activities, such as holding securities in inventory. If a broker-dealer acts as an agent on behalf of multiple issuers, its financial condition is important to capital formation for multiple issuers, and so the benefits of certification are likely higher for the broker-dealer. Moreover, the Commission notes that the benefits to broker-dealers from such an alternative may be limited by competitive effects, because an issuer that is concerned about the reliability of a broker-dealer's financial statements may choose to hire a broker-dealer with certified annual reports to act as its agent.

Second, the Commission considered eliminating the exemption. While the Commission is mindful of the significance of broker-dealer audits, as explained above, the Commission believes that the cost of this alternative to broker-dealers who are now eligible to take advantage of the exemption does not justify the benefits that would accrue to the broker-dealer's single customer, typically an affiliate of the broker-dealer, as a result of an audit. Therefore, the Commission preliminarily believes the exemption should continue to be available only where a broker-dealer is acting as an agent for a single issuer in soliciting subscriptions for securities of that issuer.

Finally, the Commission considered further specifying that the limited exemption in paragraph (e)(1)(i)(A) of Rule 17a–5 would apply only if the broker-dealer were engaged in underwriting the securities of an affiliate. While this alternative would narrow the limited exemption, based on its observation of broker-dealers' use of this exemption to date, the Commission does not believe the benefits yielded by narrowing the exemption would be substantial.

VI. Regulatory Flexibility Act Certification

Section 3(a) of the Regulatory Flexibility Act requires the Commission to undertake an initial regulatory flexibility analysis of the impact of the proposed rule on small entities unless the Commission certifies that the amendments, if adopted, would not have a significant economic impact on a substantial number of small entities. As discussed above, the proposed rule would not change the status quo in terms of the broker-dealers that would or would not qualify for the exemption from paragraph (d)(1)(i)(C) of Rule 17a–5.[25] For additional discussion of the impact of the proposal (including on small entities), please see section V above. The Commission hereby certifies, pursuant to 5 U.S.C. 605(b), that the proposed amendment to Rule 17a–5, if adopted, would not have a significant economic impact on a substantial number of small entities.

The Commission encourages written comments regarding this certification. The Commission solicits comment as to whether the proposed amendments could have an effect that the Commission has not considered and requests that commenters describe the nature of any impact on small entities and provide empirical data to support the extent of the impact.

VII. Consideration of Impact on the Economy

For purposes of the Small Business Regulatory Enforcement Fairness Act of 1996,[26] a rule is ''major'' if it has resulted, 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.

The Commission requests comment on the potential impact of the proposed rule on the economy on an annual basis. The Commission requests that commenters provide empirical data and other factual support for their views.

VIII. Statutory Authority

The Commission is proposing an amendment to Rule 17a–5 under the Exchange Act (17 CFR 240.17a–5) pursuant to the authority conferred by Exchange Act Sections 17(e)(1)(A), 17(e)(1)(C), and 36.[27]

List of Subjects in 17 CFR Part 240

Brokers, Reporting and recordkeeping requirements, Securities.

Text of Proposed Rules

In accordance with the foregoing, the Commission proposes that Title 17, Chapter II of the Code of Federal Regulation be amended as follows.

PART 240—GENERAL RULES AND REGULATIONS, SECURITIES EXCHANGE ACT OF 1934

■ 1. 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, 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, 78*ll,* 78mm, 80a–20, 80a–23, 80a–29, 80a–37, 80b–3, 80b–4, 80b–11, 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; and Pub. L. 111–203, 939A, 124 Stat. 1887 (2010); and secs. 503 and 602, Pub. L. 112–106, 126 Stat. 326 (2012), unless otherwise noted.

* * * * *

■ 2. Amend § 240.17a–5 by revising paragraph (e) to read as follows.

§ 240.17a–5 Reports to be made by certain brokers and dealers.

* * * * *

(e) Nature and form of reports.

(1)(i) The broker or dealer is not required to engage an independent public accountant to provide the reports required under paragraph (d)(1)(i)(C) of this section if, since the date of the registration of the broker or dealer under section 15 of the Act (15 U.S.C. 78o) or of the previous annual reports filed under paragraph (d) of this section:

(A) The securities business of the broker or dealer has been limited to acting as broker (agent) for a single issuer in soliciting subscriptions for securities of that issuer, the broker has promptly transmitted to the issuer all funds and promptly delivered to the subscriber all securities received in connection with the transaction, and the broker has not otherwise held funds or securities for or owed money or securities to customers; or

* * * * *

By the Commission.

Dated: September 20, 2018.

Brent J. Fields,

Secretary.

[FR Doc. 2018–20880 Filed 9–26–18; 8:45 am]

BILLING CODE 8011–01–P

[25] *See* 17 CFR 240.17a–5(d)(1)(i)(C).

[26] Public Law 104–121, Title II, 110 Stat. 857 (1996).

[27] 15 U.S.C. 78q(e)(1)(A); 15 U.S.C. 78q(e)(1)(C); 15 U.S.C. 78mm.

DEPARTMENT OF LABOR

Wage and Hour Division

29 CFR Part 570

RIN 1235–AA22

Expanding Employment, Training, and Apprenticeship Opportunities for 16- and 17-Year-Olds in Health Care Occupations Under the Fair Labor Standards Act

AGENCY: Wage and Hour Division, Department of Labor.

ACTION: Notice of proposed rulemaking; request for comments.

SUMMARY: The Department of Labor (Department) is proposing this rule to enhance employment, training, and

apprenticeship opportunities for 16- and 17-year-olds in health care occupations in the United States while maintaining worker safety. The changes proposed in this rule also respond to the concerns of a bipartisan, bicameral group of congressional lawmakers. The youth-employment provisions of the Fair Labor Standards Act (FLSA) ensure that when youth work, the work is safe and does not jeopardize their health, well-being, or education. Pursuant to those provisions, 16- and 17-year-old employees generally cannot work in a nonagricultural occupation governed by any of the Department's Hazardous Occupations Orders (HOs). HO 7 prohibits youth from working in occupations involving the operation of a power-driven patient lift. Patient lifts, however, substantially differ in form and function from the other equipment that the HO governs, including forklifts, backhoes, cranes, and other heavy industrial equipment. Additionally, patient lifts are safer for workers than the alternative method of manually lifting patients. In response to significant public input and bipartisan, bicameral requests from Members of Congress, the Department proposes to remove the operation of power-driven patient lifts from the list of activities that HO 7 prohibits. This proposal, if finalized, would increase the participation of young workers in health care occupations and enhance their future career skills and their earning potential, without reducing worker safety.

DATES: Submit written comments on or before November 26, 2018.

ADDRESSES: You may submit comments, identified by Regulatory Information Number (RIN) 1235–AA22, by either of the following methods: *Electronic Comments:* Submit comments through the Federal eRulemaking Portal at *http://www.regulations.gov.* Follow the instructions for submitting comments. *Mail:* Address written submissions to Division of Regulations, Legislation, and Interpretation, Wage and Hour Division, U.S. Department of Labor, Room S–3502, 200 Constitution Avenue NW, Washington, DC 20210. *Instructions:* Please submit only one copy of your comments by only one method. All submissions must include the agency name and RIN, identified above, for this rulemaking. Please be advised that comments received will become a matter of public record and will be posted without change to *http://www.regulations.gov,* including any personal information provided. All comments must be received by 11:59 p.m. on the date indicated for consideration in this rulemaking. Commenters should transmit comments early to ensure timely receipt prior to the close of the comment period, as the Department continues to experience delays in the receipt of mail. For additional information on submitting comments and the rulemaking process, see the ''Public Participation'' heading of the supplementary information section of this document. For questions concerning the interpretation and enforcement of labor standards related to the FLSA, individuals may contact the Wage and Hour Division (WHD) local district offices (see contact information below). *Docket:* For access to the docket to read background documents or comments, go to the Federal eRulemaking Portal at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Melissa Smith, Division of Regulations, Legislation, and Interpretation, Wage and Hour Division, U.S. Department of Labor, Room S–3502, 200 Constitution Avenue NW, Washington, DC 20210; telephone: (202) 693–0406 (this is not a toll-free number). Copies of this proposed rule may be obtained in alternative formats (Large Print, Braille, Audio Tape or Disc), upon request, by calling (202) 693–0406 (this is not a toll-free number). TTY/TDD callers may dial toll-free 1–877–889–5627 to obtain information or request materials in alternative formats. Questions of interpretation and/or enforcement of the agency's regulations may be directed to the nearest WHD district office. Locate the nearest office by calling WHD's toll-free help line at (866) 4US–WAGE ((866) 487–9243) between 8 a.m. and 5 p.m. in your local time zone, or log onto WHD's website for a nationwide listing of WHD district and area offices at *http://www.dol.gov/whd/america2.htm.*

