The estimated total increase in costs to beneficiaries is about $1,030 million (rounded to the nearest $10 million) due to—(1) the increase in the deductible and coinsurance amounts; and (2) the increase in the number of deductibles and daily coinsurance amounts paid.

V. Waiver of Proposed Notice and Comment Period

The Medicare statute, as discussed previously, requires publication of the Medicare Part A inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services for each CY. The amounts are determined according to the statute. As has been our custom, we use general notices, rather than notice and comment rulemaking procedures, to make the announcements. In doing so, we acknowledge that, under the Administrative Procedure Act (APA), interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking.

We considered publishing a proposed notice to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impracticable, unnecessary, or contrary to the public interest. We find that the procedure for notice and comment is unnecessary because the formulae used to calculate the inpatient hospital deductible and hospital and extended care services coinsurance amounts are statutorily directed, and we can exercise no discretion in following the formulae. Moreover, the statute establishes the time period for which the deductible and coinsurance amounts will apply and delaying publication would be contrary to the public interest. Therefore, we find good cause to waive publication of a proposed notice and solicitation of public comments.

VI. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

VII. Regulatory Impact Statement

We have examined the impact of this notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C., Part I, Ch. 8).

Executive Orders 12866 and 13563 direct 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). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As stated in section IV of this notice, we estimate that the total increase in costs to beneficiaries associated with this notice is about $1,030 million due to—(1) the increase in the deductible and coinsurance amounts; and (2) the increase in the number of deductibles and daily coinsurance amounts paid. Therefore, this notice is a major action as defined in Title 5, United States Code, Part I, Ch. 8), and is an economically significant action 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 small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.0 million to $34.5 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 under the RFA.

In addition, section 1102(b) of the Social Security 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 for Medicare payment regulations and has fewer than 100 beds. The Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis under 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 whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately $139 million. This notice will have no consequential effect on State, local, or tribal governments or on the private sector. However, States may be required to pay the deductibles and coinsurance for dually-eligible beneficiaries.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct 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 notice was reviewed by the Office of Management and Budget.

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

Dated: November 6, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: November 15, 2012.

Kathleen Sebelius,

Secretary.

[FR Doc. 2012–28273 Filed 11–16–12; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8048–N]

RIN 0938–AR16

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2013

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, 2013. 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 2013 are $209.80 for aged enrollees and $235.50 for disabled enrollees. The standard monthly Part B premium rate for all enrollees for 2013 is $104.90, 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 2012 standard premium rate was $99.90.) The Part B deductible for 2013 is $147.00 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.

DATES: January 1, 2013.

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 described 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 by transfers from the general fund of the Treasury.

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 of the expected average monthly cost of Part B for each aged enrollee (age 65 or over) and one-half of 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, 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 2013 Part B deductible is calculated by multiplying the 2012 deductible by the ratio of the 2013 aged actuarial rate over the 2012 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 2013, $85,000 for a beneficiary filing an individual income tax return, and $170,000 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 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, depending on income and tax filing status, a beneficiary can 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 continues 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 2012, 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, the reduced premium for the individual for that January and for each of the succeeding 11 months is the greater of—

- 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 2013 are $209.80 for enrollees age 65 and over and $235.50 for disabled enrollees under age 65. In section II.B. of this notice, we present the actuarial assumptions and bases from which these rates are derived. The Part B standard monthly premium rate for all enrollees for 2013 is $104.90. The Part B annual deductible for 2013 is $147.00. Listed below are the 2013 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 $85,000	Less than or equal to $170,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $107,000.	Greater than $170,000 and less than or equal to $214,000.	42.00	146.90
Greater than $107,000 and less than or equal to $160,000.	Greater than $214,000 and less than or equal to $320,000.	104.90	209.80
Greater than $160,000 and less than or equal to $214,000.	Greater than $320,000 and less than or equal to $428,000.	167.80	272.70
Greater than $214,000	Greater than $428,000	230.80	335.70

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 $85,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $129,000	167.80	272.70
Greater than $129,000	230.80	335.70

The Part B annual deductible for 2013 is $147.00 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 2013

Except where noted, the actuarial assumptions and bases used to determine the monthly actuarial rates and the monthly premium rates for Part B are established by the Office of the Actuary in the Centers for Medicare & Medicaid Services. The estimates underlying these determinations are prepared by actuaries meeting the qualification standards and following the actuarial standards of practice established by the Actuarial Standards Board.

