http://www.cms.hhs.gov/DemoProjectsEvalRpts/.

Paper copies can be obtained by writing to Lisa Waters at the address listed in the **ADDRESSES** section of this notice.

ADDRESSES: Mail or deliver applications to the following address: Centers for Medicare & Medicaid Services, Attention: Lisa Waters, Mail Stop: C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244.

Because of staff and resource limitations, we cannot accept applications by facsimile (fax) transmission or by e-mail.

Eligible Organizations: Section 5007 of the DRA provides that hospitals receiving payment under section 1886(d) of the Social Security Act are eligible to apply.

For the purpose of this demonstration, hospitals may provide gainsharing payments to physicians (as defined in 1861(r)(1) or (3) and practitioners (as described in 1842(b)(18)(C)). Section 5007(g)(4) permits practitioners as described in section 1842(b)(18)(C) to participate in this demonstration. We believe that the reference to section 1842(e)(18)(C) in DRA section 5007(g) is a scrivener's error, and that the reference should be to section 1842(b)(18)(C). Section 5007(g) explicitly provides that the reference to physicians who are permitted to participate in the demo is deemed to include certain practitioners, which we believe is clear evidence of Congress' intent to include such practitioners in the demo. We also note the Conference Report language specifically refers to the inclusion of practitioners as part of the gainsharing arrangement. Since section 1842(e)(18)(C) does not exist, and since section 1842(b)(18)(C) is, with the exception of substituting (b) for (e), identical to that section], specifically defines practitioners, we believe that section 1842(b)(18)(C) is the one that Congress actually intended to reference, and that the substitution of the (e) for the (b) is a scrivener's error. We do not believe that this typographical error impedes any authority to otherwise implement this demonstration. Furthermore, a comprehensive list of all eligibility requirements can be found in the ''Eligible Organizations'' section of the solicitation.

SUPPLEMENTARY INFORMATION:

I. Background

Section 5007 of the Deficit Reduction Act of 2005 (DRA) requires the establishment of a qualified gainsharing demonstration program that will test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to beneficiaries and to develop improved operational and financial hospital performance with the sharing of remuneration as specified in the project. It will have a short-term focus given the limited size of the demonstration.

II. Provisions of the Notice

This notice solicits applications to participate in the DRA Section 5007 Medicare Hospital Gainsharing Demonstration that will assist in determining if gainsharing can align incentives between hospitals and physicians to improve the quality and efficiency of care provided to beneficiaries, which will promote improved operational and financial performance of hospitals. The focus of each demonstration will be to link physician incentive payments to improvements in quality and efficiency. Each demonstration will provide measures to ensure that the quality and efficiency of care provided to beneficiaries is monitored and improved.

Overall, we seek demonstration models that result in savings to Medicare. We will assure the demonstration is budget neutral.

III. Collection of Information Requirements

This information collection requirement is subject to the Paperwork Reduction Act of 1995 (PRA); however, the collection is currently approved under OMB control number 0938–0880 entitled ''Medicare Demonstration Waiver Application.''

Authority: Section 5007 of the Deficit Reduction Act of 2005, Pub. L. 109–171.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 7, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 06–7738 Filed 9–13–06; 3:58 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8030–N]

RIN 0938–A023

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible for Calendar Year 2007

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

ACTION: Notice.

SUMMARY: This notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) beneficiaries enrolled in Part B of the Medicare Supplementary Medical Insurance (SMI) program beginning January 1, 2007. In addition, this notice announces the standard monthly premium for aged and disabled beneficiaries, as well as the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts, as required by section 811 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as modified by the Deficit Reduction Act of 2005. It also announces the annual deductible to be paid by all beneficiaries during 2007.

