consequential effect on State, local, or tribal governments or on the private sector. However, States are required to pay the premiums for dually-eligible beneficiaries.

Executive Order 13132 establishes certain requirements that an agency must meet when it 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: September 22, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 25, 2011.

Kathleen Sebelius,

Secretary.

[FR Doc. 2011–28188 Filed 10–27–11; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8045–N]

RIN 0938–AQ16

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2012

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, 2012. 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 2012 are $199.80 for aged enrollees and $192.50 for disabled enrollees. The standard monthly Part B premium rate for 2012 is $99.90, 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 2011 standard premium rate was $115.40) The Part B deductible for 2012 is $140.00 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: *Effective Date:* January 1, 2012.

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 $110.00, section 629 of the MMA (amending section 1833(b) of the Act) requires that the Part B deductible be indexed beginning in 2006. The inflation factor to be used each year is the annual percentage increase in the Part B actuarial rate for enrollees age 65 and over. Specifically, the 2012 Part B deductible is calculated by multiplying the 2011 deductible by the ratio of the 2012 aged actuarial rate over the 2011 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 2012, $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 will now have to pay an income-related monthly adjustment amount. The MMA made no change to the actuarial rate calculation, and the standard premium, which will continue to be paid by beneficiaries whose modified adjusted gross income is below the applicable thresholds, still represents 25 percent of the estimated total cost to the program of Part B coverage for an aged enrollee. However, 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 2007, the expenditure was made from the trust fund because the allocation was temporarily extended. However, because the extension occurred after the financing was determined, the allocation was not included in the calculation of the financing rates.

A further provision affecting the calculation of the Part B premium is section 1839(f) of the Act, as amended by section 211 of the Medicare Catastrophic Coverage Act of 1988 (MCCA 88) (Pub.L. 100–360). (The Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101–234) did not repeal the revisions to section 1839(f) made by MCCA 88.) Section 1839(f) of the Act, referred to as the ''hold-harmless'' provision, provides that if an individual is entitled to benefits under section 202 or 223 of the Act (the Old-Age and Survivors Insurance Benefit and the Disability Insurance Benefit, respectively) and has the Part B premiums deducted from these benefit payments, the premium increase will be reduced, if necessary, to avoid causing a decrease in the individual's net monthly payment. This decrease in payment occurs if the increase in the individual's social security benefit due to the cost-of-living adjustment under section 215(i) of the Act is less than the increase in the premium. Specifically, the reduction in the premium amount applies if the individual is entitled to benefits under section 202 or 223 of the Act for November and December of a particular year and the individual's Part B premiums for December and the following January are deducted from the respective month's section 202 or 223 benefits. The ''hold-harmless'' provision does not apply to beneficiaries who are required to pay an income-related monthly adjustment amount.

A check for benefits under section 202 or 223 of the Act is received in the month following the month for which the benefits are due. The Part B premium that is deducted from a particular check is the Part B payment for the month in which the check is received. Therefore, a benefit check for November is not received until December, but has December's Part B premium deducted from it.

Generally, if a beneficiary qualifies for hold-harmless protection, the reduced premium for the individual for that January and for each of the succeeding 11 months is the greater of the following—

- The monthly premium for January reduced as necessary to make the December monthly benefits, after the deduction of the Part B premium for January, at least equal to the preceding November's monthly benefits, after the deduction of the Part B premium for December; or
- The monthly premium for that individual for that December.

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

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

II. Provisions of the Notice

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

The Medicare Part B monthly actuarial rates applicable for 2012 are $199.80 for enrollees age 65 and over and $192.50 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 2012 is $99.90. The Part B annual deductible for 2012 is $140.00. Listed below are the 2012 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	$99.90
Greater than $85,000 and less than or equal to $107,000.	Greater than $170,000 and less than or equal to $214,000.	40.00	139.90
Greater than $107,000 and less than or equal to $160,000.	Greater than $214,000 and less than or equal to $320,000.	99.90	199.80
Greater than $160,000 and less than or equal to $214,000.	Greater than $320,000 and less than or equal to $428,000.	159.80	259.70
Greater than $214,000	Greater than $428,000	219.80	319.70

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	$99.90
Greater than $85,000 and less than or equal to $129,000	159.80	259.70
Greater than $129,000	219.80	319.70

The Part B annual deductible for 2012 is $140.00 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 2012

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 2010 and 2011.

