E. Small Business Regulatory Enforcement Fairness Act

This final rule is also exempt from congressional review prescribed under 5 U.S.C. 801 since it relates solely to agency management and personnel.

List of Subjects in 41 CFR Part 301–10

Government employees, Travel and transportation expenses.

Dated: July 11, 2008.

David L. Bibb,

Acting Administrator of General Services.

■ For the reasons set forth in the preamble, under 5 U.S.C. 5701–5709, GSA amends 41 CFR part 301–10 as set forth below:

PART 301–10—TRANSPORTATION EXPENSES

■ 1. The authority citation for 41 CFR part 301–10 continues to read as follows:

Authority: 5 U.S.C. 5707, 40 U.S.C. 121(c); 49 U.S.C. 40118, Office of Management and Budget Circular No. A–126, ''Improving the Management and Use of Government Aircraft.'' Revised April 28, 2006.

§ 301–10.303 [Amended]

■ 2. In § 301–10.303, in the table, in the second column, under the heading ''Your reimbursement is'', remove ''[1]$1.07'' and add ''[1]$1.26'' in its place; remove ''[1]$0.505'' and insert ''[1]$0.585'' in its place; and remove ''[1]$0.305'' and insert ''[1]$0.585'' in its place.

Note: The following attachment will not appear in the Code of Federal Regulations.

Attachment to Preamble

GENERAL SERVICES ADMINISTRATION

REPORTING TO CONGRESS—THE COSTS OF OPERATING PRIVATELY OWNED VEHICLES

Paragraph (b) of Section 5707 of Title 5, United States Code, requires the Administrator of General Services to periodically investigate the cost to Government employees of operating privately owned vehicles (airplanes, automobiles, and motorcycles) while on official travel, to report the results of the investigations to Congress, and to publish a report in the **Federal Register**. The following report on the privately owned vehicle mileage reimbursement rates is published in the **Federal Register**.

Dated: July 11, 2008.

David L. Bibb,

Acting Administrator of General Services.

Reporting To Congress—The Costs of Operating Privately Owned Vehicles

5 U.S.C. 5707(b)(1)(A) requires that the Administrator of General Services, in consultation with the Secretary of Defense, the Secretary of Transportation, and representatives of Government employee organizations, conduct periodic investigations of the cost of travel and operation of privately owned vehicles (airplanes, automobiles, and motorcycles) to Government employees while on official travel, and report the results to the Congress at least once a year. 5 U.S.C. 5707(a)(1) requires that the Administrator of General Services issue regulations prescribing mileage reimbursement rates and determine the average, actual cost per mile for the use of each type of privately owned vehicle based on the results of these cost investigations. Such figures must be reported to the Congress within 5 working days after the cost determination has been made in accordance with 5 U.S.C. 5707(b)(2)(C).

Pursuant to the above, the General Services Administration (GSA), in consultation with the above-specified parties conducted investigations of the cost of operating privately owned vehicles. As provided in 5 U.S.C. 5704(a)(1), the privately owned automobile (POA) reimbursement rate cannot exceed the single standard mileage rate established by the Internal Revenue Service (IRS). The IRS announced a new single standard mileage rate for a POA of $0.585, which was effective July 1, 2008 through December 31, 2008. As required, GSA is reporting the results of GSA's investigation and the cost per mile determination. Based on cost studies conducted by GSA, the Acting Administrator of General Services has determined the per-mile operating costs of a POA to be $0.585. In addition, the Acting Administrator of General Service has determined the per-mile operating costs of a privately owned airplane to be $1.26, and the per-mile operating costs of a privately owned motorcycle to be $0.585.

[FR Doc. E8–17183 Filed 7–25–08; 8:45 am]

BILLING CODE 6820–14–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 422

[CMS–4121–F]

RIN 0938–AO54

Medicare Program; Prohibition of Midyear Benefit Enhancements for Medicare Advantage Organizations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule prohibits Medicare Advantage (MA) organizations, including organizations offering MA plans to employer and union group health plan sponsors, from making midyear changes to non-prescription drug benefits, premiums, and cost-sharing submitted in their approved bids for a given contract year. This final rule also clarifies that MA organizations offering certain kinds of plans restricted to employer and union group health plan sponsors and not open to general enrollment may continue to offer benefit enhancements as they do currently, through means other than midyear benefit enhancements (MYBEs). Programs of all-inclusive care for elderly (PACE) are not subject to the provisions of this final rule and may continue to offer enhanced benefits as specified in our guidance for PACE plans.

DATES: *Effective Date:* These regulations are effective on August 27, 2008.

FOR FURTHER INFORMATION CONTACT: Christopher McClintick, (410) 786–4682.

SUPPLEMENTARY INFORMATION:

I. Background

Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) made important changes to the Medicare+Choice (M+C) program under Part C of Medicare and renamed the program Medicare Advantage (MA). On August 3, 2004, we published in the **Federal Register** a proposed rule (69 FR 46866) that set forth the provisions that would implement Title II of the MMA. On January 28, 2005, we published in the **Federal Register** a final rule (70 FR 4588) to implement our proposals. A major revision to the MA program was to implement a new bidding process for determining benefits.

In the August 3, 2004 proposed rule, we proposed to prohibit MA

organizations from offering MYBEs (that is, enhanced benefits or reductions in premiums or cost-sharing amounts not specified in the approved bid for the calendar year (CY) in question). We believed MYBEs undermined the statutory requirement for a competitive bidding process. In response to the August 3, 2004 proposed rule, several commenters objected to our proposal to eliminate MYBEs. These commenters believed that we could allow MYBEs without affecting the integrity of the bidding process.

In the January 28, 2005 final rule (70 FR 4639), we noted that under the previous M+C program, we permitted M+C organizations to offer new plans midyear and to offer MYBEs to existing benefit packages, but were concerned that this was no longer appropriate under the new bidding process. Also, in the January 28, 2005 final rule (70 FR 4640), we noted that MYBEs ''* * * would be a de facto adjustment to the benefit packages from which bids were submitted earlier in the year.'' In a related final rule (published January 28, 2005 (70 FR 4301)) implementing the Medicare prescription drug benefit (Part D regulations), we similarly stated that MYBEs ''* * * would be de facto acknowledgement that the revenue requirements submitted by the plan were overstated.'' Although we acknowledged that MYBEs could undermine the integrity of the bidding process, in response to comments on the August 3, 2004 proposed rule, we decided to permit them on an interim basis under limited circumstances. Therefore, in the January 28, 2005 final rule, we stated that we would permit MYBEs to non-drug benefits only as a transitional policy and under the following circumstances only:

- An MYBE could be effective no earlier than July 1 of the contract year, and no later than September 1 of the contract year (in subsequent instructions issued in a April 10, 2007 CMS memorandum, we further limited the effective date to September 1);
- MA organizations could not submit MYBE applications later than July 31 of the contract year (in subsequent instructions issued in an April 10, 2007 CMS memorandum, we further limited the application date to June 30); and
- Twenty-five percent of the value of the MYBE would be retained by the government.

If the MYBE met the circumstances described above, the requesting MA organization—

- Was required to submit for each plan or segment, a revised bid and any supporting documentation related to the enhancement, including information on where the revenue requirements were overstated in the annual June bid submission; and
- Would be subject to CMS consideration of whether there is a current year MYBE request when analyzing a plan's bid for the following year.

On September 1, 2006, we published in the **Federal Register** a proposed rule (71 FR 52014–52017) that proposed prohibiting MYBEs for all MA organizations. For more information concerning the basis of our proposal to prohibit MYBEs, see the proposed rule and our discussion of the proposed rule in Section II of this document.

II. Provisions of the Proposed Regulations

In the September 1, 2006 proposed rule, we proposed to prohibit all MA organizations from offering midyear benefit enhancements. We are referring the reader to 71 FR 52014–52017, for more information concerning the basis of our proposal to prohibit MYBEs.

III. Analysis of and Responses to Public Comments

We received 4 items of timely correspondence on the proposed rule, raising 5 specific issues. The comments, which we discuss below, were from an individual, a health plan, and two insurance trade organizations. We reviewed each commenter's letter and for ease of reference, we are organizing the comments and our responses to them in the sections relating to MA plans, and employer and union group health plans, in general.

A. Medicare Advantage Plans

We proposed to prohibit MYBEs as being inconsistent with the new, MMA-authorized, competitive bidding process. We proposed that the new prohibition would be effective beginning contract year 2007. We received comments concerning the timeline for implementation of MYBEs, and our contentions that MYBEs encourage overbidding; that MYBEs are inconsistent with the Part D benefit, which does not permit MYBEs; and that MYBEs can lead to an unfair advantage for plans offering them. Some commenters also stated that if we were to prohibit MYBEs, we would be affecting primarily beneficiaries who would not have the opportunity to receive additional benefits. See the proposed rule for more information on these issues.

Comment: A commenter stated that current MYBE policy achieves a balance between preserving the integrity of the bidding process and providing enrollees with additional benefits at no extra costs.

Response: We believe that beneficiaries and the MA program in general are best served by having a fair, competitive, and transparent bidding process. By prohibiting MYBEs we believe that plans will have more incentive to submit bids that reflect actual revenue needs. Establishing a level playing field and preserving the integrity of the competitive bidding process will be fair to plans and provide beneficiaries with quality benefit packages with reasonable costs.

Comment: Three commenters recommended that CMS defer for a year consideration of the policy to prohibit MYBEs. The commenters' recommendation for this request ranged from the need to have more experience with the bidding process, to the need to take into account the fact that plans would have little experience with the bidding process and, therefore, would need more time to make the transition to the new process. One of the commenters requested that if CMS concludes a new policy is needed, it should publish a new proposed rule.

Response: Based on these comments, we delayed publication of the final rule, which we had proposed to implement beginning with the 2007 calendar year (CY). While the additional year of experience has been helpful for us in assessing MYBEs, we believe that it confirms a longer transition period will not be necessary (only one MA organization, for example, applied for a MYBE in 2007). With respect to our other primary concerns, we continue to estimate that MYBEs would likely lead to bids as much as 2 to 3 percent higher than would be submitted if MYBEs were prohibited, and that the competitive nature of the bidding process would be undermined to both the detriment of beneficiaries and the MA program if MYBEs were permitted even under the current limitations. We also do not believe that there is any benefit to publishing another proposed rule. Although this final rule updates some of our original contentions, and clarifies our discussion of employer and union sponsored group health plans and MYBEs, our concerns as well as our means of addressing them remain unchanged as does the larger context surrounding MYBEs and the MA program. We believe, therefore, that it is important to proceed as indicated in the proposed rule so that we may ensure that the bidding process is competitive, fair to all, and that it continues to comply with the statute.

Comment: A commenter disagreed with our statement that there was value

in making the MA MYBE policy consistent with the prescription drug benefit program (which does not permit MYBEs). The commenter also stated that the offering of basic or supplemental benefits in MA programs often have separate requirements, and asked why this should not be the case with respect to MYBEs and Part C and D benefits. In other words, the commenter asked why would CMS prohibit MYBEs for MA benefits simply because this is the case for Part D benefits.

Response: As we stated in the proposed rule, we do not believe that non-prescription drug benefits should be treated differently than prescription drug benefits. In many MA plans (known as MA–PDs), beneficiaries also receive the Part D prescription drug benefit. (Under our current guidance, in such cases beneficiaries could receive benefit enhancements for health benefits midyear but no enhancements for the Part D portion of the benefit.) By prohibiting MYBEs we will create consistency in treatment of the Part C and D benefit components and ensure that estimates of the revenue necessary for both is accurate. In response to the comment that the sometimes different requirements surrounding Part C basic and supplemental benefits would permit different treatment of MA and Part D benefits, (that is, allow MYBEs for MA plans but not for Part D plans), we believe that the different requirements cited by the commenter would have little to do with the question of MYBEs and their relation to bidding. Instead, the prohibition on MYBEs is primarily due to our desire to ensure that bids accurately represent the revenue needed whether for MA basic or supplemental benefits.