The standard monthly Part B premium is equal to 50 percent of the monthly actuarial rate for aged enrollees or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees, plus any applicable income-related monthly adjustment amount. If a beneficiary has to pay an income-related monthly adjustment amount, they may have to pay a total monthly premium equal to 35, 50, 65, or 80 percent of the total cost of Part B coverage, by the end of the 3-year transition period. However, for 2007, the beneficiary is only responsible for one-third of any applicable income-related monthly adjustment amount.

The monthly actuarial rates for 2007 are $187.00 for aged enrollees and $197.30 for disabled enrollees. The monthly Part B premium rates to be paid in 2007, including the income-related monthly adjustment amounts, are $93.50 (the standard premium), $106.00, $124.70, $143.40, and $162.10. The specific amount payable by beneficiaries depends on their income level and income tax filing status. (The 2006 premium rate paid by all beneficiaries was $88.50.)

The Part B deductible for 2007 is $131.00 for all beneficiaries.

DATES: *Effective Date:* January 1, 2007.

FOR FURTHER INFORMATION CONTACT: M. Kent Clemens, (410) 786–6391.

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 Medicare Part A, Hospital Insurance. Medicare Part B is available to individuals who are entitled to Medicare Part A, 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 Health and Human Services (the Secretary) is required by section 1839 of the Social Security Act (the Act) to announce the Part B monthly actuarial rates for aged and disabled beneficiaries, as well as the monthly Part B premium. The Part B annual deductible is included in this notice because its determination is directly linked to the aged actuarial rate.

The monthly actuarial rates for aged and disabled enrollees are used to determine the correct amount of general revenue financing per beneficiary each month. These amounts, 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).

The Part B deductible to be paid by enrollees is also announced. Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), the Part B deductible was set in statute. After setting the 2005 deductible amount at $110.00, section 629 of the MMA (amending section 1833(b) of the Act) requires that the Part B deductible be indexed beginning in 2006. The indexing factor to be used each year is the annual percentage increase in the Part B actuarial rate for enrollees age 65 and over. Specifically, the 2007 Part B deductible is calculated by multiplying the 2006 deductible by the ratio of the 2007 aged actuarial rate over the 2006 aged actuarial rate. The amount determined under this formula is then rounded to the nearest dollar.

The monthly Part B premium rate to be paid by aged and disabled enrollees is also announced. (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 rates for 1991 through 1995 were legislated 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 standard 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, beginning in 1998, expenditures for home health services not considered ''post-institutional'' are payable under Part B rather than Part A. 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.

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 811 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173, also known as the Medicare Modernization Act, or MMA), which amended section 1839 of the Act, requires that, starting on January 1, 2007, the Part B premium a beneficiary pays each month be based on their annual income. Specifically, if a beneficiary's ''modified adjusted gross income'' is greater than the legislated threshold amounts (for 2007, $80,000 for a beneficiary filing an individual income tax return, and $160,000 for a beneficiary filing a joint tax return) the beneficiary is responsible for a larger portion of the estimated total cost of Part B benefit coverage. In addition to the standard 25 percent premium, these

beneficiaries will now have to pay an income-related monthly adjustment amount. The MMA made no change to the actuarial rate calculation, and the standard premium, which will continue to be paid by beneficiaries whose modified adjusted gross income is below the applicable thresholds, still represents 25 percent of the estimated total cost to the program of Part B coverage for an aged enrollee. However, once the adjustments are fully phased in, and depending on income and tax filing status, a beneficiary could now be responsible for 35, 50, 65, or 80 percent of the estimated total cost of Part B coverage, rather than 25 percent. The end result of the higher premium is that the Part B premium subsidy is reduced and less general revenue financing is required for beneficiaries with higher income because they are paying a larger share of the total cost with their premium. That is, the premium subsidy will continue to be approximately 75 percent for beneficiaries with income below the applicable income thresholds, but will be reduced for beneficiaries with income above these thresholds. The MMA specified that there be a 5-year transition to full implementation of this provision. However, the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) modified the transition to a 3-year period.