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, 2010	$71,435	$14,558	$56,877
December 31, 2011	76,174	16,647	59,527

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 2012 is determined by first establishing per-enrollee cost by type of service from program data through 2010 and then projecting these costs for subsequent years. The projection factors used for financing periods from January 1, 2009 through December 31, 2012 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 2012 is $192.80. 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 $199.80 provides an adjustment of $9.64 for a contingency margin and −$2.64 for interest earnings.

The size of the contingency margin for 2012 is affected by several factors. The largest factor involves the current law formula for physician fees, which is projected to result in a reduction in physician fees of 28.9 percent in 2012. For each year from 2003 through 2011, Congress has acted to prevent physician fee reductions from occurring. In recognition of the strong possibility of substantial increases in Part B expenditures that would result from similar legislation to override the decreases in physician fees in 2012, 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 2010 is not adequate to accommodate this contingency.

As noted previously, for most Part B beneficiaries the hold-harmless provision prevents their benefits under section 202 or 223 of the Act from decreasing as a result of an increase in the Part B premium. The increase in the benefits under section 202 and 223 of the Act was 0 percent in 2010 and 0 percent again in 2011. As a result, the increases in the Part B premium for 2010 and 2011 were paid by only a small percentage of Part B enrollees. In order for Part B to be adequately funded in 2010 and 2011, the contingency margin was increased to account for this situation. For 2012, the increase in benefits under section 202 or 223 of the Act is expected to be large enough to meet the Part B premium increase for nearly all Part B enrollees, and therefore not require an increase in the 2012 contingency margin.

Two other, smaller factors affect the contingency margin for 2012. Starting in 2011, manufacturers and importers of brand-name prescription drugs will pay a fee that is allocated to the Part B account of the SMI trust. For 2012, the total of these brand-name drug fees will be $2.8 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 −$0.65 for HIT bonus payments in 2012.

The traditional goal for the Part B reserve has been that assets minus liabilities at the end of a year should represent between 15 and 20 percent of the following year's total incurred expenditures. Within this range, 17 percent has been the normal target. In view of the strong likelihood of actual expenditures exceeding estimated levels, due to the enactment of legislation after the financing has been set for a given year, a contingency reserve ratio 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 $199.80 per month for aged beneficiaries, as announced in this notice for 2012, 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 2012 is $224.74. The monthly actuarial rate of $192.50 also provides an adjustment of −$5.34 for interest earnings and −$26.90 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 more than 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 large negative contingency margin is needed to decrease assets to an appropriate level.

The actuarial rate of $192.50 per month for disabled beneficiaries, as announced in this notice for 2012, reflects the combined net effect of the factors described above for aged beneficiaries and the projection assumptions listed in Table 2.

4. Sensitivity Testing

Several factors contribute to uncertainty about future trends in medical care costs. It is appropriate to test the adequacy of the rates using alternative assumptions. The results of those assumptions are shown in Table 5. One set represents increases that are lower and, therefore, more optimistic than the current estimate. The other set represents increases that are higher and, therefore, more pessimistic than the current estimate. The values for the alternative assumptions were determined from a statistical analysis of the historical variation in the respective increase factors.

As indicated in Table 5, the monthly actuarial rates would result in an excess of assets over liabilities of $67,156 million by the end of December 2012 under the assumptions used in preparing this report. This amounts to 28.4 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 $44,895 million by the end of December 2012, which amounts to 17.0 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 $97,393 million by the end of December 2012, or 45.9 percent of the estimated total incurred expenditures for the following year.