Electronic Access and Filing Comments: This proposed rule and supporting documents are available through the **Federal Register** and the *http://www.regulations.gov* website. You may also access this document via WHD's website at *http://www.dol.gov/whd/.* To comment electronically on Federal rulemakings, go to the Federal eRulemaking Portal at *http://www.regulations.gov,* which will allow you to find, review, and submit comments on Federal documents that are open for comment and published in the **Federal Register**. You must identify all comments submitted by including ''RIN 1235–AA22'' in your submission. Commenters should transmit comments early to ensure timely receipt prior to the close of the comment period (11:59 p.m. on the date identified above in the **DATES** section); comments received after the comment period closes will not be considered. Submit only one copy of your comments by only one method. Please be advised that all comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

The youth-employment provisions of the FLSA ensure that when youth work, the work is safe and does not jeopardize their health, well-being, or education.[1] Pursuant to those provisions, 16- and 17-year-old employees generally cannot work in a nonagricultural occupation governed by any of the Department's HOs. As relevant to this proposal, HO 7 prohibits 16- and 17-year-old employees from working in occupations involving the operation of a power-driven hoisting apparatus.[2] The Department originally issued HO 7 in 1946. It primarily covers devices used in industrial contexts, such as forklifts, backhoes, and cranes—which, as discussed below, differ both in form and function from patient lifts. When originally enacted, HO 7 contained an exemption for electric or air-operated hoists not exceeding a one-ton capacity. HO 7 therefore did not encompass power-driven patient lifts used to transport patients and residents in medical settings such as hospitals, nursing homes, and long-term care facilities. In 2010, however, the Department amended HO 7 to, in part, eliminate the longstanding exemption for electric or air-operated hoists not exceeding a one-ton capacity. As a result, HO 7 now encompasses power-driven patient lifts. Power-driven patient lifts, however, are far less dangerous to workers than the alternative of manual patient lifting, which causes a significant number of worker injuries. Power-driven patient lifts are different in form and function from the other kinds of machines listed in HO 7. Typically speaking, power-driven patient lifts do not have nearly the same size, power, mass, speed, or complexity as many of those other machines; they are used in health care rather than industrial facilities; and from 2012 to 2016 only 1 worker fatality was attributed to a patient hoist or lifting harness, in comparison to 930 worker fatalities associated with cranes, overhead hoists, bucket or basket hoists, manlifts, and forklifts.

After the 2010 expansion of HO 7, numerous stakeholders asked the Department to reconsider the HO's

[1] *See generally* 29 U.S.C. 203(*l*), 212, 213(c).

[2] 29 CFR 570.58(a).

inclusion of patient lifts because, among other things, it severely restricts employment opportunities for 16- and 17-year-olds in the health care industry and the alternative of manually lifting patients is more dangerous to workers than the use of powered lifts. Those stakeholders voicing concerns and requesting changes to HO 7 included multiple members of the Senate and House of Representatives from both political parties. In response to this public input, the Department issued a nonenforcement policy in 2011, specifying that it would not assert a violation of HO 7 when a trained 16- or 17-year-old, under certain specified conditions, assists a trained adult in the operation of patient lifts. The Department, however, has continued to hear concerns from the public and a bipartisan group of legislators that 16- and 17-year-olds' inability to independently operate such devices decreases their employment and training opportunities in health care occupations; often necessitates those who work in such occupations to manually lift patients—a practice that is more dangerous than using a patient lift; and, in some cases, hinders health care providers' ability to care for patients due to a lack of staff available to timely move patients. Given these and other considerations outlined below, the Department is proposing to enhance employment, training, and apprenticeship opportunities for 16- and 17-year-olds in health care by excluding power-driven patient lifts from the scope of HO 7.

This proposed rule is expected to be an Executive Order (E.O.) 13771 deregulatory action. Details on the estimated cost savings of this proposed rule can be found in the rule's economic analysis.

II. Need for Rulemaking

An important task in health care occupations, particularly in facilities that care for the elderly and disabled, is the safe handling and moving of patients. Without patient lifts, health care personnel sometimes manually lift patients who cannot transport themselves. Such practices can lead to musculoskeletal disorders, such as muscle strains and lower back injuries, among manual lifters. Among health care occupations, 40 percent of injuries resulting in days away from work are caused by overexertion or bodily reaction, which includes motions such as lifting, bending, or reaching—motions related to patient handling.[3] In contrast, the use of mechanical lifting equipment, such as powered patient lifts or hoists, has been shown to reduce exposure to manual lifting injuries by up to 95 percent.[4] Because powered patient lifts significantly reduce the risk of musculoskeletal disorders compared to manual lifting, many facilities encourage or require their use. Since 2010, however, HO 7 has prohibited 16- and 17-year-old youth from operating power-driven patient lifts.[5]

After hearing significant concerns about the application of HO 7 to power-driven patient lifts from members of the public and a bipartisan group of elected officials, the Department issued a non-enforcement policy in 2011 that applies when trained 16- and 17-year-olds, under specified conditions, assist a trained adult in the operation of patient lifts.[6] The nonenforcement policy, however, does not permit these youth to operate patient lifts independently. The Department has received correspondence and other feedback that this continued prohibition adversely affects the ability of youth to receive employment and training opportunities in health care professions, encourages youth who work in health care to engage in unsafe manual lifting, and hampers health care providers' ability to promptly and safely assist patients. The authors of this correspondence have also stated that, in their experience, 16- and 17-year-olds are capable of operating patient lifts safely.

This information, as well as other information discussed below, suggests that the operation of power-driven patient lifts may not be particularly hazardous to youth employed in health care occupations or detrimental to their health or well-being. The Department, therefore, proposes to exclude the operation of power-driven patient lifts from the list of prohibited devices under HO 7. The Department seeks public comment on this proposal, and, specifically, whether the operation of power-driven patient lifts is particularly hazardous to 16- and 17-year-olds or is otherwise detrimental to their health or well-being.

The Department expects that, if adopted in a final rule, the proposed amendment to HO 7 will encourage the creation of more employment, apprenticeship, and other training opportunities in health care by removing a regulatory restriction that bars 16- and 17-year-olds from operating power-driven patient lifts, a foundational job duty in the health care industry. The Department recognizes the importance of providing young people with opportunities to safely train and work in rewarding and meaningful health care careers. The Department also recognizes that regulatory restrictions on youth operating power-driven patient lifts may unnecessarily impede training and employment opportunities for youth interested in pursuing careers in this fast-growing field.

Early employment and training opportunities can teach 16- and 17-year-olds workplace safety, responsibility, organization, and time management. These opportunities can also help them establish good work habits, gain valuable experience, expand their networks, and achieve financial stability. Research confirms the many advantages of working during high school—especially for low-income youth—including higher employment rates, higher wages in later years, and a lower probability of dropping out of high school.[7] Part-time work during high school correlates with more schooling and work after high school graduation, and also correlates with the receipt of a college degree.[8]

Opportunities for youth employment can be particularly helpful in reducing the number of youth who become disconnected from school or work. A 2012 study found that each young person who ''disconnects'' from school or work costs the economy an estimated $704,020 over their lifetime due to lost earnings, lower economic growth, lower tax revenues, and higher government spending.[9] Many young people lose their connection to school and work at ages 16 and 17, when high-school dropout and unemployment rates are highest. Early employment and training opportunities can benefit these youth

[3] Bureau of Labor Statistics, Nonfatal cases involving days away from work: Selected characteristics (2011 forward), *https://data.bls.gov/PDQWeb/cs.*

[4] U.S. Dep't of Labor, Occupational Safety & Health Admin., Safe Patient Handling: Preventing Musculoskeletal Disorders in Nursing Homes, *https://www.osha.gov/Publications/OSHA3708.pdf.*

[5] 29 CFR 570.58(b).