Section 4732(c) of the BBA added section 1933(c) of the Act, which 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 of the Act. 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, 2004, 2005, and 2006, the expenditure was made from the trust fund because the allocation was temporarily extended. However, because the extension occurred after the Part B financing was determined, the allocation was not included in the calculation of the financing rates. For 2007, the allocation has been temporarily extended and is included in the calculation of the financing rates.

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) of the Act 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. The ''hold-harmless'' provision does not apply to beneficiaries who are required to pay an income-related monthly adjustment amount.

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:

- 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.
- 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) of the Act are made.

II. Provisions of This Notice

A. Notice of Medicare Part B Monthly Actuarial Rates, Monthly Premium Rates, and Annual Deductible

The Medicare Part B monthly actuarial rates applicable for 2007 are $187.00 for enrollees age 65 and over and $197.30 for disabled enrollees under age 65. Section II.B. of this notice, presents the actuarial assumptions and bases from which these rates are derived. Listed below are the 2007 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income	Beneficiaries who file a joint tax return with income	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $80,000	Less than or equal to $160,000	$0.00	$93.50
Greater than $80,000 and less than or equal to $100,000.	Greater than $160,000 and less than or equal to $200,000.	12.50	106.00
Greater than $100,000 and less than or equal to $150,000.	Grater than $200,000 and less than or equal to $300,00.	31.20	124.70

Beneficiaries who file an individual tax return with income	Beneficiaries who file a joint tax return with income	Income-related monthly adjustment amount	Total monthly premium amount
Greater than $150,000 and less than or equal to $200,000.	Greater than $300,000 and less than or equal to $400,000.	49.90	143.40
Greater than $200,000	Greater than $400,000	68.60	162.10

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $80,000	$0.00	$93.50
Greater than $80,000 and less than or equal to $120,000	49.90	143.40
Greater than $120,000	68.60	162.10

The Part B annual deductible for 2007 is $131.00 for all beneficiaries.

B. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Actuarial Rates and the Monthly Premium Rates for Part B Beginning January 2007

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

Under the statute, the starting point for determining the standard 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 premium 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 2005 and 2006.

TABLE 1.—ESTIMATED ACTUARIAL STATUS OF THE PART B ACCOUNT IN THE SUPPLEMENTAL MEDICAL INSURANCE TRUST FUND AS OF THE END OF THE FINANCING PERIOD

Financing period ending	Assets (millions)	Liabilities (millions)	Assets less liabilities (millions)
Dec. 31, 2005	$24,008	$10,386	$13,622
Dec. 31, 2006	29,605	7,498	22,107

2. 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: (a) The projected cost of benefits; and (b) 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 2007 is determined by first establishing per-enrollee cost by type of service from program data through 2005 and then projecting these costs for subsequent years. The projection factors used for financing periods from January 1, 2004 through December 31, 2007 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 2007 is $177.83. The monthly actuarial rate of $187.00 also provides an adjustment of −$1.86 for interest earnings and $11.03 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 faster than expected expenditure growth, along with the enactment of the Consolidated Appropriations Resolution

(Pub. L. 108–7) in February 2003, the MMA in December 2003, and the DRA in February 2006. Each of these three legislative packages was enacted after the establishment of the Part B premium (for 2003, 2004, and 2006, 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 were drawn on to cover the shortfall. Therefore, the remaining level of assets is inadequate for contingency purposes.

The contingency margin included in establishing the 2006 actuarial rate and beneficiary premiums was intended to achieve significant progress towards restoring the assets to an adequate level. As noted previously, the subsequent enactment of the DRA increased Part B expenditures and thereby limited the growth in Part B account assets, with the result that the intended progress was not achieved. 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 2007 are set to increase the asset level in the Part B account to the fully adequate level at the end of 2007 under current law (that is, in the absence of further legislation).

