Social Security Administration
One Skyline Tower
Suite 1702
Attention: LCD Complaint
5107 Leesburg Pike
Falls Church, Virginia 22041

NCD Referral

Department Appeals Board
U.S. Dept. of Health and Human Services
Room 637D, Humphrey Building
Attention: NCD Complaint
200 Independece Avenue, SW.
Washington, DC 20201

Administrative Review Process With Respect to NCDs or LCDs

If a complaint under section 1869(f) of the Act is filed with or forwarded to the DAB or an ALJ, the DAB or ALJ will:

(1) Within 10 business days, send a written response to the requestor informing them that the review process for the complaint is being delayed under this Ruling, and that the Department of Health and Human Services intends to publish regulations establishing uniform procedures.

(2) Docket any such requests.

(3) Inform the CMS of any requests received. (This should be accomplished by sending a copy of the complaint to the appropriate notification contact.)

LCD Notification Contact

Melanie Combs
7500 Security Blvd.
C3–02–16
Baltimore, MD 21244–1850
Attention: LCD Challenge Staff
Telephone Number: (410) 786–7683

NCD Notification Contact

Vadim Lubarsky
7500 Security Blvd.
C1–10–23
Baltimore, MD 21244–1850
Attention: NCD Challenge Staff
Telephone Number: (410) 786–0840

(4) Take no further action until final regulations are effective.

Once the regulation is effective, inform the requestor that processing of complaints under the new review procedures will continue.

Authority: Section 1869 of the Social Security Act (42 U.S.C. 1395ff), and section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554.

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

Dated: October 2, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

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BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8010–N]

Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 2002

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

ACTION: Notice.

SUMMARY: In accordance with section 1839 of the Social Security Act (the Act), this notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) enrollees in the Medicare Supplementary Medical Insurance (SMI) program for 2002. It also announces the monthly SMI premium to be paid by all enrollees during 2002. The monthly actuarial rates for 2002 are $109.30 for aged enrollees and $123.10 for disabled enrollees. The monthly SMI premium rate for 2002 is $54.00. (The 2001 premium rate was $50.00). This compares to projections of the 2002 SMI premium of $58.50 in the 2001 Trustees Report and $54.50 in the 2000 Trustees Report. The 2002 Part B premium is not equal to 50 percent of the monthly actuarial rate because of the differential between the amount of home health that is transferred into Part B in 2002 (five-sixths) and the amount in Part B that is included in the premium calculation (five-sevenths). Included in the monthly premium rate is $3.91 for home health services being transferred into Part B.

EFFECTIVE DATE: January 1, 2002.

FOR FURTHER INFORMATION CONTACT: Carter S. Warfield, (410) 786–6396.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare Supplementary Medical Insurance (SMI) program is the voluntary Medicare Part B program that pays all or part of the costs for physicians' services, outpatient hospital services, home health services, services furnished by rural health clinics, ambulatory surgical centers, comprehensive outpatient rehabilitation facilities, and certain other medical and health services not covered by hospital insurance (HI) (Medicare Part A). The SMI program is available to individuals who are entitled to HI and to U.S. residents who have attained age 65 and are citizens, or aliens who were lawfully admitted for permanent residence and have resided in the United States for 5 consecutive years. This program requires enrollment and payment of monthly premiums, as provided in 42 CFR part 407, subpart B, and part 408, respectively. The difference between the premiums paid by all enrollees and total incurred costs is met from the general revenues of the Federal Government.

The Secretary of the Department of Health and Human Services (the Secretary) is required by section 1839 of the Social Security Act (the Act) to issue two annual notices relating to the SMI program.

One notice announces two amounts that, according to actuarial estimates, will equal respectively, one-half the expected average monthly cost of SMI for each aged enrollee (age 65 or over) and one-half the expected average monthly cost of SMI for each disabled enrollee (under age 65) during the year beginning the following January. These amounts are called ''monthly actuarial rates.''