[6] *See* U.S. Dep't of Labor, Wage & Hour Div., Field Assistance Bulletin 2011–3, July 13, 2011, *https://www.dol.gov/whd/FieldBulletins/fab2011_3.pdf*; *see also* Field Operations Handbook (FOH) 33h07(e)(5), *https://www.dol.gov/whd/FOH/FOH_Ch33.pdf.*

[7] Marta Tienda and Avner Ahituv, Ethnic Differences in School Departure: Does Youth Employment Promote or Undermine Educational Achievement? Kalamazoo, Michigan: Upjohn Institute (1996), *http://research.upjohn.org/up_bookchapters/564/* (last visited on 26 April 2018).

[8] Staff, J., & Mortimer, J.T. (2007). *Educational and Work Strategies from Adolescence to Early Adulthood: Consequences for Educational Attainment.* Social Forces; a Scientific Medium of Social Study and Interpretation, 85(3), 1169–1194, *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1858630/* (last visited on 26 April 2018).

[9] Clive Belfield, Henry M. Levin, & Rachel Rosen, *The Economic Value of Opportunity Youth* (2012), at 2, *http://www.civicenterprises.net/MediaLibrary/Docs/econ_value_opportunity_youth.pdf.*

and improve their future employment prospects. In a survey commissioned by the Bill and Melinda Gates Foundation, for example, 81 percent of high school dropouts surveyed reported that having real-world experiences that connected school with work would have helped keep them in school.[10] One such program, Career Academies, was shown to increase earnings by 11 percent for as many as eight years after high school.[11]

Consistent with the President's E.O. on expanding apprenticeships in the United States,[12] the Department is interested in promoting workforce training program models in health care that offer safe and impactful apprenticeship opportunities. Apprenticeships in high-growth, emerging sectors, such as health care, can yield significant benefits. Research has found, for example, that apprenticeships can lead to better workplace performance, higher wages, reduced worker turnover, and portable occupational credentials. The average starting wage for apprentices is $15.00 per hour, and wages increase as apprentices gain skills and knowledge.[13] A study of a cross-section of apprenticeships by Mathematica Policy Research found that participants who participated in an apprenticeship program earned, on average, nearly $100,000 more over their careers than nonparticipants did. For those apprentices who completed their program, the average earnings premium was more than $240,000.[14]

The need for safe employment, apprenticeship, and training opportunities for youth is particularly acute in health care, which is among the fastest growing industries in the United States.[15] The Bureau of Labor Statistics (BLS) projects that numerous professions in health care will grow either faster or much faster than the national average growth rates in the next decade.[16] There are already approximately 1 million job openings in health care and social assistance.[17] According to a National Federation of Independent Business poll of its members, the top two reasons that employers did not hire applicants were lack of experience and lack of job-specific/occupational skills.[18] This further underscores the need for early employment, training, and apprenticeship opportunities—which help close the skills gap between the skills employers seek and the skills job seekers currently have. Removing unnecessary barriers to entry for youth in health care will give them more opportunities to gain those critical skills. Many jobs in health care, such as certified nursing assistant (CNA) positions, present excellent entry-level positions for young workers, including teens still in high school who seek to begin a career in health care. There are also numerous apprenticeable occupations in health care, such as certified nurse aide, home health aide, rehabilitative aide, licensed practical nurse, and CNA.[19] To help ensure that those who need care can receive it from workers who are skilled, qualified, and familiar with continuing advances in technology and service delivery, federal regulations should encourage, and not unnecessarily hinder, opportunities for younger workers to pursue careers in health care.

III. Background

The youth employment provisions of the FLSA, which Congress enacted in 1938, ensure that when young people work, the work is safe and does not jeopardize their health, well-being, or educational opportunities. The FLSA distinguishes between youth employed in agricultural work and youth employed in nonagricultural work. FLSA section 203(*l*) establishes a minimum age of 16 years for nonagricultural employment and prohibits 16- and 17-year-olds from working in any occupation that the Secretary of Labor (the Secretary) has found to be particularly hazardous or detrimental to their health or well-being. Under this authority, the Secretary has issued 17 HOs for nonagricultural employment.

HO 7, originally issued on July 16, 1946, prohibits 16- and 17-year-old employees from working in occupations involving a power-driven hoisting apparatus.[20] It prohibits 16- and 17-year-old employees from ''operating, tending, riding upon, working from, repairing, servicing, or disassembling an elevator, crane, derrick, hoist, or high-lift truck, except operating or riding inside an unattended automatic operation passenger elevator.'' [21] It also prohibits such employees from ''operating, tending, riding upon, working from, repairing, servicing, or disassembling a manlift or freight elevator, except 16- and 17-year-olds may ride upon a freight elevator operated by an assigned operator.'' [22] For purposes of these prohibitions, ''[t]ending such equipment includes assisting in the hoisting tasks being performed by the equipment.'' [23] The 1946 study that supported these prohibitions concluded that operating hoisting apparatus is ''inherently dangerous because it involves complicated mechanical equipment and because of the ever-present danger of falling or being struck by falling material should the load be dropped.'' [24]

Until 2010, HO 7 did not prohibit 16- and 17-year olds from operating power-driven patient lifts. The study that supported HO 7 did not address patient lifts, but it did conclude that electric or air-operated hoists with a capacity of

[10] John M. Bridgeland, John J. DiIulio, Jr., and Karen Burke Morison, *The silent epidemic: Perspectives of high school dropouts* (2006), at 13, *http://files.eric.ed.gov/fulltext/ED513444.pdf.*

[11] Harry Holzer, *Workforce Training: What Works? Who Benefits?* Wisconsin Family Impact Seminars, 2014, *https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2015/07/s_wifis28c02.pdf* (last visited on April 26, 2018).

[12] E.O. 13801 of June 15, 2017, Expanding Apprenticeships in America, 82 FR 28229 (Jun. 15, 2017).

[13] U.S. Dep't of Labor, ApprenticeshipUSA Toolkit, Frequently Asked Questions, *https://www.dol.gov/apprenticeship/toolkit/toolkitfaq.htm#2b.*

[14] Debbie Reed, Albert Yung-Hsu Liu, Rebecca Kleinman, Annalisa Mastri, Davin Reed, Samina Sattar, and Jessica Ziegler, An Effectiveness Assessment and Cost-Benefit Analysis of Registered Apprenticeship in 10 States, Mathematica Policy Research (July 2012), at xiv, *https://wdr.doleta.gov/research/FullText_Documents/etaop_2012_10.pdf.*

[15] Projected annual growth for health care and social assistance is 1.9% through 2026. Bureau of Labor Statistics, Employment Projections: Employment by major industry sector, *https://www.bls.gov/emp/ep_table_201.htm.*

[16] *See* Bureau of Labor Statistics, Occupational Outlook Handbook, *https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm* (home care and personal care aides projected to grow 41 percent); *https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm* (licensed practical nurses and licensed vocational nurses projected to grow 12 percent); *https://www.bls.gov/ooh/healthcare/medical-assistants.htm* (medical assistants projected to grow 29 percent); *https://www.bls.gov/ooh/healthcare/nursing-assistants.htm* (nursing assistants projected to grow 11 percent); *https://www.bls.gov/ooh/healthcare/physical-therapist-assistants-and-aides.htm* (physical therapist assistants and aides projected to grow 30 percent); *https://www.bls.gov/ooh/healthcare/occupational-therapists.htm* (occupational therapists projected to grow 24 percent); *https://www.bls.gov/ooh/healthcare/physical-therapists.htm* (physical therapists projected to grow 28 percent); *https://www.bls.gov/ooh/healthcare/occupational-therapy-assistants-and-aides.htm* (occupational therapy assistants and aides projected to grow 28 percent).

[17] Bureau of Labor Statistics, Table A. Job openings, hires, and total separations by industry, seasonally adjusted, *https://www.bls.gov/news.release/jolts.a.htm* (last visited May 7, 2018).

[18] Nat'l Fed. Of Independent Business, *Filling the Role, https://www.nfib.com/assets/nfib_fillingtherole3-1.pdf.*

[19] For a full list of apprenticeable occupations, see *https://www.doleta.gov/OA/occupations.cfm.*

[20] 29 CFR 570.58(a).

[21] *Id.*

[22] *Id.* § 570.58(a)(2).

[23] *Id.* §§ 570.58(a)(1), (2).