3. Monthly Actuarial Rate for Disabled Enrollees

Disabled enrollees are those persons under age 65 who are enrolled in Part B because of entitlement to social security 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 2007 is $201.12. The monthly actuarial rate of $197.30 also provides an adjustment of −$3.92 for interest earnings and $0.10 for a contingency margin. Based on current estimates, the assets associated with the disabled Medicare beneficiaries are 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 minimal contingency margin is needed to maintain assets at an appropriate level.

4. 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 program cost 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 $32,807 million by the end of December 2007. This amounts to 17.3 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 $13,579 million by the end of December 2007, which amounts to 6.4 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 $43,867 million by the end of December 2007, or 26.2 percent of the estimated total incurred expenditures for the following year.

The above analysis indicates that the premium and general revenue financing established for 2007, together with existing Part B account assets, would be adequate to cover estimated Part B costs for 2007 under current law, even if actual costs prove to be somewhat greater than expected.

5. Premium Rates and Deductible

As determined pursuant to section 1839 of the Act, listed below are the 2007 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income	Beneficiaries who file a joint tax return with income	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $80,000	Less than or equal to $160,000	$0.00	$93.50
Greater than $80,000 and less than or equal to $100,000.	Greater than $160,000 and less than or equal to $200,000.	12.50	106.00
Greater than $100,000 and less than or equal to $150,000.	Greater than $200,000 and less than or equal to $300,000.	31.20	124.70
Greater than $150,000 and less than or equal to $200,000.	Greater than $300,000 and less than or equal to $400,000.	49.90	143.40
Greater than $200,000	Greater than $400,000	68.60	162.10

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $80,000	$0.00	$93.50
Greater than $80,000 and less than or equal to $120,000	49.90	143.40

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse	Income-related monthly adjustment amount	Total monthly premium amount
Greater than $120,000	68.60	162.10

Also, as specified by section 1833(b) of the Act, the annual deductible for 2007 is $131.00 for all beneficiaries.

TABLE 2.—PROJECTON FACTORS [1] 12-MONTH PERIOD ENDING DECEMBER 31 OF 2004–2007

[In percent]

Calendar year	Physician's 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:										
2004	3.8	6.0	−0.4	7.7	7.7	11.1	14.6	7.4	15.5	11.4
2005	2.1	3.7	1.4	7.0	3.8	8.7	10.3	6.1	14.7	9.7
2006	0.2	5.8	7.4	7.8	10.7	12.5	8.0	14.0	13.2	10.1
2007	−7.2	7.5	3.7	5.9	12.8	10.1	8.1	4.0	−2.6	0.8
Disabled:										
2004	3.8	5.9	0.4	9.3	14.0	12.3	14.8	9.5	2.1	16.0
2005	2.1	3.9	3.2	7.9	10.0	9.4	9.6	5.9	10.1	3.4
2006	0.2	3.8	7.3	6.3	2.2	11.2	8.1	12.3	13.2	7.8
2007	−7.2	7.4	3.6	5.7	11.3	9.9	8.4	3.8	−3.4	3.4

[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 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 MONTLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FOR FINANCING PERIODS ENDING DECEMBER 31, 2004 THROUGH DECEMBER 31, 2007

	Financing periods			
	CY 2004	CY 2005	CY 2006	CY 2007
Covered services (at level recognized):				
Physician fee schedule	$76.19	$79.78	$81.55	$79.18
Durable medical equipment	9.65	9.67	10.02	10.12
Carrier lab [1]	3.44	3.64	3.79	3.91
Other carrier services [2]	18.96	19.46	20.77	22.81
Outpatient hospital	26.60	28.58	31.03	33.26
Home health	6.66	7.26	7.56	7.96
Hospital lab [3]	2.69	2.83	3.11	3.15
Other intermediary services [4]	10.98	12.45	13.59	12.88
Managed care	22.39	26.16	34.15	38.32
Total services	177.56	189.82	205.57	211.59
Cost-sharing:				
Deductible	−4.07	−4.47	−5.05	−5.33
Coinsurance	−30.83	−31.97	−32.68	−32.32
Total benefits	142.65	153.38	167.85	173.93
Administrative expenses	3.06	3.39	3.48	3.90
Incurred expenditures	145.72	156.77	171.33	177.83
Value of interest	−1.63	−1.28	−1.30	−1.86
Contingency margin for projection error and to amortize the surplus or deficit	−10.88	0.91	6.87	11.03
Monthly actuarial rate	133.20	156.40	176.90	187.00

[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.

