In addition, the attributes of M1's intercompany income and M2's corresponding deduction are redetermined to produce the same effect as if the transaction had occurred between divisions of a single corporation. Under paragraph (c)(4)(i) of this section, the attributes of M2's corresponding deduction control the attributes of M1's intercompany income. (Although M1 is the selling member with respect to the payment on April 1 of year 2, it might be the buying member in a subsequent period if it owes the net payment.)

(iii) *Dealer.* The facts are the same as in paragraph (i) of this *Example 11,* except that M2 is a dealer in securities, and the contract with M1 is not inventory in the hands of M2. Under section 475, M2 must mark its securities to fair market value at year-end. Assume that under section 475, M2's loss from marking to fair market value the contract with M1 is $10. Because M2 realizes an amount of loss from the mark to fair market value of the contract, the transaction is a triggering transaction under paragraph (g)(3)(i)(A)(1) of this section. Under paragraph (g)(3)(ii) of this section, M2 is treated as making a $10 payment to M1 to terminate the contract immediately before a new contract is treated as reissued with an up-front payment by M1 to M2 of $10. M1's $10 of income from the termination payment is taken into account under the matching rule to reflect M2's deduction under § 1.446–3(h). The attributes of M1's intercompany income and M2's corresponding deduction are redetermined to produce the same effect as if the transaction had occurred between divisions of a single corporation. Under paragraph (c)(4)(i) of this section, the attributes of M2's corresponding deduction control the attributes of M1's intercompany income. Accordingly, M1's income is treated as ordinary income. Under § 1.446–3(f), the deemed $10 up-front payment by M1 to M2 in connection with the issuance of a new contract is taken into account over the term of the new contract in a manner reflecting the economic substance of the contract (for example, allocating the payment in accordance with the forward rates of a series of cash-settled forward contracts that reflect the specified index and the $1,000 notional principal amount). (The timing of taking items into account is the same if M1, rather than M2, is the dealer subject to the mark-to-market requirement of section 475 at year-end. However in this case, because the attributes of the corresponding deduction control the attributes of the intercompany income, M1's income from the deemed termination payment from M2 might be ordinary or capital). Under paragraph (g)(3)(ii)(A) of this section, section 475 does not apply to mark the notional principal contract to fair market value after its deemed satisfaction and reissuance.

(8) *Effective/applicability date.* The rules of this paragraph (g) apply to transactions involving intercompany obligations occurring in consolidated return years beginning on or after the date of publication of the Treasury decision adopting these rules as final regulations in the **Federal Register**.

* * * * *

Kevin M. Brown,

Deputy Commissioner for Services and Enforcement.

[FR Doc. E7–19134 Filed 9–27–07; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 406, 407, and 408

[CMS–4129–P]

RIN 0938–A077

Medicare Program; Special Enrollment Period and Medicare Premium Changes

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would provide a special enrollment period (SEP) for Medicare Part B and premium Part A for certain individuals who are sponsored by prescribed organizations as volunteers outside of the United States and who have health insurance that covers them while outside the United States. Under the SEP provision, qualifying volunteers can delay enrollment in Part B and premium Part A, or terminate such coverage, for the period of service outside of the United States and reenroll without incurring a premium surcharge for late enrollment or reenrollment.

This proposed rule would also codify provisions that require certain beneficiaries to pay an income-related monthly adjustment amount (IRMAA) in addition to the standard Medicare Part B premium, plus any applicable increase for late enrollment or reenrollment. The income-related monthly adjustment amount is to be paid by beneficiaries who have a modified adjusted gross income that exceeds certain threshold amounts. It also represents the amount of decreases in Medicare Part B premium subsidy, that is, the amount of the Federal government's contribution to the Federal Supplementary Medicare Insurance (SMI) Trust Fund.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 27, 2007.

