VI. Regulatory Impact Statement

We have examined the impacts of this notice as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when 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 for small businesses. For purposes of the RFA, States and individuals are not considered small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any notice that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we consider a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 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.

This notice announces that the inpatient hospital deductible for calendar year 1999 is $768. It also announces the daily coinsurance amounts of $192 for the 61st through 90th day of hospitalization in a benefit period; $384 for lifetime reserve days; and $96 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period. We believe that the total increase in costs to beneficiaries associated with this notice is about $100 million due to (1) the increase in the deductible and coinsurance amounts and (2) the change in the number of deductibles and daily coinsurance amounts paid. Therefore, this notice is a major rule as defined in Title 5, United States Code, section 804(2) and is an economically significant rule under Executive Order 12866.

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

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

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

Dated: September 18, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: October 8, 1998.

Donna E. Shalala,

Secretary.

[FR Doc. 98–28162 Filed 10–16–98; 9:34 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–8003–N]

RIN 0938–AI98

Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 1999

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: As required by section 1839 of the Social Security Act, this notice announces the monthly actuarial rates for aged (age 65 or over) and disabled (under age 65) enrollees in the Medicare Supplementary Medical Insurance (SMI) program for 1999. It also announces the monthly SMI premium rate to be paid by all enrollees during 1999. The monthly actuarial rates for 1999 are $92.30 for aged enrollees and $103.00 for disabled enrollees. The monthly SMI premium rate for 1999 is $45.50. (The 1998 premium rate was $43.80). The 1999 Part B premium is not equal to 50 percent of the monthly actuarial rate because of the differential between the amount of home health that is transferred into Part B in 1999 (two-sixths) and the amount in Part B that is included in the premium calculation (two-sevenths).

EFFECTIVE DATE: January 1, 1999.

FOR FURTHER INFORMATION CONTACT: Carter S. Warfield, (410) 786–6396.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare Supplementary Medical Insurance (SMI) program is the voluntary Medicare Part B program that pays all or part of the costs for physicians' services, outpatient hospital services, home health services, services furnished by rural health clinics, ambulatory surgical centers, comprehensive outpatient rehabilitation facilities, and certain other medical and health services not covered by hospital insurance (HI) (Medicare Part A). The SMI program is available to individuals who are entitled to HI and to U.S. residents who have attained age 65 and are citizens, or aliens who were lawfully admitted for permanent residence and have resided in the United States for 5 consecutive years. This program requires enrollment and payment of monthly premiums, as provided in 42 CFR part 407, subpart B, and part 408, respectively. The difference between the premiums paid by all enrollees and total incurred costs is met from the general revenues of the Federal government.

The Secretary of Health and Human Services is required by section 1839 of the Social Security Act (the Act) to issue two annual notices relating to the SMI program.

One notice announces two amounts that, according to actuarial estimates, will equal respectively, one-half the expected average monthly cost of SMI for each aged enrollee (age 65 or over) and one-half the expected average monthly cost of SMI for each disabled enrollee (under age 65) during the year beginning the following January. These amounts are called ''monthly actuarial rates.''

The second notice announces the monthly SMI premium rate to be paid by aged and disabled enrollees for the year beginning the following January. (Although the costs to the program per disabled enrollee are different than for the aged, the law provides that they pay the same premium amount.) Beginning with the passage of section 203 of the Social Security Amendments of 1972 (Public Law 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 (Public Law 98–21), section 2302 of the Deficit Reduction Act of 1984 (DRA 1984) (Public Law 98–369), section 9313 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985) (Public Law 99–272), section 4080 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Public Law 100–203), and section 6301 of the Omnibus Budget Reconciliation Act of

1989 (OBRA 1989) (Public Law 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 1990) (Public Law 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 1993) (Public Law 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 1997) (Public Law 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).

