accordance with FASB ASC Topic 718, except that it must be assumed that the award's target outcome(s) will be achieved (column (e));

(vi) For awards of options granted during the covered fiscal year, the aggregate grant date fair value computed in accordance with FASB ASC Topic 718, except that it must be assumed that the award's target outcome(s) will be achieved (column (f)); and

Instruction 1 to Item 402(c)(2)(v) and (vi). The grant date fair value of an equity award is reportable in the fiscal year during which the award was granted; *provided, however,* that a registrant may elect to report an equity award in the fiscal year immediately prior to the grant year if the registrant considers the award to be for performance in that prior year and the award is granted in the first quarter of the grant year. The registrant must report equity awards on a consistent basis across the fiscal years covered in the table and, if the registrant elects to report equity awards in the fiscal year immediately prior to the grant year pursuant to this Instruction, the registrant must disclose that it is reporting equity awards in the fiscal year immediately prior to the grant year.

Instruction 2 to Item 402(c)(2)(v) and (vi). If at any time during the last completed fiscal year, the registrant has adjusted or amended the exercise price of options or SARs previously granted to

a named executive officer, whether through amendment, cancellation, or replacement grants, or any other means, or otherwise has materially modified such awards, the registrant must include, as awards required to be reported in the Option Awards Granted column (column (f)), the incremental fair value, computed as of the repricing or modification date in accordance with FASB ASC Topic 718, with respect to that repriced or modified award.

Instruction 3 to Item 402(c)(2)(v) and (vi). Report the grant date fair value based upon the target outcome(s) of the performance, market, and/or service conditions (if applicable). For equity awards with multiple potential outcomes (*e.g.,* minimum, target, and maximum), the target outcome is the achievement of the target outlined in the award at the 100 percent level. For equity awards that have a binary outcome (*i.e.,* awards that are either fully earned or not earned at all), the target outcome is that the award criteria are met and the award is fully earned.

(vii) The sum of all amounts reported in columns (c) through (f) (column (g)).

(3) A registrant that is a large accelerated filer (as defined in § 240.12b–2 of this chapter) must provide, and all other registrants are permitted to provide, the disclosure required under paragraph (c)(2) of this section in an Interactive Data File as required by 17 CFR 232.405 (Rule 405 of Regulation S–T) in accordance with the EDGAR Filer Manual (referenced in § 232.301 of this chapter).

Instruction 1 to Item 402(c)(3). Information or disclosures provided in a footnote to the Granted Compensation Table are not required to be provided in an Interactive Data File.

(d) *Status of Equity Awards Table.*

(1) Provide the information specified in paragraph (d)(2) of this Item, concerning the terms and status of equity awards outstanding as of the beginning of, or granted during, the registrant's last completed fiscal year, or otherwise reported in the Granted Compensation Table or the Earned Compensation Table with respect to the last completed fiscal year, for each named executive officer, in a Status of Equity Awards Table in the following tabular format:

STATUS OF EQUITY AWARDS TABLE

Name and position	Equity award terms						Equity award status	
	Grant date	Award type	Grant amount or range (#)	End of performance period, if applicable	Final vesting date, if known	Exercise price, if applicable	Amount vested (#)	Amount of options exercised/ expired (#)
(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g)*	*(h)*	*(i)*
[PEO]								
[PFO]								

(2) Include, on an award-by-award basis, in the Status of Equity Awards Table:

(i) The name and principal position of the named executive officer (column (a));

(ii) The grant date for each equity award (column (b));

(iii) A description of the award type or designation (column (c));

(iv) The number of shares of stock, or the number of shares underlying options, to be vested upon satisfaction of the conditions, or the range of potential payouts denominated in the number of shares of stock or the number of shares underlying options (*e.g.,* threshold, target, and maximum amounts) (column (d));

(v) The date on which the performance period ends, if applicable (column (e));

(vi) The last date on which shares of stock, or shares underlying options, may vest, if known (column (f));

(vii) The exercise or base price, if applicable (column (g));

(viii) The number of shares of stock, or the number of shares underlying options, that have vested (column (h)); and

(ix) The number of shares underlying options that have been exercised and that have expired (column (i)).

Instruction 1 to Item 402(d)(2). An equity award no longer needs to be included in the table after the award has been reported as fully vested, in the case of a stock award, or fully exercised or fully expired, in the case of an option award, in the Earned Compensation Table (or otherwise expired). Report the terms and status of each equity award as of the end of the last completed fiscal year; *provided, however,* that if a registrant has reported an equity award granted during the first quarter of the fiscal year immediately following the last completed fiscal year pursuant to Instruction 1 to Item 402(c)(2)(v) and (vi), the registrant must report the terms and status of all equity awards as of the end of the first quarter of the fiscal year immediately following the last completed fiscal year (or, if earlier, the latest practicable date).

Instruction 2 to Item 402(d)(2). If the award specifies a range of potential payouts, provide and clearly label the amounts in column (d) for each relevant scenario (*e.g.,* ''Threshold: 25,000; Target: 100,000; Maximum: 200,000''). In column (i), if applicable, state the amount of option awards that have been exercised and that have expired (*e.g.,* ''Exercised: 50,000; Expired: 10,000'').

Instruction 3 to Item 402(d)(2). Report each award granted to the named executive officer separately in its own row. Report an award consisting of a combination of options, SARs, and/or similar option-like instruments as separate awards with respect to each tranche or component with a different exercise and/or base price or expiration date.

(3) Disclose the following information relating to the Status of Equity Awards Table:

(i) The date as of which the information in the Status of Equity Awards Table is reported;

(ii) The vesting schedule of each equity award reported in the Status of Equity Awards Table; and

(iii) The material terms of any performance, market, and/or service conditions with respect to each equity award reported in the Status of Equity Awards Table.

Instruction 1 to Item 402(d)(3). The registrant has flexibility in the manner and location in which it provides the disclosures required under Item 402(d)(3). The registrant may provide such disclosures in the Status of Equity

Awards Table, any footnotes thereto, any supplemental narrative disclosures thereto, or in conjunction with other disclosures required by this Item such as, if applicable, any Compensation Discussion and Analysis provided under paragraph (e) of this Item.

Instruction 2 to Item 402(d)(3). The requirement to disclose the vesting schedule may be satisfied by disclosing the standard vesting schedule that the registrant applies to all awards of a given type and, if applicable, any material deviations from the standard vesting schedule for a specific award.

(4) A registrant that is a large accelerated filer (as defined in § 240.12b-2 of this chapter) must provide, and all other registrants are permitted to provide, the disclosure required under paragraph (d)(2) of this section in an Interactive Data File as required by 17 CFR 232.405 (Rule 405 of Regulation S–T) in accordance with the EDGAR Filer Manual (referenced in § 232.301 of this chapter).

Instruction 1 to Item 402(d)(4). Information or disclosures provided in footnotes to the Status of Equity Awards Table are not required to be provided in an Interactive Data File.