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 2011 and 2012.

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)
December 31, 2011	$79,693	$15,015	$64,678
December 31, 2012	68,164	17,162	51,002

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: (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 2013 is determined by first establishing per-enrollee cost by type of service from program data through 2011 and then projecting these costs for subsequent years. The projection factors used for financing periods from January 1, 2010 through December 31, 2013 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 2013 is $198.11. 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 monthly actuarial rate of $209.80 provides an adjustment of $14.07 for a contingency margin and −$2.38 for interest earnings.

The size of the contingency margin for 2013 is affected by several factors. The largest factor involves the current law formula for physician fees, which is scheduled to result in a reduction in physician fees of nearly 30 percent in 2013. For each year from 2003 through 2012, Congress has acted to prevent physician fee reductions from occurring. In recognition of the strong possibility of substantial increase in Part B expenditures that would result from similar legislation to override the decreases in physician fees in 2013, it is appropriate to maintain a significantly larger Part B contingency reserve than would otherwise be necessary. The asset level projected for the end of 2012 is not adequate to accommodate this contingency.

As noted, the scheduled physician fee schedule reductions have been legislatively overridden for each year since 2003. During this period, lawmakers enacted physician payment updates that ranged from 0 percent to 2.2 percent; the average increase was 1 percent per year over this period. The 2012 Medicare Technical Review Panel recommended using a 1-percent physician fee schedule update assumption for alternative analysis and financial projection purposes, and the Office of the Actuary has adopted this recommendation. However, the contingency margin for the 2013 Part B premium has been calculated based on an assumption that the scheduled physician payment reduction for 2013 will be legislatively changed to 0 percent. Use of the 0-percent physician fee update assumption for purposes of the contingency margin was directed by the Secretary, who determines the Part B premium each year under section 1839 of the Act. In view of the additional data that are now available, and the continuing uncertainty associated with the legislative process, an assessment of the reasonableness of this assumption and its impact on the adequacy of Part B assets in 2013 would require substantial additional time and analysis. Such an analysis is not feasible within the available time. Accordingly, the Office of the Actuary is unable to determine the reasonableness of this assumption for the purposes of determining the contingency margin.

Another factor affecting the size of the contingency margin comes from section 302 of The Budget Control Act of 2011 (Pub. L. 112–25), which mandates a government-wide sequestration process to reduce Federal outlays. The sequestration process will automatically start in February 2013 under current law. Medicare benefit payments are subject to a maximum 2-percent reduction. Total Part B expenditures are estimated to be reduced by $4.3 billion in 2013 as a result of this sequestration. However, reductions of this dollar magnitude from the physician payment formula have been legislatively overridden in past years, and there is a possibility that the sequestration requirements will be modified or postponed before taking effect. The contingency margin has been adjusted to accommodate this possibility.

Two other, smaller factors affect the contingency margin for 2013. Starting in 2011, manufacturers and importers of brand-name prescription drugs have paid a fee that is allocated to the Part B account of the SMI trust. For 2013, the total of these brand-name drug fees is estimated to be $2.7 billion. The contingency margin has been reduced to account for this additional revenue.

Another small factor impacting the contingency margin comes from the requirement that certain payment incentives, to encourage the development and use of health information technology (HIT) by Medicare physicians, are to be excluded from the premium determination. HIT bonuses or penalties will be directly offset through transfers with the general fund of the Treasury. The monthly actuarial rate includes an adjustment of −$0.86 for HIT bonus payments in 2013.

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. To accomplish this goal, a 17 percent reserve has been the normal target used to calculate the Part B premium. In view of the strong likelihood of actual expenditures exceeding estimated levels, due to the likelihood of the enactment of legislation after the financing has been set for 2013 as a result of the scheduled 2013 physician update and, possibly in addition, the scheduled 2013 sequestration, a contingency reserve ratio in excess of 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 actuarial rate of $209.80 per month for aged beneficiaries, as announced in this notice for 2013, reflects the combined net effect of the factors previously described 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 2013 is $231.92. The monthly actuarial rate of $235.50 also provides an adjustment of −$4.07 for interest earnings and $7.65 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 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 an appropriate level.