TABLE 4.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FINANCING PERIODS ENDING DECEMBER 31, 2004 THROUGH DECEMBER 31, 2007

	Financing periods			
	CY 2004	CY 2005	CY 2006	CY 2007
Covered services (at level recognized):				
Physician fee schedule	$77.90	$82.21	$84.21	$82.95
Durable medical equipment	16.41	16.90	17.87	18.29
Carrier lab [1]	4.17	4.47	4.69	4.90
Other carrier services [2]	22.66	24.87	25.26	27.81
Outpatient hospital	35.79	38.74	42.57	46.22
Home health	5.40	5.88	6.25	6.70
Hospital lab [3]	4.10	4.30	4.76	4.88
Other intermediary services [4]	37.40	39.75	43.99	41.65
Managed care	11.09	12.56	16.38	19.05
Total services	214.92	229.69	245.98	252.44
Cost-sharing:				
Deductible	−3.79	−4.15	−4.71	−4.98
Coinsurance	−44.22	−46.39	−48.23	−50.13
Total benefits	166.91	179.14	193.03	197.34
Administrative expenses	[5] 9.16	3.83	3.76	3.78
Incurred expenditures	176.07	182.98	196.79	201.12
Value of interest	−1.37	−2.35	−2.86	−3.92
Contingency margin for projection error and to amortize the surplus or deficit	0.80	11.18	9.77	0.10
Monthly actuarial rate	175.50	191.80	203.70	197.30

[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] Includes payment of estimated contingent liability payable to States (to reimburse them for payments they have made on behalf of beneficiaries) for probable unasserted claims that resulted from processing errors where incorrect Medicare eligibility determinations were made.

TABLE 5.—ACTUARIAL STATUS OF THE PART B ACCOUNT IN THE SMI TRUST FUND UNDER THREE SETS OF ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 2007

As of December 31	2005	2006	2007
This projection:			
Actuarial status (in millions):			
Assets	$24,008	$29,605	$39,921
Liabilities	10,386	7,498	7,114
Assets less liabilities	13,622	22,107	32,807
Ratio (in percent) [1]	8.1	12.5	17.3
Low cost projection:			
Actuarial status (in millions):			
Assets	24,008	29,605	50,192
Liabilities	10,386	6,684	6,325
Assets less liabilities	13,622	22,921	43,867
Ratio (in percent) [1]	8.5	14.2	26.2
High cost projection:			
Actuarial status (in millions):			
Assets	24,008	29,605	21,464
Liabilities	10,386	8,270	7,885
Assets less liabilities	13,622	21,336	13,579
Ratio (in percent) [1]	7.7	11.1	6.4

[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.

III. Regulatory Impact Analysis

We have examined the impact of this notice under the 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 small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1-year.

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 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any proposed or final rule that contains mandates that may result in the expenditure in any one year by State, local, and tribal governments, or by the private sector, of $100 million in 1995 dollars. This notice contains no mandates for expenditures by State, local, or tribal governments or the private sector. Accordingly, it does not trigger the threshold set under UMRA.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes 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 2007 are $187.00 for enrollees age 65 and over and $197.30 for disabled enrollees under age 65. It also announces the 2007 monthly Part B premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with a dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income	Beneficiaries who file a joint tax return with income	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $80,000	Less than or equal to $160,000	$0.00	$93.50
Greater than $80,000 and less than or equal to $100,000.	Greater than $160,000 and less than or equal to $200,000.	12.50	106.00
Greater than $100,000 and less than or equal to $150,000.	Greater than $200,000 and less than or equal to $300,000.	31.20	124.70
Greater than $150,000 and less than or equal to $200,000.	Greater than $300,000 and less than or equal to $400,000.	49.90	143.40
Greater than $200,000	Greater than $400,000	68.60	162.10