ADDRESSES: In commenting, please refer to file code CMS–4129–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–4129–P, P.O. Box 8017, Baltimore, MD 21244–8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–4129–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may

submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Sam DellaVecchia, (410) 786–4481. Denise Cox, (410) 786–3195.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–4129–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

A. General

Medicare is a Federal health insurance program that helps millions of Americans pay for health care. Beneficiaries include eligible individuals age 65 or older and certain people younger than age 65 who also qualify to receive Medicare. These individuals include those who have disabilities and those who have permanent kidney failure (end stage renal disease).

Medicare Parts A and B are the subject of this proposed rule. Hospital insurance (Part A) helps to pay for inpatient care in hospitals, skilled nursing facilities, as well as home health care and hospice care. Part B or supplementary medical insurance (SMI) helps to pay for physicians' services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered under Part A.

Part A is financed primarily through compulsory payroll taxes under the Federal Insurance Contributions Act (''FICA''). Individuals age 65 or over who are entitled to receive Social Security or railroad retirement benefits, or who are eligible for Social Security benefits and have filed an application for hospital insurance, are entitled to receive Part A benefits without paying a monthly premium. However, individuals who do not qualify for premium-free Part A, may voluntarily enroll in Part A but are required to pay a monthly premium. These individuals generally include those who have not worked 10 years in Medicare-covered employment or are not the spouse, divorced spouse or widow(er) of an individual who has worked 10 years in Medicare-covered employment. In addition, they must meet the following requirements: (1) Be at least age 65; (2) a resident of the United States; (3) a United States citizen or an alien who has been lawfully admitted for permanent residence and who has resided continuously in the United States for the 5 year period immediately preceding the month of enrollment; (4) not otherwise eligible to receive Part A benefits without having to pay a premium; and (5) entitled to Part B or are eligible and have enrolled.

Enrollment in Part B is open to all persons who are entitled to Part A benefits, as well as to persons who are not entitled to Part A benefits provided certain requirements are satisfied. Part B is financed primarily through premiums paid by or on behalf of beneficiaries, along with transfers made from the General Fund of the Treasury. Section 1839(a) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to determine the Medicare Part B standard monthly premium amount annually. Currently, the standard monthly premium represents approximately 25 percent of the estimated total Part B program cost for each aged enrollee. The remaining 75 percent of the total estimated cost is subsidized by the Federal government through transfers to the Federal SMI Trust Fund from the General Fund of the Treasury.

Individuals who do not enroll in Part B or premium Part A when first eligible or who enroll and later terminate their coverage may only enroll during the general enrollment period, which is January through March of each year, unless an exception applies. The coverage will be effective the following July 1. Under section 1839(b) of the Act, individuals who delay enrolling in premium Part A or Part B for 12 or more months must pay a premium surcharge.

B. General Enrollment Period Exceptions

1. Special Enrollment Period (SEP)

Currently, section 1837(i) provides a special enrollment period (SEP) for individuals age 65 or over who are working or who are the spouses of working individuals who are covered under a group health plan (GHP). For disabled individuals, who are under age 65, the SEP applies if the individual is covered by a GHP by reason of the current employment status of the individual or the individual's spouse, or if the individual is covered by a large group health plan (LGHP) by reason of the current employment status of the individual or a member of the individual's family. In this type of situation, enrollment in Part B can take place anytime the individual is covered under the GHP or LGHP based on current employment status or during the 8-month period that begins the first full month after the GHP or LGHP coverage ends. Because section 1818(c) of the Act provides that the enrollment provisions in section 1837 (except subsection f thereof) apply to persons authorized to enroll in premium Part A, we have extended this SEP to premium Part A enrollments.

2. Transfer Enrollment Period (TEP)

Another exception is the transfer enrollment period (TEP) for enrollment in premium Part A. The TEP is for individuals age 65 or older who are otherwise eligible to enroll in premium Part A; are enrolled in a plan with an organization listed in section 1876 of the Act; and whose coverage under the plan is terminated for any reason. Here, an individual may enroll in premium Part A beginning any month that the individual is enrolled in the plan, and ending with the last day of the 8-month period following the last month in which the individual is no longer enrolled in the plan.

