• Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;

• Projecting increases in payment amounts for each of the service types; and

• Projecting increases in administrative costs.

We base our projections for 2005 on: (a) current historical data, and (b) projection assumptions derived from current law and the Mid-Session Review of the President's Fiscal Year 2005 Budget.

We estimate that in calendar year 2005, 34.89 million people aged 65 and over will be entitled to benefits (without premium payment) and that they will incur $156.827 billion of benefits and related administrative costs. Thus, the estimated monthly average per capita amount is $374.57 and the monthly premium is $375. The full monthly premium reduced by 45 percent is $206.

IV. Costs to Beneficiaries

The 2005 premium of $375 is about 9 percent higher than the 2004 premium of $343.

We estimate that approximately 433,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium. We estimate an additional 1,000 enrollees will pay the reduced premium. We estimate that the aggregate cost to enrollees paying these premiums will be about $166 million in 2005 over the amount that they paid in 2004. We estimate that the total cost, in 2005, to enrollees paying these premiums will be about $1.951 billion.

V. Waiver of Notice of Proposed Rulemaking

We are not using notice and comment rulemaking in this notification of Part A premiums for 2005, as that procedure is unnecessary because of the lack of discretion in the statutory formula that is used to calculate the premium and the solely ministerial function that this notice serves. The Administrative Procedure Act permits agencies to waive notice and comment rulemaking when this notice and public comment thereon are unnecessary. On this basis, we waive publication of a proposed notice and a 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 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) 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, we estimate that the overall effect of these changes in the premium will be a cost to voluntary enrollees (section 1818 and 1818A of the Act) of about $166 million. 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 to be 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 will not have a substantial effect on State or local governments.

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

Authority: Sections 1818(d)(2) and 1818A(d)(2) of the Social Security Act (42 U.S.C. 1395i–2(d)(2) and 1395i–2a(d)(2)).

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

Dated: August 30, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 1, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04–20413 Filed 9–3–04; 5:00 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8020–N]

RIN: 0938–AN18

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2005

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 for the Part B account in the Medicare Supplementary Medical Insurance (SMI) trust fund for 2005. It also announces the monthly Part B premium to be paid by enrollees during 2005. The monthly actuarial rates for 2005 are $156.40 for aged enrollees and $191.80 for disabled enrollees. The monthly Part B premium rate for 2005 is $78.20. (The 2004 premium rate was $66.60.) The 2005 Part B premium is equal to 50 percent of the monthly actuarial rate for aged enrollees, or about 25 percent of Part B costs for aged enrollees.

Section 629 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173, also known informally as the Medicare Modernization Act, or MMA) requires that the Part B deductible be indexed beginning in 2006. In addition, under the statute, the 2005 deductible is set at $110.00, an increase of $10 from 2004. The inflation factor to be used beginning in 2006 and each year thereafter is the annual percentage increase in the Part B actuarial rate for enrollees age 65 and over. Since the Part B deductible is directly related to the increase in the aged actuarial rate, the announcement of the Part B deductible is included in this notice. The Part B deductible for 2005 is $110.00.

DATES: Effective January 1, 2005.

FOR FURTHER INFORMATION CONTACT: John D. Shatto, (410) 786–0706.

SUPPLEMENTARY INFORMATION:

I. Background

Part B is the voluntary portion of the Medicare program that pays all or part of the costs for physicians' services, outpatient hospital services, certain 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, or Medicare Part A). Medicare Part B is available to individuals who are entitled to HI, as well as to U.S. residents who have attained age 65 and are citizens, and aliens who were lawfully admitted for permanent residence and have resided in the United States for 5 consecutive years. Part B requires enrollment and payment of monthly premiums, as provided for 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 Part B.

One notice announces two amounts that, according to actuarial estimates, will equal, respectively, one-half the expected average monthly cost of Part B for each aged enrollee (age 65 or over) and one-half the expected average monthly cost of Part B for each disabled enrollee (under age 65) during the year beginning the following January. These amounts are called ''monthly actuarial rates.'' Also included in this notice, beginning this year, is the announcement of the Part B deductible to be paid by enrollees for the year beginning the following January.

The second notice announces the monthly Part B 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 statute 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 Part B actuarial rates and premiums for 1998 through 2003. Section 4611 of the BBA modified the home health benefit payable under Part A for individuals enrolled in Part B. Under this section, expenditures for home health services not considered ''post-institutional'' are payable under Part B rather than Part A, 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 Part A to Part B. 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 the purpose 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 for CY 2002 in tables 3 and 4 reflect the net transitional cost only.