B. Employer and Union Group Health Plans

In the January 28, 2005 final rule (70 FR 4639), we noted that under the previous M+C program, we permitted M+C organizations to offer MYBEs to existing benefit packages (that is, enhanced benefits, or reductions in premiums or cost-sharing amounts). We also noted that because employers and unions offering group health plans through an MA organization may operate on different bidding and negotiation timelines, MA organizations offering certain kinds of restricted enrollment plans to employer and union group health plan sponsors would be allowed to offer MYBEs on a flow basis and would not be subject to the new restrictions on MYBEs. This exemption from the proposed MYBE restriction included both the ''800-series'' employer and union-only group health plans and the new type of employer and union group health plan, where we directly contract with the employer or union sponsor offering an MA product (both of these restricted enrollment employer-only plans have since become known as employer and union-only group waiver plans or ''EGWPs''). We noted that we did not believe the competitive nature of the bidding process was affected if benefit packages for these plans were adjusted midyear in accordance with our guidance.

However, we noted that an MA organization would be subject to the policy of restricted MYBEs if it is offering an employer or union group health plan sponsor a plan that enrolls both individual beneficiaries and employer or union group health plan members, (that is, a plan open to general enrollment). For these latter plans, we also noted that employers and unions would still be free to enhance benefits midyear for the part of the group health plan benefit that is a ''wrap-around'' to the MA plan and that is only available to that employer or union group health plan sponsor's members. Additionally, we noted that these ''wrap-around'' benefits are not technically part of the MA plan.

In the September 1, 2006 proposed rule (71 FR 52016), we noted that there was no longer a need for an interim MYBE policy and applied the same rule to ''800-series'' EGWPs that was proposed for all other MA plans (with the exception of PACE plans). That is, we proposed that beginning with CY 2007, all MA organizations, including organizations offering MA plans to employer and union group health plan sponsors, would not be permitted to make any midyear changes in benefits, premiums or cost-sharing even under the circumstances in which these types of changes were permitted in CY 2006. We proposed that this policy apply to MA organizations that offer plans open to general enrollment to employer and union group health plan sponsors and MA organizations that offer restricted enrollment plans to employer and union group health plan sponsors (that is, ''800 series'' EGWPs).

Comment: Two insurance trade associations commented that the proposed rule should not apply to restricted enrollment MA plans. The commenters stated that the proposed rule would severely limit the longstanding flexibility for MA organizations and employers or unions to negotiate benefits throughout the year that are responsive to the needs and interests of these employer and union group health plan sponsors and their members and thereby discourage employer and union health plan sponsors from enrolling their members in MA plans. The commenters also indicated that it is crucial for MA plans to be able to accommodate the timing of arrangements with employers and unions that offer ''800-series'' non-calendar year plans, and those ''800-series'' plans and/or contracts that begin midyear. For example, the commenters stated that it would be extremely difficult for MA organizations that must submit a bid by June of each year to anticipate the needs of employers who have plan years that start in July of the following year (for example, State and local governments).

Response: We agree that MA organizations should retain the longstanding flexibility to customize benefits, including enhancing benefits and reducing premiums and cost-sharing, for all ''800-series'' EGWPs in order to be able to accommodate the various needs of employer and union group health plan sponsors throughout the year. The proposed prohibition on MYBEs was not intended in any way to limit the current flexibility that MA organizations have to negotiate customized benefit designs for these ''800-series'' employer and union-only types of plans. The proposed rule was merely intended to clarify that these kinds of plans do not need to be exempted from the policy restricting MYBEs because, due to their unique nature, they may continue to enhance benefits for employer and union group health plan sponsors at any point during the contract year without submitting MYBEs to CMS. Accordingly, we are clarifying that MA organizations will retain the flexibility to enhance benefits when offering these kinds of ''800-series'' employer and union-only plans to employer and union group health plan sponsors throughout the year despite being restricted from filing a formal MYBE with CMS. Filing an MYBE is not necessary to exercise this flexibility.

