operating costs exceeding target amounts by 10 percent or more receive the market basket index percentage. The market basket percentage increases for fiscal year 1996 are 3.5 percent for prospective payment system hospitals and 3.4 percent for hospitals excluded from the prospective payment system, as announced in the Federal Register on September 1, 1995 (60 FR 45778). Therefore, the percentage increases for Medicare prospective payment rates are 1.5 percent for all hospitals. The average payment percentage increase for hospitals excluded from the prospective payment system is 2.84 percent. Thus, weighting 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 1996 is 1.65 percent.

To develop the adjustment for real case mix, an average case mix was first calculated for each hospital that reflects the relative costliness of that hospital's mix of cases compared to that of other hospitals. We then computed the increase in average case mix for hospitals paid under the Medicare prospective payment system in fiscal year 1995 compared to fiscal year 1994. (Hospitals excluded from the prospective payment system were excluded from this calculation since their payments are based on reasonable costs and are affected only by real increases in case mix.) We used bills from prospective payment hospitals received in HCFA as of July 1995. These bills represent a total of about 8.0 million discharges for fiscal year 1995 and provide the most recent case mix data available at this time. Based on these bills, the increase in average case mix in fiscal year 1995 is 1.1 percent. Based on past experience, we expect overall case mix to increase to 1.4 percent as the year progresses and more fiscal year 1995 data become available.

Section 1813 of the Act requires that the inpatient hospital deductible be increased only by that portion of the case mix increase that is determined to be real. We estimate that the increase in real case mix is about 1 percent. Since real case mix had been assumed to be increasing at about 1 percent per year in prior years, we expect a return to this trend.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 1.65 percent, and the real case mix adjustment factor for the deductible is 1 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in calendar year 1996 is $736. This deductible amount is determined by multiplying $716 (the inpatient hospital deductible for 1995) by the payment rate increase of 1.0165 multiplied by the increase in real case mix of 1.01 which equals $735.09 and is rounded to $736.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 1996

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 1996, in accordance with the fixed percentages defined in the law, the daily coinsurance for the 61st through 90th days of hospitalization in a benefit period will be $184 (1/4 of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $368 (1/2 of the inpatient hospital deductible); and the daily coinsurance for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period will be $92 (1/8 of the inpatient hospital deductible).

IV. Cost to Beneficiaries

We estimate that in 1996 there will be about 9.2 million deductibles paid at $736 each, about 3.4 million days subject to coinsurance at $184 per day (for hospital days 61 through 90), about 1.5 million lifetime reserve days subject to coinsurance at $368 per day, and about 21.9 million extended care days subject to coinsurance at $92 per day. Similarly, we estimate that in 1995 there will be about 8.9 million deductibles paid at $716 each, about 3.3 million days subject to coinsurance at $179 per day (for hospital days 61 through 90), about 1.5 million lifetime reserve days subject to coinsurance at $358 per day, and about 21.2 million extended care days subject to coinsurance at $89.50 per day. Therefore, the estimated total increase in cost to beneficiaries is about $570 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. Impact Statement

This notice merely announces amounts required by legislation. This notice is not a proposed rule or a final rule issued after a proposal and does not alter any regulation or policy. Therefore, we have determined, and certify, that no analyses are required under Executive Order 12866, the Regulatory Flexibility Act (5 U.S.C. 601 through 612), or section 1102(b) of the Act.

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 26, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: September 29, 1995.

Donna E. Shalala,

Secretary.

[FR Doc. 95–25518 Filed 10–13–95; 8:45 am]

BILLING CODE 4120–01–P

[OACT–050–N]

RIN 0938–AH07

Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 1996

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 1996. It also announces the monthly SMI premium rate to be paid by all enrollees during 1996. The monthly actuarial rates for 1996 are $84.90 for aged enrollees and $105.10 for disabled enrollees. The monthly SMI premium rate for 1996 is $42.50.

EFFECTIVE DATE: January 1, 1996.

