response to Supplement to Program Announcement Number 04064.

Contact Person For More Information: Jennifer Galbraith, Behavioral Scientist, CDC, National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS Prevention Intervention Research and Support, Prevention Research Branch, 1600 Clifton Road, NE, MS–E37, Atlanta, GA 30333, Telephone (404) 639–8649.

The Director, Management Analysis and Services Office, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: September 1, 2004.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 04–20417 Filed 9–8–04; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8021–N]

RIN 0938–AN16

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2005

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

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year 2005 under Medicare's Hospital Insurance program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts.

The inpatient hospital deductible will be $912. The daily coinsurance amounts will be: (a) $228 for the 61st through 90th day of hospitalization in a benefit period; (b) $456 for lifetime reserve days; and (c) $114 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: This notice is effective on January 1, 2005.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390. For case-mix analysis only: Gregory J. Savord, (410) 786–1521.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires us to determine and publish, between September 1 and September 15 of each year, the amount of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year.

II. Computing the Inpatient Hospital Deductible for 2005

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by our best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year that begins on October 1 of the same preceding calendar year, and adjusted to reflect real case mix. The adjustment to reflect real case mix is determined on the basis of the most recent case mix data available. The amount determined under this formula is rounded to the nearest multiple of $4 (or, if midway between two multiples of $4, to the next higher multiple of $4).

Under section 1886(b)(3)(B)(i) of the Act, the percentage increase used to update the payment rates for fiscal year 2005 for hospitals paid under the prospective payment system is the market basket percentage increase. However, under Section 501 of The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003), hospitals will receive the full market basket update, for fiscal years 2005 through 2007, only if they submit quality data as specified by the Secretary. Those hospitals that do not submit such data will receive an update of the market basket reduced by 0.4 percentage point (4/10of one percent). In determining the payment-weighted average of the updates to payment rates to hospitals in 2005, we are estimating that the payments to hospitals not submitting quality data will be insignificant.

Under section 1886(b)(3)(B)(ii) of the Act, the percentage increase used to update the payment rates for fiscal year 2005 for hospitals excluded from the prospective payment system is the market basket percentage increase, defined according to section 1886(b)(3)(B)(iii) of the Act.

The market basket percentage increase for fiscal year 2005 is 3.3 percent, as announced in the final rule titled ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates,'' published in the **Federal Register** on August 11, 2004 (69 FR 48915). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system is 3.3 percent. The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 3.3 percent. Weighing these percentages in accordance with payment volume, our best estimate of the payment-weighted average of the increases in the payment rates for fiscal year 2005 is 3.3 percent.

To develop the adjustment for real case mix, we first calculated for each hospital an average case mix that reflects the relative costliness of that hospital's mix of cases compared to those of other hospitals. We then computed the change in average case mix for hospitals paid under the Medicare prospective payment system in fiscal year 2004 compared to fiscal year 2003. (We excluded from this calculation hospitals excluded from the prospective payment system because their payments are based on reasonable costs.) We used bills from prospective payment hospitals that we received as of July 2004. These bills represent a total of about 9.5 million discharges for fiscal year 2004 and provide the most recent case mix data available at this time. Based on these bills, the change in average case mix in fiscal year 2004 is 0.44 percent. Based on past experience, we expect the overall case mix change to be 0.7 percent as the year progresses and more fiscal year 2004 data become available.

Section 1813 of the Act requires that the inpatient hospital deductible be adjusted only by that portion of the case mix change that is determined to be real. We estimate that the change in real case mix for fiscal year 2004 is 0.7 percent.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.3 percent, and the real case mix adjustment factor for the

deductible is 0.7 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in calendar year 2005 is $912. This deductible amount is determined by multiplying $876 (the inpatient hospital deductible for 2004) by the payment-weighted average increase in the payment rates of 1.033 multiplied by the increase in real case mix of 1.007, which equals $911 and is rounded to $912.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 2005

The coinsurance amounts provided for in section 1813 of the Act are defined as fixed percentages of the inpatient hospital deductible for services furnished in the same calendar year. Thus, the increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in 2005, in accordance with the fixed percentages defined in the law, the daily coinsurance for the 61st through 90th day of hospitalization in a benefit period will be $228 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $456 (one-half of the inpatient hospital deductible); and the daily coinsurance for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period will be $114 (one-eighth of the inpatient hospital deductible).

IV. Cost to Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for 2004 and 2005, as well as the number of each that is estimated to be paid.

TABLE 1.—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2004 AND 2005

Type of cost sharing	Value		Number paid (in millions)	
	2004	2005	2004	2005
Inpatient hospital deductible	$876	$912	9.07	9.14
Daily coinsurance for 61st–90th day	219	228	2.36	2.37
Daily coinsurance for lifetime reserve days	438	456	1.09	1.10
SNF coinsurance	109.50	114	28.79	29.16

The estimated total increase in cost to beneficiaries is about $610 million (rounded to the nearest $10 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.

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 calendar year. 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, 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 those 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. Regulatory Impact Statement

We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). As stated in Section IV, we estimate that the total increase in costs to beneficiaries associated with this notice is about $610 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.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. For purposes of the RFA, States and individuals are not considered small entities. We have determined that this notice will not have a significant economic impact on a substantial number of small entities. Therefore, we are not preparing an analysis for the RFA.

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

not preparing an analysis for section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice has no consequential effect on State, local, or tribal governments or on the private sector.

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 has no consequential 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.

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

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

Dated: August 30, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 1, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04–20414 Filed 9–3–04; 5:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8022–N]

RIN 0938–AN15

Medicare Program; Part A Premium for 2005 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 notice announces the Hospital Insurance premium for calendar year 2005 under Medicare's Hospital Insurance program (Part A) for the uninsured, not otherwise eligible aged (hereafter known as 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, 2005 for these individuals is $375. The reduced premium for certain other individuals as described in this notice is $206. Section 1818(d) of the Social Security Act specifies the method to be used to determine these amounts.

EFFECTIVE DATE: This notice is effective January 1, 2005.

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. (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to 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 determine, during September of each year, 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 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 2004 premium under this method was $343 and was effective January 1, 2004. (*See* 68 FR 61002, October 24, 2003.)

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 are individuals who are not currently entitled to Part A coverage, but who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, and who would still be entitled to Part A coverage if their earnings had not exceeded 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 (f) of the Act for the aged will also apply to certain disabled individuals as described above.

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 (section 1818 and 1818A) enrollees. 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 calendar year 2005 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for 2005

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement, for the 12 months beginning January 1, 2005, is $375.

The monthly premium for those individuals subject to the 45 percent reduction in the monthly premium is $206.

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 2005 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 individuals aged 65 and over entitled to Hospital Insurance and the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are: