emergency waiver when the waiver expired, as well as our intention to publish a rule removing § 405.2175 from our regulations after the waiver expired. We find good cause to waive a notice-and-comment procedure to remove the waiver provisions from the regulation. We believe that a notice-and-comment procedure is unnecessary because the June 20, 2001 final rule puts the public on notice that the waiver of the conditions for coverage for the specifically named hospitals was created to address a public health crisis in Houston and it was to be of limited duration (it was to remain in effect until no later than December 15, 2001). This rule merely conforms the Medicare regulation to the mandate expressed by the agency on June 20. Therefore, we are waiving notice-and-comment procedures under 5 U.S.C. 553(b)(3)(B).

Given the fact that the waiver has already expired by its own terms, we find good cause to waive the 30-day delay in the effective date established by 5 U.S.C. 553(d)(3). We believe that delaying the effective date of this regulation is unnecessary since it does not require the public to adjust its behavior before the final rule takes place.

List of Subjects in 42 CFR Part 405

Administrative practice and procedures, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Part 405, Subpart U as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart U—Conditions for Coverage of Suppliers of End-Stage Renal Disease (ESRD)

1. The authority citation for Part 405, Subpart U continues to read as follows:

Authority: Secs. 1102, 1138, 1861, 1862(a), 1871, 1874, and 1881 of the Social Security Act (42 U.S.C. 1302, 1320b–8, 1365x, 1395y(a), 1395hh, 1395kk, and 1395rr, unless otherwise noted).

§ 405.2175 [Removed]

2. Section 405.2175 is removed.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: March 15, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 2, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–17622 Filed 7–25–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

CMS–1883–F3

RIN 0938–AI80

Medicare Program; Revision of the Procedures for Requesting Exceptions to Cost Limits for Skilled Nursing Facilities and Elimination of Reclassifications; Technical Correction

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

ACTION: Technical correction.

SUMMARY: In the October 10, 2000 issue of the **Federal Register** (65 FR 60104), we published a technical correction to the August 5, 1999 issue of the **Federal Register** (64 FR 42610). This technical correction amends the regulations text to correct an inadvertent error that occurred when the Code of Federal Regulations (CFR) was published. It also explains a technical correction that is accurately reflected in the current language as it appears in the CFR, as it was intended in the correction notice of October 10, 2000.

EFFECTIVE DATE: September 7, 1999.

FOR FURTHER INFORMATION CONTACT: Julie Stankivic, (410) 786–5725.

SUPPLEMENTARY INFORMATION:

Background

In the October 10, 2000 technical correction (65 FR 60104), we amended the regulations text to make technical corrections to those parts of the regulation unrelated to the skilled nursing facilities (SNFs) exception procedures that were inadvertently changed. In the regulations text corrected under 42 CFR 413.30(d), we stated that we were removing the words ''the type of'' from the first sentence. It was our intention to remove these words; however, we referenced the first sentence, and these words were found in the second sentence. We note that the regulations text as published in the Code of Regulations (CFR) actually accurately reflects the change that was intended in the correction notice of October 10, 2000. Therefore, we are not amending the regulations text in this technical correction.

In addition, in the most recent publication of the CFR in § 413.30(d), the word ''as'' has been inadvertently removed from the third sentence. In the October 10, 2000 technical correction, we did not intend to make any changes that would have resulted in the removal of the word ''as'' after the phrase ''has operated'' in the third sentence of § 413.30(d). We are reinserting the word as no change was intended.

Provisions of the Technical Correction

We are making the necessary technical correction to the regulations text to restore the text to conform to the stated purpose of the correction notice.

Waiver of Notice of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule such as this take effect. We can waive this procedure, however, if we find good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of the finding and its reasons in the notice issued.

We find it unnecessary to undertake notice and comment rulemaking because this document merely provides a technical correction to the regulations and does not make any substantive changes to the regulations. Therefore, for good cause, we waive notice and comment procedures.

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and record keeping requirements.

Corrections to the Regulations Text

Accordingly, 42 CFR part 413 is corrected by making the following correcting amendment:

PART 413–PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883,

and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395(g), 13951(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

§ 413.30 [Corrected]

2. In paragraph (d) the word ''as'' is added after the phrase ''has operated'' in the third sentence.

(Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance)

Dated: April 25, 2002.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 02–17620 Filed 7–25–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

45 CFR Part 146

[CMS–2033–IFC]

RIN 0938–AK00

Technical Change to Requirements for the Group Health Insurance Market; Non-Federal Governmental Plans Exempt From HIPAA Title I Requirements

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period amends the exemption election requirements that apply to self-funded non-Federal governmental plans. In it, we clarify the circumstances under which plan sponsors may exempt these plans from most of the requirements of title XXVII of the Public Health Service (PHS) Act and provide guidance on the procedures, limitations, and documentation associated with exemption elections.

In this interim final rule with comment period, we provide that a sponsor of a self-funded, non-Federal governmental plan may elect to exempt its plan from the Women's Health and Cancer Rights Act of 1998. Additionally, we revise a number of procedural requirements affecting the exemption election process and establish certain enrollee protections with respect to exemption elections.

In response to public comments on an interim final rule published in the **Federal Register** on April 8, 1997 (62 FR 16894), we amend our regulation to clarify that nothing in the statute or regulation affects a State's right to limit the extent to which its non-Federal governmental employers may exempt their self-funded plans from title XXVII of the PHS Act.

Finally, we include a technical correction to our regulation on guaranteed availability of health insurance coverage for employers in the small group market.

DATES: *Effective date:* These regulations are effective on September 24, 2002.

Comment date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 4 p.m. on September 24, 2002.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2033–IFC, P.O. Box 8010, Baltimore, MD 21244–8010.

To ensure that mailed comments are received in time for us to consider, please allow for possible delays in delivery.

If you prefer, you may deliver (by hand or courier) your written comments (1 original and 3 copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code CMS–2033–IFC. For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: David Holstein, (410) 786–1565.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments

Comments received timely will be available for public inspection in Room C5–16–03, 7500 Security Blvd., Baltimore, Maryland 21244–1850, generally beginning approximately 3 weeks after the document has been published. Members of the public who are interested in reviewing timely public comments are asked to schedule an appointment by calling (410) 786–9994 Monday through Friday from 8:30 a.m. to 5 p.m.

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I. Background

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new title XXVII to the PHS Act to establish various reforms to the group and individual health insurance markets. The group market reforms are contained under Part A of title XXVII, which includes, among other things, guaranteed availability of coverage to small group market employers and renewability of coverage in the small and large group markets; limitations on pre-existing condition exclusion periods; special enrollment periods under certain circumstances; and prohibition of discrimination against individual participants and beneficiaries based on health status.

Part A of title XXVII was amended by the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Mental Health Parity Act of 1996 (MHPA), and the Women's Health and Cancer Rights Act of 1998 (WHCRA), which added new sections 2704, 2705 and 2706 (subpart 2 of Part A of title XXVII), respectively. NMHPA provides protections for mothers and newborn children for hospital stays following childbirth. MHPA, which applies to group health plans sponsored by employers with more than 50 employees, provides for parity between annual and lifetime dollar limits applicable to mental health benefits, and annual and lifetime dollar limits applicable to medical and surgical benefits. WHCRA requires group health plans that provide medical and surgical benefits for mastectomies to cover, among other things, reconstructive