

beneficiary eligibility, and notification of premium reductions.

In § 408.21(a), we set forth language reflecting the fact that, under section 606 of BIPA, an M+C organization may offer, as an additional benefit under an M+C plan, a reduction in the amount that an enrollee in the M+C plan pays to Medicare for the Medicare Part B premium. For the Medicare Part B premium reduction to occur, the M+C organization must accept a reduction in its monthly capitation payments under § 422.250(a)(1). The Medicare Part B premium paid by a beneficiary enrolled in an M+C plan that offers this additional benefit will be reduced by 80 percent of the amount that the capitation payment to the M+C organization is reduced. The Medicare Part B premium reduction may not exceed the standard Medicare Part B premium amount, and if the beneficiary owes less than this amount, the difference is not paid to the Medicare beneficiary.

In § 408.21(b), we set forth the administrative requirements under section 606 of BIPA for the Medicare Part B premium reductions. These requirements include: (1) The M+C capitation reduction must not result in a Medicare Part B premium reduction greater than the standard premium amount determined for the year under section 1839 of the Act (the reduction to the Medicare Part B premium may be less); (2) the Medicare Part B premium reduction will use only multiples of 10 cents; (3) the Medicare Part B premium reduction will be applied to all beneficiaries who are enrolled in the M+C plan under which the benefit is offered without regard to who actually pays/collects the Medicare Part B premium (Social Security Administration (SSA), Railroad Retirement Board (RRB), Office of Personnel Management (OPM), the beneficiary, the State, or employer); (4) The Medicare Part B premium reduction will never result in a payment to a beneficiary. (If the amount of the reduction is equal to or greater than the amount a beneficiary owes due to hold harmless premiums, the beneficiary will owe \$0.)

Section 408.21(c) specifies the eligibility requirements under section 606 of BIPA for the Medicare Part B premium reduction; namely that, in order to be eligible for the reduction, a beneficiary must be enrolled in an M+C plan that offers the reduction to the Medicare Part B premium as an additional benefit.

Section 408.21(d) explains that after the Centers for Medicare & Medicaid Services (CMS) determines the Medicare

Part B premium reduction amount for each eligible beneficiary, the SSA, RRB, or OPM, as applicable, will include the adjusted amount of the Medicare Part B premium in benefit check amounts as appropriate and notify the beneficiaries of their new benefit amount. The paragraph also notes that we will notify States, formal groups, and directly billed beneficiaries of each beneficiary's reduced Medicare Part B premium amounts in the regular monthly billing process.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506c(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

There are no information collection requirements associated with this final rule. This provision is strictly voluntary and is provided as a benefit option for M+C organizations.

IV. Regulatory Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1955 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety

effects; distributive impacts; and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more annually). This is not a major rule. It will have no significant economic impact on either costs or savings and may result in lower premiums for some beneficiaries.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 million to \$29 million annually (*see* 65 FR 69432). Individuals and States are not included in the definition 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 located outside of a Metropolitan Statistical Area with fewer than 100 beds.

We are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will have no impact on any small entities or rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This final rule will have a positive effect on the annual expenditures of any State, local, or tribal government, or private sector with enrollees covered under a State buy-in agreement or group payer arrangement as set forth in subpart C and E, respectively, of part 407 of this chapter; and, whose enrollees opt to enroll in a Medicare+Choice organization's (M+CO) Plan Benefit Package that offers a reduction to the Medicare Part B premium permitted as an additional benefit, authorized under section 606 of the BIPA and defined under part 422, subpart A of this chapter. Any reduction to the beneficiary's Medicare Part B premium will be applied regardless of the entity that actually pays the Medicare Part B premium on behalf of the beneficiary. The entity that actually pays the