DEPARTMENT OF ENERGY

10 CFR Part 431

[Docket No. EERE–2008–BT–STD–0015]

RIN 1904–AB86

Energy Conservation Program: Public Meeting and Availability of the Preliminary Technical Support Document for Walk-In Coolers and Walk-In Freezers; Correction and Date Change

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy.

ACTION: Date changes and corrections.

SUMMARY: The U. S. Department of Energy (DOE) published a document in the **Federal Register** on April 5, 2010, concerning a public meeting and availability of the preliminary technical support document regarding energy conservation standards for walk-in coolers and walk-in freezers. This document corrects the docket number in that document and corrects the rulemaking e-mail address. This document also changes the dates of the public meeting, the deadline for requesting to speak at the public meeting, and the deadline for submitting written comments on the preliminary analysis.

FOR FURTHER INFORMATION CONTACT: Mr. Charles Llenza, U.S. Department of Energy, Building Technologies Program, EE–2J, 1000 Independence Avenue, SW., Washington, DC 20585–0121, (202) 586–2192, *Charles.Llenza@ee.doe.gov* or Mr. Michael Kido, Esq., U.S. Department of Energy, Office of General Counsel, GC–71, 1000 Independence Avenue, SW., Washington, DC 20585–0121, (202) 586–8145, *Michael.Kido@hq.doe.gov*.

DATES: DOE will hold a public meeting in Washington, DC on Wednesday, May 19, 2010, beginning at 9 a.m. DOE must receive requests to speak at the meeting before 4 p.m., Wednesday, May 5, 2010. DOE must receive a signed original and an electronic copy of statements to be given at the public meeting before 4 p.m., Wednesday, May 12, 2010. Written comments are welcome, especially following the public meeting, and should be submitted by Friday, May 28, 2010.

ADDRESSES: The public meeting will be held at the U.S. Department of Energy, Forrestal Building, Room 8E–089, 1000 Independence Avenue, SW., Washington, DC 20585–0121. To attend the public meeting, please notify Ms. Brenda Edwards at (202) 586–2945. Please note that foreign nationals participating in the public meeting are subject to advance security screening procedures, requiring a 30-day advance notice. If you are a foreign national and wish to participate in the public meeting, please inform DOE as soon as possible by contacting Ms. Brenda Edwards at (202) 586–2945 so that the necessary procedures can be completed. Interested persons may submit comments, identified by docket number EERE–2008–BT–STD–0015, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov* Follow the instructions for submitting comments.
- *E-mail: WICF–2008–STD–0015@ee.doe.gov;* Include EERE–2008–BT–STD–0015 in the subject line of the message.
- *Postal Mail:* Ms. Brenda Edwards, U.S. Department of Energy, Building Technologies Program, Mailstop EE–2J, Public Meeting for Walk-in Coolers and Walk-in Freezers, EERE–2008–BT–STD–0015, 1000 Independence Avenue, SW., Washington, DC 20585–0121. Telephone (202) 586–2945. Please submit one signed paper original.
- *Hand Delivery/Courier:* Ms. Brenda Edwards, U.S. Department of Energy, Building Technologies Program, Sixth Floor, 950 L'Enfant Plaza, SW., Washington, DC 20024. Telephone (202) 586–2945. Please submit one signed paper original.

Instructions: All submissions received must include the agency name and docket number.

Docket: For access to the docket to read background documents or a copy of the transcript of the public meeting or comments received, go to the U.S. Department of Energy, Sixth Floor, 950 L'Enfant Plaza, SW., Washington, DC 20024, (202) 586–2945, between 9 a.m. and 4 p.m., Monday through Friday, except Federal holidays. Please call Ms. Brenda Edwards at (202) 586–2945 for additional information regarding visiting the Resource Room.

SUPPLEMENTARY INFORMATION: DOE published a notice in the **Federal Register** on April 5, 2010, (75 FR 17080) concerning a public meeting and availability of the preliminary technical support document regarding energy conservation standards for walk-in coolers and walk-in freezers. This notice corrects the docket number in that notice to EERE–2008–BT–STD–0015 and corrects the rulemaking e-mail address in that notice to *WICF–2008–STD–0015@ee.doe.gov*.