Also, we are further clarifying that MA organizations will continue to be able to accommodate different timing arrangements for different employer or union group health plan sponsors by either contracting with employers and unions on a non-calendar year basis or by entering into new employer and union contracts midyear. MA organizations do not need to file MYBEs to continue to negotiate with employers or unions to provide enhanced benefits on a non-calendar year basis or to enter into midyear contracts with employer and union group health plan sponsors.

Comment: One commenter expressed concern that the MYBE prohibition may

cause employer and union group health plan sponsors to lose the ability to incorporate Medicare in their benefits and thereby negatively affect the ability to reduce health care costs and employers' access to affordable health care.

Response: CMS' longstanding policy allowing enhancement of ''800 series'' EGWP plans for employer and union group health plan sponsors throughout the year, as explained in response to the previous comment, is not being modified by the proposed rule. We are clarifying that the proposed rule does not limit the current flexibility for employer and union group health plan sponsors to continue to contract with MA plans to offer employment-based health coverage that incorporates Medicare benefits (that is, ''800-series'' EGWPs) and thereby enhances the cost effectiveness for employer and union health plan sponsors and the retention of employment-based coverage.

IV. Provisions of the Final Regulations

We are finalizing, with the clarifications described in section III, Analysis of and Responses to Public Comments, the policy specified in the September 1, 2006 proposed rule (71 FR 52014–52017) and section II, Provisions of the Proposed Rule. Beginning in contract year 2008, MA organizations will no longer be permitted to offer midyear benefit enhancements. As discussed in section III of this rule, employer and union group health plans sponsors offering ''800 series'' MA plans will continue to be able to offer benefit enhancements as they do currently, through means other than MYBEs under existing CMS employer group waiver policies. PACE plans are not affected by the prohibition.

We have had the opportunity to reevaluate our MYBE policy over the course of the first 2 contract years of the new bidding process, and we remain convinced that MYBEs are an obstacle to the statutory requirement of a competitive bidding process and that there is no longer a need for this interim policy. As stated in the proposed rule on September 1, 2006, this policy was intended to assist MA organizations during the initial phase of the new bidding process, while ensuring that beneficiaries have a choice of plans. The lack of MYBE applications support this conclusion as we had only one application for a MYBE in CY 2007, and approximately six in CY 2006. Under the new bidding process, the focus is, as it should be in a competitive environment, on establishing a level playing field by ensuring that the initial bidding process is not skewed by the opportunity later in the year to adjust benefits and bids through benefit enhancements. Prohibiting MYBEs will ensure that the focus is squarely on the integrity of the bidding process established by statute.

As indicated in the proposed rule, the rationales for our proposal to prohibit MYBEs remain valid after another year of experience with MYBEs and the bidding process. To summarize those concerns—

- MA organizations, knowing that they could alter their benefit packages after the bidding process was complete, could misrepresent their actual costs (revenue requirements) to provide benefits (overbid) and noncompetitively revise their benefit packages later in the year, once competitors' benefits are known.
- MYBEs offered in July or September of the contract year could be offered primarily to attract individuals in their initial coverage election period (ICEP). We believe that individuals are very attractive to MA organizations because of their relatively low utilization (they are new to the program and tend to be healthier) and because of their numbers (nationally, over 200,000 individuals per month ''age-in'' to Medicare).
- We estimate that organizations planning on revising their bids through MYBEs could overbid by as much as 2 to 3 percent in order to distinguish themselves from other plans later in the year and attract ICEP beneficiaries.
- MYBEs encourage overbidding, and second, penalize MA organizations that do not attempt to ''game the system'' and which instead offer a bid that more accurately represents their costs to offer benefits over the full course of a contract year.
- MYBEs are not consistent with the Part D program (the Part D program does not allow MYBEs).