Section 4611(e)(3) of the BBA also specified, for the purpose of determining the premium, that the monthly actuarial rate for enrollees age 65 and over be computed as though the transition would occur for 1998 through 2003 and that 1/7 of the cost 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 was 7 years while the transition period for including these services in the actuarial rate was 6 years.

Section 1933(c) of the Act, as added by section 4732(c) of the BBA, required the Secretary to allocate money from the Part B trust fund to the State Medicaid programs for the purpose of providing Medicare Part B premium assistance from 1998 through 2002 for the low-income Medicaid beneficiaries who qualify under section 1933. This allocation, while not a benefit expenditure, was an expenditure of the trust fund and was included in calculating the Part B actuarial rates through 2002. For 2003 and 2004, the expenditure was made from the trust fund because the allocation was temporarily extended. However, because the extension occurred after the

financing was determined, the allocation was not included in the calculation of the financing rates.

As determined according to section 1839(a)(3) of the Act and section 4611(e)(3) of the BBA, the premium rate for 2005 is $78.20.

A further provision affecting the calculation of the Part B 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 Part B premiums deducted from these benefit payments, the premium increase will be reduced, if necessary, 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 Part B 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 Part B premium that is deducted from a particular check is the Part B payment for the month in which the check is received. Therefore, a benefit check for November is not received until December, but has December's Part B 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 for 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 Part B premium for January, at least equal to the preceding November's monthly benefits, after the deduction of the Part B 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 is 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 Part B late or who 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 Medicare Part B Monthly Actuarial Rates, Monthly Premium Rate, and Annual Deductible

The Medicare Part B monthly actuarial rates applicable for 2005 are $156.40 for enrollees age 65 and over, and $191.80 for disabled enrollees under age 65. Section III of this notice presents the actuarial assumptions and bases from which these rates are derived. The Part B monthly premium rate will be $78.20 during 2005. The Part B deductible for 2005 is $110.00.

III. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Actuarial Rates and the Monthly Premium Rate for Part B Beginning January 2005

A. Actuarial Status of the Part B Account in the Supplementary Medical Insurance Trust Fund

Under the statute, the starting point for determining the monthly premium is the amount that would be necessary to finance Part B 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 was established, but effective for the period in which the financing is set, may affect program costs. As a result, the income to the program may not equal incurred costs. Therefore, trust fund assets must 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. Numerous factors determine what level of assets is appropriate to cover a moderate degree of variation between actual and projected costs. The two 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. Both factors are analyzed on an ongoing basis, 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 2003 and 2004.

TABLE 1.—ESTIMATED ACTUARIAL STATUS OF THE PART B ACCOUNT IN 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, 2003	$23,953	$7,322	$16,631
Dec. 31, 2004	20,327	7,414	12,913

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 sum of monthly amounts for (1) the projected cost of benefits, and (2) administrative expenses for each enrollee age 65 and older, after adjustments to this sum to allow for interest earnings on assets in the trust fund and an adequate 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.

The monthly actuarial rate for enrollees age 65 and older for 2005 is determined by first establishing per-enrollee cost by type of service from program data through 2003 and then projecting these costs for subsequent years. The projection factors used for financing periods from January 1, 2002 through December 31, 2005 are shown in table 2.

As indicated 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 2005 is $152.25. The monthly actuarial rate of $156.40 also provides an adjustment of −$2.00 for interest earnings and $6.15 for a contingency margin. Based on current estimates, 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. This situation has arisen primarily due to the enactment of (1) the Consolidated Appropriations Resolution (Pub. L. 108–7) in February 2003, and (2) the Medicare Modernization Act (Pub. L. 108–173) in December 2003. Each of these two legislative packages was enacted after the establishment of the Part B premium (for 2003 and 2004, respectively). Because each act raised Part B expenditures subsequent to the setting of the premium, total Part B revenues from premiums and general fund transfers have been inadequate to cover total costs. As a consequence, the assets of the Part B account in the Supplementary Medical Insurance trust fund have been drawn on to cover the shortfall, and the remaining level of assets is inadequate for contingency purposes.

The contingency margin included in establishing the 2005 actuarial rate and beneficiary premiums takes a first step towards restoring the assets to an adequate level. In an effort to balance the financial integrity of the Part B account with the increase in the Part B premium, the financing rates for 2005 are set to increase the asset level in the Part B account about halfway towards the fully adequate level, with the expectation that future financing rates will need to include contingency margins to fully restore the assets.