[24] *See* U.S. Dep't of Labor, Div. of Labor Standards, *Occupational Hazards to Young Workers,* Report No. 7, *The Operation of Hoisting Apparatus,* at 6 (1946) (Report No. 7).

one ton or less were ''much less dangerous to operate than larger hoists,'' were used for light work, and were simple to operate.[25] The Department accordingly included an exemption in HO 7 for electric or air-operated hoists with a capacity of one ton or less, and patient lifts fall within that category. Thus, between 1946 and 2010, HO 7 did not prohibit the operation of patient lifts.

On May 20, 2010, the Department issued a final rule amending several HOs, including HO 7.[26] The amendment to HO 7, among other things, eliminated the exemption for hoists with a capacity of one ton or less.[27] This decision was informed, in part, by a statement in a 2002 report from the National Institute for Occupational Safety and Health (NIOSH) that ''[a] hoisted load weighing less than one ton has the potential to cause injury or death as a result of falling, or being improperly rigged or handled.'' [28] The 2010 Final Rule also expanded HO 7 to prohibit repairing, servicing, disassembling, and assisting in the operation of the machines.[29]

In July 2010, the Department released Fact Sheet 52, which explained that the amended HO 7 barred 16- and 17-year-olds from operating or assisting in the operation of power-driven hoists designed to lift and move patients. The Department thereafter received a number of inquiries from a bipartisan group of legislators regarding this matter. The inquiries raised a number of concerns, including businesses' need to meet critical staff shortages at health care facilities, particularly in rural areas, through 16- and 17-year-old trainees; the continued success of nursing aide education programs; the future careers of youth in health care; the need for staff to use power-driven patient lifts; and the safety of workers and health care facility residents. For example, then-Congressman Michael Michaud (D–ME) noted that many facilities have adopted ''zero-lift policies'' that prohibit the lifting of patients without safe assistance. As a result of the regulatory change, however, young CNAs' only method to assist a patient may be the unsafe practice of manually lifting the patient. Similarly, a letter from then-Senator Herb Kohl (D–WI), Senator Amy Klobuchar (D–MN), then-Senator Mike Johanns (R–NE), and then-Senator Kent Conrad (D–ND) asserted that the Department's restrictions were ''discouraging long-term care facilities from employing and training minors at the very point in time that this employment sector needs to grow rapidly in order to accommodate the needs of our now rapidly-aging population'' and ''hampering youth employment programs for high school students, and those health care facilities that wish to employ them.'' They also asserted that power-driven patient lifts are safe for both residents and workers, including 16- and 17-year-old workers. For example, Senators Kohl, Klobuchar, Johanns, and Conrad stated that power-driven patient lifts are ''extremely safe'' because they ''move quite slowly, and have multiple safety and failsafe features.'' Likewise, a letter from then-Congressman Earl Pomeroy (D–ND) stated that ''according to the North Dakota Workforce Safety and Insurance (WSI) Department, not one 16- or 17-year-old worker has been found to be injured by using an electronic patient lift.''

The Department also heard from interested stakeholders, particularly health care providers and their representatives. By way of example, a March 2011 statement by the American Health Care Association and the National Center for Assisted Living noted that some community colleges and apprenticeship programs had ceased accepting 16- and 17-year-olds into their programs as a result of the regulatory change, imperiling the supply of health care workers in nursing homes. Similarly, several small nursing facilities in North Dakota that employed 16- and 17-year-old CNAs expressed concern that the regulatory change may prevent them from employing these individuals as CNAs—which would both create staff shortages and discourage youth from pursuing careers in health care—and may encourage 16- and 17-year-old CNAs to engage in unsafe manual lifting. Some facilities stated that they instituted procedures in which an adult would be summoned to operate a power-driven patient lift when needed. According to these facilities, such procedures not only caused delays and made patients feel that they were unduly burdening staff, but also deprived 16- and 17-year-olds of valuable work experience. Like the legislators, these stakeholders also asserted that power-driven patient lifts were safe for workers, including 16- and 17-year-old workers, to operate. A letter from the Healthcare Education Industry Partnership Council noted that staff using or assisting with lifts, regardless of age, are trained on how to safely operate patient lifts, and receive such training both as part of their nursing assistant curriculum and when hired by health care providers. Another letter from a health care provider stated that the facility had never had an employee injured using power-driven patient lifts, but had countless employees injured from failing to use such equipment.

In October 2010, the Department asked NIOSH for assistance to determine when 16- and 17-year-old employees could safely operate or assist in the operation of power-driven patient lifts.[30] In March 2011, NIOSH opined that 16- and 17-year-olds could only perform these tasks safely when assisting an experienced caregiver.[31] NIOSH did not express any specific concerns about the actual operation of the equipment. Rather, it cited the force necessary to place slings under patients and to push a lift loaded with a patient. NIOSH also stated that adolescent workers often underestimate dangers associated with hazardous tasks and concluded that specific training alone is insufficient to protect young workers in this context. NIOSH also agreed that manually lifting patients is far more likely to result in lower back injuries than using a power-driven patient lift, and recommended that WHD consider regulations prohibiting youth under 18 from manually lifting patients.[32]

The Department issued a Field Assistance Bulletin (FAB) on July 13, 2011, establishing a nonenforcement policy when, under specified conditions, trained 16- and 17-year-olds assist a trained adult in the operation of

[25] *Id.* at 13. HO 7 was amended on August 31, 1955 to include riding on a manlift. 20 FR 6386.

[26] 75 FR 28404 (May 20, 2010) (2010 Final Rule).

[27] 75 FR at 28433–34. In addition, the 2010 Final Rule amended HO 7 to prohibit youth from riding on any part of a forklift as a passenger (including the forks); to prohibit work from truck-mounted bucket or basket hoists; and to include operating or tending aerial platforms (*e.g.* scissor lifts) in the definition of manlift. It also revised the definition of ''high-lift truck'' to incorporate a longstanding enforcement position that industrial trucks such as skid loaders, skid-steer loaders, and Bobcat loaders fall within that definition.

[28] 75 FR at 28433; NIOSH, *National Institute for Occupational Safety & Health (NIOSH) Recommendations to the U.S. Department of Labor for Changes to Hazardous Orders* (May 3, 2002), at 36, *https://www.cdc.gov/niosh/docs/nioshrecsdolhaz/pdfs/dol-recomm.pdf* (NIOSH Report). The NIOSH Report was issued after the Department had commissioned NIOSH in 1998 to conduct a comprehensive review of literature and data related to workplace hazards and to assess the adequacy of existing child labor protections in preventing them.

[29] 75 FR at 28433–34.

[30] *See* Letter by WHD Deputy Administrator Nancy Leppink to NIOSH Director John Howard, Oct. 21, 2010.

[31] *See* NIOSH Assessment of Risks for 16- and 17-Year Old Workers Using Power-Driven Patient Lift Devices, *https://www.dol.gov/whd/CL/NIOSH_PatientLifts.pdf* (''*NIOSH 2011 Report*''), at 10–11.

[32] The Department has considered NIOSH's report and discusses it, at pp. 11, 13–14, and 17–18. As discussed below, the Department believes that it is important to separately consider the potential risks and benefits to youth using power-driven patient lifts because of the distinctions between patient lifts and the other covered equipment in HO 7.

power-driven patient lifts/hoists.[33] In the FAB, the Department stated that it would not ''assert child labor violations involving 16- and 17-year-olds who assist a trained adult worker . . . in the operation of floor-based vertical powered patient/resident lift devices, ceiling-mounted vertical powered patient/resident lift devices, and powered sit-to-stand patient/resident lift devices (lifting devices)'' when the youth worker met specific training requirements, was not injured in the process, did not make ''hands on'' physical contact with the patient during the lifting or transferring process, and, among other things, received necessary documentation in advance.

Nonetheless, stakeholders and legislators have continued to voice concerns about the strict limitations that HO 7 and the nonenforcement policy place on 16- and 17-year-olds' ability to operate power-driven patient lifts. In general, these stakeholders and legislators have argued that the current limits on the use of power-driven patient lifts are both unnecessary and far too restrictive. They have argued, for instance, that power-driven patient lifts are safer than manual lifting; that the demand for workers in health care can often exceed supply; that the restrictions resulting from the 2010 Final Rule and the 2011 FAB prevent health care facilities from recruiting sufficient employees; and that these restrictions deprive 16- and 17-year-olds of valuable training opportunities.