The previous analysis indicates that the premium and general revenue financing established for 2012, together with existing Part B account assets would be adequate to cover estimated Part B costs for 2012 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 2012 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	$99.90
Greater than $85,000 and less than or equal to $107,000.	Greater than $170,000 and less than or equal to $214,000.	40.00	139.90
Greater than $107,000 and less than or equal to $160,000.	Greater than $214,000 and less than or equal to $320,000.	99.90	199.80
Greater than $160,000 and less than or equal to $214,000.	Greater than $320,000 and less than or equal to $428,000.	159.80	259.70
Greater than $214,000	Greater than $428,000	219.80	319.70

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	$99.90
Greater than $85,000 and less than or equal to $129,000	159.80	259.70
Greater than $129,000	219.80	319.70

TABLE 2—PROJECTION FACTORS [1] 12-MONTH PERIODS ENDING DECEMBER 31 OF 2009–2012

[In percent]

Calendar year	Physicians' services		Durable medical equipment	Carrier lab [4]	Other carrier services [5]	Outpatient hospital	Home health agency	Hospital lab [6]	Other intermediary services [7]	Managed care
	Fees [2]	Residual [3]								
Aged:										
2009	1.6	1.5	−7.4	8.6	8.1	8.5	13.5	9.0	10.3	0.3
2010	3.2	0.8	2.1	1.6	3.5	6.2	2.0	2.7	2.3	−1.6
2011	0.3	4.7	−3.9	−4.4	4.8	6.5	−1.9	0.7	2.5	1.7
2012	−30.2	8.5	7.7	7.2	4.8	5.7	−1.0	2.7	−4.2	0.6
Disabled:										
2009	1.6	5.0	−1.8	21.3	9.8	9.7	13.8	10.8	12.5	0.8
2010	3.2	2.6	3.4	−2.4	3.9	6.1	1.2	4.3	3.9	−1.3
2011	0.3	4.1	−3.8	−3.6	2.4	6.2	−1.4	2.3	−2.2	2.0
2012	−30.2	8.4	7.6	7.2	4.7	5.7	−0.1	2.7	−0.7	0.4

[1] All values for services other than managed care are per fee-for-service enrollee. Managed care values are per managed care enrollee.
[2] As recognized for payment under the program.
[3] Increase in the number of services received per enrollee and greater relative use of more expensive services.
[4] Includes services paid under the lab fee schedule furnished in the physician's office or an independent lab.
[5] Includes physician-administered drugs, ambulatory surgical center facility costs, ambulance services, parenteral and enteral drug costs, supplies, etc.
[6] Includes services paid under the lab fee schedule furnished in the outpatient department of a hospital.
[7] Includes services furnished in dialysis facilities, rural health clinics, Federally qualified health centers, rehabilitation and psychiatric hospitals, etc.

TABLE 3—DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FOR FINANCING PERIODS ENDING DECEMBER 31, 2009 THROUGH DECEMBER 31, 2012

	Financing Periods			
	CY 2009	CY 2010	CY 2011	CY 2012
Covered services (at level recognized):				
Physician fee schedule	78.53	80.76	83.78	63.51
Durable medical equipment	8.90	8.98	8.53	9.20
Carrier lab [1]	4.30	4.32	4.08	4.38
Other carrier services [2]	20.80	21.27	22.03	23.12
Outpatient hospital	32.38	33.99	35.74	37.83
Home health	11.77	11.86	11.49	11.38
Hospital lab [3]	2.95	2.99	2.98	3.06
Other intermediary services [4]	14.25	14.41	14.58	13.99
Managed care	54.11	54.92	57.61	57.77
Total services	227.99	233.50	240.81	224.23
Cost sharing:				
Deductible	−5.50	−6.32	−6.61	−5.72
Coinsurance	−30.39	−30.69	−31.10	−27.73
HIT payment incentives	0.00	0.00	−0.51	−0.65
Total benefits	192.10	196.49	203.10	190.13
Administrative expenses	2.97	2.94	3.38	2.66
Incurred expenditures	195.08	199.43	206.48	192.80
Value of interest	−2.80	−2.74	−2.62	−2.64
Contingency margin for projection error and to amortize the surplus or deficit	0.42	24.31	26.84	9.64
Monthly actuarial rate	192.70	221.00	230.70	199.80