The second notice announces the monthly SMI premium rate to be paid by aged and disabled enrollees for the year beginning the following January. (Although the costs to the program per disabled enrollee are different than for the aged, the law provides that they pay the same premium amount.) Beginning with the passage of section 203 of the Social Security Amendments of 1972 (Public Law 92–603), the premium rate, which was determined on a fiscal year basis, was limited to the lesser of the actuarial rate for aged enrollees, or the current monthly premium rate increased by the same percentage as the most recent general increase in monthly Title II social security benefits.

However, the passage of section 124 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97–248) suspended this premium determination process. Section 124 of TEFRA changed the premium basis to 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees). Section 606 of the Social Security Amendments of 1983 (Public Law 98–21), section 2302 of the Deficit Reduction Act of 1984 (DRA 1984) (Public Law 98–369), section 9313 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985) (Public Law 99–272), section 4080 of the Omnibus Budget Reconciliation

Act of 1987 (OBRA 1987) (Public Law 100–203), and section 6301 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) (Public Law 101–239) extended the provision that the premium be based on 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees). This extension expired at the end of 1990.

The premium rate for 1991 through 1995 was legislated by section 1839(e)(1)(B) of the Act, as added by section 4301 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) (Public Law 101–508). In January 1996, the premium determination basis would have reverted to the method established by the 1972 Social Security Act Amendments. However, section 13571 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) (Public Law 103–66) changed the premium basis to 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees) for 1996 through 1998.

Section 4571 of the Balanced Budget Act of 1997 (BBA 1997) (Public Law 105–33) permanently extended the provision that the premium be based on 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees).

BBA 1997 included a further provision affecting the calculation of the SMI actuarial rates and premiums for 1998 though 2003. Section 4611 of BBA 1997 modified the home health benefit payable under the HI program for individuals enrolled in the SMI program. Under this section, expenditures for home health services not considered ''post-institutional'' are payable under the SMI program rather than the HI program, beginning in 1998. However, section 4611(e)(1) of BBA 1997 requires that there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from the HI program to the SMI program. Section 4611(e)(2) also provides a specific yearly proportion for the transferred funds. The proportions are 1/6 for 1998, 1/3 for 1999, 1/2 for 2000, 2/3 for 2001, and 5/6 for 2002. For purposes of determining the correct amount of financing from general revenues of the Federal Government, it is necessary to include only these transitional amounts in the monthly actuarial rates for both aged and disabled enrollees, rather than the total cost of the home health services being transferred. Accordingly, the actuarial rates shown in this announcement reflect the net transitional cost only.

Section 4611(e)(3) of BBA 1997 also specifies, for the purposes of determining the premium, that the monthly actuarial rate for enrollees age 65 and over shall be computed as though the transition would occur for 1998 through 2003 and that 1/7 of the cost would be transferred in 1998, 2/7 in 1999, 3/7 in 2000, 4/7 in 2001, 5/7 in 2002, and 6/7 in 2003. Therefore, the transition period for incorporating this home health transfer into the premium is 7 years while the transition period for including these services in the actuarial rate is 6 years. As a result, the premium rate for this year and next year, 2003, will be less than 50 percent of the actuarial rate for aged enrollees announced by the Secretary.

New section 1933(c) of the Act, as added by section 4732(c) of BBA 1997, requires the Secretary to allocate money from the SMI trust fund to the State Medicaid programs for the purpose of providing Medicare Part B premium assistance from 1998 through 2002 for the section 1933 qualifying low-income Medicaid beneficiaries. This allocation, while not being a benefit expenditure, will be an expenditure of the trust fund and has been included in calculating the SMI actuarial rates for this year. The allocation will be included in calculating the SMI actuarial rates through 2002.

As determined according to section 1839(a)(3) of the Act and section 4611(e)(3) of BBA 1997, the premium rate for 2002 is $54.00. Included in the premium rate is $3.91 for home health services being transferred into Part B.