This notice also changes the date of the public meeting, the date of the deadline for requesting to speak at the public meeting, and the date of the deadline for submitting written comments on the preliminary analysis. The public meeting will now be held on Wednesday, May 19, 2010, beginning at 9 a.m. The close of the comment period has been changed to Friday, May 28, 2010, in order to accommodate comments received at the public meeting and comments that may be submitted based on issues raised at the public meeting. Interested parties are directed to submit their comments to the rulemaking e-mail address, *WICF–2008–STD–0015@ee.doe.gov*, with instructions to include docket number EERE–2008–BT–STD–0015.

The purpose of the meeting is to discuss the preliminary analysis for standards for walk-in coolers and walk-in freezers. The Department welcomes all interested parties, regardless of whether they participate in the public meeting, to submit written comments regarding matters addressed in the preliminary analysis, as well as any other related issues, by May 28, 2010.

Issued in Washington, DC, on April 8, 2010.

Cathy Zoi,

Assistant Secretary, Energy Efficiency and Renewable Energy.

[FR Doc. 2010–8499 Filed 4–13–10; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Parts 146 and 148

Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of the Secretary, Department of Health and Human Services.

ACTION: Request for information.

SUMMARY: This document is a request for comments regarding Section 2718 of the Public Health Service Act (PHS Act), which was added by Sections 1001 and 10101 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148, enacted on March 23, 2010. Section 2718 of the PHS Act, among other provisions, requires health insurance issuers offering individual or group coverage to submit annual reports to the Secretary on the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year. Section 1562 of PPACA also added section 715 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 9815 of the Internal Revenue Code of 1986 (the Code). These two sections effectively incorporate by reference section 2718 and other amendments to title XXVII of the PHS Act. The Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) invite public comments in advance of future rulemaking.

DATES: Submit written or electronic comments by May 14, 2010.

ADDRESSES: Written or electronic comments should be submitted to the Department of HHS as directed below. Any comment that is submitted to the Department of HHS will be shared with the Departments of Labor and Treasury.

All comments will be made available to the public. Please do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed.

All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Comments, identified by DHHS–2010–MLR, may be submitted to the Department of HHS by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Written comments (one original and two copies) may be mailed to: Department of Health and Human Services, Attention: DHHS–2010–MLR, Hubert H. Humphrey Building, Room 445–G, 200 Independence Avenue, SW., Washington, DC 20201.
- *Hand or courier delivery:* Written comments (one original and two copies) may be delivered (by hand or courier) to Room 445–G, Department of Health and Human Services, Attention: DHHS–2010–MLR, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the DHHS–2010–MLR drop box located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.

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 electronic comments received before the close of the comment period on the following public Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at Room 445–G, Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 1–800–743–3951.

FOR FURTHER INFORMATION CONTACT: Sharon Arnold, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (202) 690–5480; Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622–6080.

Customer Service Information: Individuals interested in obtaining information about the Patient Protection and Affordable Care Act may visit the Department of Health and Human Services' Web site (*http://www.healthreform.gov*). In addition, information concerning employment-based health coverage laws is available by calling the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visiting the Department of Labor's Web site (*http://www.dol.gov/ebsa*).

SUPPLEMENTARY INFORMATION:

I. Background

A. General

Section 1001 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148, enacted on March 23, 2010, amended the Public Health Service Act (PHS Act) to provide several individual and group market reforms. In 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which added title XXVII to the PHS Act, and parallel provisions to the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 (the Code). The HIPAA amendments provided for, among other things, improved portability and continuity of coverage with respect to health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment. Title XXVII of the PHS Act is codified at 42 U.S.C. 300gg, *et seq.* PPACA expanded Title XXVII of the PHS Act, redesignated several sections, and created new requirements affecting the individual and group markets. These amendments were incorporated by reference into ERISA and the Code by creating new sections 715 and 9815, respectively. The Secretaries of HHS, Labor, and the Treasury have shared interpretive and enforcement authority under Title XXVII of the PHS Act, Part 7 of ERISA, and Chapter 100 of the Code. See section 104 of HIPAA and Memorandum of Understanding applicable to Title XXVII of the PHS Act, Part 7 of ERISA, and Chapter 100 of the Code, published at 64 FR 70164, December 15, 1999.

B. Public Reporting of the Ratio of Incurred Claims to Earned Premiums (Medical Loss Ratio) for Individual and Group Coverage

PPACA sections 1001 and 10101 added Section 2718 of the PHS Act, which, among other provisions, requires health insurance issuers offering individual or group coverage to submit annual reports to the Secretary on the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year.

Specifically, Section 2718(a) of the PHS Act requires health insurance issuers offering group or individual

coverage to submit a report to the Secretary for each plan year, concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums (also known as the medical loss ratio (MLR)). Section 2718(a) requires that each report include the percentage of total premium revenue—after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance—that the coverage spends:

(1) On reimbursement for clinical services provided to enrollees;

(2) for activities that improve health care quality;

and

(3) on all other non-claims costs, including an explanation of the nature of these costs, and excluding Federal and State taxes and licensing or regulatory fees.

Section 2718(a) also directs the Secretary to make these reports available to the public on the Internet Web site of HHS.

C. Uniform Definitions

Section 2718(c) of the PHS Act directs the National Association of Insurance Commissioners (NAIC) to establish uniform definitions of the activities being reported to the Secretary under Section 2718(a), and standardized methodologies for calculating measures of these activities no later than December 31, 2010. Section 2718(c) specifies that NAIC's responsibilities relating to this provision are to include defining which activities constitute activities that improve quality (under Section 2718(a)(2)). Section 2718(c) also directs that the uniform methodologies that NAIC develops are to be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans. Finally, Section 2718(c) specifies that the uniform definitions and standardized methodologies that NAIC develops are to be subject to the certification of the Secretary.

D. Payment of Rebates to Enrollees if the Amount Spent on Clinical Services and Quality Improvement Does Not Meet Minimum Standards

Section 2718(b)(1)(A) of the PHS Act provides that, beginning not later than January 1, 2011, health insurance issuers offering group or individual health insurance coverage must with respect to each plan year, provide an annual rebate to each enrollee under such coverage if the ratio of: (1) The amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve health care quality to (2) the total amount of premium revenue for the plan year (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of PPACA) is less than the following percentages, referred to here as "the applicable minimum standards":

(1) 85 percent for coverage offered in the large group market (or a higher percentage that a given State may have determined by regulation); or

(2) 80 percent for coverage offered in the small group market or in the individual market (or a higher percentage that a given State may have determined by regulation), except that the Secretary may adjust this percentage for a State if the Secretary determines that the application of the 80 percent minimum standard may destabilize the individual market in that State).

Section 2718(b)(2) requires that in determining these minimum percentages, States shall seek to ensure adequate participation by health insurance issuers, competition in the State's health insurance market, and value for consumers so that premiums are used for clinical services and quality improvements.

Additionally, Section 2718(d) provides that the Secretary may adjust the rates described in Section 2718(b) if the Secretary determines that it is appropriate to do so, on account of the volatility of the individual market due to the establishment of State Exchanges. (In this context, the terms "State Exchange" and "Exchange" refer to the State health insurance exchanges established under PPACA).

Section 2718(b)(1)(A) requires that the annual rebate be paid to each enrollee on a "pro rata basis". Section 2718(b)(1)(B)(i) specifies that the total amount of the annual rebate required under this provision shall be equal to the product of:

(1) The amount by which the applicable minimum standard exceeds the actual ratio of the issuer's expenditures to its premium revenue as described above; and

(2) The total amount of the premium revenue described above.