These commenters have argued that HO 7 and the 2011 FAB unnecessarily restrict programs that train high school students to become nursing assistants and allow them to apprentice in medical settings such as nursing homes and long-term care facilities. They further argue that the 16- and 17-year-old students in these programs are trained in the operation of power-driven patient lifts and therefore can operate the lifts safely. For example, letters in 2017 from Senator Tammy Baldwin (D–WI), Representative Ron Kind (D–WI), and Senator Ron Johnson (R–WI) cited an organization that enables students in Wisconsin to take college-level nursing courses, receive CNA certifications, and work as apprentices with employers. Highlighting the difficulties such programs have faced, a 2012 survey of vocational schools by the Massachusetts Department of Public Health's Teens at Work Project indicated that nearly 60 percent of respondents said that employers had commented about increased burdens due to restrictions on teens' use of power-driven patient lifts, and that 23 percent of respondents reported that students had to change jobs as a result of the revised HO 7.[34] Survey respondents further indicated that the restrictions made it more difficult to place students participating in cooperative education job programs in health care. Notably, some students performed more manual lifting. And even when employers were willing and able to adjust the job duties of youth to comply with the FAB, such adjustments were often extremely time- and resource-consuming.[35]

IV. Review of Proposed Changes

The Department has regularly reviewed and revised the criteria for permissible youth employment to address amendments to the FLSA, improvements in workplace safety, the introduction of new processes and technologies, the emergence of new types of businesses in which young workers may find employment opportunities, the existence of differing federal and state standards, divergent views on how best to correlate school and work experiences, and changing needs of employers and businesses in the economy.[36] Consistent with these principles, and based on the information provided by stakeholders and available data, the Department is considering whether the operation of power-driven patient lifts is indeed particularly hazardous to youth employed in the health care occupations or detrimental to their health or well-being. This Notice of Proposed Rulemaking proposes to exclude power-driven patient lifts from the list of devices covered under HO 7 and asks for comment on that proposal.

As explained above, the Department has received numerous letters, including from health care providers and a bipartisan group of Members of Congress, requesting that the Department reconsider its policies with respect to patient lifts to address industry needs and to promote learning opportunities and safety for youth workers. These letters contained useful information in support of their arguments, including indications that the restrictions stemming from HO 7 interfere with facilities' ability to care for patients, potentially encourage 16- and 17-year-olds to engage in less safe manual lifting, and hinder the employment of 16- and 17-year-olds in health care.

Although they fit within the technical definition of devices covered by HO 7, power-driven patient lifts differ in significant ways from the other devices addressed by that HO. For example, power-driven patient lifts are used in settings far different from the industrial settings in which most of the other devices addressed by that HO are used (and for which HO 7 was principally promulgated).[37] Moreover, data from BLS shows that from 2012 through 2016, only one worker fatality was attributed to patient hoists or lifting harnesses. By contrast, during this same period, 221 worker fatalities were associated with cranes, 10 were associated with overhead hoists, 200 were associated with bucket or basket hoists, 35 were associated with manlifts, and 464 were associated with forklifts.[38] BLS data also shows that, during the same period, the annual median days lost associated with injuries caused by patient lifts ranged from 5 to 10, compared to 5 to 41 for manlift injuries; 14 to 21 for forklift injuries, 4 to 23 for overhead hoist injuries, 8 to 27 for bucket or basket hoist injuries, and 14 to 34 for crane injuries.[39] Put simply, a power-driven patient lift is different, both in form and function, from a forklift, backhoe, crane, and the numerous other industrial devices mentioned in HO 7. The Department believes that it is important to separately consider the potential risks and benefits to youth using this equipment because patient lifts differ so significantly from the other covered equipment in HO 7.

Use of power-driven patient lifts also has important benefits for worker safety. In particular, as NIOSH recognized in its 2011 report, power-driven patient lifts have significantly reduced the risk of

[33] *See* U.S. Dep't of Labor, Wage & Hour Div., Field Assistance Bulletin 2011–3, July 13, 2011, *https://www.dol.gov/whd/FieldBulletins/fab2011_3.pdf*; *see also* FOH 33h07(e)(5), *https://www.dol.gov/whd/FOH/FOH_Ch33.pdf.*

[34] Mass. Dep't of Public Health, Occupational Health Surveillance Program, Federal Child Labor Law Hazardous Occupations Order No. 7 (HO7) and Power-driven Patient Lift Assist Devices: Revisions to the Law, at 2.

[35] *Id.*

[36] In addition to the proposals herein, the Department is consulting with NIOSH to determine what other updates to the HOs, if any, are appropriate to expand employment, apprenticeship, and training opportunities while maintaining worker protections.

[37] Highlighting the industrial nature of the devices that HO 7 was intended to prohibit 16- and 17-year-olds from operating, the appendix to the 1946 report supporting HO 7 includes a table showing that injuries in one state caused by hoisting apparatus were concentrated primarily in manufacturing, construction, mining and quarrying, and trade, with only 5.8 percent of such injuries occurring in ''service industries.'' Report No. 7, Appendix II, Table I (1946).

[38] *See* Bureau of Labor Statistics, Census of Fatal Occupational Injuries (2011 forward), *https://data.bls.gov/PDQWeb/fw.*

[39] *See* Bureau of Labor Statistics, Nonfatal cases involving days away from work: Selected characteristics (2011 forward), *https://data.bls.gov/PDQWeb/cs.*

lower back injuries to workers, which is much more prevalent when caregivers use their own physical strength to transfer patients manually.[40] DOL's Occupational Safety and Health Administration (OSHA) has also recommended that manual lifting of nursing home residents ''be minimized in all cases and eliminated when feasible.''[41] Thus, while the operation of power-driven patient lifts is not risk-free, these devices ultimately improve worker safety. Given that power-driven patient lifts are widely regarded as safer for the worker than manual lifting, the Department believes that it is incongruous for 16- and 17-year-olds to be prohibited from independently operating power-driven patient lifts but permitted to manually lift patients without any restrictions (since manual lifting of patients is not prohibited by any HO). Such a framework creates incentives that are inconsistent with worker and patient safety.

Additionally, best practices developed by OSHA and other government agencies can help mitigate the risks associated with power-driven patient lifts. NIOSH informed WHD that research has demonstrated that ''comprehensive safe patient handling and movement programs that incorporate power-driven patient lifts have made an enormous difference in reducing musculoskeletal disorders among health care workers in the United States.''[42] The Department believes that adhering to such best practices, rather than a blanket prohibition on the independent operation of power-driven patient lifts, may be the best way to ensure that 16- and 17-year-old workers can operate these devices safely. For example, guidance developed in part by the Veterans Health Administration and Department of Defense provides recommendations for the circumstances under which one, two, or three or more caregivers are appropriate to operate a lift.[43] Generally, this guidance recommends that two to three caregivers are appropriate when lifting or transferring a patient who cannot bear weight, cannot offer assistance, or is uncooperative, but that under certain circumstances, only one caregiver is needed for a patient who can bear at least partial weight and is cooperative. OSHA's guidelines for nursing homes concur with these recommendations.[44] Additional guidance for employers who are considering engaging 16- and 17-year-olds in the operation of power-driven patient lifts is available through NIOSH.[45]

Finally, requirements under other federal and state statutes and regulations may help ensure that 16- and 17-year-olds can operate power-driven patient lifts safely. For example, regulations under the Federal Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987, require that nurses' aides in nursing facilities or skilled nursing facilities complete a competency evaluation and receive at least 75 hours of training, including at least 16 hours of supervised practical or clinical training, under the supervision of a registered nurse who has at least two years of nursing experience.[46] ''Transfers, positioning, and turning'' are required parts of the training.[47] Over half of states require more training hours than this federal minimum, and 13 states require at least 120 training hours.[48] Many states require that CNAs learn about transitioning or moving a patient using power-driven patient lifts as part of their curriculum.

In light of these considerations, the Department proposes to remove the operation of power-driven patient lifts from HO 7. The Department welcomes comments on this proposal. The proposed rule defines ''patient lift'' as a power-driven device, either fixed or mobile, used to lift and transport a patient or resident (such as of a medical care, nursing, long-term care, or assisted living facility) in the horizontal or other required position from one place to another, as from a bed to a bath, including any straps and a sling used to support the patient. This definition derives from two definitions of patient lifts in U.S. Food and Drug Administration regulations on medical devices, 21 CFR 880.5500 and 880.5510. The Department welcomes comments on whether the Department's proposed definition is appropriate or, if not, how the proposed definition should be revised. In addition, the Department proposes minor conforming and technical edits to existing paragraph 570.58(c).

V. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501 *et seq.,* and its attendant regulations, 5 CFR part 1320, require the Department to consider the agency's need for its information collections, their practical utility, the impact of paperwork and other information collection burdens imposed on the public, and how to minimize those burdens. The PRA typically requires an agency to provide notice and seek public comments on any proposed collection of information contained in a proposed rule.[49]

This NPRM does not contain a collection of information subject to OMB approval under the Paperwork Reduction Act. The Department welcomes comments on this determination.

VI. Analysis Conducted in Accordance With E.O. 12866, Regulatory Planning and Review, and E.O. 13563, Improved Regulation and Regulatory Review

A. Introduction

Under E.O. 12866, OMB's Office of Information and Regulatory Affairs determines whether a regulatory action is significant and, therefore, subject to the requirements of the E.O. and OMB review.[50] Section 3(f) of E.O. 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule that: (1) Has an annual effect on the economy of $100 million or more, or adversely affects in a material way a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as economically significant); (2) creates serious inconsistency or otherwise interferes with an action taken or planned by another agency; (3) materially alters the budgetary impacts of entitlement grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or (4) raises novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the E.O. OIRA has determined that this proposed rule is not significant under section 3(f) of E.O. 12866.

[40] NIOSH 2011 Report at 2.

[41] OSHA, Ergonomics for the Prevention of Musculoskeletal Disorders, Guidelines for Nursing Homes (OSHA 3182–3R–2009), at 9, *https://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.pdf.*

[42] Letter by NIOSH Director John Howard to WHD Deputy Administrator Nancy Leppink, Mar. 11, 2011, *https://www.dol.gov/whd/CL/NIOSH_CoverLetter.pdf.*

[43] *See* Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration and Department of Defense, Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement, at 73–78, *https://osha.oregon.gov/edu/grants/train/Documents/va-patient-care-ergonomics-resource-guide-part-1-rev-8-2005.pdf.*

[44] OSHA Ergonomics for the Prevention of Musculoskeletal Disorders, Guidelines for Nursing Homes, at 13, 15–16.

[45] CDC/NIOSH, Safe Patient Handling and Mobility (SPHM), *https://www.cdc.gov/niosh/topics/safepatient/default.html.*

[46] 42 CFR 483.152, 483.154.

[47] 42 CFR 483.152(b)(3)(viii).

[48] PHI (Paraprofessional Health Care Institute), Nursing Assistant Training Requirements by State, *https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/.*

[49] *See* 44 U.S.C. 3506(c)(2)(B); 5 CFR 1320.8.

[50] 58 FR 51735 (Sept. 30, 1993).

E.O. 13563 directs agencies to propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs; that it is tailored to impose the least burden on society, consistent with achieving the regulatory objectives; and that, in choosing among alternative regulatory approaches, the agency has selected the approaches that maximize net benefits. E.O. 13563 recognizes that some benefits are difficult to quantify and provides that, where appropriate and permitted by law, agencies may consider and discuss qualitatively values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts.

B. Economic Analysis

1. Overview of Proposed Changes

In this NPRM, the Department proposes to remove the operation of power-driven patient lifts from the list of HO-governed activities. This analysis assumes that federal regulations would govern all entities. The Department does not herein interpret any state laws or regulations that may have greater restrictions on the type of work that 16- and 17-year-olds are allowed to perform, or the hours they are allowed to work. As a result, this analysis may overestimate the number of workers and employers affected by the NPRM. The Department seeks public comment regarding state and local regulations and laws governing 16- and 17-year-olds, and how they differ from these federal regulations.

2. Increased Earnings for 16- and 17-Year-Olds Who Become Employed

The proposal to remove the operation of power-driven patient lifts from the list of HO-governed activities is expected to expand employment opportunities in the health care sector for 16- and 17-year-olds. The total universe of 16- and 17-year-olds who could enter these new jobs is the number who are unemployed (that is, jobless, looking for a job, and available for work). Unlike for the general adult population, the Department assumes that 16- and 17-year-olds who are not looking for work—and are, therefore, not in the labor force—are focused on school and would not choose to move into the labor force even if additional employment opportunities became available. According to annual average data from BLS, which includes individuals who are not working but who have looked for a job in the past month, there were 347,000 unemployed 16- and 17-year-olds in 2017.[51]

If 16- and 17-year-olds are no longer prohibited from independently operating power-driven patient lifts, employers may be more likely to hire youth for health care occupations that use these lifts. In the Department's analysis, home health care services (NAICS 6216), hospitals (NAICS 622), and nursing and residential care facilities (NAICS 623) are summed to estimate the portion of the health care industry that relies the most on the use of patient lifts. Going forward in this economic analysis, discussions involving health care calculations refer to these industries, which together constituted 6.7 percent of total employment in the United States in 2017.[52]

To determine the number of new 16- and 17-year-old workers that the amendment to HO 7 would add to the economy, it is necessary to estimate the share of unemployed teens who could gain employment in these health care industries. The Department used the employment share discussed above (6.7 percent) and multiplied it by the total number of unemployed teens (347,000) to calculate a proxy for the share of 16- and 17-year-olds who would choose to work in health care given the opportunity. The Department estimates that the change to HO 7 could potentially add up to 23,249 new workers to these industries. The Department seeks public comments regarding the estimated number of 16- and 17-year-olds who would gain employment as a result of the changes proposed in this NPRM.

To quantify the wages that these new workers would earn, the Department used the average hourly pay rate for 16- and 17-year-olds in health care. BLS data show that, on average, 16- and 17-year-olds in the health care and social assistance industry earned $9.60 per hour in 2017.[53]

BLS data show that, on average, 16- and 17-year-olds work 18.2 hours per week.[54] In addition, data show that 60 percent of 16- and 17-year olds work 26 or fewer weeks out of the year, with almost 40 percent working less than 14 weeks.[55] Therefore, the Department assumes that 16- and 17-year-olds work, on average, 20 weeks per year. If a 16- or 17-year-old works 18.2 hours per week for 20 weeks per year and earns $9.60 per hour, his or her average annual earnings would be $3,494. Multiplying this annual wage by the estimated 23,249 potential new workers in health care yields a total annual wage impact of $81,241,306 at either a 3 or 7 percent discount rate.

3. Benefits

In association with the earnings that 16- and 17-year-olds would receive through employment in the health care industry, there are many unquantifiable benefits. As discussed earlier, research has shown that working as a teen correlates with better attachment to the workforce over a person's entire career. By working or participating in an apprenticeship program, 16- and 17-year-olds receive training and develop skills for in-demand jobs. For example, employment in the health care and social assistance sector is projected to add nearly 4 million jobs by 2026, about one-third of all new jobs, creating high demand for skilled workers in this field.[56]

The availability of 16- and 17-year-olds to perform these activities would also benefit society in other ways. For example, if the Department adopts the proposal to remove the operation of power-driven patient lifts from HO 7, these youth workers may be permitted to independently operate a patient lift, so adult employees could work more efficiently, resulting in higher workplace productivity. Additionally, increased earnings for youth, both currently and over their future career, would enable workers to contribute more in the form of income taxes and decrease their reliance on social welfare programs given their steadier employment and income.

4. Regulatory Familiarization Costs

Regulatory familiarization costs represent direct costs to businesses associated with reviewing the new regulation. To calculate the cost associated with reviewing the rule, the Department first estimated the number of establishments that would review the rule. The Department used

[51] BLS Current Population Survey, Annual Averages, Employment status of the civilian noninstitutional population by age, sex, and race. *https://www.bls.gov/cps/cpsaat03.htm.*

[52] BLS Current Employment Statistics Databases, annual average employment, 2017, Series IDs CEU0000000001, CEU6562160001, CEU6562200001, and CEU6562300001. *www.bls.gov/ces/data.htm.*

[53] BLS Current Population Survey, results generated through DataFerrett (*https://dataferrett.census.gov/*) using PTERNH10 for hourly earnings, PRTAGE for age, and PRIMIND1 for industry.