A further provision affecting the calculation of the SMI premium is section 1839(f) of the Act, as amended by section 211 of the Medicare Catastrophic Coverage Act of 1988 (MCCA 1988) (Public Law 100–360). (The Medicare Catastrophic Coverage Repeal Act of 1989 (Public Law 101–234) did not repeal the revisions to section 1839(f) made by MCCA 1988.) Section 1839(f), referred to as the hold-harmless provision, provides that if an individual is entitled to benefits under section 202 or 223 of the Act (the Old-Age and Survivors Insurance Benefit and the Disability Insurance Benefit, respectively) and has the SMI premiums deducted from these benefit payments, the premium increase will be reduced to avoid causing a decrease in the individual's net monthly payment. This decrease in payment occurs if the increase in the individual's social security benefit due to the cost-of-living adjustment under section 215(i) of the Act is less than the increase in the premium. Specifically, the reduction in the premium amount applies if the individual is entitled to benefits under section 202 or 223 of the Act for November and December of a particular year and the individual's SMI premiums for December and the following January are deducted from the respective month's section 202 or 223 benefits.

A check for benefits under section 202 or 223 of the Act is received in the month following the month for which the benefits are due. The SMI premium that is deducted from a particular check is the SMI payment for the month in which the check is received. Therefore, a benefit check for November is not received until December, but has the December's SMI premium deducted from it.

Generally, if a beneficiary qualifies for hold-harmless protection—that is, the beneficiary must have been in current payment status for November and December of the previous year—the reduced premium for the individual for that January and each of the succeeding 11 months for which he or she is entitled to benefits, under section 202 or 203 of the Act, is the greater of the following:

(1) The monthly premium for January reduced as necessary to make the December monthly benefits, after the deduction of the SMI premium for January, at least equal to the preceding November's monthly benefits, after the deduction of the SMI premium for December; or

(2) The monthly premium for that individual for that December.

In determining the premium limitations under section 1839(f) of the Act, the monthly benefits to which an individual is entitled under section 202 or 223 do not include retroactive adjustments or payments and deductions on account of work. Also, once the monthly premium amount has been established under section 1839(f) of the Act, it will not be changed during the year even if there are retroactive adjustments or payments and deductions on account of work that apply to the individual's monthly benefits.

Individuals who have enrolled in the SMI program late or have reenrolled after the termination of a coverage period are subject to an increased premium under section 1839(b) of the Act. The increase is a percentage of the premium and is based on the new premium rate before any reductions under section 1839(f) are made.

II. Notice of Monthly Actuarial Rates and Monthly Premium Rate

The monthly actuarial rates applicable for 2002 are $109.30 for enrollees age 65 and over, and $123.10 for disabled enrollees under age 65. Section III of this notice gives the

actuarial assumptions and bases from which these rates are derived. The monthly premium rate will be $54.00 during 2002. Included in the monthly premium rate is $3.91 for home health services being transferred into Part B.

III. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Actuarial Rates and the Monthly Premium Rate for the Supplementary Medical Insurance Program Beginning January 2002

A. Actuarial Status of the Supplementary Medical Insurance Trust Fund

Under the law, the starting point for determining the monthly premium is the amount that would be necessary to finance the SMI program on an incurred basis. This is the amount of income that would be sufficient to pay for services furnished during that year (including associated administrative costs) even though payment for some of these services will not be made until after the close of the year. The portion of income required to cover benefits not paid until after the close of the year is added to the trust fund and used when needed.

The rates are established prospectively and are, therefore, subject to projection error. Additionally, legislation enacted after the financing has been established, but effective for the period in which the financing has been set, may affect program costs. As a result, the income to the program may not equal incurred costs. Therefore, trust fund assets should be maintained at a level that is adequate to cover a moderate degree of variation between actual and projected costs, and the amount of incurred, but unpaid expenses. An appropriate level for assets to cover a moderate degree of variation between actual and projected costs depends on numerous factors. The most important of these factors are: (1) The difference from prior years between the actual performance of the program and estimates made at the time financing was established, and (2) the expected relationship between incurred and cash expenditures. Ongoing analysis is made of both factors as the trends vary over time.

Table 1 summarizes the estimated actuarial status of the trust fund as of the end of the financing period for 2000 and 2001.