3. Statutory Changes

Section 5115(a)(2) of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) amended section 1837 of the Act to add a new subsection (k), which provides a SEP for certain international volunteers. Beginning January 1, 2007, a SEP for Part B is provided to qualifying international volunteers who are eligible

to enroll in Part B because they meet the requirements in section 1836(1) or (2) of the Act, but who do not enroll in Part B during the initial enrollment period or who terminate enrollment during a month in which they qualify as an international volunteer. Enrollment can take place during the 6-month period beginning on the first day of the month which includes the date the individual no longer qualifies under this provision. Coverage for an individual who enrolls during a SEP in accordance with this provision begins on the first day of the month following the month in which the individual enrolls.

Under new section 1837(k)(3) of the Act, an individual qualifies as an international volunteer if he or she is serving in a program outside of the United States that covers at least a 12-month period, and that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 (the Code) and exempt from taxation under section 501(a) of the same Code. The individual must also have health insurance coverage to cover medical services while serving overseas in the program. Specifically, qualifying organizations under section 501(c)(3) of the Code that are exempt from taxation under section 501(a) of the Code are ''corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals * * *''. Furthermore, to qualify for this exemption, no part of the net earnings of the organization can inure to the benefit of any private shareholder or individual and no substantial part of the activities can be used for propaganda, or otherwise attempt to influence legislation (except as otherwise provided in section 510(h) of the Code) or participate or intervene (including the publishing or distributing of statements) in political campaigns on behalf of (or in opposition to) any candidate for public office.

C. Income-Related Monthly Adjustment Amount under Medicare Part B

Section 811 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) amends section 1839 of the Act and establishes a Medicare Part B premium subsidy reduction referred to as the ''Income-Related Monthly Adjustment Amount'' (IRMAA). Section 1839(i) of the Act requires that an income-related monthly adjustment amount be added to beneficiary's Part B premium if his or her modified adjusted gross income exceeds the established threshold amounts. The IRMAA reduces the amount that the beneficiary's premium is subsidized by the Federal government. All beneficiaries will continue to receive some subsidy of their premium.

Section 1839(i) of the Act establishes a sliding scale that we would use to establish four income-related monthly adjustment amounts that would increase a beneficiary's Medicare Part B premium by specific percentages. If a beneficiary's modified adjusted gross income is greater than the statutory threshold amounts, the beneficiary will pay a larger portion of the estimated total cost of Part B coverage. The income ranges, as set forth in section 1839(i)(3)(C)(i) of the Act, start at $80,000 for a beneficiary filing an individual tax return, and $160,000 for a beneficiary filing a joint income tax return, and are listed in the following table:

Individual tax filers with income:	Joint tax filers with income:	Premium percentage
Greater than $80,000 and less than or equal to $100,000	Greater than $160,000 and less than or equal to $200,000	35
Greater than $100,000 and less than or equal to $150,000	Greater than $200,000 and less than or equal to $300,000	50
Greater than $150,000 and less than or equal to $200,000	Greater than $300,000 and less than or equal to $400,000	65
Greater than $200,000	Greater than $400,000	80

In calendar year (CY) 2007, individual tax filers with income less than or equal to $80,000 and joint tax filers with income less than or equal to $160,000 will continue to pay the standard premium which represents roughly 25 percent of the estimated total Part B program costs. As specified in section 1839(i)(5) of the Act, each dollar amount in this table would be adjusted annually based on the Consumer Price Index.

Section 811 of the MMA also provided for a 5-year phase-in of the Medicare Part B premium subsidy reduction. However, section 1839(i) was subsequently amended by section 5111 of the DRA to provide for a 3-year phase-in period. Therefore, the percentages presented in this table reflect the Part B premium percentages that certain beneficiaries would pay once IRMAA is fully phased-in.