[54] BLS Current Population Survey, Average Hours at Work in Nonagricultural Industries, 16 to 17 years. *https://www.bls.gov/cps/cpsaat22.htm.*

[55] BLS Current Population Survey, unpublished table: Work Experience of the Population by Extent of Employment in 2016, Sex, Race, Hispanic or Latino ethnicity, and Age, March 2017.

[56] BLS Employment Projections, *https://www.bls.gov/news.release/ecopro.nr0.htm.*

establishment data from the Quarterly Census of Employment and Wages for the three relevant health care industries. The 2016 annual average number of establishments in Home Health Care Services (NAICS 6216) was 34,090, the number of establishments in Hospitals (NAICS 622) was 12,754, and the number of establishments in Nursing and Residential Care Facilities (NAICS 623) was 80,252, totaling 127,096 establishments in the three relevant health care industries.

Next, the Department estimated the time it would take for an establishment to review the rule. The Department estimates that it would take approximately 15 minutes for a health care establishment to review the provisions related to removing the operation of power-driven patient lifts from the list of HO-governed activities.

Then, the Department estimated the hourly compensation of the employees who would likely review the rule. The Department assumes that a Human Resources Manager (SOC 11–3121) would review the rule. The mean hourly wage of Human Resources Managers is $59.38.[57] The Department adjusted this wage rate to reflect fringe benefits such as health insurance and retirement benefits, as well as overhead costs such as rent, utilities, and office equipment. The Department used a fringe benefits rate of 46 percent [58] and an overhead rate of 17 percent,[59] resulting in a fully loaded hourly compensation rate for Human Resources Managers of $96.79 (= $59.38 + ($59.38 × 46%) + ($59.38 × 17%)).

Therefore, regulatory familiarization costs in Year 1 for establishments in the pertinent health care sectors are estimated to be $3,075,386 (= 127,096 establishments × 15 minutes × $96.79), which amounts to a 10-year annualized cost of $350,028 at a discount rate of 3 percent (which is $2.75 per establishment) or $409,220 at a discount rate of 7 percent (which is $3.22 per establishment). The Department seeks public comments regarding the estimated number of establishments that would review the rule, the estimated time to review the rule, and whether a Human Resources Manager would be the most likely staff member to review the rule.

Table 1. Regulatory Familiarization Costs

Total number of establishments	127,096
Home Health Care Services (NAICS 6216) establishments	34,090
Hospitals (NAICS 622) establishments	12,754
Nursing and Residential Care Facilities (NAICS 623) establishments	80,252
Time to review rule	15 minutes
Human Resources Manager fully loaded hourly compensation	$96.79
Regulatory familiarization cost	$3,075,386
Annualized with 3% Discounting	$350,028
Annualized with 7% Discounting	$409,220

5. Additional Costs

If the Department adopts this proposed rule without change, health care employers would likely increase the number of employment, apprenticeship, and training opportunities for 16- and 17-year-olds.

One potential cost to employers that seek to hire 16- and 17-year-olds in health care occupations through apprenticeship or other training program models is the cost of the training programs themselves. For example, apprenticeship programs vary significantly in length—from one to six years—and in cost. A 2016 study by the Department of Commerce found that the most expensive program in their sample cost $250,000 per apprentice, while the least expensive cost less than $25,000. The study found that apprentices' compensation costs over the duration of the program were the major cost for all companies. Other important costs included program start-up, tuition and educational materials, mentors' time, and overhead.

The proposed rule, however, would not impose these costs on employers; rather, the above-described costs would only result from employers' voluntary employment decisions as a result of the proposed rule, such as the decision to employ additional apprentices.

In addition to the potential costs and benefits to employers, the potential costs to youth should be considered. Although power-driven patient lifts are widely regarded as safer for workers than manual lifting, worker injuries have nonetheless been attributed to the use of patient lifts. But while the operation of power-driven patient lifts is not risk-free, these devices do improve worker safety. As discussed, power-driven patient lifts have significantly reduced the risk to workers of musculoskeletal disorders, which can be caused by manually lifting patients. The Department seeks comments and additional data on the potential risks or safety improvements associated with additional apprenticeship and employment opportunities for 16- and 17-year-olds in health care.

6. Summary of Costs

Table 2 summarizes the total quantifiable costs.

[57] BLS, Occupational Employment Statistics, Occupational Employment and Wages, May 2017, 11–3121 Human Resources Managers, *https://www.bls.gov/oes/current/oes113121.htm.*

[58] BLS, Employer Costs for Employee Compensation, *https://www.bls.gov/ncs/data.htm.* Wages and salaries averaged $24.26 per hour worked in 2017, while benefit costs averaged $11.26, which is a benefits rate of 46%.

[59] Cody Rice, U.S. Environmental Protection Agency (June 10, 2002), ''Wage Rates for Economic Analyses of the Toxics Release Inventory Program,'' at 4. *https://www.regulations.gov/document?D=EPA-HQ-OPPT-2014-0650-0005.*

Table 2. Quantifiable Costs

Regulatory Familiarization Costs		
First Year Costs	$3,075,386	
	Disc Rate = 3%	Disc Rate = 7%
10- year Annualized Costs	$350,028	$409,220

C. Analysis of Regulatory Alternatives

In developing this NPRM, the Department considered one regulatory alternative that would be less restrictive than what is currently proposed and one that would be more restrictive. For the option that would be less restrictive, the Department considered creating an exemption in HO 7 for all hoists with a capacity of two tons or less. But without additional information concerning the safety and potential risks associated with the various hoisting apparatuses that such an exemption would affect, the Department has decided to limit the scope of this proposed rule to address the operation of power-driven patient lifts only.

For a more restrictive alternative, the Department considered codifying into the regulations the restrictions and conditions in its 2011 nonenforcement policy concerning power-driven patient lifts. To encourage more employers to hire 16- and 17-year-olds in health care-related jobs and to allow youth to safely obtain the training and skills they need for these in-demand careers, however, the Department decided to propose eliminating power-driven patient hoists from the list of prohibited devices in HO 7. The Department believes that the current proposal would increase youth employment and participation in these fields, while also keeping these workers safe.

D. Initial Regulatory Flexibility Analysis

In accordance with the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.* (as amended), the Department examined the regulatory requirements of the proposed rule to determine whether they would have a significant economic impact on a substantial number of small entities. As indicated in Section VI.B, Economic Analysis, the annualized burden is estimated to be $3.22 per establishment. At the firm level, each firm in Home Health Care Services (NAICS 6216), Hospitals (NAICS 622), and Nursing and Residential Care Facilities (NAICS 623) has on average 1.94 establishments,[60] so the number of firms is estimated to be 65,624. Table 3 shows the estimated number of firms in the three health care subsectors, as well as the annualized cost per firm.

Table 3. Regulatory Familiarization Cost per Firm

Total number of firms	65,624
Home Health Care Services (NAICS 6216) firms	24,020
Hospitals (NAICS 622) firms	5,990
Nursing and Residential Care Facilities (NAICS 623) firms	35,614
Time to review rule	15 minutes
Human Resources Manager fully loaded hourly compensation	$96.79
Ratio of establishments to firms	1.94
Regulatory familiarization cost	$3,075,386
Annualized with 7% Discounting	$409,220
Annualized cost per firm	$6.24

Table 4 provides the annualized cost per firm as a percentage of revenue by firm size in the health care and social assistance industry. As the table shows, the annualized burden as a percent of the smallest employer's revenue would be far less than 1 percent. Accordingly, the Department certifies that the proposed rule would not have a significant economic impact on a substantial number of small entities.

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[60] Census Bureau, Statistics of U.S. Businesses, 2015.

