percent as the year progresses and more fiscal year 1996 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 this pattern to continue.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 2.0 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 1997 is $760. This deductible amount is determined by multiplying $736 (the inpatient hospital deductible for 1996) by the payment rate increase of 1.02 multiplied by the increase in real case mix of 1.01 which equals $758.23 and is rounded to $760.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 1997

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 1997, 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 $190 (¼ of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $380 (½ 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 $95 (⅛ of the inpatient hospital deductible).

IV. Cost to Beneficiaries

We estimate that in 1997 there will be about 9.2 million deductibles paid at $760 each, about 3.1 million days subject to coinsurance at $190 per day (for hospital days 61 through 90), about 1.4 million lifetime reserve days subject to coinsurance at $380 per day, and about 21.3 million extended care days subject to coinsurance at $95 per day. Similarly, we estimate that in 1996 there will be about 8.9 million deductibles paid at $736 each, about 3.0 million days subject to coinsurance at $184 per day (for hospital days 61 through 90), about 1.4 million lifetime reserve days subject to coinsurance at $368 per day, and about 20.8 million extended care days subject to coinsurance at $92 per day. Therefore, 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 Notice of Proposed Rulemaking

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 formal notice and comment rulemaking procedures, to make such announcements. In doing so, we acknowledge that, under the Administrative Procedure Act, interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking.

We considered publishing a proposed notice to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impracticable, unnecessary, or contrary to the public interest. We find that the procedure for notice and comment is unnecessary because the formula used to calculate the inpatient hospital deductible and the hospital and extended care services coinsurance amounts is statutorily directed, and we can exercise no discretion in following that formula. Moreover, the statute establishes the time period for which the deductible and coinsurance amounts will apply and delaying publication of these amounts 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. 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 10, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: September 27, 1996.

Donna E. Shalala,

Secretary.

[FR Doc. 96–28142 Filed 11–1–96; 8:45 am]

BILLING CODE 4120–01–M

[OACT–053–N]

RIN 0938–AH45

Medicare Program; Part A Premium for 1997 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 1997 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, 1997 for these individuals is $311. The reduced premium for certain other individuals as described in this notice is $187. 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, 1997.

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 month 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 1996 premium under this method was $289 and was effective January 1, 1996. (See 60 FR 53631, October 16, 1995.)

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.

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66, enacted on August 10, 1993) amended section 1818(d) of the Act to provide 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 1997, section 1818(d)(4)(A) of the Act, specifies that the monthly premium that these individuals will pay for calendar year 1997 will be equal to the monthly premium for aged voluntary enrollees reduced by 40 percent.

II. Premium Amount for 1997

Under the authority of sections 1818(d)(2) and 1818A(d)(2) of the Act, the Secretary has determined that the monthly Medicare Part A hospital insurance premium for the uninsured aged and for certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 1997, is $311.

The monthly premium for those individuals entitled to a 40 percent reduction in the monthly premium for the 12-month period beginning January 1, 1997 is $187.

III. Statement of actuarial Assumptions and Bases Employed in Determining the Monthly Premium Rate

As discussed in section I of this notice, the monthly Medicare Part A premium for 1997 is equal to the estimated monthly actuarial rate for 1997 rounded to the nearest multiple of $1. The monthly actuarial rate is defined to be one-twelfth of the average per capita amount that the Secretary estimates will be paid from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in 1997 for individuals age 65 and over who will be entitled to benefits under the hospital insurance program. Thus, the number of individuals age 65 and over who will be entitled to hospital insurance benefits and the costs incurred on behalf of these beneficiaries must be projected to determine the premium rate.

The principal steps involved in projecting the future costs of the hospital insurance program are (a) establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base; (b) projecting increases in payment amounts for each of the various service types; and (c) projecting increases in administrative costs. Establishing historical Medicare Part A enrollment and projecting future enrollment, by type of beneficiary, is part of this process.

We have completed all of the above steps, basing our projections for 1997 on (a) current historical data and (b) projection assumptions under current law from the Midsession Review of the President's Fiscal Year 1997 Budget. It is estimated that in calendar year 1997, 32.809 million people age 65 and over will be entitled to Medicare Part A benefits (without premium payment), and that these individuals will, in 1997, incur $122.621 billion of benefits for services performed and related administrative costs. Thus, the estimated monthly average per capita amount is $311.45 and the monthly premium is $311. The monthly premium for those individuals eligible to pay this premium reduced by 40 percent is $187.

IV. Costs to Beneficiaries

The 1997 Medicare Part A premium is about 8 percent higher than the $289 monthly premium amount for the 12-month period beginning January 1, 1996.

We estimate that there will be, in calendar year 1997, approximately 324,000 enrollees who will voluntarily enroll in Medicare Part A by paying the full premium and who do not otherwise meet the requirements for entitlement. An additional 9,000 enrollees will be paying the reduced premium. The estimated overall effect of the changes in the premium will be a cost to these voluntary enrollees of about $90 million.