(e) *Compensation Discussion and Analysis.* Disclose the material principles underlying the registrant's executive compensation policies and decisions and the most important factors relevant to analysis of those policies and decisions. The Compensation Discussion and Analysis must reflect the individual circumstances of the registrant, and must describe:

(1) The objectives of the registrant's compensation program in relation to the registrant's corporate strategy;

(2) The material elements of compensation and how amounts are determined; and

(3) If applicable, whether the registrant has considered the results of the most recent shareholder advisory vote on executive compensation required by section 14A of the Exchange Act (15 U.S.C. 78n–1) in determining compensation policies and decisions and, if so, how that consideration has affected the registrant's executive compensation policies and decisions.

Instruction to Item 402(e). The Compensation Discussion and Analysis must avoid boilerplate language and should address the information contained in the tables and otherwise disclosed pursuant to this Item while avoiding repetition of such detailed information. The Compensation Discussion and Analysis should also cover material actions regarding executive compensation that were taken after the registrant's last completed fiscal year's end that could affect a fair understanding of the named executive officer's compensation for the last completed fiscal year. Moreover, in some situations, it may be necessary to discuss years prior to the registrant's last completed fiscal year in order to give context to the disclosure provided.

(f) *Pay-versus-performance.*

(1) In connection with any proxy or information statement for which the rules of the Commission require executive compensation disclosure pursuant to this Item, provide a clear description of the relationship across the registrant's last three completed fiscal years between:

(i) The executive compensation actually paid to each of the PEO and the PFO, which is the Total Compensation Earned (column (h) of the Earned Compensation Table) for each person who served as the PEO or the PFO, as applicable, for each fiscal year included in the disclosure; and

(ii) The registrant's financial performance measure, which is the cumulative total shareholder return of the registrant on a class of the registrant's common stock registered under section 12 of the Exchange Act (15 U.S.C. 78*l*) for each fiscal year included in the disclosure.

(2) Cumulative total shareholder return means, for purposes of this Item, the dollar value as of the end of each fiscal year covered by the disclosure, including cumulative dividends and assuming dividend reinvestment, of a $100 investment in the registrant's common stock made at market close on the last trading day of the fiscal year immediately prior to the period covered by the disclosure.

(3) A registrant may disclose one or more additional company-selected financial performance measures that it views as important to an understanding of the Total Compensation Earned by the PEO and the PFO. A financial performance measure means a measure that is determined and presented in accordance with the accounting principles used in preparing the registrant's financial statements, any measures that are derived wholly or in part from such measures, or stock price. A financial performance measure need not be presented within the registrant's financial statements or otherwise included in a filing with the Commission. If a registrant discloses a company-selected financial performance measure, it should either present the same company-selected financial performance measure for each of the last three completed fiscal years or explain why it chose different measures for certain fiscal years or omitted a measure for certain fiscal years.

(4) The disclosure provided pursuant to this paragraph (f) will not be deemed to be incorporated by reference into any filing under the Securities Act or the Exchange Act, except to the extent that the registrant specifically incorporates it by reference.

(g) *Disclosure of a registrant's action to recover erroneously awarded compensation.*

(1) If at any time during or after the last completed fiscal year the registrant was required to prepare an accounting restatement that required recovery of erroneously awarded compensation pursuant to the registrant's compensation recovery policy required by the listing standards adopted pursuant to 17 CFR 240.10D–1, or there was an outstanding balance as of the end of the last completed fiscal year of erroneously awarded compensation to be recovered from the application of the policy to a prior restatement, the registrant must provide the following information:

(i) For each such restatement:

(A) The date on which the registrant was required to prepare an accounting restatement;

(B) The aggregate dollar amount of erroneously awarded compensation attributable to such accounting restatement, including an analysis of how the amount was calculated;

(C) If the financial reporting measure (as defined in 17 CFR 240.10D–1(d)) related to a stock price or total shareholder return metric, the estimates that were used in determining the erroneously awarded compensation attributable to such accounting restatement and an explanation of the methodology used for such estimates;

(D) The aggregate dollar amount of erroneously awarded compensation that remained outstanding at the end of the last completed fiscal year; and

(E) If the aggregate dollar amount of erroneously awarded compensation has not yet been determined, disclose this fact, explain the reason(s) and disclose the information required in paragraphs (g)(1)(i)(B) through (D) of this Item in the next filing that is required to include disclosure pursuant to this Item;

(ii) If recovery would be impracticable pursuant to 17 CFR 240.10D–1(b)(1)(iv), disclose the amount of recovery forgone and a brief description of the reason the listed registrant decided in each case not to pursue recovery; and

(iii) For each current and former named executive officer from whom, as of the end of the last completed fiscal year, erroneously awarded compensation had been outstanding for

180 days or longer since the date the registrant determined the amount the individual owed, disclose the dollar amount of outstanding erroneously awarded compensation due from each such individual.

(2) The information is required only in proxy or information statements that require disclosure under this Item and the registrant's annual report on Form 10–K, and will not be deemed to be incorporated by reference into any filing under the Securities Act, except to the extent that the listed registrant specifically incorporates it by reference.

(h) *Pay ratio disclosure.*

(1) Disclose:

(i) The annual total compensation of the employee earning the median of the annual total compensation of all employees of the registrant and any of its consolidated subsidiaries who are employed on a full-time basis in any jurisdiction of the United States or its territories, except for temporary or seasonal employees and the PEO of the registrant;

(ii) The annual total compensation of the PEO of the registrant; and

(iii) The ratio of the amount in paragraph (h)(1)(i) of this section to the amount in paragraph (h)(1)(ii) of this section, expressed as:

(A) a ratio with the amount in paragraph (h)(1)(i) of this section equal to one, or

(B) a narrative of the multiple that the amount in paragraph (h)(1)(ii) of this Item bears to the amount in paragraph (h)(1)(i) of this Item.

(2) At least once every five years, registrants must identify the median employee as of a date chosen by the registrant within the last three months of the registrant's last completed fiscal year.

(3) Registrants must determine annual total compensation in accordance with paragraph (c)(2)(vii) of this Item, which is the Total Compensation Granted in the Granted Compensation Table (column (g)). For purposes of this paragraph (h), references in paragraph (c) and the Instructions to paragraph (c) to ''named executive officer'' may be deemed to refer instead, as applicable, to ''employee'' and, for non-salaried employees, references to ''base salary'' and ''salary'' may be deemed to refer instead, as applicable, to ''wages plus overtime.''

(4) Registrants may use reasonable methods, adjustments (including annualizing the total compensation for all full-time employees that were employed by the registrant for less than the full fiscal year), and estimates to identify the median employee and to calculate the annual total compensation for employees other than the PEO.