Table 4. Annual Cost per Firm in the Health Care and Social Assistance Industry

Health Care and Social Assistance Industry						
Small Business Size Standard: $7.5 million – $38.5 million						
	Number of Firms	Total Number of Employees	Annual Cost per Firm	Annual Receipts	Average Receipts per Firm	Annual Cost per Firm as Percent of Receipts
Firms with sales/receipts/revenue below $100,000	110,259	162,885	$6.24	$5,260,895,000	$47,714	0.01%
Firms with sales/receipts/revenue of $100,000 to $499,999	249,219	1,010,642	$6.24	$67,642,299,000	$271,417	0.00%
Firms with sales/receipts/revenue of $500,000 to $999,999	128,577	1,073,376	$6.24	$90,967,720,000	$707,496	0.00%
Firms with sales/receipts/revenue of $1,000,000 to $2,499,999	91,324	1,576,609	$6.24	$138,206,644,000	$1,513,366	0.00%
Firms with sales/receipts/revenue of $2,500,000 to $4,999,999	28,520	1,156,550	$6.24	$98,200,090,000	$3,443,201	0.00%
Firms with sales/receipts/revenue of $5,000,000 to $7,499,999	10,167	729,810	$6.24	$60,941,395,000	$5,994,039	0.00%
Firms with sales/receipts/revenue of $7,500,000-$9,999,999	5,380	556,088	$6.24	$45,627,101,000	$8,480,874	0.00%
Firms with sales/receipts/revenue of $10,000,000 to $14,999,999	5,700	785,047	$6.24	$67,302,238,000	$11,807,410	0.00%
Firms with sales/receipts/revenue of $15,000,000 to $19,999,999	2,953	556,945	$6.24	$48,758,779,000	$16,511,608	0.00%
Firms with sales/receipts/revenue of $20,000,000 to $24,999,999	1,642	384,059	$6.24	$34,859,152,000	$21,229,691	0.00%
Firms with sales/receipts/revenue of $25,000,000 to $29,999,999	1,139	318,772	$6.24	$29,550,252,000	$25,944,032	0.00%
Firms with sales/receipts/revenue of $30,000,000 to $34,999,999	731	244,490	$6.24	$22,423,595,000	$30,675,233	0.00%
Firms with sales/receipts/revenue of $35,000,000 to $39,999,999	579	213,048	$6.24	$20,384,881,000	$35,207,048	0.00%

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E. Unfunded Mandates Reform Act Analysis

The Unfunded Mandates Reform Act of 1995 (UMRA), 2 U.S.C. 1532, requires that agencies prepare a written statement, which includes an assessment of anticipated costs and benefits, before proposing any Federal mandate that may result in excess of $100 million (adjusted annually for inflation) in expenditures in any one year by state, local, and tribal governments in the aggregate, or by the private sector. This rulemaking is not expected to result in such expenditures by state, local, or tribal governments. While this rulemaking would affect employers in the private sector, it is not expected to result in expenditures greater than $100 million in any one year. Please see Section B for an assessment of anticipated costs and benefits to the private sector.

F. E.O. 13132, Federalism

The Department has (1) reviewed this proposed rule in accordance with E.O. 13132 regarding federalism and (2) determined that it does not have federalism implications. The proposed rule would 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. E.O. 13175, Indian Tribal Governments

This proposed rule would not have substantial direct effects 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.

H. Effects on Families

The undersigned hereby certifies that the proposed rule would not adversely affect the well-being of families, as discussed under section 654 of the Treasury and General Government Appropriations Act, 1999.

I. E.O. 13045, Protection of Children

E.O. 13045, dated April 21, 1997 (62 FR 19885), applies to any rule that (1) is determined to be ''economically significant'' as defined in E.O. 12866, and (2) concerns an environmental health or safety risk that the promulgating agency has reason to believe may have a disproportionate effect on children. This proposal is not subject to E.O. 13045 because it is not economically significant as defined in E.O. 12866.

List of Subjects in 29 CFR Part 570

Administrative practice and procedure, Agriculture, Child labor, Intergovernmental relations, Occupational safety and health, Reporting and recordkeeping requirements.

VII. Proposed Regulatory Changes

For the reasons set forth in the preamble, the Department of Labor proposes to amend part 570 of title 29 of the Code of Federal Regulations as follows:

PART 570—CHILD LABOR REGULATIONS, ORDERS AND STATEMENTS OF INTERPRETATION

Subpart E—Occupations Particularly Hazardous for the Employment of Minors Between 16 and 18 Years of Age or Detrimental to Their Health or Well-Being

■ 1. The authority citation for Subpart E continues to read as follows:

Authority: 29 U.S.C. 203(*l*), 212, 213(c).

§ 570.58 [Amended]

■ 2. In § 570.58, add in alphabetical order a definition for ''patient lift'' paragraph (b) and revise paragraph (c) to read as follows:

§ 570.58 Occupations involved in the operation of power-driven hoisting apparatus (Order 7).

* * * * *

(b) * * *

Patient lift is a power-driven device, either fixed or mobile, used to lift and transport a patient or resident (such as of a medical care, nursing, long-term care, or assisted living facility) in the horizontal or other required position from one place to another, as from a bed to a bath, including any straps and a sling used to support the patient or resident.

(c) *Exceptions.* (1) *Automatic elevators and automatic signal elevators.* (i) This section shall not prohibit the operation of an automatic elevator and an automatic signal operation elevator provided that the exposed portion of the car interior (exclusive of vents and other necessary small openings), the car door, and the hoistway doors are constructed of solid surfaces without any opening through which a part of the body may extend; all hoistway openings at floor level have doors which are interlocked with the car door so as to prevent the car from starting until all such doors are closed and locked; the elevator (other than hydraulic elevators) is equipped with a device which will stop and hold the car in case of overspeed or if the cable slackens or breaks; and the elevator is equipped with upper and lower travel limit devices which will normally bring the car to rest at either terminal and a final limit switch which will prevent the movement in either direction and will open in case of excessive over travel by the car.

(ii) For the purpose of this exception, the term ''*automatic elevator*'' shall mean a passenger elevator, a freight elevator, or a combination passenger-freight elevator, the operation of which is controlled by pushbuttons in such a manner that the starting, going to the landing selected, leveling and holding, and the opening and closing of the car and hoistway doors are entirely automatic.

(iii) For the purpose of this exception, the term ''*automatic signal operation elevator*'' shall mean an elevator which is started in response to the operation of a switch (such as a lever or pushbutton) in the car which when operated by the operator actuates a starting device that automatically closes the car and hoistway doors—from this point on, the movement of the car to the landing selected, leveling and holding when it gets there, and the opening of the car and hoistway doors are entirely automatic.

(2) *Patient lifts.* This section shall not prohibit the work of operating or assisting in the operation of patient lifts, as defined in this section.

Signed at Washington, DC, this 21st day of September 2018.

Bryan L. Jarrett,

Acting Administrator, Wage and Hour Division.

[FR Doc. 2018–20996 Filed 9–26–18; 8:45 am]

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DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2018–0849]

RIN 1625–AA00

Safety Zone; The Gut, South Bristol, ME

AGENCY: Coast Guard, DHS.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard proposes to establish a temporary safety zone for the navigable waters within a 50 yard radius from the center point of The Gut Bridge in South Bristol, ME between Rutherford Island and Bristol Neck. The safety zone is necessary to protect personnel, vessels, and the marine environment from potential hazards created during bedrock removal operations. When enforced, this proposed rule would prohibit entry of vessels or persons into the safety zone unless authorized by the Captain of the Port Northern New England or a designated representative. We invite your comments on this proposed rulemaking.

DATES: Comments and related material must be received by the Coast Guard on or before October 29, 2018.

ADDRESSES: You may submit comments identified by docket number USCG–2018–0849 using the Federal eRulemaking Portal 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: If you have questions about this proposed rulemaking, call or email LT Matthew Odom, Waterways Management Division, U.S. Coast Guard Sector Northern New England, telephone 207–347–5015, email *Matthew.T.Odom@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
COTP Captain of the Port
DHS Department of Homeland Security
FR Federal Register
MEDOT Maine Department of Transportation
NPRM Notice of proposed rulemaking
§ Section
U.S.C. United States Code

II. Background, Purpose, and Legal Basis

On October 08, 2014, the Coast Guard published a temporary final rule titled, ''Regulated Navigation Area; South Bristol Gut Bridge Replacement, South Bristol, ME.'' in the **Federal Register** (79 FR 60745) to enforce a regulated navigation area during bridge replacement operations. This regulated navigation area allowed the Coast Guard to enforce speed and wake restrictions and prohibit all vessel traffic through the regulated navigation area during bridge replacement operations. This rule was effective until April 30, 2017. No comments were received during the public comment period of this rule making.

On August 21, 2018, the Maine Department of Transportation (MEDOT) notified the Coast Guard that it will be removing bedrock in the areas between Rutherford Island and Bristol Neck underneath The Gut Bridge. The removal operations include removing bedrock from between the bridge abutments and areas near the navigation channel both upstream and downstream