TABLE 1.—ESTIMATED ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND AS OF THE END OF THE FINANCING PERIOD

[In millions of dollars]

Financing period ending	Assets	Liabilities	Assets less liabilities
Dec. 31, 2000	44,027	5,086	38,941
Dec. 31, 2001	41,781	6,043	35,739

B. Monthly Actuarial Rate for Enrollees Age 65 and Older

The monthly actuarial rate for enrollees age 65 and older is one-half of the monthly projected cost of benefits, the Medicaid transfer (for 1998 through 2002), and administrative expenses for each enrollee age 65 and older, adjusted to allow for interest earnings on assets in the trust fund and a contingency margin. The contingency margin is an amount appropriate to provide for a moderate degree of variation between actual and projected costs and to amortize any surplus or unfunded liabilities. As noted in section I of this announcement, section 4611(e)(2) of BBA 1997 requires that only 5/6 of the cost of the home health services being transferred be included in the actuarial rate for 2002, rather than the full cost of such benefits.

The monthly actuarial rate for enrollees age 65 and older for 2002 is determined by first establishing per-enrollee cost by type of service from program data through 2000 and then projecting these costs for subsequent years. The projection factors used are shown in Table 2. The projected values for financing periods from January 1, 1999 through December 31, 2002, are shown in Table 3.

The projected monthly rate required to pay for one-half of the total of benefits, the transfer to Medicaid, and administrative costs for enrollees age 65 and over for 2002 is $118.74. Included in the total of $118.74 is $9.25 for home health services and $21.64 for managed care services. The amount of $9.25 for home health services includes (1) the full cost of fee-for-service home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply ($9.02) as well as (2) the cost of furnishing all home health services to those individuals enrolled in SMI only ($0.23). The amount of $21.64 for managed care services includes (1) The full cost of managed care home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply ($1.92), as well as (2) the cost of furnishing all other SMI services to those individuals enrolled in managed care plans ($19.72). Since section 4611(e)(2) of BBA 1997 requires that only 5/6 of the cost for those services being transferred be included in the actuarial rate for 2002, the monthly actuarial rate provides for an adjustment of −$1.82, representing 1/6 of the full cost of such −$3.20 for interest earnings and −$4.42 for a contingency margin. Based on current estimates, it appears that the assets are more than sufficient to cover the amount of incurred but unpaid expenses and to provide for a moderate degree of variation between actual and projected costs. Thus, a negative contingency margin is needed to reduce assets to a more appropriate level.

C. Monthly Actuarial Rate for Disabled Enrollees

Disabled enrollees are those persons enrolled in SMI because of entitlement (before age 65) to disability benefits for more than 24 months or because of entitlement to Medicare under the end-stage renal disease (ESRD) program. Projected monthly costs for disabled enrollees (other than those suffering from ESRD) are prepared in a fashion parallel to the projection for the aged using appropriate actuarial assumptions (see Table 2). Costs for the ESRD program are projected differently because of the different nature of services offered by the program. The combined results for all disabled enrollees are shown in Table 4.

The projected monthly rate required to pay for one-half of the total of benefits, the transfer to Medicaid, and administrative costs for disabled enrollees for 2002 is $128.43. Included in the total of $128.43 is $6.64 for home health services and $10.98 for managed care services. The amount of $6.64 is the full cost of the home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply. The amount of $10.98 for

managed care services includes (1) the full cost of managed care home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply ($1.00) as well as (2) the cost of furnishing all other SMI services to those individuals enrolled in managed care plans ($9.98). Since section 4611(e)(2) of BBA 1997 requires that only 5/6 of the cost for those services being transferred be included in the actuarial rate for 2002, the monthly actuarial rate provides for an adjustment of −$1.27, representing 1/6 of the full cost of such services. The monthly actuarial rate of $123.10 also provides an adjustment of −$2.72 for interest earnings and −$1.34 for a contingency margin. Based on current estimates, it appears that the assets are more than sufficient to cover the amount of incurred, but unpaid expenses and to provide for a moderate degree of variation between actual and projected costs. Thus, a negative contingency margin is needed to reduce assets to a more appropriate level.