Section 2718(b)(1)(B)(ii) requires that beginning on January 1, 2014, the determination of whether the percentage that the coverage spent on clinical services and quality improvement exceeds the applicable minimum standard (under Section 2718(b)(1)(A)) for the year involved shall be based on the average of the premiums expended on these costs and total premium revenue for each of the previous three years for the plan.

E. Enforcement

Section 2718(b)(3) of the PHS Act requires the Secretary to promulgate regulations for enforcing the provisions of Section 2718, and specifies that the Secretary may provide for appropriate penalties.

F. Taxation of Certain Insurers

Section 9016 of the PPACA amends Section 833 of the Code to provide that Section 833 does not apply to any organization unless the organization's percentage of total premium revenue expended on reimbursement for clinical services (as reported under Section 2718 of the Public Health Service Act) is not less than 85 percent. In general, Section 833 provides a special deduction and a higher unearned premium reserve for certain Blue Cross or Blue Shield organizations that were in existence in 1986 and to other organizations that satisfy enumerated criteria. The amendment to Section 833 applies to taxable years beginning after December 31, 2009.

G. Effective Dates

Section 1004(a) of the PPACA provides that the provisions of Section 2718 of the PHS Act shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of PPACA. (The date of enactment of PPACA is March 23, 2010).

II. Solicitation of Comments

The Departments are inviting public comment to aid in the development of regulations regarding Section 2718 of the PHS Act. The Departments are interested in comments from all interested parties and are especially interested in the perspectives of health insurance issuers and States. To assist interested parties in responding, this request for comments describes specific areas in which the Departments are particularly interested.

This request for comments identifies a wide range of issues that are of interest to the Departments. Commenters should use the questions below to assist in providing the Departments with useful information relating to the development of regulations regarding Section 2718 of the PHS Act. However, it is not necessary for commenters to address every question below and commenters may also address additional issues under Section 2718. Individuals, groups, and organizations interested in providing comments may do so at their

discretion by following the above mentioned instructions.

Specific Areas in Which the Departments Are Particularly Interested Include the Following:

A. Actual MLR Experience and Minimum MLR Standards

The PPACA sets an 85 percent minimum standard for the percentage of premiums that coverage in the large group market spends on reimbursement for clinical services and activities that improve quality, and an 80 percent minimum standard for the small group and individual markets—allowing for higher State-level standards where appropriate (if they are specified in regulations). The PPACA allows the Secretary to adjust this percentage for the individual market in a given State: (1) If the Secretary determines that application of the 80 percent standard may destabilize the individual market in that State, and/or (2) on account of the volatility of the individual market due to the establishment of State Exchanges.

1. How Do Health Insurance Issuers' Current Medical Loss Ratios for the Individual, Small Group, and Large Group Markets Compare to the Minimum Standards Required in PPACA?

a. What factors contribute to annual fluctuations in issuers' medical loss ratios?

b. To what extent do States have different minimum MLR requirements based on plan size, plan type, number of years of operation, or other factors?

2. What Criteria Do States and Other Entities Consider When Determining if a Given Minimum MLR Standard Would Potentially Destabilize the Individual Market? What Other Criteria Could Be Considered?

B. Uniform Definitions and Calculation Methodologies

The statute requires health insurance issuers offering group or individual health insurance coverage to annually submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums—including the percentage of premiums spent on reimbursement for clinical services provided to enrollees, activities that improve health care quality, and on all other non-claims costs. PPACA also directs NAIC to develop uniform definitions and methodologies for calculating these statistics (subject to certification by the Secretary).

1. What Definitions and Methodologies Do States and Other Entities Currently Require When Calculating MLR-Related Statistics?

a. What assumptions and methodologies do issuers use when calculating MLR-related statistics? What are some of the major differences that exist, as well as pros and cons of these various methods?

b. What kinds of assumptions and methodologies do issuers currently use for allocating administrative overhead by product, geographic area, etc.? What are the pros and cons of these various methods?

c. What kinds of assumptions and methodologies do issuers currently use when calculating the loss adjustment expense (or change in contract reserves)? What are the pros and cons of these various methods?

d. To what extent do States and other entities receive detailed information about the distribution of non-claims costs by function (for example, claims processing and marketing)? To what extent do they set standards as to which administrative overhead costs may be allocated to processing claims, or providing health improvements?

e. What kinds of criteria do States and other entities use in determining if a given company has credible experience for purposes of calculating MLR-related statistics?

f. What kinds of special considerations, definitions, and methodologies do States and other entities currently use relating to calculating MLR-related statistics for newer plans, smaller plans, different types of plans or coverage?