Finally, based on our experience since permitting MYBEs under even the current limited circumstances, we have found it difficult to determine the credibility of ''excess'' profits an MA organization has for a specific plan (on which MYBEs are based), since the assessment is based only on a few months of incomplete utilization data that occur between the beginning of the calendar year and the MYBE application deadline. Therefore, based on comments received, we are accepting all of the provisions as proposed.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

VI. Regulatory Impact Statement

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

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

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. The MA program, by having both regional and local plans, provides an opportunity for health insurance entities of all types and most sizes (but probably not below the ''small'' insurance entity cutoff level defined by the SBA ($6 million), which is lower than appears viable for a comprehensive, risk-bearing insurance plan) to participate. Therefore, we are not preparing an analysis for the RFA because we have determined that this rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b)

of the Act because we have determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This rule will have no consequential effect on State, local, or tribal governments or on the private sector.

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

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

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: January 10, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: March 12, 2008.

Michael O. Leavitt,

Secretary.

[FR Doc. E8–17056 Filed 7–25–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 64

[Docket No. FEMA–8033]

Suspension of Community Eligibility

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: This rule identifies communities, where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP), that are scheduled for suspension on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If the Federal Emergency Management Agency (FEMA) receives documentation that the community has adopted the required floodplain management measures prior to the effective suspension date given in this rule, the suspension will not occur and a notice of this will be provided by publication in the **Federal Register** on a subsequent date.

DATES: *Effective Dates:* The effective date of each community's scheduled suspension is the third date (''Susp.'') listed in the third column of the following tables.

FOR FURTHER INFORMATION CONTACT: If you want to determine whether a particular community was suspended on the suspension date or for further information, contact David Stearrett, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2953.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance which is generally not otherwise available. In return, communities agree to adopt and administer local floodplain management aimed at protecting lives and new construction from future flooding. Section 1315 of the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage as authorized under the NFIP, 42 U.S.C. 4001 *et seq.*, unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed in this document no longer meet that statutory requirement for compliance with program regulations, 44 CFR part 59. Accordingly, the communities will be suspended on the effective date in the third column. As of that date, flood insurance will no longer be available in the community. However, some of these communities may adopt and submit the required documentation of legally enforceable floodplain management measures after this rule is published but prior to the actual suspension date. These communities will not be suspended and will continue their eligibility for the sale of insurance. A notice withdrawing the suspension of the communities will be published in the **Federal Register**.

In addition, FEMA has identified the Special Flood Hazard Areas (SFHAs) in these communities by publishing a Flood Insurance Rate Map (FIRM). The date of the FIRM, if one has been published, is indicated in the fourth column of the table. No direct Federal financial assistance (except assistance pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act not in connection with a flood) may legally be provided for construction or acquisition of buildings in identified SFHAs for communities not participating in the NFIP and identified for more than a year, on FEMA's initial flood insurance map of the community as having flood-prone areas (section 202(a) of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4106(a), as amended). This prohibition against certain types of Federal assistance becomes effective for the communities listed on the date shown in the last column. The Administrator finds that notice and public comment under 5 U.S.C. 553(b) are impracticable and unnecessary because communities listed in this final rule have been adequately notified.

Each community receives 6-month, 90-day, and 30-day notification letters addressed to the Chief Executive Officer stating that the community will be suspended unless the required floodplain management measures are met prior to the effective suspension date. Since these notifications were made, this final rule may take effect within less than 30 days.

National Environmental Policy Act. This rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Considerations. No environmental impact assessment has been prepared.

Regulatory Flexibility Act. The Administrator has determined that this rule is exempt from the requirements of the Regulatory Flexibility Act because the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed no longer comply with the statutory requirements, and after the effective date, flood insurance will no longer be available in the communities unless remedial action takes place.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This rule involves no policies that have federalism implications under Executive Order 13132.