Instruction to Item 402(h) A registrant with more than one non-concurrent PEO serving during the last completed fiscal year may either calculate the annual total compensation provided to each person who served as PEO during the year for the time he or she served as PEO and combine those figures or look to the PEO serving in that position on the date it selects to identify the median employee and annualize that PEO's compensation. Regardless of the alternative selected, the registrant must disclose which option it chose and how it calculated its PEO's annual total compensation.

(i) *Potential payments upon termination or change-in-control.* For each person who served as the registrant's PEO or PFO during the last completed fiscal year, describe the material terms of each contract, agreement, plan, or arrangement, whether written or unwritten, that provided for payment(s) at, following, or in connection with any termination, including without limitation resignation, severance, retirement, or a constructive termination (including a change in responsibilities) of such person, or a change in control of the registrant.

Instruction 1 to Item 402(i). If a registrant has provided the disclosure required by this paragraph in a filing under Item 5.02 of Form 8–K (17 CFR 249.308), then no further disclosure is required by this paragraph.

Instruction 2 to Item 402(i). The registrant need not provide information with respect to contracts, agreements, plans, or arrangements that do not discriminate in scope, terms, or operation in favor of executive officers of the registrant and are available generally to all salaried employees.

(j) *Golden parachute compensation.*

(1) In connection with any proxy or consent solicitation material providing the disclosure required by section 14A(b)(1) of the Exchange Act (15 U.S.C. 78n–1(b)(1)) or any proxy or consent solicitation that includes disclosure under Item 14 of Schedule 14A (§ 240.14a–101 of this chapter) pursuant to Note A of Schedule 14A, with respect to each named executive officer of the acquiring company and the target company, provide material information relevant to an assessment of any agreement or understanding, whether written or unwritten, between such named executive officer and the acquiring company or target company, concerning any type of compensation, whether present, deferred, or contingent, that is based on or otherwise relates to an acquisition, merger, consolidation, sale, or other disposition of all or substantially all assets of the issuer, as follows:

GOLDEN PARACHUTE COMPENSATION TABLE

Name	Cash ($)	Equity ($)	Miscellaneous ($)	Total ($)
(a)	*(b)*	*(c)*	*(d)*	*(e)*
[PEO]				
[PFO]				

(2) Include in the Golden Parachute Compensation Table for each named executive officer:

(i) The name of the named executive officer (column (a));

(ii) The aggregate dollar value of any cash severance payments, including but not limited to payments of base salary, bonus, and pro-rated non-equity incentive compensation plan payments (column (b));

(iii) The aggregate dollar value of:

(A) Stock awards for which vesting would be accelerated;

(B) In-the-money option awards for which vesting would be accelerated; and

(C) Payments in cancellation of stock and option awards (column (c));

(iv) The aggregate dollar value of any other material compensation that is based on or otherwise relates to the transaction not properly reported in any other column of the Golden Parachute Compensation Table (column (d)); and

(v) The aggregate dollar value of the sum of all amounts reported in columns (b) through (d) (column (e)).

Instruction 1 to Item 402(j)(2). If this disclosure is included in a proxy or consent solicitation seeking approval of an acquisition, merger, consolidation, or proposed sale or other disposition of all or substantially all the assets of the registrant, or in a proxy or consent solicitation that includes disclosure under Item 14 of Schedule 14A (§ 240.14a–101 of this chapter) pursuant to Note A of Schedule 14A, quantify the disclosure provided in this table assuming that the triggering event took place on the latest practicable date, and determine the price per share of the registrant's securities as follows: If the shareholders are to receive a fixed dollar amount, the price per share must be that fixed dollar amount, and if that value is not a fixed dollar amount, the price per share must be the average closing market price of the registrant's securities over the first five business days following the first public announcement of the transaction. Compute the dollar value of in-the-money option awards for which vesting would be accelerated by determining the difference between this price and the exercise or base price of the options. Include only compensation that is based on or otherwise relates to the subject transaction.

Instruction 2 to Item 402(j)(2). If this disclosure is included in a proxy solicitation for the annual meeting at which directors are elected for purposes of subjecting the disclosed agreements or understandings to a shareholder vote under section 14A(a)(1) of the Exchange Act (15 U.S.C. 78n–1(a)(1)), quantify the disclosure provided by this table assuming that the triggering event took place on the last business day of the registrant's last completed fiscal year, and the price per share of the registrant's securities is the closing market price as of that date. Compute the dollar value of in-the-money option awards for which vesting would be accelerated by determining the difference between this price and the exercise or base price of the options.

Instruction 3 to Item 402(j)(2). In the event that uncertainties exist as to the provision of payments and benefits or the amounts involved, the registrant is required to make a reasonable estimate applicable to the payment or benefit and disclose material assumptions underlying such estimates in its disclosure. In such event, the disclosure would require forward-looking information as appropriate.

(3) A registrant conducting a shareholder advisory vote pursuant to § 240.14a–21(c) of this chapter to cover new agreements or understandings, and/or revised terms of agreements or understandings that were previously subject to a shareholder advisory vote pursuant to § 240.14a–21(a) of this chapter, must separately disclose both the agreements or understandings and amounts previously disclosed and subject to a shareholder advisory vote under section 14A(a)(1) of the Exchange Act (15 U.S.C. 78n–1(a)(1))) and § 240.14a–21(a) of this chapter and the new agreements or understandings and/or revised terms subject to the separate shareholder advisory vote under section 14A(b)(2) of the Exchange Act (15 U.S.C. 78n–1(b)(2)) and § 240.14a–21(c) of this chapter.

(4) In cases where disclosure of agreements or understandings between an acquiring company and the named executive officers of the soliciting target company is required, the registrant must clarify whether these agreements or understandings are subject to the separate shareholder advisory vote pursuant to § 240.14a–21(c) of this chapter by providing separate disclosure of all agreements or understandings subject to the shareholder advisory vote required by section 14A(b)(2) of the Exchange Act (15 U.S.C. 78n–1(b)(2)) and § 240.14a–21(c) of this chapter, if different from the full scope of golden parachute compensation subject to Item 402(j) disclosure.

(5) Disclose any material information necessary to an understanding of the payments quantified in the tabular disclosure required by this paragraph (j)(2).

(k) *Compensation of directors.*

(1) Describe the material aspects of the registrant's director compensation program, including separate quantification of the cash and equity retainer(s) for board, committee, chairmanship, and other director services.

(2) For each person who served as a director of the registrant during any part of the last completed fiscal year, separately disclose the following information:

(i) The aggregate dollar amount of all cash earned during the last completed fiscal year as fees for services as a director;

(ii) The aggregate dollar value realized upon the following, in each case during the last completed fiscal year:

(A) vesting of stock awards (computed by multiplying the number of shares of stock or units by the closing market price of the underlying shares or units on the vesting date),

(B) exercise of option awards (computed by multiplying the total number of securities underlying the options by the difference between the closing market price of the underlying securities on the exercise date and the exercise or base price of the options), and

(C) upon the transfer of a stock or option award for value;

Instruction to Item 402(k)(2)(ii). Include the value of any related payment or other consideration provided (or to be provided) by the registrant to or on behalf of a director, including payment of the exercise price or related taxes.

