through 90), about 1.01 million lifetime reserve days subject to coinsurance at $406 per day, and about 25.99 million extended care days subject to coinsurance at $101.50 per day. Therefore, the estimated total increase in cost to beneficiaries is about $580 million (rounded to the nearest $10 million), due to (1) the increase in the deductible and coinsurance amounts and (2) the change in the number of deductibles and daily coinsurance amounts paid.

V. Waiver of Proposed Notice and Comment Period

The Medicare statute, as discussed previously, requires publication of the Medicare Part A inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services for each calendar year. The amounts are determined according to the statute. As has been our custom, we use general notices, rather than notice and comment rulemaking procedures, to make the announcements. In doing so, we acknowledge 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 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 formulae used to calculate the inpatient hospital deductible and hospital and extended care services coinsurance amounts are statutorily directed, and we can exercise no discretion in following those formulae. Moreover, the statute establishes the time period for which the deductible and coinsurance amounts will apply and delaying publication would be contrary to the public interest. Therefore, we find good cause to waive publication of a proposed notice and solicitation of public comments.

VI. Regulatory Impact Statement

We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 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). As stated in section IV of this notice, we estimate that the total increase in costs to beneficiaries associated with this notice is about $580 million due to (1) the increase in the deductible and coinsurance amounts and (2) the change in the number of deductibles and daily coinsurance amounts paid. 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.

The RFA requires agencies to analyze options for regulatory relief of small entities. 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 $6 million to $29 million in any 1 year. Individuals and States are not considered small entities. We have determined that this notice will not have a significant economic impact on a substantial number of small entities. Therefore, we are not preparing an analysis for the RFA.

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 604 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 the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis for section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice has 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 rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This notice has no consequential effect on State or local governments.

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

Authority: Secs. 1813(b)(2) of the Social Security Act (42 U.S.C. 1395e–2(b)(2)).

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

Dated: September 4, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 20, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–26674 Filed 10–18–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8014–N]

RIN 0938–AL63

Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 2003

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 2003. It also announces the monthly SMI premium to be paid by all enrollees during 2003. The monthly actuarial rates for 2003 are $118.70 for aged enrollees and $141.00 for disabled enrollees. The monthly SMI premium rate for 2003 is $58.70. (The 2002 premium rate was $54.00). This compares to projections of the 2003 SMI premium of $57.00 in the 2002 Trustees Report and $63.30 in the 2001 Trustees Report. The 2003 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 2003 (the

full cost) and the amount in Part B that is included in the premium calculation (six-sevenths). Included in the monthly premium rate is $3.68 for home health services being transferred into Part B.

EFFECTIVE DATE: January 1, 2003.

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 (Pub. L. 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) (Pub. L. 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 (Pub. L. 98–21), section 2302 of the Deficit Reduction Act of 1984 (DEFRA '84) (Pub. L. 98–369), section 9313 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85) (Pub. L. 99–272), section 4080 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–203), and section 6301 of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) (Pub. L. 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 '90) (Pub.L. 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 '93) (Pub. L. 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) (Pub. L. 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).

The BBA included a further provision affecting the calculation of the SMI actuarial rates and premiums for 1998 through 2003. Section 4611 of the BBA 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 the BBA required 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) of the BBA also provided a specific yearly proportion for the transferred funds. The proportions were 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 was 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 the BBA also specified, 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 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 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 the BBA, required 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, was an expenditure of the trust fund and was 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 the BBA, the premium rate for 2003 is $58.70. Included in the premium rate is $3.68 for home health services 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 '88) (Pub. L. 100–360). (The Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101–234) did not repeal the revisions to section 1839(f) made by MCCA '88.) 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, if the beneficiary was 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 of the Act 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 2003 are $118.70 for enrollees age 65 and over, and $141.00 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 $58.70 during 2003. Included in the monthly premium rate is $3.68 for home health services 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 2003

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 2001 and 2002.

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, 2001	$41,889	$7,799	$34,091
Dec. 31, 2002	36,187	7,557	28,630

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 the BBA required that the full cost of the home health services transferred be included in the actuarial rate for 2003.

The monthly actuarial rate for enrollees age 65 and older for 2003 is determined by first establishing per-enrollee cost by type of service from program data through 2001 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, 2000 through December 31, 2003, are shown in Table 3.