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are also announced and listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $80,000	$0.00	$93.50
Greater than $80,000 and less than or equal to $120,000	49.90	143.40
Greater than $120,000	68.60	162.10

The Part B deductible for calendar year 2007 is $131.00. The standard Part B premium rate of $93.50 is 5.6 percent higher than the $88.50 premium rate for 2006. We estimate that this increase will cost approximately 41 million Part B enrollees about $2.5 billion for 2007. The monthly impact on the beneficiaries who are required to pay a higher premium for 2007 because their incomes exceed specified thresholds is $12.50, $31.20, $49.90, or $68.60, which is in addition to the standard monthly premium. 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.

IV. Waiver of Proposed Notice and Comment

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 and the income-related monthly adjustment amounts are statutorily directed and we can exercise no discretion in applying

those formulas. 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.

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

Dated: September 11, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: September 12, 2006.

Michael O. Leavitt,

Secretary.

[FR Doc. 06–7709 Filed 9–12–06; 4:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review: Comment Request

Title: Tribal Temporary Assistance for Needy Families (TANF) Program Data Reporting Instructions and Requirements.

OMB No.: 0970–0215.

Description: 42 U.S.C. 612 (Section 412 of the Social Security Act as amended by Public Law 104–193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)) mandates that federally recognized Indian Tribes with an approved Tribal TANF program collect and submit to the Secretary of the Department of Health and Human Services data on the recipients served by the Tribes' programs. This information includes both aggregated and disaggregated data on case characteristics and individual characteristics. In addition, Tribes that are subject to a penalty are allowed to provide reasonable cause justifications as to why a penalty should not be imposed or may develop and implement corrective compliance procedures to eliminate the source of the penalty. Finally, there is an annual report, which requires the Tribes to describe program characteristics. All of the above requirements are currently approved by OMB and the Administration for Children and Families is simply proposing to extend them without any changes.

Respondents: Indian Tribes.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Final Tribal TANF Data Report	56	4	451	101,024
Tribal TANF Annual Report	56	1	40	2,240
Tribal TANF Reasonable Cause/Corrective Action Documentation Process	56	1	60	3,360

Estimated Total Annual Burden Hours: 106,624.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the Information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register.** Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, Attn: Desk Officer for ACF; E-mail address: *Katherine_T._Astrich@omb.eop.gov.*

Dated: September 12, 2006.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 06–7727 Filed 9–15–06; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Notice

The National Institute on Aging and several other Institutes of the National Institutes of Health will hold a conference entitled ''Conference on Alzheimer's Disease: Setting the Research Agenda a Century after Auguste D'' on October 26–27, 2006. The purpose of the conference is to discuss future directions for the NIH Alzheimer's disease research agenda. The focus of the conference will be on discussing the research issues that must be addressed in order to provide more efficacious diagnostics and therapeutics to patients and their families.

The conference will include a series of 30 minute presentations by experts in covering a broad spectrum of Alzheimer's disease research. The speakers will provide an overview of where research in a particular field is now and discuss what the critical questions and issues are that must be addressed to move the field forward.

Persons interested in attending the conference should register at: *http://www.tech-res-intl.com/nia/alzheimers_conference/default.htm.*

Registration is free but seating is limited. The Web site also provides information about hotel accommodations.

Dated: September 12, 2006.

Neil Buckholtz,

Chief, Dementias of Aging Branch, Neuroscience and Neuropsychology of Aging Program, National Institute on Aging, National Institutes of Health.

[FR Doc. 06–7732 Filed 9–15–06; 8:45 am]

BILLING CODE 4140–01–M