BBA 1997 included a further provision affecting the calculation of the SMI actuarial rates and premiums for 1998 though 2003. Section 4611 of BBA 1997 modified the home health benefit payable under the HI program for individuals enrolled in the SMI program. In doing so, expenditures for home health services not considered ''post-institutional'' will be payable under the SMI program rather than the HI program beginning in 1998. However, section 4611(e)(1) of BBA 1997 requires that there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from the HI program to the SMI program. Section 4611(e)(2) also provides a specific yearly proportion for the transferred funds. The proportions are 1/6 for 1998, 1/3 for 1999, 1/2 for 2000, 2/3 for 2001, and 5/6 for 2002. For purposes of determining the correct amount of financing from general revenues of the Federal government, it is necessary to include only these transitional amounts in the monthly actuarial rates for both aged and disabled enrollees, rather than the total cost of the home health services being transferred. Accordingly, the actuarial rates shown in this announcement reflect the net transitional cost only.

Section 4611(e)(3) of BBA 1997 also specifies, for the purposes of determining the premium, that the monthly actuarial rate for aged enrollees shall be computed as though the transition would occur for 1998 through 2003 and that 1/7 of the cost would 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 is 7 years while the transition period for including these services in the actuarial rate is 6 years. As a result, the premium rate for this year and each of the next 4 years, through 2003, will be less than 50 percent of the actuarial rate for aged enrollees announced by the Secretary.

New section 1933(c)(2) of the Act, as added by section 4732(c) of BBA 1997, requires the Secretary to allocate money from the SMI trust fund to the State Medicaid programs for the purpose of providing Medicare Part B premium assistance from 1998 through 2002 for the section 1933 qualifying low-income Medicare beneficiaries. This allocation, while not a benefit expenditure, will be an expenditure of the trust fund and has been included in calculating the SMI actuarial rates for this year. The allocation will be included in calculating the SMI actuarial rates through 2002.

As determined according to section 1839(a)(3) of the Act and section 4611(e)(3) of BBA 1997, the premium rate for 1999 is $45.50.

A further provision affecting the calculation of the SMI premium is section 1839(f) of the Act, as amended by section 211 of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360). (The Medicare Catastrophic Coverage Repeal Act of 1989 (Public Law 101–234) did not repeal the revisions to section 1839(f) made by Public Law 100–360.) Section 1839(f) provides that if an individual is entitled to benefits under section 202 or 223 of the Act (the Old-Age and Survivors Insurance Benefit and the Disability Insurance Benefit, respectively) and has the SMI premiums deducted from these benefit payments, the premium increase will be reduced to avoid causing a decrease in the individual's net monthly payment. This occurs if the increase in the individual's social security benefit due to the cost-of-living adjustment under section 215(i) of the Act is less than the increase in the premium. Specifically, the reduction in the premium amount applies if the individual is entitled to benefits under section 202 or 223 of the Act for November and December of a particular year and the individual's SMI premiums for December and the following January are deducted from the respective month's section 202 or 223 benefits. (A check for benefits under section 202 or 223 is received in the month following the month for which the benefits are due. The SMI premium that is deducted from a particular check is the SMI payment for the month in which the check is received. Therefore, a benefit check for November is not received until December, but has the December's SMI premium deducted from it.) (This change, in effect, perpetuates former amendments that prohibited SMI premium increases from reducing an individual's benefits in years in which the dollar amount of the individual's cost-of-living increase in benefits was not at least as great as the dollar amount of the individual's SMI premium increase.)

Generally, if a beneficiary qualifies for this protection (that is, the beneficiary must have been 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 223 of the Act is the greater of the following:

(1) The monthly premium for January reduced as necessary to make the December monthly benefits, after the deduction of the SMI premium for January, at least equal to the preceding November's monthly benefits, after the deduction of the SMI premium for December; or

(2) The monthly premium for that individual for that December.

In determining the premium limitations under section 1839(f) of the Act, the monthly benefits to which an individual is entitled under section 202 or 223 do not include retroactive adjustments or payments and deductions on account of work. Also, once the monthly premium amount has been established under section 1839(f) of the Act, it will not be changed during the year even if there are retroactive adjustments or payments and deductions on account of work that apply to the individual's monthly benefits.