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 (Medicare Part A). The SMI program is available to individuals who

are entitled to hospital insurance 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), enacted on October 30, 1972, 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) (Public Law 97–248), enacted on September 3, 1982, 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), enacted on April 20, 1983; section 2302 of the Deficit Reduction Act of 1984 (DRA) (Public Law 98–369), enacted on July 18, 1984; section 9313 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985) (Public Law 99–272), enacted on April 7, 1986; section 4080 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Public Law 100–203), enacted on December 22, 1987; and section 6301 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) (Public Law 101–239), enacted on December 19, 1989, extended the provision that the premium be based on 50 percent of the monthly actuarial rate 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), enacted on November 5, 1990. 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), enacted on August 10, 1993, changed the premium basis to 50 percent of the monthly actuarial rate for aged enrollees for 1996 through 1998. In January 1999, the premium determination basis will revert to the method established by the 1972 Social Security Act Amendments, except on a calendar year basis.

As determined according to section 1839(a)(3) of the Act, the premium rate for 1996 is $42.50. This premium rate is $3.60 lower than the $46.10 premium rate for 1995. As stated above, the premium rate for 1995 was legislated by OBRA 1990. The legislated premium rate for 1995 was determined to be 50 percent of the projected monthly actuarial rate for aged enrollees for 1995 based on the projections at the time of enactment. In the intervening years before the announcement of the 1995 actuarial rates, on December 1, 1994, the growth of program costs had slowed from the projections that were used to establish the legislated rate for 1995. Consequently, the actuarial rate for aged enrollees for 1995 that was announced on December 1, 1994 was lower than the actuarial rate projected at the time of the enactment of OBRA 1990. As a result, the 1995 premium rate was actually 63.1 percent of the announced 1995 actuarial rate for aged enrollees (that is, 31.5 percent of program costs for aged enrollees). Although program costs are projected to increase in 1996 over 1995, the premium rate will be 50 percent of the 1996 actuarial rate for aged enrollees instead of 63.1 percent as in 1995. It is the fact that the premium rate will cover a lower percentage of program costs in 1996 that results in a lower premium rate in spite of increasing program costs.

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), enacted on July 1, 1988. (The Medicare Catastrophic Coverage Repeal Act of 1989 (Public Law 101–234), enacted on December 13, 1989, 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 1996 are $84.90 for enrollees age 65 and over, and $105.10 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 $42.50 during 1996.

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 1996

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. Table 1 summarizes the estimated actuarial status of the trust fund as of the end of the financing period for 1994 and 1995.

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
Dec. 31, 1994	$19.422	$4.049	$15.373
Dec. 31, 1995	18.531	4.876	13.655

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 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.

The monthly actuarial rate for enrollees age 65 and older for 1996 was determined by projecting per-enrollee cost for the 12-month periods ending June 30, 1996, and June 30, 1997, by type of service. 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 Public Law 98–369. The values for the 12-month period ending June 30, 1993 were established from program data. 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, 1993, through December 31, 1996, are shown 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 1996 is $87.05. The monthly actuarial rate of $84.90 provides an adjustment of −$2.28 for interest earnings and $0.13 for a contingency margin. Based on current estimates, it appears that the assets are sufficient to cover the amount of incurred but unpaid expenses and to provide for a moderate degree of projection error. Thus, only a slight positive contingency margin is needed to maintain assets at an appropriate level.

An appropriate level for assets 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 the former as the trends in the differences vary over time.

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 and administrative costs for disabled enrollees for 1996 is $106.04. The monthly actuarial rate of $105.10 provides an adjustment of −$1.11 for interest earnings and $0.17 for a contingency margin. Based on current estimates, it appears that assets are 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, only a slight positive contingency margin is needed to maintain assets at an 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 that began implementation January 1, 1992. 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 from a study on 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 $13.696 billion by the end of December 1996. This amounts to 15.9 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 $0.268 billion by the end of December 1996, which amounts to 0.3 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 $26.240 billion by the end of December 1996, which amounts to 33.7 percent of the estimated total incurred expenditures for the following year.