(iii) For equity awards outstanding as of the end of the most recently completed fiscal year:

(A) The aggregate number of stock awards and aggregate number of option awards outstanding; and

(B) For each award outstanding, the grant date, vesting schedule, and any other material terms of any performance, market, and/or service conditions with respect to the award;

Instruction to Item 402(k)(2)(iii). The requirement to disclose the vesting schedule may be satisfied by disclosing the standard vesting schedule that the registrant applies to all awards of a given type and, if applicable, any material deviations from the standard vesting schedule for a specific award.

(iv) The aggregate dollar value of any other material compensation earned during the last completed fiscal year; and

(v) Any material information necessary to an understanding of the information disclosed pursuant to paragraph (2)(i) through (iv).

Instruction 1 to Item 402(k). If a named executive officer is also a director who receives compensation solely for his or her services as a director, disclose such compensation pursuant to this paragraph (k) and exclude such amounts from the information called for pursuant to paragraphs (b), (c), and (d) of this Item.

Instruction 2 to Item 402(k). A registrant may disclose the information required pursuant to this paragraph (k) in any format it determines to be appropriate, including in tabular or in narrative disclosure.

Instruction 1 to Item 402. Registrants are not required to disclose information, including target levels with respect to specific quantitative or qualitative performance-related factors considered by the compensation committee or board of directors, involving confidential trade secrets or confidential commercial or financial information, the disclosure of which would result in competitive harm for the registrant. The standard to use when determining whether disclosure would cause

competitive harm for the registrant is the same standard that would apply when a registrant requests confidential treatment of confidential trade secrets or confidential commercial or financial information pursuant to Securities Act Rule 406 (17 CFR 230.406) and Exchange Act Rule 24b–2 (17 CFR 240.24b–2), each of which incorporates the criteria for non-disclosure when relying upon Exemption 4 of the Freedom of Information Act (5 U.S.C. 552(b)(4)). A registrant is not required to seek confidential treatment under the procedures in Securities Act Rule 406 and Exchange Act Rule 24b–2 if it determines that the disclosure would cause competitive harm in reliance on this instruction; however, in that case, the registrant must discuss how difficult it will be for the executive or how likely it will be for the registrant to achieve the any target level not disclosed based on this instruction.

Instruction 2 to Item 402. Disclosure of a target level or company-selected financial performance measure that is a non-GAAP financial measure will not be subject to Regulation G (17 CFR 244.100–102) or Item 10(e) (§ 229.10(e)); provided, however, that if such non-GAAP financial performance measure is based on historical financial results (including performance, financial position, or cash flows), the disclosure must include a quantitative reconciliation of the differences between the non-GAAP financial measure and the most directly comparable GAAP financial measure, and if such non-GAAP financial performance measure is a projected non-GAAP financial measure (not based on historic financial performance, financial position, or cash flows), the disclosure must include a narrative description of how the non-GAAP financial measure is calculated from the registrant's audited financial statements. In addition, any disclosure of a target level or company-selected financial performance measure that is a non-GAAP financial measure must include disclosure of the reason(s) that the registrant believes the non-GAAP financial measure is more appropriate than a GAAP financial measure for determining executive compensation or showing the relationship between executive compensation and registrant performance, as applicable.

■ 4. Amend § 229.403 by revising paragraph (b) to read as follows:

§ 229.403 (Item 403) Security ownership of certain beneficial owners and management.

* * * * *

(b) Security ownership of management. Furnish the following information, as of the most recent practicable date, in substantially the tabular form indicated, as to each class of equity securities of the registrant or any of its parents or subsidiaries, including directors' qualifying shares, beneficially owned by all directors and nominees, naming them, each of the named executive officers as defined in Item 402(a)(2) (§ 229.402(a)(2)), and directors and executive officers of the registrant as a group, without naming them. Show in column (3) the total number of shares beneficially owned and in column (4) the percent of the class so owned. Of the number of shares shown in column (3), indicate, by footnote or otherwise, the amount of shares that are pledged as security and the amount of shares with respect to which such persons have the right to acquire beneficial ownership as specified in § 240.13d–3(d)(1) of this chapter.

* * * * *

■ 5. Amend § 229.404 by revising Instruction 5 to the *Instructions to Item 404(a)* to read as follows:

§ 229.404 (Item 404) Transactions with related persons, promoters and certain control persons.

* * * * *

Instructions to Item 404(a).

* * * * *

5.a. Disclosure of an employment relationship or transaction involving an executive officer and any related compensation solely resulting from that employment relationship or transaction need not be provided pursuant to paragraph (a) of this Item if:

i. The compensation arising from the relationship or transaction is reported pursuant to Item 402 (§ 229.402);

ii. The executive officer is not an immediate family member (as specified in Instruction 1 to paragraph (a) of this Item) and such compensation would have been reported under Item 402 (§ 229.402) as compensation earned for services to the registrant if the executive officer was a named executive officer as that term is defined in Item 402(a)(2) (§ 229.402(a)(2)), and such compensation had been approved, or recommended to the board of directors of the registrant for approval, by the compensation committee of the board of directors (or group of independent directors performing a similar function) of the registrant; or

iii. The transaction involves the recovery of erroneously awarded compensation computed as provided in 17 CFR 240.10D–1(b)(1)(iii) and the applicable listing standards for the registrant's securities, that is disclosed pursuant to Item 402(g) (§ 229.402(g)).

b. Disclosure of compensation to a director need not be provided pursuant to paragraph (a) of this Item if the compensation is reported pursuant to Item 402(k) (§ 229.402(k)).

* * * * *

■ 6. Amend § 229.407 by revising paragraph (e)(5)(i)(A) to read as follows:

§ 229.407 (Item 407) Corporate Governance.

* * * * *

(e) *Compensation committee.* * * *

(5) * * *

(i) * * *

(A) The compensation committee has reviewed and discussed the Compensation Discussion and Analysis required by Item 402(e) (§ 229.402(e)) with management; and

* * * * *

■ 7. Amend § 229.601 by revising paragraph (b)(10)(iii)(A) and (b)(10)(iii)(C)(5) to read as follows:

§ 229.601 (Item 601) Exhibits.

* * * * *

(10) *Material Contracts.* * * *

(iii)

(A) Any management contract or any compensatory plan, contract or arrangement, including but not limited to plans relating to options, warrants or rights, pension, retirement or deferred compensation or bonus, incentive or profit sharing (or if not set forth in any formal document, a written description thereof) in which any director or any of the named executive officers of the registrant, as defined by Item 402(a)(2) (§ 229.402(a)(2)), participates will be deemed material and must be filed; and any other management contract or any other compensatory plan, contract, or arrangement in which any other executive officer of the registrant participates must be filed unless immaterial in amount or significance.