C. Monthly Actuarial Rate for Disabled Enrollees

Disabled enrollees are those persons under age 65 who are enrolled in Part B because of entitlement 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.

As 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 2005 is $175.13. The monthly actuarial rate of $191.80 also provides an adjustment of −$2.13 for interest earnings and $18.80 for a contingency margin. Based on current estimates, the assets associated with the disabled Medicare beneficiaries 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 $21,802 million by the end of December 2005. This amounts to 14.0 percent of the estimated total incurred expenditures for the following year. Assumptions that are somewhat more pessimistic (and that therefore test the adequacy of the assets to accommodate projection errors) produce a surplus of $9,410 million by the end of December 2005, which amounts to 5.4 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 $33,315 million by the end of December 2005, or 23.7 percent of the estimated total incurred expenditures for the following year.

E. Premium Rate

As determined by section 1839(a)(3) of the Act, the monthly premium rate for 2005, for both aged and disabled enrollees, is $78.20.

F. Deductible

As specified by section 1833(b) of the Act, the annual deductible for 2005 is $110.00.

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Table 2—PROJECTION FACTORS[1]
12-MONTH PERIODS ENDING DECEMBER 31 OF 2002-2005
(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:										
2002	-4.0	5.6	13.0	6.8	16.7	-1.7	3.4	13.0	20.3	11.7
2003	1.5	4.7	14.7	7.2	16.4	5.1	-0.2	7.7	3.2	3.0
2004	3.8	3.2	0.2	6.5	3.9	8.2	13.4	5.1	8.7	12.7
2005	1.5	3.5	-0.4	6.5	13.0	6.4	7.4	7.3	9.5	6.3
Disabled:										
2002	-4.0	7.4	21.0	10.9	21.0	4.3	31.0	13.9	17.5	13.5
2003	1.5	6.5	17.7	7.6	25.9	6.2	-4.9	7.0	-2.8	0.4
2004	3.8	2.4	-0.1	6.1	6.1	6.6	12.5	6.3	-4.8	9.2
2005	1.5	3.4	-0.5	6.3	11.8	6.7	6.7	7.3	12.0	6.2

[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, 2002 THROUGH DECEMBER 31, 2005

	Financing periods			
	CY 2002	CY 2003	CY 2004	CY 2005
Covered services (at level recognized):				
Physician fee schedule	64.71	69.42	74.47	76.78
Durable medical equipment	8.46	9.79	9.83	9.60
Carrier lab[1]	2.97	3.21	3.42	3.58
Other carrier services[2]	14.98	17.61	18.33	20.34
Outpatient hospital	22.50	23.89	25.87	27.02
Home health	5.62 [5]	5.66	6.42	6.77
Hospital lab[3]	2.30	2.50	2.63	2.77
Other intermediary services[4]	9.05	9.44	10.27	11.04
Managed care	20.58 [6]	20.09	22.50	26.41
Total services	151.17 [7]	161.62 [7]	173.75 [7]	184.32
Cost-sharing:				
Deductible	-4.06	-4.07	-4.05	-4.48
Coinsurance	-26.85	-28.54	-30.25	-30.94
Total benefits	120.26	129.01	139.45	148.90
Administrative expenses	2.35	2.45	3.25	3.34
Incurred expenditures	122.61	131.46	142.71	152.25
Value of interest	-3.20	-2.31	-1.79	-2.00
Adjustment for home health agency services transferred from HI	-1.07 [8]	—	—.	—
Contingency margin for projection error and to amortize the surplus or deficit	-9.04	-10.45	-7.72	6.15
Monthly actuarial rate	109.30	118.70	133.20	156.40

[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 Part A 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 Part B only.

[6] This amount includes the full cost of the managed care home health services being transferred from Part A as a result of the BBA as if the transition did not apply, as well as the cost of furnishing all other Part B 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 Part B account in the SMI trust fund to the state Medicaid programs. This transfer is for the purpose of paying the Part B premiums for certain low-income beneficiaries. It is not benefit expenditure but is used in determining the Part B 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 Part B rather than Part A beginning in 1998. However, section 4611(e)(1) requires that there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from Part A to Part B. 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 2002 represents 1/6 of the full cost. 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, 2002 THROUGH DECEMBER 31, 2005