V. Waiver of Notice of Proposed Rulemaking

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

We considered publishing a proposed notice to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impracticable, unnecessary, or contrary to the public interest. We find that the procedure for notice and comment is unnecessary because the formula used

to calculate the Part A hospital insurance premium is statutorily directed, and we can exercise no discretion in following that formula. Moreover, the statute established the time period for which the premium will apply and delaying publication of the premium amount 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. 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 it 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: Sections 1818(d)(2) and 1818A(d)(2) of the Social Security Act (42 U.S.C. 1395i–2(d)(2) and 1395i–2a(d)(2)).

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

Dated: September 10, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: September 27, 1996.

Donna E. Shalala,

Secretary.

[FR Doc. 96–28141 Filed 11–1–96; 8:45 am]

BILLING CODE 4120–01–M

Health Resources and Services Administration

HIV Emergency Relief Grant Program

AGENCY: Health Resources and Services Administration.

ACTION: Notice of grants made to eligible metropolitan areas.

SUMMARY: (Note: On May 20, 1996, PL 104–146 reauthorized the Ryan White CARE Act of 1990. Because most of the new provisions found in Title XXVI of the Public Health Service Act did not become effective until October 1, 1996, most of the information in this notice will reflect the language of the original legislation.) The Health Resources and Services Administration (HRSA) announces that fiscal year 1996 funds have been awarded to the 49 eligible metropolitan areas (EMAs) that have been the most severely affected by the HIV epidemic. Although these funds have already been awarded to the EMAs, HRSA is publishing this notice to inform the general public of the existence of the funds. In addition, HRSA determined that it would be useful for the general public to be aware of the structure of the HIV Emergency Relief Grant Program and the statutory requirements governing the use of the funds.

The purposes of these funds are to deliver or enhance HIV-related (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services, for individuals and families with HIV disease; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. The HIV Emergency Relief Grant Program is authorized by Title I of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Public Law 101–381, as amended by the Ryan White CARE Act Amendments of 1996, Public Law 104–146, which amended Title XXVI of the Public Health Service Act. Funds were appropriated under Public Law 104–134.

FOR FURTHER INFORMATION, CONTACT: Individuals interested in the Title I HIV Emergency Relief Grant Program should contact the Office of the Chief Elected Official (CEO) in their locality, and may obtain information on their CEO contact by calling Anita Eichler, M.P.H., Director, Division of HIV Services, at (301) 443–6745.

SUPPLEMENTARY INFORMATION:

Availability of Funds

A total of $372,141,000 was made available for the Title I HIV Emergency Relief Grant Program. Because of the delay in the passage of fiscal year 1996 appropriations legislation for the Department of Health and Human Services and also because of the ''hold-harmless'' provisions of the the Ryan White CARE Act Amendments of 1996, the normal 50–50 split between formula and supplemental grants was affected. Below is a table showing the total award of grants made to the 49 EMAs.

Grantee	Award
Atlanta, GA	$9,208,162
Austin, TX	2,398,671
Baltimore, MD	8,364,074
Bergen-Passaic, NJ	3,369,095
Boston, MA	8,360,436
Caguas, PR	1,064,876
Chicago, IL	13,164,930
Cleveland, OH	1,384,956
Dallas, TX	7,820,653
Denver, CO	3,549,707
Detroit, MI	4,405,380
Dutchess County, NY	581,761
Ft. Lauderdale, FL	6,584,204
Ft. Worth, TX	2,255,398
Hartford, CT	3,048,467
Houston, TX	10,312,524
Jacksonville, FL	2,725,251
Jersey City, NJ	3,767,874
Kansas City, MO	2,514,291
Los Angeles, CA	26,313,561
Miami, FL	15,156,078
Middlesex-Somerset-Hunterdon, NJ	2,198,883
Minneapolis-St. Paul, MN	1,370,726
Nassau-Suffolk, NY	3,683,885
New Haven, CT	4,002,182
New Orleans, LA	2,087,199
New York, NY	92,241,697
Newark, NJ	9,725,848
Oakland, CA	4,741,595
Orange County, CA	3,492,993
Orlando, FL	3,599,489
Philadelphia, PA	10,345,478
Phoenix, AZ	2,901,602
Ponce, PR	1,685,036
Portland, OR	2,688,924
Riverside-San Bernardino, CA	4,687,432
Sacramento, CA	2,463,814
St. Louis, MO	2,587,364
San Antonio, TX	2,396,426
San Diego, CA	6,592,104
San Francisco, CA	35,172,274
San Jose, CA	2,275,044
San Juan, PR	8,199,506
Santa Rosa, CA	1,142,456
Seattle, WA	4,289,545
Tampa-St. Petersburg, FL	4,610,201
Vineland-Millville-Bridgeton, NJ	454,338
Washington, D.C.	12,763,696
West Palm Beach, FL	3,390,914

Eligible Grantees

Metropolitan areas which were eligible for grant awards under Title I were those areas for which, as of March 31, 1995, there had been reported to and confirmed by the CDC a cumulative total of more than 2,000 cases of AIDS; or, for which an award had been made prior to fiscal year 1996.

Grants were awarded to the chief elected official (CEO) of the city or urban county in each EMA that administers the public health agency providing outpatient and ambulatory services to the greatest number of individuals with AIDS.

To be eligible for assistance under Title I, the CEO was required to establish or designate an HIV health services planning council to: (1) Establish priorities for the allocation of funds within the eligible area; (2) develop a comprehensive plan for the organization and delivery of health services described in the statute that is