E. Premium Rate

As determined by section 1839(a)(3) of the Act, the monthly premium rate for 1996, for both aged and disabled enrollees, is $42.50.

TABLE 2.—PROJECTION FACTORS[1]—12-MONTH PERIODS ENDING JUNE 30 OF 1993 THROUGH 1997

[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:						
1993	0.5	0.4	12.4	63.8	16.1	2.8
1994	2.7	3.0	7.4	4.2	15.5	−0.4
1995	4.4	4.8	15.1	15.0	17.7	1.6
1996	2.2	6.8	8.1	15.0	33.7	6.6
1997	−0.3	8.6	9.8	16.2	17.6	10.6
Disabled:						
1993	0.5	4.1	16.2	0.0	14.8	11.4
1994	2.7	3.7	1.7	0.0	−14.0	9.5
1995	4.4	2.9	18.9	0.0	11.6	1.3
1996	2.2	4.7	15.4	0.0	43.2	4.0
1997	−0.3	6.7	14.6	0.0	13.5	9.4

[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] Since July 1, 1981, home health agency services have been almost exclusively provided by the Medicare hospital insurance (HI) program. However, for those SMI enrollees not entitled to HI, the coverage of these services is provided by the SMI program. Since all SMI disabled enrollees are entitled to HI, their coverage of these services is provided by the HI program.

TABLE 3.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER—FINANCING PERIODS ENDING DECEMBER 31, 1993 THROUGH DECEMBER 31, 1996

	Financing periods			
	CY 1993	CY 1994	CY 1995	CY 1996
Covered services (at level recognized):				
Physicians' reasonable charges	$52.97	$57.04	$62.34	$67.74
Outpatient hospital and other institutions	17.28	19.25	21.44	23.36
Home health agencies	0.15	0.16	0.19	0.21
Group practice prepayment plans	8.13	9.49	11.99	14.92
Independent lab	2.43	2.38	2.43	2.64
Total services	80.96	88.32	98.39	108.87
Cost-sharing:				
Deductible	−3.68	−3.70	−3.73	−3.75

TABLE 3.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER—FINANCING PERIODS ENDING DECEMBER 31, 1993 THROUGH DECEMBER 31, 1996—Continued

	Financing periods			
	CY 1993	CY 1994	CY 1995	CY 1996
Coinsurance	−14.67	−16.13	−18.09	−20.12
Total benefits	62.61	68.49	76.57	85.00
Administrative expenses	1.91	1.95	1.99	2.05
Incurred expenditures	64.52	70.44	78.56	87.05
Value of interest	−2.45	−2.49	−2.05	−2.28
Contingency margin for projection error and to amortize the surplus or deficit	8.43	−6.15	−3.41	0.13
Monthly actuarial rate	70.50	61.80	73.10	84.90

TABLE 4.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES—FINANCING PERIODS ENDING DECEMBER 31, 1993 THROUGH DECEMBER 31, 1996

	Financing periods			
	CY 1993	CY 1994	CY 1995	CY 1996
Covered services (at level recognized):				
Physicians' reasonable charges	$61.64	$65.31	$69.84	$74.34
Outpatient hospital and other institutions	40.38	42.66	46.89	51.47
Home health agencies	0.00	0.00	0.00	0.00
Group practice prepayment plans	1.92	1.88	2.41	3.03
Independent lab	2.86	3.00	3.11	3.31
Total services	106.80	112.85	122.25	132.15
Cost-sharing:				
Deductible	−3.47	−3.50	−3.53	−3.55
Coinsurance	−20.02	−21.19	−23.02	−24.95
Total benefits	83.31	88.16	95.70	103.65
Administrative expenses	2.68	2.42	2.40	2.39
Incurred expenditures	85.99	90.58	98.10	106.04
Value of interest	−2.33	−1.62	−0.93	−2.05
Contingency margin for projection error and to amortize the surplus or deficit	−0.76	−12.86	8.63	1.11
Monthly actuarial rate	82.90	76.10	105.80	105.10

TABLE 5.—ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND—UNDER THREE SETS OF ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 1996

	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,		
	1995	1996	1997	1995	1996	1997	1995	1996	1997
Projection factors (in percent):									
Physician fees: [1]									
Aged	4.4	2.2	−0.3	4.2	1.0	−2.1	4.6	3.4	1.5
Disabled	4.4	2.2	−0.3	4.2	1.0	−2.1	4.6	3.4	1.5
Utilization of physician services: [2]									
Aged	4.8	6.8	8.6	3.0	4.6	6.1	6.7	9.0	11.0
Disabled	2.9	4.7	6.7	0.0	1.8	3.6	5.8	7.7	9.8
Outpatient hospital services per enrollee:									
Aged	15.1	8.1	9.8	10.7	3.5	4.9	19.5	12.7	14.8
Disabled	18.9	15.4	14.6	13.6	9.9	9.0	24.3	21.0	20.3
	As of December 31,			As of December 31,			As of December 31,		
	1994	1995	1996	1994	1995	1996	1994	1995	1996
Actuarial status (in billions):									
Assets	$19.422	$18.531	$19.327	$19.422	$22.020	$29.345	$19.422	$14.854	$8.499

	As of December 31,			As of December 31,			As of December 31,		
	1994	1995	1996	1994	1995	1996	1994	1995	1996
Liabilities	4.049	4.876	5.631	1.886	2.567	3.105	6.245	7.229	8.231
Assets less liabilities	15.373	13.655	13.696	17.536	19.453	26.240	13.177	7.625	0.268
Ratio of assets less liabilities to expenditures (in percent)[3]	22.2	17.6	15.9	26.7	27.2	33.7	18.1	9.0	0.3

[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. Cost to Beneficiaries

The monthly SMI premium rate of $42.50 for all enrollees during 1996 is 7.8 percent lower than the $46.10 monthly premium amount for the previous financing period. The estimated savings of this reduction from the current premium to the approximately 36 million SMI enrollees will be about $1.565 billion for 1996.

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 15, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: September 27, 1995.

Donna E. Shalala,

Secretary.

[FR Doc. 95–25519 Filed 10–13–95; 8:45 am]

BILLING CODE 4120–01–P

[OACT–051–N]

RIN 0938–AH06

Medicare Program; Part A Premium for 1996 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 1996 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, 1996 for these individuals is $289. The reduced premium for certain other individuals as described in this notice is $188. 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, 1996.

FOR FURTHER INFORMATION CONTACT: John Wandishin, (410) 786–6389.

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 who are age 65 and older, 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 for related administrative costs incurred in the following year with respect to individuals age 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 to be applicable for the monthly premium in the succeeding 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 1995 premium under this method was $261 and was effective January 1995. (See 59 FR 61626, December 1, 1994.)

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 entitled under section 226(b) of the Act, continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because they had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the premium determined under section 1818(d)(2) of the Act for the aged will also apply to certain disabled individuals as described above.

In addition, section 1818(d) of the Act provides for a reduction in the monthly premium amount for certain voluntary enrollees. The reduction applies for individuals who are not eligible for social security or railroad retirement benefits but who:

- Had at least 30 quarters of coverage under title II of the Act;
- Were married and had been married for the previous 1-year period to an individual who had at least 30 quarters of coverage;
- Had been married to an individual for at least 1 year at the time of the individual's death and the individual had at least 30 quarters of coverage; or
- Are divorced from an individual who at the time of divorce had at least 30 quarters of coverage and the marriage lasted at least 10 years.

For calendar year 1996, section 1818(d)(4)(A) of the Act specifies that the monthly premium that these individuals will pay for calendar year 1996 will be equal to the monthly premium for aged voluntary enrollees reduced by 35 percent.

II. Premium Amount for 1996

Under the authority of sections 1818(d)(2) and 1818A(d)(2) of the Act, we have determined that the monthly Medicare Part A hospital insurance premium for the uninsured aged and for