The actuarial rate of $235.50 per month for disabled beneficiaries, as announced in this notice for 2013, 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 cost growth rate 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 $71,851 million by the end of December 2013 under the cost growth rate assumptions used in preparing this report and assuming that the provisions of current law are fully implemented. This amounts to 28.5 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 $38,839 million by the end of December 2013 under current law, which amounts to 13.8 percent of the estimated total incurred expenditures for the following year. If the physician fee reduction and the scheduled 2-percent sequestration of Medicare expenditures were legislatively overridden, the ratio under the pessimistic assumptions would be very close to zero. Under fairly optimistic assumptions, the monthly actuarial rates would result in a surplus of $96,011 million by the end of December 2013, or 42.0 percent of the estimated total incurred expenditures for the following year.

The previous analysis indicates that the premium and general revenue financing established for 2013, together with existing Part B account assets would be adequate to cover estimated Part B costs for 2013 under current law, even if actual costs prove to be somewhat greater than expected.

5. Premium Rates and Deductible

As determined in accordance with section 1839 of the Act, listed are the 2013 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 $85,000	Less than or equal to $170,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $107,000.	Greater than $170,000 and less than or equal to $214,000.	42.00	146.90
Greater than $107,000 and less than or equal to $160,000.	Greater than $214,000 and less than or equal to $320,000.	104.90	209.80
Greater than $160,000 and less than or equal to $214,000.	Greater than $320,000 and less than or equal to $428,000.	167.80	272.70
Greater than $214,000	Greater than $428,000	230.80	335.70

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 $85,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $129,000	167.80	272.70
Greater than $129,000	230.80	335.70

TABLE 2—PROJECTION FACTORS [1] 12-MONTH PERIODS ENDING DECEMBER 31 OF 2010–2013

[In percent]

Calendar year	Physicians' services		Durable medical equipment	Carrier lab [4]	Other carrier services [5]	Out-patient hospital	Home health agency	Hospital lab [6]	Other intermediary services [7]	Managed care
	Fees [2]	Residual [3]								
Aged:										
2010	2.5	1.4	1.8	1.4	3.4	5.1	2.4	2.2	1.0	−1.8
2011	0.9	1.8	−3.9	−2.9	4.5	7.6	−1.6	4.9	4.4	0.9
2012	−1.0	2.6	4.4	6.8	3.6	9.3	0.5	5.1	8.1	2.6
2013	−28.5	8.1	−0.3	2.9	5.0	5.6	1.7	1.6	−6.4	4.3

TABLE 2—PROJECTION FACTORS [1] 12-MONTH PERIODS ENDING DECEMBER 31 OF 2010–2013—Continued

[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]								
Disabled:										
2010	2.5	2.9	2.7	−3.9	3.2	5.4	1.1	0.5	−0.1	−0.9
2011	0.9	1.9	−2.2	3.7	3.5	8.3	−1.4	7.2	0.9	1.3
2012	−1.0	2.5	4.4	21.8	3.5	10.3	2.1	4.3	7.4	0.9
2013	−28.5	8.0	−0.4	2.8	4.9	5.5	2.7	1.6	−0.6	4.6

[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, 2010 THROUGH DECEMBER 31, 2013

	Financing periods			
	CY 2010	CY 2011	CY 2012	CY 2013
Covered services (at level recognized):				
Physician fee schedule	80.62	81.75	81.25	62.90
Durable medical equipment	8.94	8.49	8.67	8.66
Carrier lab [1]	4.31	4.13	4.32	4.45
Other carrier services [2]	21.23	21.89	22.20	23.36
Outpatient hospital	32.93	34.99	37.41	39.58
Home health	11.85	11.50	11.31	11.53
Hospital lab [3]	3.66	3.79	3.90	3.97
Other intermediary services [4]	14.18	14.62	15.47	14.50
Managed care	54.74	57.06	61.63	64.00
Total services	232.47	238.22	246.16	232.95
Cost sharing:				
Deductible	−5.91	−6.19	−5.37	−5.62
Coinsurance	−30.91	−30.92	−31.77	−28.13
HIT payment incentives	0.00	−0.17	−0.74	−0.86
Total pre-sequester benefits	195.64	200.94	208.28	198.34
Pre-sequester administrative expenses	2.94	3.29	3.66	3.43
Sequester	0.00	0.00	0.00	−3.65
Incurred expenditures	198.58	204.23	211.94	198.11
Value of interest	−2.74	−2.52	−2.12	−2.38
Contingency margin for projection error and to amortize the surplus or deficit	25.16	28.99	−10.02	14.07
Monthly actuarial rate	221.00	230.70	199.80	209.80