2. What Are the Similarities and Differences Between the Requirements in Section 2718 Compared to Current Practices in States?

a. What MLR-related data elements that are required by PPACA do issuers currently capture in their financial accounting systems, and how are they defined? What elements are likely to require systems changes in order to be captured?

b. What MLR-related data elements that are required by PPACA do States or other entities currently require issuers to submit, and how are they defined? What elements are not currently submitted?

3. What Definitions Currently Exist for Identifying and Defining Activities That Improve Health Care Quality?

a. What criteria do States and other entities currently use in identifying activities that improve health care quality?

b. What, if any, lists of activities that improve health care quality currently exist? What are the pros and cons associated with including various kinds of activities on these lists (for example disease management and case management)?

c. To what extent do current calculations of medical loss ratios include the amount spent on improving health care quality? Is there any data available relating to how much this amount is?

4. What Other Terms or Provisions Require Additional Clarification To Facilitate Implementation and Compliance? What Specific Clarifications Would Be Helpful?

C. Level of Aggregation

Depending on the context, insurance-related data may be aggregated at the policy form level, by plan type, by line of business, by company, by State.

1. What Are the Pros and Cons Associated With Using Various Possible Level(s) of Aggregation for Different Contexts Relating to Implementation of the Provisions in Section 2718 (That Is, Submitting Medical Loss Ratio-Related Statistics to the Secretary, Publicly Reporting This Information, Determining if Rebates Are Owed, and Paying Out Rebates)?

2. What Are the Pros and Cons Associated With Using Various Possible Geographic Level(s) of Aggregation (*e.g.,* State-Level, National, etc.) for Medical Loss Ratio-Related Statistics in These Same Contexts (*i.e.,* Submitting Medical Loss Ratio-Related Statistics to the Secretary, Publicly Reporting This Information, Determining if Rebates Are Owed, and Paying Out Rebates)?

D. Data Submission and Public Reporting

PPACA requires health insurance issuers offering group or individual health insurance coverage to annually submit data to the Secretary relating to several medical loss ratio-related statistics (including the percentage of premiums spent on reimbursement for clinical services provided to enrollees, activities that improve health care quality, and on all other non-claims costs) for posting on the Department's Internet Web site.

1. To what extent do States or other entities currently require annual submission of actual medical loss ratio-related statistics for the individual, small group, and large group markets? How do these current requirements compare with the requirements in PPACA?

2. How soon after the end of the plan year do States and other entities typically require issuers to submit the required MLR-related statistics? What are the pros and cons associated with various timeframes?

3. What kinds of supporting documentation are necessary for interpreting these kinds of statistics? What data elements and format are typically used for submitting this information?

4. What methods do issuers use for purposes of submitting medical loss ratio-related data to these entities (for example, electronic filing and paper filing)?

5. To what extent is MLR-related information submitted to States or other entities currently made available to the public, and how is it made available (for example, level of aggregation, and mechanism for public reporting)? What are the pros and cons associated with these various methods?

6. Are there any industry standards or best practices relating to submission, interpretation, and communication of MLR-related statistics?

7. What, if any, special considerations are needed for non-calendar year plans?

E. Rebates

PPACA requires health insurance issuers whose coverage does not meet the applicable minimum standard for a given plan year to provide rebates to enrollees on a pro rata or proportional basis. The rebate is to be calculated based on the product of: (1) The amount by which the applicable minimum standard exceeds the percentage that the coverage spent on clinical services and quality improvement for a given plan year; and (2) the total amount of premium revenue for that plan year (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of PPACA).