* * * * *

(C) * * *

(5) Any compensatory plan, contract or arrangement if the registrant is a foreign private issuer that furnishes compensatory information under Item 402(a)(6)(iii) (§ 229.402(a)(6)(iii)) and the public filing of the plan, contract or arrangement, or portion thereof, is not required in the registrant's home country and is not otherwise publicly disclosed by the registrant.

* * * * *

■ 8. Amend § 229.1011(b) by revising Item 1011(b) and Instruction 2 to the *Instructions to Item 1011(b)* to read as follows:

§ 229.1011 (Item 1011) Additional Information.

* * * * *

(b) Furnish the information required by Item 402(j)(2) and (5) of this part (§ 229.402(j)(2) and (5)) and in the tabular format set forth in Item 402(j)(1) of this part (§ 229.402(j)(1)) with respect to each named executive officer:

(1) Of the subject company in a Rule 13e–3 transaction (§ 229.240.13e–3 of this chapter); or

(2) Of the issuer whose securities are the subject of a third-party tender offer, regarding any agreement or understanding, whether written or unwritten, between such named executive officer and the subject company, issuer, bidder, or the acquiring company, as applicable, concerning any type of compensation, whether present, deferred or contingent, that is based upon or otherwise relates to the Rule 13e–3 transaction or third-party tender offer.

Instructions to Item 1011(b). * * *

2. For the purposes of Instruction 1 to Item 402(j)(2) of this part: If the disclosure is included in a Schedule 13E–3 (§ 240.13e–100 of this chapter) or Schedule 14D–9 (§ 240.14d–101 of this chapter), the disclosure provided by this table shall be quantified assuming that the triggering event took place on the latest practicable date and that the price per share of the securities of the subject company in a Rule 13e–3 transaction, or of the issuer whose securities are the subject of the third-party tender offer, shall be determined as follows: If the shareholders are to receive a fixed dollar amount, the price per share shall be that fixed dollar amount, and if such value is not a fixed dollar amount, the price per share shall be the average closing market price of such securities over the first five business days following the first public announcement of the transaction. Compute the dollar value of in-the-money option awards for which vesting would be accelerated by determining the difference between this price and the exercise or base price of the options. Include only compensation that is based on or otherwise relates to the subject transaction.

* * * * *

PART 232—REGULATION S–T—GENERAL RULES AND REGULATIONS FOR ELECTRONIC FILINGS

■ 9. The authority citation for part 232 continues to read in part as follows:

Authority: 15 U.S.C. 77c, 77f, 77g, 77h, 77j, 77s(a), 77z–3, 77sss(a), 78c(b), 78*l,* 78m, 78n, 78n–1, 78o(d), 78w(a), 78*ll,* 80a–6(c), 80a–8, 80a–29, 80a–30, 80a–37, 7201 *et seq.;* and 18 U.S.C. 1350, unless otherwise noted.

* * * * *

■ 10. Amend § 232.405(b) by:

■ a. Removing and reserving paragraphs (b)(2)(v) and (b)(4)(ii); and

■ b. Revising paragraphs (b)(4)(i) and (iii).

The amendments read as follows:

§ 232.405 Interactive Data File Submissions.

* * * * *

(b) * * *

(2) * * *

(v) [Reserved]

* * * * *

(4) * * *

(i) The information provided pursuant to § 229.402(b)(2), (c)(2) and (d)(2) of this chapter (Item 402(b)(2), (c)(2) and (d)(2) of Regulation S–K).

(ii) [Reserved]

(iii) Any disclosure provided in response to: § 229.408(a)(1) and (2) of this chapter (Item 408(a)(1) and (2) of Regulation S–K); § 229.408(b)(1) of this chapter (Item 408(b)(1) of Regulation S–K); and Item 16J(a) of Form 20–F (§ 249.220f of this chapter).

* * * * *

PART 239—FORMS PRESCRIBED UNDER THE SECURITIES ACT OF 1933

■ 11. The authority citation for part 239 continues to read in part as follows:

Authority: 15 U.S.C. 77c, 77f, 77g, 77h, 77j, 77s, 77z–2, 77z–3, 77sss, 78c, 78*l,* 78m, 78n, 78*o*(d), 78*o*–7 note, 78u–5, 78w(a), 78*ll,* 78mm, 80a–2(a), 80a–3, 80a–8, 80a–9, 80a–10, 80a–13, 80a–24, 80a–26, 80a–29, 80a–30, 80a–37, and sec. 71003 and sec. 84001, Pub. L. 114–94, 129 Stat. 1321, unless otherwise noted.

* * * * *

■ 12. Amend Form S–1 (referenced in § 239.11) by revising Item 11(*l*) to read as shown in Appendix A.

Note: The text of Form S–1 does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form S–1 are attached as Appendix A to this document.

■ 13. Amend Form S–4 (referenced in § 239.25) by revising Item 18(a)(7)(ii) and Item 19(a)(7)(ii) to read as shown in Appendix B.

Note: The text of Form S–4 does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form S–4 are attached as Appendix B to this document.

■ 14. Amend Form S–11 (referenced in § 239.18) by revising Item 22 to read as shown in Appendix C.

Note: The text of Form S–11 does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form S–11 are attached as Appendix C to this document.

■ 15. Amend Form N–2 (referenced in §§ 239.14 and 274.11a–1) by revising Item 18.14 to read as shown in Appendix D.

Note: The text of Form N–2 does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form N–2 are attached as Appendix D to this document.

PART 240—GENERAL RULES AND REGULATIONS, SECURITIES EXCHANGE ACT OF 1934

■ 16. The authority citation for part 240 continues to read in part as follows:

Authority: 15 U.S.C. 77c, 77d, 77g, 77j, 77s, 77z–2, 77z–3, 77eee, 77ggg, 77nnn, 77sss, 77ttt, 78c, 78c–3, 78c–5, 78d, 78e, 78f, 78g, 78i, 78j, 78j–1, 78j–4, 78k, 78k–1, 78*l,* 78m, 78n, 78n–1, 78*o,* 78*o*–4, 78*o*–10, 78p, 78q, 78q–1, 78s, 78u–5, 78w, 78x, 78dd, 78*ll,* 78mm, 80a–20, 80a–23, 80a–29, 80a–37, 80b–3, 80b–4, 80b–11, 1681w(a)(1), 6801–6809, 6825, 7201 *et seq.,* and 8302; 7 U.S.C. 2(c)(2)(E); 12 U.S.C. 5221(e)(3); 18 U.S.C. 1350; Pub. L. 111–203, 939A, 124 Stat. 1376 (2010); and Pub. L. 112–106, sec. 503 and 602, 126 Stat. 326 (2012), unless otherwise noted.

* * * * *

■ 17. Amend § 240.14a–6 by revising paragraph (a)(5) to read as follows:

§ 240.14a–6 Filing requirements.