D. Sensitivity Testing

Several factors contribute to uncertainty about future trends in medical care costs. It is appropriate to test the adequacy of the rates using alternative assumptions. The results of those assumptions are shown in Table 5. One set represents increases that are lower and is, therefore, more optimistic than the current estimate. The other set represents increases that are higher and is therefore, more pessimistic than the current version. The values for the alternative assumptions were determined from a statistical analysis of the historical variation in the respective increase factors.

Table 5 indicates that, under the assumptions used in preparing this report, the monthly actuarial rates would result in an excess of assets over liabilities of $32,077 million by the end of December 2002. This amounts to 28.0 percent of the estimated total incurred expenditures for the following year. Assumptions that are somewhat more pessimistic (and therefore, test the adequacy of the assets to accommodate projection errors) produce a surplus of $18,336 million by the end of December 2002, which amounts to 14.4 percent of the estimated total incurred expenditures for the following year. Under fairly optimistic assumptions, the monthly actuarial rates would result in a surplus of $44,795 million by the end of December 2002, which amounts to 44.0 percent of the estimated total incurred expenditures for the following year.

E. Premium Rate

As determined by with section 1839(a)(3) of the Act and section 4611(e)(3) of BBA 1997, the monthly premium rate for 2002, for both aged and disabled enrollees, is $54.00.

TABLE 2.—PROJECTION FACTORS [1] 12-MONTH PERIODS ENDING DECEMBER 31 OF 1999–2002

[In percent]

Calendar year	Physicians' services		Durable medical equipment	Carrier lab[4]	Other carrier services[5]	Outpatient hospital	Home health agency	Hospital lab[6]	Other intermediary services[7]	Managed care
	Fees[2]	Residual[3]								
Aged:										
1999	2.7	1.3	5.0	0.0	9.8	6.5	−21.3	8.5	−20.1	4.6
2000	5.9	3.6	10.6	7.7	15.2	−4.1	3.6	5.9	18.0	5.9
2001	6.1	0.6	12.4	1.7	10.1	6.8	4.9	3.9	11.8	5.5
2002	−3.2	3.6	7.1	1.8	7.8	2.4	23.8	3.7	6.0	3.1
Disabled:										
1999	2.7	0.4	3.3	3.1	9.7	6.9	−14.5	14.4	−8.6	−0.9
2000	5.9	3.9	11.8	6.0	12.8	−3.9	−1.9	1.8	−11.3	−0.2
2001	6.1	0.5	11.1	2.7	13.6	6.5	2.7	7.5	4.2	7.9
2002	−3.2	3.6	7.1	1.8	7.6	2.4	22.5	3.7	7.2	4.4

[1] All values for services other than managed care are per fee-for-service enrollee. Managed care values are per managed care enrollee.
[2] As recognized for payment under the program.
[3] Increase in the number of services received per enrollee and greater relative use of more expensive services.
[4] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[5] Includes ambulatory surgical center facility costs, ambulance services, parenteral and enteral drug costs, supplies, etc.
[6] Includes services paid under the lab fee schedule furnished in the outpatient department of a hospital.
[7] Includes services furnished in rehabilitation and psychiatric hospitals, dialysis facilities, rural health clinics, federally qualified health centers, etc.

TABLE 3.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FINANCING PERIODS ENDING DECEMBER 31, 1999 THROUGH DECEMBER 31, 2002

	Financing periods			
	CY 1999	CY 2000	CY 2001	CY 2002
Covered services (at level recognized):				
Physician fee schedule	$50.47	$55.51	$60.83	$61.01
Durable medical equipment	5.73	6.35	7.32	7.84
Carrier lab [1]	2.29	2.47	2.57	2.62
Other carrier services [2]	9.13	10.54	11.89	12.83
Outpatient hospital	19.26	18.51	20.28	20.77
Home health	[5] 6.69	[5] 6.94	[5] 7.47	[5] 9.25
Hospital lab [3]	1.76	1.87	1.99	2.06
Other intermediary services [4]	5.37	6.35	7.28	7.72
Managed care	[6] 21.21	[6] 22.26	[6] 21.05	[6] 21.64
Total services	121.89	130.80	140.68	145.75
Cost-sharing:				

