significant effects ($100 million or more in any 1 year). As stated in section IV of this notice, we estimate that the overall effect of these changes in the Part A premium will be a cost to voluntary enrollees (section 1818 and section 1818A of the Act) of about $91 million. Therefore, this notice is not a major rule as defined in Title 5, United States Code, section 804(2) and is not 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 included in the definition of a small entity. 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 (MSA) 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 expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $120 million. This notice has no consequential effect on State, local, or tribal governments or on the private sector. However, States are required to pay the premiums for dually-eligible beneficiaries.

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 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: September 26, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: September 26, 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. 07–4909 Filed 10–1–07; 11:18 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8033–N]

RIN 0938–AO68

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2008

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, 2008. In addition, this notice announces the 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. The monthly actuarial rates for 2008 are $192.70 for aged enrollees and $209.70 for disabled enrollees. The standard monthly Part B premium rate for 2008 is $96.40, which 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. (The 2007 standard premium rate was $93.50.) The Part B deductible for 2008 is $135.00 for all Part B beneficiaries. If a beneficiary has to pay an income-related monthly adjustment, they may have to pay a total monthly premium of about 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 2008, the beneficiary is only responsible for 67 percent of any applicable income-related monthly adjustment amount. (For 2007, the beneficiary was responsible for 33 percent of the applicable amount.)

DATES: *Effective Date:* January 1, 2008.

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 the Department 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 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 inflation 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 2008 Part B deductible is calculated by multiplying the 2007 deductible by the ratio of the 2008 aged actuarial rate over the 2007 aged actuarial rate. The amount determined under this formula is then rounded to the nearest $1.

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 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, 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 2008, $82,000 for a beneficiary filing an individual income tax return, and $164,000 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, section 5111 of 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 through 2007, 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.

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; or
- 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 re-enrolled 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 the 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 2008 are $192.70 for enrollees age 65 and over and $209.70 for disabled enrollees under age 65. Section II.B. of this notice below, presents the actuarial assumptions and bases from which these rates are derived. The Part B standard monthly premium rate for 2008 is $96.40. The Part B annual deductible for 2008 is $135.00. Listed below are the 2008 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 $82,000	Less than or equal to $164,000	$0.00	$96.40
Greater than $82,000 and less than or equal to $102,000.	Greater than $164,000 and less than or equal to $204,000.	25.80	122.20
Greater than $102,000 and less than or equal to $153,000.	Greater than $204,000 and less than or equal to $306,000.	64.50	160.90
Greater than $153,000 and less than or equal to $205,000.	Greater than $306,000 and less than or equal to $410,000.	103.30	199.70
Greater than $205,000	Greater than $410,000	142.00	238.40

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 $82,000	$0.00	$96.40
Greater than $82,000 and less than or equal to $123,000	103.30	199.70
Greater than $123,000	142.00	238.40

The Part B annual deductible for 2008 is $135.00 for all beneficiaries.

B. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Actuarial Rates and the Monthly Premium Rate for Part B Beginning January 2008

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 an appropriate 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 variation between actual and projected costs. The three 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; (2) the likelihood and potential magnitude of expenditure changes resulting from enactment of legislation affecting Part B costs in a year subsequent to the establishment of financing for that year, and (3) the expected relationship between incurred and cash expenditures. These factors are analyzed on an ongoing basis, as the trends can vary over time.

Table 1 summarizes the estimated actuarial status of the trust fund as of the end of the financing period for 2006 and 2007.

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

Financing period ending	Assets (millions)	Liabilities (millions)	Assets less liabilities (millions)
Dec. 31, 2006	$32,325	$10,929	$21,396
Dec. 31, 2007	39,469	9,470	29,999

2. Monthly Actuarial Rate for Enrollees Age 65 and Older

The monthly actuarial rate for enrollees age65 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 possible variation between actual and projected costs and to amortize any surplus assets or unfunded liabilities.

The monthly actuarial rate for enrollees age 65 and older for 2008 is determined by first establishing per-enrollee cost by type of service from program data through 2006 and then projecting these costs for subsequent years. The projection factors used for financing periods from January 1, 2005 through December 31, 2008 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 2008 is $183.25. The monthly actuarial rate of $192.70 also provides an adjustment of −$2.40 for interest earnings and $11.85 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 significant degree of variation between actual and projected costs. Thus, a positive contingency margin is needed to increase assets to a more appropriate level.