The projected monthly rate required to pay for one-half of the total of benefits and administrative costs for enrollees age 65 and over for 2003 is $122.11. The monthly actuarial rate of $118.70 also provides an adjustment of -$3.38 for interest earnings and -$0.03 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 reduces 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 with 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 and administrative costs for disabled enrollees for 2003 is $137.86. The monthly actuarial rate of $141.00 also provides an adjustment of -$2.10 for interest earnings and $5.24 for a contingency margin. Based on current estimates, it appears that the assets are not 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 positive contingency margin is needed to increase 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, therefore, more optimistic than the current estimate. The other set represents increases that are higher and, therefore, more pessimistic than the current estimate. 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 $29,268 million by the end of December 2003. This amounts to 24.5 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 $24,976 million by the end of December 2003, which amounts to 19.2 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 $33,751 million by the end of December 2003, which amounts to 30.9 percent of the estimated total incurred expenditures for the following year.

E. Premium Rate

As determined by section 1839(a)(3) of the Act and section 4611(e)(3) of the BBA, the monthly premium rate for 2003, for both aged and disabled enrollees, is $58.70.

TABLE 2.—PROJECTION FACTORS [1], 12-MONTH PERIODS ENDING DECEMBER 31 OF 2000–2003

[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:										
2000	5.8	3.5	10.1	7.3	14.1	−1.1	−10.7	5.3	21.4	5.8
2001	5.7	3.4	12.5	7.4	16.4	−1.3	24.3	−8.7	5.1	5.2
2002	−4.1	3.6	7.4	3.8	11.5	3.7	12.0	8.7	10.9	7.5
2003	−4.3	4.2	7.2	5.3	11.1	2.9	6.5	5.2	−16.3	2.1
Disabled:										
2000	5.8	3.5	11.1	4.0	12.0	45.2	−9.8	8.3	−1.2	1.3
2001	5.7	5.3	15.0	9.5	20.5	37.6	21.9	1.3	−8.2	0.9
2002	−4.1	3.4	6.6	3.6	11.4	−18.6	9.4	7.1	9.8	4.5
2003	−4.3	4.1	7.2	5.2	10.9	−29.1	5.7	5.1	−28.1	2.0

[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 physician administered drugs, 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 dialysis facilities, rural health clinics, federally qualified health centers, rehabilitation and psychiatric hospitals, etc.

TABLE 3.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FINANCING PERIODS ENDING DECEMBER 31, 2000 THROUGH DECEMBER 31, 2003

	Financing periods			
	CY 2000	CY 2001	CY 2002	CY 2003
Covered services (at level recognized):				
Physician fee schedule	55.37	62.11	63.20	63.39
Durable medical equipment	6.33	7.31	8.02	8.66
Carrier lab [1]	2.46	2.71	2.88	3.05
Other carrier services [2]	10.53	12.58	14.35	16.05
Outpatient hospital	19.31	19.55	20.74	21.49
Home health	[5] 5.68	[5] 7.24	[5] 8.30	8.90
Hospital lab [3]	1.93	1.81	2.01	2.13
Other intermediary services [4]	6.36	6.86	7.78	6.56
Managed care	[6] 22.26	[6] 20.89	[6] 20.07	19.74
Total services	[7] 130.22	[7] 141.06	[7] 147.35	149.96
Cost-sharing:				
Deductible	−3.78	−3.94	−3.73	−3.85
Coinsurance	−24.41	−25.17	−26.12	−26.38
Total benefits	102.02	111.95	117.51	119.74
Administrative expenses	1.95	2.19	2.23	2.37
Incurred expenditures	103.97	114.14	119.73	122.11
Value of interest	−4.18	−3.57	−3.21	−3.38
Adjustment for home health agency services transferred from HI	[8] −3.43	[8] −2.81	[8] −1.59	.....
Contingency margin for projection error and to amortize the surplus or deficit	−4.46	−6.75	−5.63	−0.03
Monthly actuarial rate	$91.90	$101.00	$109.30	$118.70

[1] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[2] Includes physician administered drugs, 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 dialysis facilities, rural health clinics, federally qualified health centers, rehabilitation and psychiatric hospitals, 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 the BBA 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 the BBA 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] Includes transfers to Medicaid. Section 1933(c)(2) of the Act, as added by section 4732(c) of the BBA, 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 the BBA 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 2000 represents 1/6 of the full cost, for 2001, 1/2, and for 2002, 1/3. 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, 2000 THROUGH DECEMBER 31, 2003