1. To what extent do States and other entities currently require MLR-related rebates for the individual, small group, large group, and/or other insurance markets, and how are these rebates calculated and distributed?

2. How soon after the end of the plan year do States and other entities currently require issuers to determine if rebates are owed?

3. What are the pros and cons of various timeframes and methodologies for calculating rebates?

4. How do States and other entities currently determine which enrollees should receive medical loss ratio-related rebates? [1] What are the pros and cons associated with these approaches?

5. What method(s) do States and other entities currently require issuers to use when notifying enrollees if rebates are owed, and paying the rebates? What are the pros and cons associated with these approaches?

6. Are there any important technical issues that may affect the processes for determining if rebates are owed, and calculating the amount of rebates to be paid to each enrollee?

F. Federal Income Tax

Under Section 9016 of the PPACA, the amendment to Section 833 of the Code applies to taxable years beginning after December 31, 2009. Under Section 2718(c) of the PHS Act, the NAIC is directed to establish uniform definitions for purposes of the reporting required under Section 2718(a) not later than December 31, 2010.

What guidance, if any, is needed for purposes of applying Section 833 of the Code for the first taxable year beginning after December 31, 2009?

G. Enforcement

PPACA requires the Secretary to publish regulations for enforcing the provisions of this section, and specifies that the Secretary may provide for appropriate penalties.

1. What methods do States and other entities currently use in enforcing medical loss ratio-related requirements for the individual, small group, large group, and other insurance markets (for example, oversight and audit requirements)? What other methods could be used?

2. What, if any, penalties do these entities currently apply relating to noncompliance with medical loss ratio-related requirements? What, if any, related appeals processes are currently available to issuers?

H. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of Section 2718 of the PHS Act will be economically significant. A rule that has an annual effect on the economy of $100 million or more is considered economically significant.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans, employers, and issuers and, in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant regulatory alternatives considered that would accomplish the stated objectives of the statute and minimize the impact on small entities.

The Paperwork Reduction Act requires an estimate of how many "respondents" will be required to comply with any "collection of information" requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures.

Furthermore, Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $135 million.

The Departments are requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

1. What Policies, Procedures, or Practices of Group Health Plans, Health Insurance Issuers, and States May Be Impacted by Section 2718 of the PHS Act?

a. What direct or indirect costs and benefits would result?

b. Which stakeholders will be impacted by such benefits and costs?

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

[1] *For example:* Current policyholders, current policyholders who were enrolled in the coverage during the applicable time period, or all policyholders who were enrolled in the coverage during the applicable time period (regardless of whether they are still active policyholders).

2. Are There Unique Costs and Benefits for Small Entities Subject to Section 2718 of the PHS Act?

a. What special consideration, if any, is needed for these health insurance issuers or plans?

b. What costs and benefits have issuers experienced in implementing requirements relating to minimum medical loss ratio standards, reporting and rebates under State insurance laws or otherwise?

3. Are There Additional Paperwork Burdens Related to Section 2718 of the PHS Act, and, if so, What Estimated Hours and Costs Are Associated With Those Additional Burdens?

Signed at Washington, DC this 6th day of April, 2010.

Clarissa C. Potter,

Deputy Chief Counsel, (Technical), Internal Revenue Service, U.S. Department of the Treasury.

Signed at Washington, DC this 7th day of April, 2010.

Michael F. Mundaca,

Assistant Secretary, (Tax Policy), U.S. Department of the Treasury.

Signed at Washington, DC this 7th day of April, 2010.

Phyllis C. Borzi,

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

Signed at Washington, DC this 8th day of April, 2010.

Donald B. Moulds,

Acting Assistant Secretary for Planning and Evaluation, Office of the Secretary, Department of Health and Human Services.

[FR Doc. 2010–8599 Filed 4–12–10; 10:15 am]

BILLING CODE 4150–03–P

DEPARTMENT OF DEFENSE

Department of the Army

32 CFR Part 655

RIN 0702–AA58

[Docket No. USA–2008–0001]

Radiation Sources on Army Land

AGENCY: Department of the Army, DoD.