	Financing periods			
	CY 2002	CY 2003	CY 2004	CY 2005
Covered services (at level recognized):				
Physician fee schedule	66.06	71.15	75.63	78.64
Durable medical equipment	14.20	16.66	16.64	16.41
Carrier lab[1]	3.50	3.84	4.10	4.31
Other carrier services[2]	16.25	20.06	21.24	23.55
Outpatient hospital	29.88	31.97	34.10	36.05
Home health	4.73 [5]	4.50	5.05	5.34
Hospital lab[3]	3.46	3.70	3.92	4.17
Other intermediary services[4]	34.16	34.96	35.64	37.21
Managed care	10.21 [6]	9.85	11.22	13.50
Total services	182.47 [7]	196.69 [7]	207.52 [7]	219.18
Cost-sharing:				
Deductible	-3.77	-3.78	-3.78	-4.17
Coinsurance	-38.14	-40.55	-42.21	-43.67
Total benefits	140.55	152.35	161.53	171.34
Administrative expenses	2.74	2.89	3.74	3.79
Incurred expenditures	143.30	155.25	165.27	175.13
Value of interest	-2.14	-1.23	-0.75	-2.13
Adjustment for home health agency services transferred from HI	-0.89 [8]	—	—	—
Contingency margin for projection error and to amortize the surplus or deficit	-17.17	-13.01	10.98	18.80
Monthly actuarial rate	$123.10	$141.00	$175.50	$191.80

[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 Part A 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 Part B only.

[6] This amount includes the full cost of the managed care home health services being transferred from Part A as a result of the BBA as if the transition did not apply, as well as the cost of furnishing all other Part B 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 Part B account in the SMI trust fund to the state Medicaid programs. This transfer is for the purpose of paying the Part B premiums for certain low-income beneficiaries. It is not a benefit expenditure but is used in determining the Part B 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 Part B rather than Part A beginning in 1998. However, section 4611(e)(1) requires that there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from Part A to Part B. 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 2002 represents 1/6 of the full cost. This amount adjusts the actuarial rate to reflect the correct amount attributable to home health services.

Table 5—Actuarial Status of the Part B Account in the SMI Trust Fund under Three Sets of Assumptions Financing Periods through December 31, 2005

As of December 31,	2003	2004	2005
This projection:			
Actuarial status (in millions):			
Assets	23,953	20,327	28,495
Liabilities	7,322	7,414	6,693
Assets less liabilities	16,631	12,913	21,802
Ratio (in percent)[1]	12.2	8.7	14.0
Low cost projection:			
Actuarial status (in millions):			
Assets	23,953	20,327	39,475
Liabilities	7,322	6,726	6,159
Assets less liabilities	16,631	13,600	33,315
Ratio (in percent)[1]	12.8	10.0	23.7
High cost projection:			
Actuarial status (in millions):			
Assets	23,953	20,327	16,577
Liabilities	7,322	8,221	7,167
Assets less liabilities	16,631	12,106	9,410
Ratio (in percent)[1]	11.5	7.5	5.4

[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 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 million 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 or 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 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. 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 2005 are $156.40 for enrollees age 65 and over and $191.80 for disabled enrollees under age 65. It also announces that the monthly Part B premium rate for calendar year 2005 is $78.20 and that the Part B deductible for calendar year 2005 is $110.00. The Part B premium rate of $78.20 is 17.4 percent higher than the $66.60 premium rate for 2004. We estimate that this increase will cost the approximately 40 million Part B enrollees about $5.5 billion for 2005. 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 Part B 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 Part B 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: August 30, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services

Dated: September 1, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04–20412 Filed 9–3–04; 5:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: HHS/ACF/ASPE/DOL Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project Follow-up Surveys.

OMB No.: New collection.

Description: The Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project (HtE) is the most ambitious, comprehensive effort to learn what works in this area to date and is explicitly designed to build on previous and ongoing research by rigorously testing a wide variety of approaches to promote employment and improve family functioning and child well-being. The HtE project will ''conduct a multi-site evaluation that studies the implementation issues, program design, net impact and benefit-costs of selected programs'' [1] designed to help Temporary Assistance for Needy Families (TANF) recipients, former TANF recipients, or low-income parents who are hard-to-employ. The project is sponsored by the Office of Planning, Research and Evaluation (OPRE) of the Administration for children and Families (ACF), the Office of the Assistance Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS), and the U.S. Department of Labor (DOL).

The evaluation involves an experimental, random assignment design in five sites (four are confirmed), testing a diverse set of strategies to promote employment for low-income parents who face serious obstacles to employment. The four include: (1) Intensive care management to facilitate the use of evidence-based treatment for major depression among parents receiving Medicaid in Rhode Island; (2) job readiness training, worksite

[1] From the Department of Health and Human Services RFP No.: 233–01–0012.