TABLE 3.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FINANCING PERIODS ENDING DECEMBER 31, 1999 THROUGH DECEMBER 31, 2002—Continued

	Financing periods			
	CY 1999	CY 2000	CY 2001	CY 2002
Deductible	−3.78	−3.78	−3.80	−3.81
Coinsurance	−22.72	−24.15	−25.34	−25.45
Total benefits	95.39	102.87	111.54	116.49
Transfer to Medicaid	[7] 0.00	[7] 0.00	[7] 0.07	[7] 0.07
Administrative expenses	1.77	1.95	2.03	2.18
Incurred expenditures	97.16	104.82	113.64	118.74
Value of interest	−3.52	−4.18	−3.60	−3.20
Adjustment for home health agency services transferred from HI	[8] −5.47	[8] 4.21	[8] −2.95	[8] −1.82
Contingency margin for projection error and to amortize the surplus or deficit	4.13	−4.53	−6.09	−4.42
Monthly actuarial rate	$92.30	$91.90	$101.00	109.30

[1] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[2] Includes ambulatory surgical center facility costs, ambulance services, parenteral and enteral drug costs, supplies, etc.
[3] Includes services paid under the lab fee schedule furnished in the outpatient department of a hospital.
[4] Includes services furnished in rehabilitation and psychiatric hospitals, dialysis facilities, rural health clinics, federally qualified health centers, etc.
[5] This amount includes the full cost of the fee-for-service home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply, as well as the cost of furnishing all home health services to those individuals enrolled in SMI only.
[6] This amount includes the full cost of the managed care home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply, as well as the cost of furnishing all other SMI services to individuals enrolled in managed care.
[7] Section 1933(c)(2) of the Act, as added by section 4732(c) of BBA 1997, allocates an amount to be transferred from the SMI trust fund to the state Medicaid programs. This transfer is for the purpose of paying the SMI premiums for certain low-income beneficiaries. It is not a benefit expenditure but is used in determining the SMI actuarial rates since it is an expenditure of the trust fund.
[8] Section 4611 of BBA 1997 specifies that expenditures for home health services not considered ''post-institutional'' will be payable under the SMI program rather than the HI program beginning in 1998. However, section 4611(e)(1) requires there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from the HI program to the SMI program. For 1998, the amount transferred is 1/6 of the full cost for such services, for 1999, 1/3, for 2000, 1/2, for 2001, 2/3, and for 2002, 5/6. Therefore, the adjustment for 1999 represents 2/3 of the full cost, for 2000, 1/2, for 2001, 1/3, and for 2002, 1/6. This amount adjusts the actuarial rate to reflect the correct amount attributable to home health services.

TABLE 4.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FINANCING PERIODS ENDING DECEMBER 31, 1999 THROUGH DECEMBER 31, 2002

	Financing periods			
	CY 1999	CY 2000	CY 2001	CY 2002
Covered services (at level recognized):				
Physician fee schedule	$51.26	$55.87	$60.12	$60.21
Durable medical equipment	9.04	10.04	11.27	12.05
Carrier lab [1]	2.70	2.85	2.95	3.01
Other carrier services [2]	10.03	11.12	12.99	14.05
Outpatient hospital	23.77	22.43	24.08	24.66
Home health	[5] 5.35	[5] 5.24	[5] 5.43	[5] 6.64
Hospital lab [3]	2.58	2.59	2.78	2.89
Other intermediary services [4]	27.84	27.11	28.61	29.37
Managed care	[6] 10.28	[6] 10.44	[6] 10.32	[6] 10.98
Total services	142.86	147.70	158.55	163.85
Cost-sharing:				
Deductible	−3.40	−3.41	−3.42	−3.43
Coinsurance	−32.69	−33.45	−34.20	−34.40
Total benefits	106.77	110.83	120.93	126.02
Transfer to Medicaid	[7] 0.00	[7] 0.00	[7] 0.05	[7] 0.05
Administrative expenses	2.00	2.10	2.20	2.36
Incurred expenditures	108.78	112.93	123.18	128.43
Value of interest	−0.91	−1.56	−1.92	−2.72
Adjustment for home health agency services transferred from HI	[8] −4.17	[8] −3.07	[8] −2.09	[8] −1.27
Contingency margin for projection error and to amortize the surplus or deficit	−0.69	12.80	13.03	−1.34
Monthly actuarial rate	$103.00	$121.10	$132.20	$123.10