(a) *Preliminary proxy statement.*

* * *

(5) The approval or ratification of a plan as defined in paragraph (a)(7) of Item 402 of Regulation S–K (§ 229.402(a)(7) of this chapter) or amendments to such a plan;

* * * * *

■ 18. Amend § 240.14a–21 by revising paragraph (c) and the *Instructions to § 240.14a–21* to read as follows:

§ 240.14a–21 Shareholder approval of executive compensation, frequency of votes for approval of executive compensation and shareholder approval of golden parachute compensation.

* * * * *

(c) If a solicitation is made by a registrant, other than an emerging growth company as defined in Rule 12b–2 (§ 240.12b–2), for a meeting of shareholders at which shareholders are asked to approve an acquisition, merger, consolidation or proposed sale or other disposition of all or substantially all the assets of the registrant, the registrant must include a separate resolution subject to shareholder advisory vote to approve any agreements or understandings and compensation disclosed pursuant to Item 402(j) of Regulation S–K (§ 229.402(j) of this chapter), unless such agreements or understandings have been subject to a shareholder advisory vote under paragraph (a) of this section. Consistent

with section 14A(b) of the Exchange Act (15 U.S.C. 78n–1(b)), any agreements or understandings between an acquiring company and the named executive officers of the registrant, where the registrant is not the acquiring company, are not required to be subject to the separate shareholder advisory vote under this paragraph.

Instruction 1 to § 240.14a–21: Disclosure relating to the compensation of directors required by Item 402(k) (§ 229.402(k) of this chapter) is not subject to the shareholder vote required by paragraph (a) of this section. To the extent that risk considerations are a material aspect of the registrant's compensation policies or decisions for named executive officers, the registrant may discuss them as part of its Compensation Discussion and Analysis under § 229.402(e) of this chapter, and therefore such disclosure could be considered by shareholders when voting on executive compensation.

Instruction 2 to § 240.14a–21: If a registrant includes disclosure of golden parachute compensation arrangements pursuant to Item 402(j) (§ 229.402(j) of this chapter) in an annual meeting proxy statement, such disclosure would be subject to the shareholder advisory vote required by paragraph (a) of this section.

Instruction 3 to § 240.14a–21: Registrants that are smaller reporting companies entitled to provide scaled disclosure in accordance with Item 402(a)(6)(i) of Regulation S–K (§ 229.402(a)(6)(i) of this chapter) are not required to include a Compensation Discussion and Analysis in their proxy statements in order to comply with this section. For smaller reporting companies, the vote required by paragraph (a) of this section must be to approve the compensation of the named executive officers as disclosed pursuant to Item 402(a)(6)(i) of Regulation S–K (§ 229.402(a)(6)(i) of this chapter).

Instruction 4 to § 240.14a–21: A registrant that has ceased being an emerging growth company shall include the first separate resolution described under § 240.14a–21(a) not later than the end of (i) in the case of a registrant that was an emerging growth company for less than two years after the date of first sale of common equity securities of the registrant pursuant to an effective registration statement under the Securities Act of 1933 (15 U.S.C. 77a *et seq.*), the three-year period beginning on such date; and (ii) in the case of any other registrant, the one-year period beginning on the date the registrant is no longer an emerging growth company.

■ 19. Amend § 240.14a–101 by:

■ a. Revising paragraph (a)(5) of Item 5;

■ b. Revising paragraph (b)(3) of Item 5;

■ c. Revising paragraph (a)(2)(ii)(A) and the Instruction of Item 10;

■ d. Revising paragraph (a)(2)(iii)(A) of Item 10;

■ e. Revising paragraph (b)(1)(ii) of Item 10;

■ f. Revising paragraph (b)(2)(ii)(A) of Item 10;

■ g. Redesignating ''Instructions'' in Item 10, to read ''*Instructions to Item 10*'';

■ h. Revising instruction 1 to the Instructions to Item 10; and

■ i. Removing and reserving paragraph (a) of Item 25.

The amendments read as follows:

§ 240.14a–101 Schedule 14A. Information required in proxy statement.

* * * * *

Item 5. Interest of certain Persons in Matters To Be Acted Upon

(a) *Solicitations not subject to Rule 14a–12(c) (§ 240.14a–12(c)).* * * *

(5) If the solicitation is made on behalf of the registrant, furnish the information required by Item 402(j) of Regulation S–K (§ 229.402(j) of this chapter).

* * * * *

(b) *Solicitation subject to Rule 14a–12(c) (§ 240.14a–12(c)).* * * *

(3) If the solicitation is made on behalf of the registrant, furnish the information required by Item 402(j) of Regulation S–K (§ 229.402(j) of this chapter).

* * * * *

Item 10. Compensation Plans. * * *

(a) * * *

(2) * * *

(ii) * * *

(A) Each person (stating name and position) specified in paragraph (a)(2) of Item 402 of Regulation S–K (§ 229.402(a)(2) of this chapter);

Instruction: In the case of investment companies registered under the Investment Company Act of 1940, furnish the information for Compensated Persons as defined in Item 22(b)(13) of this Schedule in lieu of the persons specified in paragraph (a)(2) of Item 402 of Regulation S–K (§ 229.402(a)(2) of this chapter).

* * * * *

(iii) * * *

(A) Each person (stating name and position) specified in paragraph (a)(2) of Item 402 of Regulation S–K (§ 229.402(a)(2) of this chapter;

* * * * *

(b) * * *

(1) * * *

(ii) The estimated annual payment to be made with respect to current services.

Instruction to paragraph (b)(1)(ii). In the case of investment companies registered under the Investment Company Act of 1940 (15 U.S.C. 80a), refer to Instruction 4 in Item 22(b)(13)(i) of this Schedule.

(2) * * *

(ii) * * *

(A) Each person (stating name and position) specified in paragraph (a)(2) of Item 402 of Regulation S–K (§ 229.402(a)(2) of this chapter);

* * * * *

Instructions to Item 10

1. The term plan as used in this Item means any plan as defined in paragraph (a)(7) of Item 402 of Regulation S–K (§ 229.402(a)(7) of this chapter).

* * * * *

Item 25. Exhibits. * * *

(a) [Reserved];

* * * * *

■ 20. Amend § 240.14c–5 by revising paragraph (a)(4) to read as follows:

§ 240.14c–5 Filing requirements.

(a) * * *

(4) The approval or ratification of a plan as defined in paragraph (a)(7) of Item 402 of Regulation S–K (§ 229.402(a)(7) of this chapter) or amendments to such a plan.

* * * * *

■ 21. Amend § 240.14c–101 by revising Item 3(c) to read as follows:

§ 240.14c–101 Schedule 14C. Information required in information statement.

* * * * *

Item 3. Interest of certain persons in or opposition to matters to be acted upon. * * *

(c) Furnish the information required by Item 402(j) of Regulation S–K (§ 229.402(j) of this chapter).