Individuals who have enrolled in the SMI program late or have reenrolled after the termination of a coverage period are subject to an increased premium under section 1839(b) of the Act. That increase is a percentage of the premium and is based on the new premium rate before any reductions under section 1839(f) are made.

II. Notice of Monthly Actuarial Rates and Monthly Premium Rate

The monthly actuarial rates applicable for 1999 are $92.30 for enrollees age 65 and over, and $103.00 for disabled enrollees under age 65.

Section III of this notice gives the actuarial assumptions and bases from which these rates are derived. The monthly premium rate will be $45.50 during 1999. This is an increase from the 1998 premium rate of $43.80.

III. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Actuarial Rates and the Monthly Premium Rate for the Supplementary Medical Insurance Program Beginning January 1999

A. Actuarial Status of the Supplementary Medical Insurance Trust Fund

Under the law, the starting point for determining the monthly premium is the amount that would be necessary to finance the SMI program on an incurred basis; that is, the amount of income that would be sufficient to pay for services furnished during that year (including associated administrative costs) even though payment for some of these services will not be made until after the close of the year. The portion of income required to cover benefits not paid until after the close of the year is added to the trust fund and used when needed.

The rates are established prospectively and are, therefore, subject to projection error. Additionally, legislation enacted after the financing has been established, but effective for the period for which the financing has been set, may affect program costs. As a result, the income to the program may not equal incurred costs. Therefore, trust fund assets should be maintained at a level that is adequate to cover a moderate degree of variation between actual and projected costs (in addition to the amount of incurred but unpaid expenses). An appropriate level for assets to cover a moderate degree of variation between actual and projected costs depends on numerous factors. The most important of these factors are: (1) The difference from prior years between the actual performance of the program and estimates made at the time financing was established, and (2) the expected relationship between incurred and cash expenditures. Ongoing analysis is made of both factors as the trends vary over time.

Table 1 summarizes the estimated actuarial status of the trust fund as of the end of the financing period for 1997 and 1998.

TABLE 1.—ESTIMATED ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND AS OF THE END OF THE FINANCING PERIOD

[In billions of dollars]

Financing period ending	Assets	Liabilities	Assets less liabilities
December 31, 1997	$36.131	$6.681	$29.450
December 31, 1998	36.754	4.422	32.332

B. Monthly Actuarial Rate for Enrollees Age 65 and Older

The monthly actuarial rate for enrollees age 65 and older is one-half of the monthly projected cost of benefits, the Medicaid transfer (for 1998 through 2002), and administrative expenses for each enrollee age 65 and older, adjusted to allow for interest earnings on assets in the trust fund and a contingency margin. The contingency margin is an amount appropriate to provide for a moderate degree of variation between actual and projected costs and to amortize any surplus or unfunded liabilities. As noted in section I. of this announcement, section 4611(e)(2) of BBA 1997 requires that only ⅓ of the cost of the home health services being transferred be included in the actuarial rate for 1999, rather than the full cost of such benefits.

The monthly actuarial rate for enrollees age 65 and older for 1999 was determined by first establishing per-enrollee cost by type of service from program data through 1996 and then projecting these costs for subsequent years. Although the actuarial rates are now applicable for calendar years, projections of per-enrollee costs were determined on a July to June period, consistent with the July annual fee screen update used for benefits before the passage of section 2306(b) of DRA 1984. Accordingly, the values for the 12-month period ending June 30, 1996 were established from program data, and subsequent periods were projected using a combination of program data and data from external sources. The projection factors used are shown in Table 2. Those per-enrollee values are then adjusted to apply to a calendar year period. The projected values for financing periods from January 1, 1996, through December 31, 1999, are shown in Table 3.