ACTION: Proposed rule; request for comments.

SUMMARY: The Department of the Army proposes to revise its regulations concerning radiation sources on Army land. The Army requires Non-Army agencies (including their civilian contractors) to obtain an Army Radiation Permit (ARP) from the garrison commander to use, store or possess ionizing radiation sources on an Army Installation. For the purpose of this proposed rule, "ionizing radiation source" means any source that, if held or owned by an Army organization, would require a specific Nuclear Regulatory Commission (NRC) license or Army Radiation Authorization (ARA). The purpose of the ARP is to protect the public, civilian employees and military personnel on an installation from potential exposure to radioactive sources. The U.S. Army Safety Office which is the proponent for the Army Radiation Safety Program is revising the regulation to reflect the Nuclear Regulatory Commission changes to licensing of Naturally-Occurring and Accelerator-Produced Radioactive Material (NARM). Executive Order 12866 Regulatory Planning and Review and Executive Order 13422 Further Amendment to Executive Order 12866 on Regulatory Planning and Review were followed to rewrite this rule.

DATES: Consideration will be given to all comments received by June 14, 2010.

ADDRESSES: You may submit comments, identified by 32 CFR Part 655, Docket No. USA–2008–0001 and/or RIN 0702–AA58, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Federal Docket Management System Office, 1160 Defense Pentagon, Washington, DC 20301–1160.

Instructions: All submissions received must include the agency name and docket number or Regulatory Information Number (RIN) for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: Tim Mikulski, (703) 601–2408.

SUPPLEMENTARY INFORMATION:

A. Background

On October 1, 2007, the Nuclear Regulatory Commission (NRC) issued a final rule which establishes requirements for the expanded definition of byproduct material. 72 FR 55864 (Oct. 1, 2007). The final regulation became effective on November 30, 2007. The NRC revised the definition of byproduct material in 10 CFR Parts 20, 30, 50, 72, 150, 170, and 171 to be consistent with section 651(e) of the Energy Policy Act of 2005. The same revision to the definition of byproduct material was made in a separate rulemaking for 10 CFR Part 110 (April 20, 2006; 71 FR 20336). The Department of the Army is revising 32 CFR Part 655 to reflect the changes of the expanded definition of byproduct material that include Naturally-Occurring and Accelerator-Produced Radioactive Material (NARM). Specifically, the current 32 CFR 655.10 paragraphs (a)(2), (3) and (4) have been removed, as the sources described in these sections will now be covered under 32 CFR 655.10(a)(1), which incorporates the expanded NRC definition of byproduct material (*see, e.g.,* 10 CFR 20.1003).

Additional changes in the rule include:

—Clarification that the use, storage, or possession of ionizing radiation sources must be in connection with an activity of the Department of Defense or in connection with a service to be performed on the installation for the benefit of the Department of Defense, in accordance with 10 U.S.C. 2692(b)(1).

—The use of ionizing radiation to differentiate between ionizing and nonionizing radioactive sources. Nonionizing radiation sources include lasers and radio frequency sources that are not covered by an ARP.

—The addition of an exemption of (1) non-Army entities using Army owned/licensed radioactive materials and (2) other Military Departments needing an ARP to bring radioactive sources on Army lands. The Radiation Safety Officer (RSO) must be notified prior to ionizing radiation sources being brought onto the installation.

—Clarification on when to file a NRC Form 241.

—The time the ARP is valid has been extended from three months to twelve months to reduce the need for reapplication.

—Consideration of host nation regulations was included for Outside the Continental United States (OCONUS) military installations.

—The land will be restored to the condition it was in prior to the effective date of the ARP.

B. Regulatory Flexibility Act

The Department has certified that the rule will not have a significant economic impact on a substantial number of small entities because the rule imposes no additional costs. However, since this is a proposed rule, the Department of the Army seeks comments from small entities that may be impacted by this proposed rule change.