The size of the contingency margin for 2008 is affected by several factors. First, a significant portion of the assets of the Part B account in the SMI trust fund was drawn down in 2003 and 2004 as a result of faster-than-expected expenditure growth, along with the enactment of the Consolidated Appropriations Resolution (Pub. L. 108–7) in February 2003 and the Medicare Modernization Act 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 were 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. Due to continuing faster-than-expected growth in Part B expenditures, only a minimal increase in assets occurred in 2005, despite a large increase in the 2005 Part B premium that was intended to partially replenish the assets in the Part B account. In 2006 and 2007, the Part B expenditures were again higher in each year than expected when the Part B financing was determined as a result of the enactment of legislation after the financing was set (specifically, the Deficit Reduction Act of 2005 and the Tax Relief and Health Care Act of 2006). Therefore, while the Part B assets increased in 2006 and 2007, the asset level remains lower than intended for contingency purposes.

In addition, the likelihood and magnitude of possible differences between actual and estimated Part B expenditures have increased significantly. Under current law, the cumulative actual level of physician (and physician-related) Part B expenditures is substantially in excess of the ''allowable'' level provided by the Sustainable Growth Rate (SGR) provisions. As a result, current law mandates a reduction in Medicare payment rates for physicians of approximately 10 percent for 2008 and another 5 percent per year for roughly another 10 years. As noted above, Congress has acted repeatedly in recent years to prevent such fee reductions from occurring, and is very likely to continue to do so for 2008 and subsequent years. Because of this continuing possibility, and the significant increase in Part B expenditures that results when Congress

overrides the statutory provisions that otherwise mandate decreases in physician fees, it is appropriate to maintain a somewhat larger Part B contingency reserve than would otherwise be necessary.

The traditional goal for the Part B reserve has been that assets minus liabilities at the end of a year should represent between 15 and 20 percent of the following year's total incurred expenditures. Within this range, 17 percent has been the normal target. In view of the strong likelihood of actual expenditures exceeding estimated levels, due to the enactment of legislation after the financing has been set for a given year, a contingency reserve ratio of about 20 percent of the following year's expenditures would better ensure that the assets of the Part B account can adequately cover the cost of incurred-but-not-reported benefits together with variations between actual and estimated cost levels.

The final factor affecting the contingency margin in the 2008 aged actuarial rate is the correction of an accounting error. Beginning in May 2005, expenditures for certain Part A hospice benefits were inadvertently drawn from the Part B account of the SMI trust fund, rather than from the Hospital Insurance (HI) trust fund. Correction of this error will result in adjustments to the HI and SMI trust funds to account for the misallocated hospice expenditures during fiscal years 2005 through 2007. As a result of this error, Part B outlays had been overstated in 2005 through 2007; Part B benefit costs estimated for 2008 are lower than previously projected, and Part B assets available for contingency purposes will be greater. Both factors serve to reduce the level of assets needed to serve as an adequate contingency reserve. In addition, the lower expected amount of Part B outlays in 2008 reduces the premium increase that, together with matching general fund transfers, is needed to finance Part B benefits and administrative expenses. This error has no impact on the 2008 Part A premium.

The actuarial rate of $192.70 per month for aged beneficiaries, as announced in this notice for 2008, reflects the combined net effect of the factors described above and the projection assumptions listed in Table 2.

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 2008 is $213.50. The monthly actuarial rate of $209.70 also provides an adjustment of -$3.83 for interest earnings and $0.03 for a contingency margin, reflecting the same factors described above for the aged actuarial rate. 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 significant degree of variation between actual and projected costs. Thus, a near-zero contingency margin is sufficient to maintain assets at an appropriate level.

The actuarial rate of $209.70 per month for disabled beneficiaries, as announced in this notice for 2008, reflects the combined net effect of the factors described above for aged beneficiaries and the projection assumptions listed in table 2.

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 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.

As indicated in Table 5, the monthly actuarial rates would result in an excess of assets over liabilities of $41,627 million by the end of December 2008—(1) Under the assumptions used in preparing this report; and (2) with the Part B account of the SMI trust fund fully reimbursed for the cost of Part A hospice benefits inadvertently drawn from the Part B account. This amounts to 20.8 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 $27,532 million by the end of December 2008, which amounts to 12.4 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 $53,492 million by the end of December 2008, or 29.6 percent of the estimated total incurred expenditures for the following year.