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

TABLE 4—DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FOR FINANCING PERIODS ENDING DECEMBER 31, 2010 THROUGH DECEMBER 31, 2013

	Financing periods			
	CY 2010	CY 2011	CY 2012	CY 2013
Covered services (at level recognized):				
Physician fee schedule	85.33	86.85	86.45	66.85
Durable medical equipment	16.89	16.24	16.62	16.59
Carrier lab [1]	5.84	5.10	6.05	6.24
Other carrier services [2]	25.89	26.27	26.38	27.72
Outpatient hospital	46.13	49.37	53.31	56.33
Home health	10.10	9.82	9.82	10.11
Hospital lab [3]	5.16	5.38	5.50	5.59
Other intermediary services [4]	41.05	41.70	42.66	42.61
Managed care	40.77	43.51	47.40	48.99

TABLE 4—DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FOR FINANCING PERIODS ENDING DECEMBER 31, 2010 THROUGH DECEMBER 31, 2013—Continued

	Financing periods			
	CY 2010	CY 2011	CY 2012	CY 2013
Total services	277.16	284.24	294.20	281.03
Cost sharing:				
Deductible	−5.55	−5.81	−5.05	−5.28
Coinsurance	−45.71	−46.19	−46.76	−42.62
HIT payment incentives	0.00	−0.18	−0.77	−0.90
Total pre-sequester benefits	225.90	232.05	241.62	232.23
Pre-sequester administrative expenses	3.38	3.80	4.26	3.97
Sequester	0.00	0.00	0.00	−4.27
Incurred expenditures	229.28	235.85	245.87	231.92
Value of interest	−4.05	−5.05	−4.52	−4.07
Contingency margin for projection error and to amortize the surplus or deficit	45.17	35.49	−48.85	7.65
Monthly actuarial rate	270.40	266.30	192.50	235.50

[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 5—ACTUARIAL STATUS OF THE PART B ACCOUNT IN THE SMI TRUST FUND UNDER THREE SETS OF ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 2013

As of December 31,	2011	2012	2013
This projection:			
Actuarial status (in millions):			
Assets	79,693	68,164	88,193
Liabilities	15,015	17,162	16,341
Assets less liabilities	64,678	51,002	71,851
Ratio (in percent) [1]	26.6	21.7	28.5
Low cost projection:			
Actuarial status (in millions):			
Assets	79,693	77,325	111,554
Liabilities	15,015	16,144	15,542
Assets less liabilities	64,678	61,180	96,011
Ratio (in percent) [1]	27.8	28.2	42.0
High cost projection:			
Actuarial status (in millions):			
Assets	79,693	57,291	55,997
Liabilities	15,015	18,370	17,158
Assets less liabilities	64,678	38,921	38,839
Ratio (in percent) [1]	25.3	15.2	13.8

[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. These estimates are based on the assumption that all provisions of current law will be implemented in full, including (i) the approximately 28.0-percent reduction in Medicare payment rates to physicians required by the statutory ''sustainable growth rate'' formula, and (ii) the sequestration of up to 2 percent of all Medicare payments to providers and plans as required by the Budget Control Act of 2011. Under the intermediate projection assumptions (as shown in table 2), if the 2013 physician payment reduction were overridden through new legislation, then the Part B asset reserve ratio for December 31, 2013 would be approximately 9.3 percentage points lower than shown here. If, in addition, the 2013 sequestration were similarly overridden, then the reserve ratios at the end of 2013 would be reduced by approximately another 2 percentage points. The impacts of these potential overrides on the 2013 reserve ratio for the low cost and high cost projections would be similar.