[1] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[2] Includes ambulatory surgical center facility costs, ambulance services, parenteral and enteral drug costs, supplies, etc.
[3] Includes services paid under the lab fee schedule furnished in the outpatient department of a hospital.
[4] Includes services furnished in rehabilitation and psychiatric hospitals, dialysis facilities, rural health clinics, federally qualified health centers, etc.

[5] This amount includes the full cost of the fee-for-service home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply.

[6] This amount includes the full cost of the managed care home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply, as well as the cost of furnishing all other SMI services to individuals enrolled in managed care.

[7] Section 1933(c)(2) of the Act, as added by section 4732(c) of BBA 1997, allocates an amount to be transferred from the SMI trust fund to the state Medicaid programs. This transfer is for the purpose of paying the SMI premiums for certain low-income beneficiaries. It is not a benefit expenditure but is used in determining the SMI actuarial rates since it is an expenditure of the trust fund.

[8] Section 4611 of BBA 1997 specifies that expenditures for home health services not considered ''post-institutional'' will be payable under the SMI program rather than the HI program beginning in 1998. However, section 4611(e)(1) requires there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from the HI program to the SMI program. For 1998, the amount transferred is 1/6 of the full cost for such services, for 1999, 1/3, for 2000, 1/2, for 2001, 2/3, and for 2002, 5/6. Therefore, the adjustment for 1999 represents 2/3 of the full cost, for 2000, 1/2, for 2001, 1/3, and for 2002, 1/6. This amount adjusts the actuarial rate to reflect the correct amount attributable to home health services.

TABLE 5.—ACTUARIAL STATUS OF THE SMI TRUST FUND UNDER THREE SETS OF ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 2002

As of December 31,	2000	2001	2002
This projection:			
Actuarial status (in millions):			
Assets	$44,027	$41,781	$38,514
Liabilities	5,086	6,043	6,438
Assets less liabilities	$38,941	$35,739	$32,077
Ratio (in percent) [1]	38.3	33.0	28.0
Low cost projection:			
Actuarial status (in millions):			
Assets	$44,027	$46,007	$50,877
Liabilities	5,086	5,573	6,082
Assets less liabilities	$38,941	$40,434	$44,795
Ratio (in percent) [1]	40.1	40.4	44.0
High cost projection:			
Actuarial status (in millions):			
Assets	$44,027	$37,012	$25,174
Liabilities	5,086	6,572	6,838
Assets less liabilities	$38,941	$30,439	$18,336
Ratio (in percent) [1]	36.4	25.9	14.4

[1] Ratio of assets less liabilities at the end of the year to the total incurred expenditures during the following year, expressed as a percent.

IV. Regulatory Impact Analysis

We have examined the impacts of this notice as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). 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).

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 government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $25 million or less annually (65 FR 69432). For purposes of the RFA, States and individuals are not considered to be small entities.

In addition, section 1102(b) of the Act requires us to prepare a RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 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 have determined that this notice will not have a significant effect on a substantial number of small entities nor on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis for section 1102(b) of the Act.

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 compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have determined that this notice does not significantly affect the rights, roles, and responsibilities of States.