The above analysis indicates that the premium and general revenue financing established for 2008, together with existing Part B account assets (including the restoration of assets inadvertently drawn from the Part B account to pay the cost of Part A hospice benefits), would be adequate to cover estimated Part B costs for 2008 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 2008 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 $82,000	Less than or equal to $164,000	$0.00	$96.40
Greater than $82,000 and less than or equal to $102,000.	Greater than $164,000 and less than or equal to $204,000.	25.80	122.20
Greater than $102,000 and less than or equal to $153,000.	Greater than $204,000 and less than or equal to $306,000.	64.50	160.90

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 $153,000 and less than or equal to $205,000.	Greater than $306,000 and less than or equal to $410,000.	103.30	199.70
Greater than $205,000	Greater than $410,000	142.00	238.40

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 $82,000	$0.00	$96.40
Greater than $82,000 and less than or equal to $123,000	103.30	199.70
Greater than $123,000	142.00	238.40

TABLE 2.—PROJECTION FACTORS[1] 12-MONTH PERIODS ENDING DECEMBER 31 OF 2005–2008

[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:										
2005	2.1	3.4	1.6	6.6	3.4	8.4	16.2	3.5	13.6	9.8
2006	0.2	4.7	6.8	7.9	5.8	4.6	6.3	4.8	5.2	13.5
2007	−1.4	4.7	4.4	7.9	9.7	2.8	8.9	3.1	−3.7	3.5
2008	10.1	7.7	4.6	5.5	12.7	10.0	7.4	3.4	−2.6	6.4
Disabled:										
2005	2.1	2.8	1.9	7.9	8.5	6.2	17.3	5.5	11.6	2.3
2006	0.2	0.9	5.1	7.1	−5.7	2.0	5.9	3.5	7.4	8.9
2007	−1.4	2.6	3.7	12.3	1.6	3.3	8.5	−1.0	−18.4	3.4
2008	−10.1	7.7	4.9	5.4	11.6	9.9	8.1	3.4	−3.2	7.8

[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 FOR FINANCING PERIODS ENDING DECEMBER 31, 2005 THROUGH DECEMBER 31, 2008

	Financing periods			
	CY 2005	CY 2006	CY 2007	CY 2008
Covered services (at level recognized):				
Physician fee schedule	79.51	79.96	79.06	75.12
Durable medical equipment	9.68	9.92	9.92	10.19
Carrier lab[1]	3.63	3.75	3.88	4.02
Other carrier services[2]	19.38	19.68	20.67	22.86
Outpatient hospital	28.23	28.31	27.88	30.11
Home health	7.64	7.79	8.13	8.57
Hospital lab[3]	2.79	2.80	2.77	2.81
Other intermediary services[4]	12.32	12.44	11.47	10.97
Miscellaneous intermediary[5]	2.25	5.63	4.42	1.34
Managed care	26.12	36.06	43.86	49.56
Total services	191.56	206.34	212.07	215.55
Cost-sharing:				
Deductible	−4.48	−5.05	−5.33	−5.50
Coinsurance	−31.81	−31.18	−29.97	−29.51
Total benefits	155.27	170.12	176.76	180.54
Administrative expenses	3.39	3.37	3.03	2.71
Incurred expenditures	158.66	173.48	179.79	183.25
Value of interest	−1.27	−1.52	−1.70	−2.40

TABLE 3.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FOR FINANCING PERIODS ENDING DECEMBER 31, 2005 THROUGH DECEMBER 31, 2008—Continued

	Financing periods			
	CY 2005	CY 2006	CY 2007	CY 2008
Contingency margin for projection error and to amortize the surplus or deficit	−0.98	4.94	8.91	11.85
Monthly actuarial rate	156.40	176.90	187.00	192.70

[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] Represents intermediary Part B expenditures reported on a cash basis that have not yet been reconciled with corresponding incurred benefit costs.

TABLE 4.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FINANCING PERIODS ENDING DECEMBER 31, 2005 THROUGH DECEMBER 31, 2008

	Financing periods			
	CY 2005	CY 2006	CY 2007	CY 2008
Covered services (at level recognized):				
Physician fee schedule	81.05	80.70	80.26	77.02
Durable medical equipment	16.73	17.25	17.58	18.29
Carrier lab [1]	4.43	4.70	5.14	5.37
Other carrier services [2]	24.32	22.92	23.11	25.59
Outpatient hospital	37.51	37.98	38.53	42.01
Home health	6.25	6.50	6.91	7.42
Hospital lab [3]	4.28	4.33	4.26	4.37
Other intermediary services [4]	39.06	39.48	37.29	35.49
Miscellaneous intermediary [5]	2.59	6.22	5.00	1.57
Managed care	12.45	16.80	20.69	23.74
Total services	228.68	236.88	238.77	240.87
Cost-sharing:				
Deductible	−4.17	−4.71	−4.98	−5.14
Coinsurance	−45.63	−44.37	−33.98	−25.33
Total benefits	178.87	187.80	199.80	210.39
Administrative expenses	3.78	3.56	3.24	3.11
Incurred expenditures	182.66	191.36	203.04	213.50
Value of interest	−2.33	−3.53	−3.74	−3.83
Contingency margin for projection error and to amortize the surplus or deficit	11.47	15.87	−2.00	0.03
Monthly actuarial rate	$191.80	$203.70	$197.30	$209.70

[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] Represents intermediary Part B expenditures reported on a cash basis that have not yet been reconciled with corresponding incurred benefit costs.