PART 249—FORMS, SECURITIES EXCHANGE ACT OF 1934

■ 22. The authority citation for part 249 continues to read in part as follows:

Authority: 15 U.S.C. 78a *et seq.* and 7201 *et seq.;* 12 U.S.C. 5461 *et seq.;* 18 U.S.C. 1350; Sec. 953(b) Pub. L. 111–203, 124 Stat. 1904; Sec. 102(a)(3) Pub. L. 112–106, 126 Stat. 309; Sec. 107 Pub. L. 112–106, 126 Stat. 313, Sec. 72001 Pub. L. 114–94, 129 Stat. 1312; and secs. 2 and 3 Pub. L. 116–222, 134 Stat. 1063, unless otherwise noted.

Section 249.220f is also issued under secs. 3(a), 202, 208, 302, 306(a), 401(a), 401(b), 406 and 407, Pub. L. 107–204, 116 Stat. 745, and secs. 2 and 3, Pub. L. 116–222, 134 Stat. 1063.

Section 249.240f is also issued under secs. 3(a), 202, 208, 302, 306(a), 401(a), 406 and 407, Pub. L. 107–204, 116 Stat. 745.

Section 249.308 is also issued under 15 U.S.C. 80a–29 and 80a–37.

* * * * *

Section 249.310 is also issued under secs. 3(a), 202, 208, 302, 406 and 407, Pub. L. 107–204, 116 Stat. 745.

* * * * *

■ 23. Amend Form 10 (referenced in § 249.10) by revising Item 6 to read as shown in Appendix E.

Note: The text of Form 10 does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form 10 are attached as Appendix E to this document.

■ 24. Amend Form 20–F (referenced in § 249.220f) by:
■ a. On the cover, removing the words ''If securities are registered pursuant to section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements.'' and the accompanying check box;
■ b. On the cover, removing the words ''Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to § 240.10D–1(b).'' and the accompanying check box; and
■ c. In Part I, Item 6.F.(1)(ii), removing the words '', for each current and former named executive officer and for all other current and former executive officers as a group.''
■ d. In Part I, removing and reserving Items 6.F.(2) and 6.F.(4).

Note: The text of Form 20–F does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form 20–F are attached as Appendix F to this document.

■ 25. Amend Form 40–F (referenced in § 249.240f) by:
■ a. On the cover, removing the words ''If securities are registered pursuant to section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements.'' and the accompanying check box;
■ b. On the cover, removing the words ''Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to § 240.10D–1(b).'' and the accompanying check box; and
■ c. In General Instruction B.(19)(b)(2), removing the words ''for each current and former named executive officer and for all other current and former executive officers as a group.''
■ d. In General Instruction B.(19), removing and reserving General Instruction B.(19)(c) and (e).

Note: The text of Form 40–F does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form 40–F are attached as Appendix G to this document.

■ 26. Amend Form 8–K (referenced in § 249.308) by:
■ a. Removing and reserving Item 5.02(f); and
■ b. Revising instruction 4 of the Instructions to Item 5.02 to read as shown in Appendix G.

Note: The text of Form 8–K does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form 8–K are attached as Appendix H to this document.

■ 27. Amend Form 10–K (referenced in § 249.310) by:
■ a. On the cover, removing the words ''If securities are registered pursuant to section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements.'' and the accompanying check box; and
■ b. On the cover, removing the words ''Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to § 240.10D–1(b).'' and the accompanying check box.

Note: The text of Form 10–K does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form 10–K are attached as Appendix I to this document.

PART 274—FORMS PRESCRIBED UNDER THE INVESTMENT COMPANY ACT OF 1940

■ 28. The authority citation for part 274 continues to read as follows:

Authority: 15 U.S.C. 77f, 77g, 77h, 77j, 77s, 78c(b), 78*l,* 78m, 78n, 78n–1, 78*o*(d), 80a–8, 80a–24, 80a–26, 80a–29, and sec. 939A, Pub. L. 111–203, 124 Stat. 1376 unless otherwise noted.

■ 29. Amend Form N–CSR (referenced in § 274.128) by removing and reserving paragraph (b) from Item 18.

Note: The text of Form N–CSR does not, and these amendments will not, appear in the Code of Federal Regulations. The amendments to Form N–CSR are attached as Appendix J to this document.

By the Commission.

Dated: November 13, 2026.

J. Matthew DeLesDernier,

Deputy Secretary.

Note: The following appendices will not appear in the Code of Federal Regulations.

Appendix A—Form S–1

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM S–1

* * * * *

PART I—INFORMATION REQUIRED IN PROSPECTUS

* * * * *

Item 11. Information With Respect to the Registrant

* * * * *

(*l*) Item 402 of Regulation S–K (§ 229.402 of this chapter), executive compensation, and paragraph (e)(4) of Item 407 of Regulation S–K (§ 229.407(e)(4) of this chapter), corporate governance. A registrant is not required to provide the information required by Item 402 for the most recently completed fiscal year until the earlier of the date that the registrant otherwise discloses such information in a document filed pursuant to Section 13(a), 14, or 15(d) of the Exchange Act or 120 days after the end of such fiscal year. If a registrant files a registration statement on this Form without the Item 402 information for the most recently completed fiscal year as permitted by this Item and the registration statement will either automatically become effective or the registrant requests an effective date of such registration statement after the earliest date that the disclosure is due as specified by this Item, the registrant must file a pre-effective amendment to this Form which includes such information.

* * * * *

Appendix B—Form S–4

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM S–4

* * * * *

PART I. INFORMATION REQUIRED IN THE PROSPECTUS

* * * * *

Item 18. Information if Proxies, Consents or Authorizations Are To Be Solicited

* * * * *

(ii) Item 402 of Regulation S–K (§ 229.402 of this chapter), executive compensation, and paragraph (e)(4) of Item 407 of Regulation S–K (§ 229.407(e)(4) of this chapter), corporate governance. For any entity for which Item 402 disclosure is required pursuant to this Form, but which does not meet the requirements for use of Form S–3, the information required by Item 402 for the

most recently completed fiscal year is not required to be disclosed until the earlier of the date that the registrant otherwise discloses such information in a document filed pursuant to Section 13(a), 14, or 15(d) of the Exchange Act or 120 days after the end of such fiscal year. If a registrant files a registration statement on this Form without the Item 402 information for the most recently completed fiscal year as permitted by this Item, and the registration statement will either automatically become effective or the registrant requests an effective date of such registration statement after the earliest date that the disclosure is due as specified by this Item, the registrant must file a pre-effective amendment to this Form which includes such information.