	Financing periods			
	CY 2000	CY 2001	CY 2002	CY 2003
Covered services (at level recognized):				
Physician fee schedule	57.10	63.98	64.03	63.90
Durable medical equipment	10.20	11.86	12.74	13.68
Carrier lab [1]	2.87	3.10	3.23	3.41
Other carrier services [2]	11.42	13.74	15.38	17.11
Outpatient hospital	34.26	47.46	38.96	27.66
Home health	[5] 4.40	[5] 5.42	[5] 5.97	6.32
Hospital lab [3]	2.83	2.82	3.02	3.18
Other intermediary services [4]	28.78	28.53	29.88	28.61
Managed care	[6] 10.73	[6] 9.82	[6] 9.43	9.43
Total services	[7] 162.59	[7] 186.73	[7] 182.64	173.29
Cost-sharing:				
Deductible	−3.67	−3.88	−3.57	−3.74
Coinsurance	−44.70	−57.11	−47.08	−34.37
Total benefits	114.22	125.74	131.99	135.19
Administrative expenses	2.18	2.46	2.50	2.68

TABLE 4.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FINANCING PERIODS ENDING DECEMBER 31, 2000 THROUGH DECEMBER 31, 2003—Continued

	Financing periods			
	CY 2000	CY 2001	CY 2002	CY 2003
Incurred expenditures	116.40	128.19	134.49	137.86
Value of interest	−1.60	−2.26	−1.99	−2.10
Adjustment for home health agency services transferred from HI	[8] −2.59	[8] −2.08	[8] −1.13	.....
Contingency margin for projection error and to amortize the surplus or deficit	8.89	8.34	−8.27	5.24
Monthly actuarial rate	$121.10	$132.20	$123.10	$141.00

[1] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[2] Includes physician administered drugs, 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 dialysis facilities, rural health clinics, federally qualified health centers, rehabilitation and psychiatric hospitals, 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 the BBA 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 the BBA 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] Includes transfers to Medicaid. Section 1933(c)(2) of the Act, as added by section 4732(c) of the BBA, 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 the BBA 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 2000 represents 1/2 of the full cost, 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, 2003

As of December 31	2001	2002	2003
This projection:			
Actuarial status (in millions):			
Assets	41,889	36,187	37,830
Liabilities	7,799	7,557	8,561
Assets less liabilities	34,091	28,630	29,268
Ratio (in percent) [1]	31.1	25.0	24.5
Low cost projection:			
Actuarial status (in millions):			
Assets	41,889	36,187	41,988
Liabilities	7,799	7,097	8,237
Assets less liabilities	34,091	29,090	33,751
Ratio (in percent) [1]	32.5	27.3	30.9
High cost projection:			
Actuarial status (in millions):			
Assets	41,889	36,187	33,901
Liabilities	7,799	8,027	8,925
Assets less liabilities	34,091	28,160	24,976
Ratio (in percent) [1]	29.8	23.0	19.2

[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 impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) September 19, 1980 (Pub. L. 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 $6 to $29 million in any 1 year (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 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 604 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 analyses for either the RFA or section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in an 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice has no consequential effect on State, local, or tribal governments. We believe the private sector costs of this notice fall below this threshold as well.

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 2003 are $118.70 for enrollees age 65 and over, and $141.00 for disabled enrollees under age 65. It also announces that the monthly SMI premium rate for calendar year 2003 is $58.70. The SMI premium rate of $58.70 is 8.7 percent higher than the $54.00 premium rate for 2002. We estimate that the cost of this increase from the current premium to the approximately 38 million SMI enrollees will be about $2.161 billion for 2003. 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 4, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 23, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–26675 Filed 10–18–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8015–N]

RIN 0938–AL69

Medicare Program; Part A Premium for 2003 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

ACTION: Notice.

SUMMARY: This notice announces the Hospital Insurance premium for calendar year 2003 under Medicare's Hospital Insurance program (Part A) for the uninsured, not otherwise eligible aged (hereafter known as the ''uninsured aged'') and for certain disabled individuals who have exhausted other entitlement. The monthly Medicare Part A premium for the 12 months beginning January 1, 2003 for these individuals is $316. The reduced premium for certain other individuals as described in this notice is $174. Section 1818(d) of the Social Security Act specifies the method to be used to determine these amounts.

EFFECTIVE DATE: This notice is effective January 1, 2003.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare Hospital Insurance program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors and Disability Insurance Program (OASDI) or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for hospital insurance.)

Section 1818(d) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the following calendar year with respect to individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine, during September of each year, the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding calendar year. If the premium is not a multiple of $1, the premium is rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not of $1, it is rounded to the next highest $1). The 2002 premium under this method was $319 and was effective January 1, 2002. (See 66 FR 54264, October 26, 2001.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, of certain disabled individuals who have exhausted other entitlement. These are individuals who are not currently entitled to Part A coverage, but who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, and who would still be entitled to Part A coverage if their earnings had not exceeded the statutorily defined substantial gainful activity amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through (f) of the Act for the aged will