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, 2008

	As of December 31		
	2006	2007	2008
This projection:			
Actuarial status (in millions):			
Assets	32,325	39,469	51,547
Liabilities	10,929	9,470	9,920
Assets less liabilities	21,396	29,999	41,627
Ratio (in percent) [1]	11.9	16.0	20.8

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, 2008—Continued

	As of December 31		
	2006	2007	2008
Low cost projection:			
Actuarial status (in millions):			
Assets	32,325	39,488	62,911
Liabilities	10,929	8,687	9,419
Assets less liabilities	21,396	30,761	53,492
Ratio (in percent) [1]	12.5	17.7	29.6
High cost projection:			
Actuarial status (in millions):			
Assets	32,325	39,448	38,098
Liabilities	10,929	10,267	10,566
Assets less liabilities	21,396	29,181	27,532
Ratio (in percent) [1]	11.4	14.5	12.4

[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 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 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 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 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 2008 are $192.70 for enrollees age 65 and over and $209.70 for disabled enrollees under age 65. It also announces the 2008 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 $82,000	Less than or equal to $164,000	$0.00	$96.40
Greater than $82,000 and less than or equal to $102,000.	Greater than $164,000 and less than or equal to $204,000.	25.80	122.20
Greater than $102,000 and less than or equal to $153,000.	Greater than $204,000 and less than or equal to $306,000.	64.50	160.90
Greater than $153,000 and less than or equal to $205,000.	Greater than $306,000 and less than or equal to $410,000.	103.30	199.70
Greater than $205,000.	Greater than $410,000.	142.00	238.40

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 $82,000	$0.00	$96.40
Greater than $82,000 and less than or equal to $123,000	103.30	199.70
Greater than $123,000	142.00	238.40

The Part B deductible for calendar year 2008 is $135.00. The standard Part B premium rate of $96.40 is 3.1 percent higher than the $93.50 premium rate for 2007. We estimate that this increase will cost approximately 41.5 million Part B enrollees about $1.4 billion for 2008. The monthly impact on the beneficiaries who are required to pay a higher premium for 2008 because their incomes exceed specified thresholds is $25.80, $64.50, $103.30, or $142.00, 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

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 formulas used to calculate the Part B premiums 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 26, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: September 26, 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. 07–4910 Filed 10–1–07; 11:18 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Project

Title: Supporting Healthy Marriage (SHM) Demonstration and Evaluation Project: 12-month Follow-up and Implementation Research Data Collection.

OMB No.: New Collection.

The Administration for Children and Families (ACF), U.S. Department of Health and Human Services, is conducting a demonstration and evaluation called the Supporting Healthy Marriage (SHM) project. SHM is a test of marriage education demonstration programs in eight separate locations that will aim to enroll up to 1,000 couples per location, up to 500 couples participating in SHM programs and 500 control group couples.

SHM is designed to inform program operators and policymakers of the most effective ways to help low-income married couples strengthen and maintain healthy marriages. In particular, the project will measure the effectiveness of marriage education programs by randomly assigning eligible volunteer couples to SHM program groups and control groups.

This data collection request includes three components. First, a survey will be administered to couples 12 months after they are enrolled in the program. The survey is designed to assess the effects of the SHM program on marital status and stability, quality of relationship with spouse, marital expectations and ideals, marital satisfaction, participation in services, parenting outcomes, child outcomes, parental well-being, employment, income, material hardship, and social support characteristics of study participants assigned to both the program and control groups. Second, survey data will be complemented by videotaped observations of couple, co-parenting, and parent-child interactions with a subset of intact and separated couples at the 12-month follow-up. Third, qualitative data will be collected through a process and implementation study in each of the eight SHM demonstration programs across the country.

These data will complement the information gathered by the SHM baseline data collection (OMB Control No. 0970–0299). The information collected at the 12-month follow-up will allow the research team to examine the effects of SHM services on outcomes of interest and to identify mechanisms that might account for these effects. The process and implementation research will consist of a qualitative component that will help ACF to better understand the results from the impact analysis as well as how to replicate programs that prove to be successful.

Respondents: Low-income married couples with children.