The projected monthly rate required to pay for one-half of the total of benefits, the transfer to Medicaid, and administrative costs for enrollees age 65 and over for 1999 is $110.97. Included in the total of $110.97 is $12.91 for home health services and $33.44 for group practice prepayment plan services. The amount of $12.91 for home health services includes (1) the full cost of fee-for-service home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply ($12.51) as well as (2) the cost of furnishing all home health services to those individuals enrolled in SMI only ($0.40). The amount of $33.44 for group practice prepayment plan services includes (1) the full cost of managed care home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply ($3.11) as well as (2) the cost of furnishing all other SMI services to those individuals enrolled in group practice prepayment plans ($30.33). Since section 4611(e)(2) of BBA 1997 requires that only ⅓ of the cost for those services being transferred be included in the actuarial rate for 1999, the monthly actuarial rate provides for an adjustment of −$10.41, representing ⅔ of the full cost of such services. The monthly actuarial rate of $92.30 also provides an adjustment of −$3.65 for interest earnings and −$4.61 for a contingency margin. Based on current estimates, it appears that the assets are more than sufficient to cover the amount of incurred but unpaid expenses and to provide for a moderate degree of variation between actual and projected costs. Thus, a negative contingency margin is needed to reduce assets to a more appropriate level.

C. Monthly Actuarial Rate for Disabled Enrollees

Disabled enrollees are those persons enrolled in SMI because of entitlement (before age 65) to disability benefits for more than 24 months or because of entitlement to Medicare under the end-stage renal disease program. Projected monthly costs for disabled enrollees (other than those suffering from end-stage renal disease) are prepared in a fashion exactly parallel to the projection for the aged, using appropriate actuarial

assumptions (see Table 2). Costs for the end-stage renal disease program are projected differently because of the different nature of services offered by the program. The combined results for all disabled enrollees are shown in Table 4.

The projected monthly rate required to pay for one-half of the total of benefits, the transfer to Medicaid, and administrative costs for disabled enrollees for 1999 is $119.77. Included in the total of $119.77 is $16.70 for home health services and $8.23 for group practice prepayment plan services. The amount of $16.70 is the full cost of the home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply. The amount of $8.23 for group practice prepayment plan services includes (1) the full cost of managed care home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply ($1.07) as well as (2) the cost of furnishing all other SMI services to those individuals enrolled in group practice prepayment plans ($7.16). Since section 4611(e)(2) of BBA 1997 requires that only ⅓ of the cost for those services being transferred be included in the actuarial rate for 1999, the monthly actuarial rate provides for an adjustment of −$11.84, representing ⅔ of the full cost of such services. The monthly actuarial rate of $103.00 also provides an adjustment of −$0.27 for interest earnings and −$4.66 for a contingency margin. Based on current estimates, it appears that the assets are more than sufficient to cover the amount of incurred but unpaid expenses and to provide for a moderate degree of variation between actual and projected costs. Thus, a negative contingency margin is needed to reduce assets to a more appropriate level.

D. Sensitivity Testing

Several factors contribute to uncertainty about future trends in medical care costs. In view of this, it is appropriate to test the adequacy of the rates announced here using alternative assumptions. The most unpredictable factors that contribute significantly to future costs are outpatient hospital costs, physician residual (as defined in Table 2), and increases in physician fees as governed by the program's physician fee schedule. Two alternative sets of assumptions and the results of those assumptions are shown in Table 5. One set represents increases that are lower and is, therefore, more optimistic than the current estimate. The other set represents increases that are higher and is, therefore, more pessimistic than the current version. The values for the alternative assumptions were determined by studying the average historical variation between actual and projected increases in the respective increase factors. All assumptions not shown in Table 5 are the same as in Table 2.

Table 5 indicates that, under the assumptions used in preparing this report, the monthly actuarial rates would result in an excess of assets over liabilities of $29.222 billion by the end of December 1999. This amounts to 30.7 percent of the estimated total incurred expenditures for the following year. Assumptions that are somewhat more pessimistic (and, therefore, test the adequacy of the assets to accommodate projection errors) produce a surplus of $14.857 billion by the end of December 1999, which amounts to 14.3 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 $42.551 billion by the end of December 1999, which amounts to 48.6 percent of the estimated total incurred expenditures for the following year.