III. Regulatory Impact Analysis

A. Statement of Need

Section 1839 of the Act requires us to annually announce (that is by September 30th of each year) the Part B monthly actuarial rates for aged and disabled beneficiaries as well as the monthly Part B premium. We also announce the Part B annual deductible because its determination is directly linked to the aged actuarial rate.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96 354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism

(August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2).

Executive Orders 12866 and 13563 direct 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). A regulatory impact analysis (RIA) must be prepared for major notice with economically significant effects ($100 million or more in any 1 year).

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. 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 $7.0 million to $34.5 million in any 1 year. Individuals and States are not included in the definition of a small entity. This notice will not have a significant impact on a substantial number of small businesses or other small entities. Therefore, the Secretary has determined that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this notice will not have a significant effect on a substantial number of small entities or on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately $139 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 2013 are $209.80 for enrollees age 65 and over and $235.50 for disabled enrollees under age 65. It also announces the 2013 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 $85,000	Less than or equal to $170,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $107,000.	Greater than $170,000 and less than or equal to $214,000.	42.00	146.90
Greater than $107,000 and less than or equal to $160,000.	Greater than $214,000 and less than or equal to $320,000.	104.90	209.80
Greater than $160,000 and less than or equal to $214,000.	Greater than $320,000 and less than or equal to $428,000.	167.80	272.70
Greater than $214,000	Greater than $428,000	230.80	335.70

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 in the following chart.

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 $85,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $129,000	167.80	272.70
Greater than $129,000	230.80	335.70

The standard Part B premium rate of $104.90 is 5 percent higher than the $99.90 premium rate for 2012. We estimate that this increase will cost approximately 48.1 million Part B enrollees about $2.4 billion for 2013. Therefore, this notice is a major rule as defined in 5 U.S.C. 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. 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. Moreover, we find that notice and comment are unnecessary because the formulas used to calculate the Part B premiums are statutorily directed. Therefore, we find good cause to waive publication of a proposed notice and solicitation of public comments.

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

Dated: November 15, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: November 15, 2012.

Kathleen Sebelius,

Secretary. Department of Health and Human Services.

[FR Doc. 2012–28275 Filed 11–16–12; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8047–N]

RIN 0938–AR15

Medicare Program; Part A Premiums for CY 2013 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

ACTION: Notice.

SUMMARY: This annual notice announces Medicare's Hospital Insurance (Part A) premium for uninsured enrollees in calendar year (CY) 2013. This premium is paid by enrollees age 65 and over who are not otherwise eligible for benefits under Medicare Part A (hereafter known as the ''uninsured aged'') and by certain disabled individuals who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning January 1, 2013, for these individuals will be $441. The reduced premium for certain other individuals as described in this notice will be $243.

DATES: This notice is effective on January 1, 2013.

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

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare Hospital Insurance Program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors, and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. These ''uninsured aged'' individuals are uninsured under the OASDI program or the Railroad Retirement Act, because they do not have 40 quarters of coverage under Title II of the Act (or are/were not married to someone who did). (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for Medicare Part A.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium for certain disabled individuals who have exhausted other entitlement. These are individuals who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, but who are no longer entitled to disability benefits and free Medicare Part A coverage because they have gone back to work and their earnings exceed the statutorily defined ''substantial gainful activity'' amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through section 1818(f) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 1818(d) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the impending calendar year (CY) (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of $1, the premium is rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not of $1, it is rounded to the next highest $1).

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary enrollees (section 1818 and section 1818A of the Act). The reduction applies to an individual who is eligible to buy into the Medicare Part A program and who, as of the last day of the previous month—

- Had at least 30 quarters of coverage under Title II of the Act;
- Was married, and had been married for the previous 1-year period, to a person who had at least 30 quarters of coverage;
- Had been married to a person for at least 1 year at the time of the person's death if, at the time of death, the person had at least 30 quarters of coverage; or
- Is divorced from a person and had been married to the person for at least 10 years at the time of the divorce if, at the time of the divorce, the person had at least 30 quarters of coverage.

Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for CY 2013 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for CY 2013

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 2013, is $441.

The monthly premium for those individuals subject to the 45 percent reduction in the monthly premium is $243.

III. Monthly Premium Rate Calculation

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for CY 2013 rounded to the nearest multiple of $1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of Part A enrollees aged 65 years and over as well as the benefits and administrative costs that will be incurred on their behalf.