[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, 2009 THROUGH DECEMBER 31, 2012

	Financing Periods			
	CY 2009	CY 2010	CY 2011	CY 2012
Covered services (at level recognized):				
Physician fee schedule	81.92	85.99	89.41	67.87
Durable medical equipment	16.62	17.03	16.28	17.57
Carrier lab [1]	6.08	5.93	4.88	5.25
Other carrier services [2]	25.97	26.15	26.60	27.94
Outpatient hospital	44.65	46.89	49.75	52.74
Home health	10.17	10.21	10.01	10.04
Hospital lab [3]	4.76	4.90	4.60	4.74
Other intermediary services [4]	42.27	42.01	41.18	41.66
Managed care	40.29	40.84	42.36	41.95
Total services	272.73	279.96	285.07	269.77
Cost sharing:				
Deductible	−5.15	−5.92	−6.20	−5.37
Coinsurance	−45.32	−45.96	−46.14	−42.09
HIT payment incentives	0.00	0.00	−0.54	−0.68
Total benefits	222.25	228.07	232.19	221.63
Administrative expenses	3.44	3.40	3.88	3.10
Incurred expenditures	225.69	231.48	236.07	224.74
Value of interest	−3.31	−4.07	−4.71	−5.34
Contingency margin for projection error and to amortize the surplus or deficit	1.82	42.99	34.94	−26.90
Monthly actuarial rate	224.20	270.40	266.30	192.50

[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, 2012

As of December 31,	2010	2011	2012
This projection:			
Actuarial status (in millions).			
Assets	71,435	76,174	83,245
Liabilities	14,558	16,647	16,089
Assets less liabilities	56,877	59,527	67,156
Ratio (in percent) [1]	24.9	26.9	28.4
Low cost projection:			
Actuarial status (in millions).			
Assets	71,435	84,855	112,748
Liabilities	14,558	15,683	15,355
Assets less liabilities	56,877	69,173	97,393
Ratio (in percent) [1]	26.0	33.8	45.9
High cost projection:			
Actuarial status (in millions).			
Assets	71,435	66,857	61,820
Liabilities	14,558	17,683	16,925
Assets less liabilities	56,877	49,174	44,895
Ratio (in percent) [1]	23.8	20.5	17.0

[1] Ratio of assets less liabilities at the end of the year to the total incurred expenditures during the following year, expressed as a percent.

III. Regulatory Impact Analysis

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 notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), 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 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year).

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity).

The RFA requires agencies to analyze options for regulatory relief of small businesses, 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 2011, that threshold is approximately $136 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 2012 are $199.80 for enrollees age 65 and over and $192.50 for disabled enrollees under age 65. It also announces the 2011 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	$99.90
Greater than $85,000 and less than or equal to $107,000.	Greater than $170,000 and less than or equal to $214,000.	40.00	139.90
Greater than $107,000 and less than or equal to $160,000.	Greater than $214,000 and less than or equal to $320,000.	99.90	199.80
Greater than $160,000 and less than or equal to $214,000.	Greater than $320,000 and less than or equal to $428,000.	159.80	259.70
Greater than $214,000	Greater than $428,000	219.80	319.70

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	$99.90
Greater than $85,000 and less than or equal to $129,000	159.80	259.70
Greater than $129,000	219.80	319.70

Approximately 2 million Part B enrollees paid the 2011 standard premium rate of $115.40 which is $15.50 higher than the 2012 standard premium rate of $99.90. These enrollees will have about $0.4 billion in reduced costs in 2012. For the approximately 30 million Part B enrollees who paid a 2011 premium of $96.40 under the hold-harmless provision, the standard Part B premium rate of $99.90 is $3.50 higher than the 2011 premium that they paid, so there will be about $1.3 billion of additional costs in 2012 to the these Part B enrollees. Therefore, this notice is a major action as defined in 5 U.S.C. 804(2) and is an economically significant action 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: September 20, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 25, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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