E. Premium Rate

As determined by section 1839(a)(3) of the Act and section 4611(e)(3) of BBA 1997, the monthly premium rate for 1999, for both aged and disabled enrollees, is $45.50.

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Table 2.--PROJECTION FACTORS 1/
12-MONTH PERIODS ENDING JUNE 30 OF 1996-2000
(In Percent)

12-month period ending June 30	Physicians' Services		Outpatient hospital services	Home health agency services 4/	Group practice prepayment plans	Independent lab services
	Fees 2/	Residual 3/				
Aged:						
1996	2.2	1.9	0.5	14.1	24.4	-6.6
1997	0.5	0.7	4.0	5.7	23.9	-3.0
1998	1.0	2.3	-2.2	5/	34.5	-0.4
1999	1.3	0.8	2.7	95.2 5/	44.9	-0.4
2000	0.4	-2.4	0.9	1.9	16.3	-1.0
Disabled:						
1996	2.2	0.5	10.1	0.0	15.5	0.1
1997	0.5	0.7	7.1	0.0	20.9	3.3
1998	1.0	1.4	-1.8	5/	29.0	-2.5
1999	1.3	2.6	-0.9	98.4 5/	55.7	-4.9
2000	0.4	-3.5	-3.1	-1.6	35.2	-9.6

1/ All values are per 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/ From July 1, 1981 to December 31, 1997, home health agency services have been provided by the SMI program only for those SMI enrollees not entitled to HI. Otherwise these services were provided by the HI program. Since all SMI disabled enrollees are entitled

to HI, their coverage of these services has been provided by the HI program during this period.

5/ Effective January 1, 1998, the coverage of home health agency services not considered "post-institutional" for those individuals entitled to HI and enrolled in SMI will be transferred from the HI program to the SMI program. As a result, as of January 1, 1998, there will be a large increase in SMI expenditures for these services for the aged enrollees, and SMI coverage for these services will resume for disabled enrollees.

Table 3.--DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FINANCING PERIODS ENDING DECEMBER 31, 1996 THROUGH DECEMBER 31, 1999

	Financing Periods			
	CY 1996	CY 1997	CY 1998	CY 1999
Covered services (at level recognized):				
Physicians' reasonable charges	$61.67	$63.11	$64.85	$64.87
Outpatient hospital and other institutions	21.41	21.60	21.64	22.03
Home health agencies	0.32	0.33	12.71 1/	12.91 1/
Group practice prepayment plans	14.34	17.67	27.06 2/	33.44 2/
Independent lab	2.29	2.25	2.24	2.23
Total services	100.03	104.96	128.50	135.48
Cost-sharing:				
Deductible	-3.80	-3.84	-3.86	-3.87
Coinsurance	-18.53	-19.71	-21.33	-22.59
Total benefits	77.70	81.41	103.31	109.02
Transfer to Medicaid	0.00	0.00	0.30 3/	0.30 3/
Administrative expenses	2.04	1.53	1.59	1.65
Incurred expenditures	79.74	82.94	105.20	110.97
Value of interest	-2.33	-3.11	-3.71	-3.65
Adjustment for home health agency services transferred from HI	0.00	0.00	-13.38 4/	-10.41 4/

Contingency margin for projection error and to amortize the surplus or deficit	7.49	7.77	-0.21	-4.61
Monthly actuarial rate	$84.90	$87.60	$87.90	92.30

1/ This amount includes the full cost of the fee-for-service home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply, as well as the cost of furnishing all home health services to those individuals enrolled in SMI only.

2/ This amount includes the full cost of the managed care home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply, as well as the cost of furnishing all other SMI services to individuals enrolled in group practice prepayment plans.

3/ Section 1933(c)(2) of the Act, as added by section 4732(c) of BBA 1997, allocates an amount to be transferred from the SMI trust fund to the State Medicaid programs. The transfer is for the purpose providing Medicare Part B premium assistance for qualifying low-income Medicare beneficiaries. It is not a benefit expenditure but is used in determining the SMI actuarial rates since it is an expenditure of the trust fund.

4/ Section 4611 of BBA 1997 specifies that expenditures for home health services not considered "post-institutional" will be payable under the SMI program rather than the HI program beginning in 1998. However, section 4611(e)(1) requires that there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from the HI program to the SMI program. For 1998, the amount transferred is 1/6 of the full cost for such services and for 1999, 1/3. Therefore, the adjustment for 1998 represents 5/6 of the full cost, and for 1999, 2/3. This amount adjusts the actuarial rate to reflect the correct amount attributable to home health services.

Table 4.--DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FINANCING PERIODS ENDING DECEMBER 31, 1996 THROUGH DECEMBER 31, 1999

	Financing Periods			
	CY 1996	CY 1997	CY 1998	CY 1999
Covered services (at level recognized):				
Physicians' reasonable charges	$66.77	$68.38	$69.30	$68.24
Outpatient hospital and other institutions	47.88	49.19	49.65	49.66
Home health agencies	0.00	0.00	16.81 1/	16.70 1/
Group practice prepayment plans	3.20	3.68	6.09 2/	8.23 2/
Independent lab	3.03	3.07	3.04	2.85
Total services	120.88	124.32	144.89	145.68
Cost-sharing:				
Deductible	-3.59	-3.62	-3.64	-3.65
Coinsurance	-22.83	-23.59	-24.09	-24.34
Total benefits	94.46	97.11	117.16	117.69
Transfer to Medicaid	0.00	0.00	0.29 3/	0.30 3/
Administrative expenses	2.48	1.81	1.78	1.78
Incurred expenditures	96.94	98.92	119.23	119.77
Value of interest	-0.29	-0.61	-0.73	-0.27
Adjustment for home health agency services transferred from HI	0.00	0.00	-15.09 4/	-11.84 4/

Contingency margin for projection error and to amortize the surplus or deficit	8.45	12.09	-6.31	-4.66
Monthly actuarial rate	$105.10	$110.40	$97.10	$103.00

1/ This amount includes the full cost of the fee-for-service home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply.

2/ This amount includes the full cost of the managed care home health services being transferred from the HI program as a result of BBA 1997 as if the transition did not apply, as well as the cost of furnishing all other SMI services to individuals enrolled in group practice prepayment plans.

3/ Section 1933(c)(2) of the Act, as added by section 4732(c) of BBA 1997, allocates an amount to be transferred from the SMI trust fund to the State Medicaid programs. The transfer is for the purpose providing Medicare Part B premium assistance for qualifying low-income Medicare beneficiaries. It is not a benefit expenditure but is used in determining the SMI actuarial rates since it is an expenditure of the trust fund.

4/ Section 4611 of BBA 1997 specifies that expenditures for home health services not considered "post-institutional" will be payable under the SMI program rather than the HI program beginning in 1998. However, section 4611(e)(1) requires that there be a transition from 1998 through 2002 for the aggregate amount of the expenditures transferred from the HI program to the SMI program. For 1998, the amount transferred is 1/6 of the full cost for such services and for 1999, 1/3. Therefore, the adjustment for 1998 represents 5/6 of the full cost and for 1999, 2/3. This amount adjusts the actuarial rate to reflect the correct amount attributable to home health services.

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Table 5.--ACTUARIAL STATUS OF THE SMI TRUST FUND UNDER THREE SETS OF ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 1999