* * * * *

Item 19. Information if Proxies, Consents or Authorizations Are Not To Be Solicited or in an Exchange Offer

* * * * *

(ii) Item 402 of Regulation S–K (§ 229.402 of this chapter), executive compensation, and paragraph (e)(4) of Item 407 of Regulation S–K (§ 229.407(e)(4) of this chapter), corporate governance. For any entity for which Item 402 disclosure is required pursuant to this Form, but which does not meet the requirements for use of Form S–3, the information required by Item 402 for the most recently completed fiscal year is not required to be disclosed until the earlier of the date that the registrant otherwise discloses such information in a document filed pursuant to Section 13(a), 14, or 15(d) of the Exchange Act or 120 days after the end of such fiscal year. If a registrant files a registration statement on this Form without the Item 402 information for the most recently completed fiscal year as permitted by this Item, and the registration statement will either automatically become effective or the registrant requests an effective date of such registration statement after the earliest date that the disclosure is due as specified by this Item, he registrant must file a pre-effective amendment to this Form which includes such information.

* * * * *

Appendix C—Form S–11

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM S–11

* * * * *

PART I. INFORMATION REQUIRED IN PROSPECTUS

* * * * *

Item 22. Executive Compensation

Furnish the information required by Item 402 of Regulation S–K (§ 229.402 of this chapter), executive compensation, and paragraph (e)(4) of Item 407 of Regulation S–K (§ 229.407(e)(4) of this chapter), corporate governance. A registrant is not required to provide the information required by Item 402 for the most recently completed fiscal year until the earlier of the date that the registrant otherwise discloses such information in a document filed pursuant to Section 13(a), 14, or 15(d) of the Exchange Act or 120 days after the end of such fiscal year. If a registrant files a registration statement on this Form without the Item 402 information for the most recently completed fiscal year as permitted by this Item, and the registration statement will either automatically become effective or the registrant requests an effective date of such registration statement after the earliest date that the disclosure is due as specified by this Item, the registrant must file a pre-effective amendment to this Form which includes such information.

* * * * *

Appendix D—Form N–2

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM N–2

* * * * *

Item 18. Management

* * * * *

14. In the case of a Registrant that is a business development company, provide the information required by Item 402 of Regulation S–K [17 CFR 229.402]. A Registrant is not required to provide the information required by Item 402 for the most recently completed fiscal year until the earlier of the date that the Registrant otherwise discloses such information in a document filed pursuant to Section 13(a), 14, or 15(d) of the Exchange Act or 120 days after the end of such fiscal year. If a Registrant files a registration statement on this Form without the Item 402 information for the most recently completed fiscal year as permitted by this Item and the registration statement will either automatically become effective or the Registrant requests an effective date of such registration statement after the earliest date that the disclosure is due as specified by this Item, the Registrant must file a pre-effective amendment to this Form which includes such information.

* * * * *

Appendix E—Form 10

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10

* * * * *

INFORMATION REQUIRED IN REGISTRATION STATEMENT

* * * * *

Item 6. Executive Compensation

Furnish the information required by Item 402 of Regulation S–K (§ 229.402 of this chapter), executive compensation, and paragraph (e)(4) of Item 407 of Regulation S–K (§ 229.407(e)(4) of this chapter), corporate governance. A registrant is not required to provide the information required by Item 402 for the most recently completed fiscal year until the earlier of the date that the registrant otherwise discloses such information in a document filed pursuant to Section 13(a), 14, or 15(d) of the Exchange Act or 120 days after the end of such fiscal year. If a registrant files a registration statement on this Form without the Item 402 information for the most recently completed fiscal year as permitted by this Item, and the registration statement will either automatically become effective or the registrant requests an effective date of such registration statement after the earliest date that the disclosure is due as specified by this Item, the registrant must file a pre-effective amendment to this Form which includes such information.

* * * * *

Appendix F—Form 20–F

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 20–F

* * * * *

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☐

Indicate by check mark which basis of accounting the registrant has used to prepare the financial statements included in this filing:

U.S. GAAP ☐

International Financial Reporting Standards as issued by the International Accounting Standards Board ☐

Other ☐

* * * * *

PART I

* * * * *

Item 6. Directors, Senior Management and Employees

* * * * *

F. Disclosure of a Registrant's Action To Recover Erroneously Awarded Compensation

* * * * *

(1) * * *

(ii) If recovery would be impracticable pursuant to 17 CFR 240.10D

1(b)(1)(iv), disclose the amount of recovery forgone and a brief description of the reason the listed registrant decided in each case not to pursue recovery; and

* * * * *

(2) [Reserved];

(3) The information must appear with, and in the same format as, the rest of the disclosure required to be provided pursuant to this Item 6, is required only in annual reports and does not apply to registration statements on Form 20–F, and will not be

deemed to be incorporated by reference into any filing under the Securities Act, except to the extent that the listed registrant specifically incorporates it by reference; and

(4) [Reserved].

Appendix G—Form 40–F

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 40–F

* * * * *

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☐

GENERAL INSTRUCTIONS

* * * * *

B. Information To Be Filed on This Form

* * * * *

(19) Recovery of erroneously awarded compensation.

* * * * *

(b) * * *

(2) If recovery would be impracticable pursuant to 17 CFR 240.10D–1(b)(1)(iv), disclose the amount of recovery forgone and a brief description of the reason the listed registrant decided in each case not to pursue recovery; and

* * * * *

(c) [Reserved]

* * * * *

(e) [Reserved]

* * * * *

Appendix H—Form 8–K

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 8–K

* * * * *

INFORMATION TO BE INCLUDED IN THE REPORT

* * * * *

Item 5.02 Departure of Directors or Certain Officers; Election of Directors; Appointment of Certain Officers; Compensatory Arrangements of Certain Officers

* * * * *

(f) [Reserved]

* * * * *

Instructions to Item 5.02.

* * * * *

4. For purposes of this Item, the term ''named executive officer'' refers to those executive officers for whom disclosure was required in the registrant's most recent filing with the Commission under the Securities Act (15 U.S.C. 77a *et seq.*) or Exchange Act (15 U.S.C. 78a *et seq.*) that required disclosure pursuant to Item 402(b) of Regulation S–K (17 CFR 229.402(b)).

* * * * *

Appendix I—Form 10–K

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10–K

* * * * *

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.

☐ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.

☐ Yes ☐ No

Note—Checking the box above will not relieve any registrant required to file reports pursuant to Section 13 or 15(d) of the Exchange Act from their obligations under those Sections.

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

☐ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S–T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).

☐ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of ''large accelerated filer,'' ''accelerated filer,'' ''smaller reporting company'' and ''emerging growth company'' in Rule 12b–2 of the Exchange Act.

Large accelerated filer ☐

Accelerated filer ☐

Non-accelerated filer ☐

Smaller reporting company ☐

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b–2 of the Act).

☐ Yes ☐ No

* * * * *

Appendix J—Form N–CSR

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM N–CSR

* * * * *

Item 18. Recovery of Erroneously Awarded Compensation

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(b) [Reserved]

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[FR Doc. 2026–23555 Filed 11–18–26; 8:45 am]

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