This notice announces that the monthly actuarial rates applicable for 2002 are $109.30 for enrollees age 65 and over, and $123.10 for disabled enrollees under age 65. It also announces that the monthly SMI premium rate for calendar year 2002 is $54.00. The SMI premium rate of $54.00 is 8% higher than the $50.00 premium rate for 2001. We estimate that the cost of this increase from the current premium to the approximately 38 million SMI enrollees will be about $1.831 billion for 2002. Therefore, this notice is a major rule as defined in Title 5, United States Code, section 804(2) and is an economically significant rule under Executive Order 12866.

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

V. Waiver of Proposed Notice

The Medicare statute requires the publication of the monthly actuarial rates and the Part B premium amounts in September. We ordinarily use general notices, rather than notice and comment rulemaking procedures, to make such announcements. In doing so, we note that under the Administrative Procedure Act interpretive rules; general statements of policy; and rules of agency

organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking.

We considered publishing a proposed notice to provide a period for public comment. However, we may waive that procedure if we find, for good cause, that prior notice and comment are impracticable, unnecessary, or contrary to the public interest. We find that the procedure for notice and comment is unnecessary because the formula used to calculate the SMI premium is statutorily directed, and we can exercise no discretion in applying that formula. Moreover, the statute establishes the time period for which the premium rates will apply, and delaying publication of the SMI premium rate such that it would not be published before that time would be contrary to the public interest. Therefore, we find good cause to waive publication of a proposed notice and solicitation of public comments.

(Section 1839 of the Social Security Act; 42 U.S.C. 1395r)

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

Dated: September 17, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 27, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–26700 Filed 10–19–01; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3061–NC]

RIN 0938–AH15

Medicare Program; Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers

AGENCY: Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), HHS.

ACTION: Notice with comment period.

SUMMARY: This notice announces the request we received from Alcon Laboratories seeking review of the appropriateness of the Medicare payment amount for new technology intraocular lenses furnished by an ambulatory surgical center. This document also announces the 30-day period for the public to comment on the appropriateness or the payment amount of the IOL for which a review was requested.

DATES: We will consider comments regarding the lenses listed in this notice if we receive them at the appropriate address, as provided below, no later than 5 p.m. on November 26, 2001.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services (HHS), Attention: CMS–3061–NC, P.O. Box 8017, Baltimore, MD 21244–8017.

If you prefer, you may deliver 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 Mailstop S3–02–01, 7500 Security Boulevard, Baltimore, Maryland 21244.

Because of the staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code CMS–3061–NC. For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Betty Shaw, (410) 786–6100.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments:

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room C5–14–03 of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (Phone (410) 786–7195 or (410) 786–7201.)

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I. Background

On June 16, 1999, we published a final rule in the **Federal Register** titled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers' (64 FR 32198), which added subpart F to 42 CFR part 416.

In accordance with the June 16, 1999 final rule, we published a notice in the **Federal Register**, titled ''Annual Review of the Appropriateness of Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical'' (66 FR 18959) on April 12, 2001. In this notice, we solicited interested parties to submit requests for review of the appropriateness of the payment amount with regard to a particular intraocular lens.

II. Provisions of this Notice

On May 16, 2001, the following request was submitted to the Centers for Medicare & Medicaid Services for review:

Manufacturer: Alcon Laboratories.

Model Numbers: ACRYSOF ® Acrylic Foldable Sterile UV-Absorbing Multipiece Posterior Chamber Lenses, Models MA30BA ,MA60BM, MA50BM, MA60MA, MA30AC, MA60AC.

Reason for Requesting Review: The manufacturer states that these lenses provide the following:

—Reduced risk of intra- or post-operative complications or trauma by a reduction in the area of lens epithelial cells (LEC), a major contributor to posterior capsule opacification (PCO) when compared with silicone and PMMA lenses, as evidenced by reduced Sommering's Ring scores.

—Ability to fold smaller, requiring a smaller incision than required for PMMA lenses, inducing less astigmatism thereby promoting accelerated postoperative recovery. Smaller size allows the lens to be easily explanted through the original incision.

—Reduced induced astigmatism because the lens can be inserted into the anterior ocular chamber with an average incision size of 3.5mm.

—Improved postoperative visual acuity due to their findings that the loss of visual acuity associated with