	This projection			Low cost projection			High cost projection		
	12-Month period ending June 30,			12-Month period ending June 30,			12-Month period ending June 30,		
	1998	1999	2000	1998	1999	2000	1998	1999	2000
Projection factors (in percent):									
Physician fees 1/									
Aged	1.0	1.3	0.4	0.8	0.2	-1.4	1.3	2.5	2.3
Disabled	1.0	1.3	0.4	0.8	0.2	-1.4	1.3	2.5	2.3
Utilization of physician services 2/									
Aged	2.3	0.8	-2.4	0.5	-1.4	-4.9	4.2	3.0	0.0
Disabled	1.4	-2.6	-3.5	-1.5	-5.6	-6.6	4.4	0.4	-0.4
Outpatient hospital services per enrollee									
Aged	-2.2	2.7	0.9	-6.6	-1.9	-4.0	2.2	7.2	5.9
Disabled	-1.8	-0.9	-3.1	-7.1	-6.4	-8.7	3.6	4.7	2.6
	As of December 31,			As of December 31,			As of December 31,		
	1997	1998	1999	1997	1998	1999	1997	1998	1999
Actuarial status (in billions):									
Assets	$36.131	$36.754	$34.278	$36.131	$40.595	$44.566	$36.131	$32.711	$23.048
Liabilities	6.681	4.422	5.056	4.089	1.625	2.015	9.313	7.274	8.191
Assets less liabilities	$29.450	$32.332	$29.222	$32.042	$38.970	$42.551	$26.818	$25.437	$14.857
Ratio of assets less liabilities to expenditures (in percent) 3/	37.6	36.3	30.7	43.0	47.1	48.6	32.5	26.5	14.3

1/ As recognized for payment under the program.
2/ Increase in the number of services received per enrollee and greater relative use of more expensive services.
3/ Ratio of assets less liabilities at the end of the year to total incurred expenditures during the following year, expressed as a percent.

IV. Waiver of Notice of Proposed Rulemaking

The Medicare statute, as discussed previously, requires publication of the monthly actuarial rates and the Part B premium amount in September. The amounts are determined according to the statute. As has been our custom, we use general notices, rather than formal notice and comment rulemaking procedures, to make such announcements. In doing so, we acknowledge that, under the Administrative Procedure Act, interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking.

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

VI. Regulatory Impact Statement

We have examined the impacts of this notice as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when 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 for small businesses. For purposes of the RFA, States and individuals are not considered small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any notice that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we consider a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 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.

This notice announces that the monthly actuarial rates applicable for 1999 are $92.30 for enrollees age 65 and over, and $103.00 for disabled enrollees under age 65. It also announces that the monthly SMI premium rate for calendar year 1999 is $45.50. The SMI premium rate of $45.50 is 3.9 percent higher than the $43.80 premium rate for 1998. We estimate that the cost of this increase from the current premium to the approximately 37 million SMI enrollees will be about $0.754 billion for 1999. 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.

(Section 1839 of the Social Security Act; 42 U.S.C. 1395r)
(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance)

Dated: September 28, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: October 8, 1998.

Donna E. Shalala,

Secretary.

[FR Doc. 98–28163 Filed 10–16–98; 8:45 am]
BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–8000–N]

RIN 0938–AJ03

Medicare Program; Part A Premium for 1999 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This notice announces the hospital insurance premium for calendar year 1999 under Medicare's hospital insurance program (Part A) for the uninsured aged and for certain disabled individuals who have exhausted other entitlement. The monthly Medicare Part A premium for the 12 months beginning January 1, 1999 for these individuals is $309, the same as in 1998. The reduced premium for certain other individuals as described in this notice is $170. Section 1818(d) of the Social Security Act specifies the method to be used to determine these amounts.

EFFECTIVE DATE: This notice is effective on January 1, 1999.

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 for social security or railroad retirement benefits and do not otherwise meet the requirements for entitlement to Medicare Part A. (Persons insured under the Social Security or Railroad Retirement Acts need not pay premiums for hospital insurance.)

Section 1818(d) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services performed, and related administrative costs incurred, in the following calendar year with respect to individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then, during September of each year, determine the monthly actuarial rate (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding calendar year. If the premium is not a multiple of $1, the premium is rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not of $1, it is rounded to the next highest $1). The 1998 premium under this method was $309 and was effective January 1, 1998. (See 62 FR 59366, November 3, 1997.)

Section 1818(d)(2) of the Act requires us to determine and publish, during September of each calendar year, the amount of the monthly premium for the following calendar year for persons who voluntarily enroll in Medicare Part A.

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, of certain disabled individuals who have exhausted other entitlement. These individuals are those not now entitled but who have been