The ''hold-harmless'' provision in section 1839(f) of the Act provides for a reduction to the Part B premium for beneficiaries whose Social Security [or Railroad Board (RRB) annuity] cost of living adjustments (COLAs) are not sufficient to cover the Part B premium increase. If in a given year, the increase in the Part B premium would cause an individual's Social Security or RRB check to be less than it was the year before, the premium is reduced to ensure that the amount of the individual's Social Security benefit (or RRB annuity) stays the same. To be held harmless, a beneficiary must have had the Part B premium deducted from both the December check of the prior year and the January check of the next year. Under section 1839(f) of the Act, the ''hold-harmless'' provision does not apply to beneficiaries who are required to pay an IRMAA based on their modified adjusted gross income. These beneficiaries must pay the full Medicare Part B standard monthly premium, plus any applicable penalty for late enrollment or reenrollment, plus the income-related monthly adjustment amount.

Section 702(a)(5) of the Act allows SSA to make the rules and regulations necessary or appropriate to carry out the functions of SSA. Other provisions in section 811 of the MMA provide SSA with additional specific authorization to make rules and regulations to determine which beneficiaries are required to pay the different income-related monthly adjustment amounts.

On October 27, 2006, SSA issued a final rule implementing regulations governing SSA's determination of income-related monthly adjustment amounts (71 FR 62923). This final rule explains: (1) The statutory requirement to implement an income-related adjustment to the Part B premium subsidy; (2) the information that would be used to determine whether a beneficiary must pay an income-related monthly adjusted amount and the amount of any adjustment; (3) when SSA will consider a major life-changing event that results in a significant reduction in a beneficiary's modified

adjusted gross income; and (4) how a beneficiary can appeal SSA's determination about the beneficiary's income-related monthly adjustment amount. For a more detailed discussion see the October 27, 2006 SSA final rule (71 FR 62923).

II. Provisions of the Proposed Rule

We are proposing to add a new § 406.25, which would allow certain individuals who are sponsored by prescribed organizations as volunteers outside of the United States and have health care insurance to qualify for a SEP for premium hospital insurance (Part A) special enrollment period. We recognize that section 5115 of the DRA, in amending section 1839(b) of the Act, explicitly provides only for a SEP for Part B. However, since section 1818(c) of the Act applies all of the provisions of section 1837 of the Act (except subsection (f) thereof) to persons authorized to enroll under section 1818 of the Act, we believe that the SEP provided in section 5115 of the DRA also applies to enrollment in premium Part A.

In § 406.33(a)(3), we propose to make a technical correction by removing an incorrect phrase ''the 7-month special enrollment period under § 406.21(e)'' and replacing it with the phrase ''the special enrollment period under § 406.24.''

In § 406.33(a)(5) and (6), we propose to exclude from the calculation of the premium surcharge those months the individual qualifies for the SEP described in § 406.25(a).

We are proposing to add a new § 407.21, which implements section 5115 of the DRA by allowing certain individuals who are sponsored by prescribed organizations as volunteers outside of the United States and have health care insurance that covers medical services while serving overseas to qualify for a Medicare Part B SEP.

In proposed § 408.20(e)(3)(iii), we would implement section 811(b)(1)(c) of the MMA by excluding from the ''hold harmless'' provision (known as the ''nonstandard premium'') individuals who are required to pay the income-related monthly adjustment amount (IRMAA). Such beneficiaries must pay the full Medicare Part B standard monthly premium plus any applicable premium surcharge for late enrollment or re-enrollment, plus the income-related monthly adjustment amount.

In proposed § 408.24(a)(10), we would implement section 5115(a) of the DRA by excluding from the calculation of the premium surcharge those months the individual meets the requirements of proposed § 407.21. We are also making a conforming change in § 408.24(b)(2)(i) of this section by revising the cross reference to include the new paragraph § 408.24(a)(10).

Finally, we propose to add a new § 408.28, to specify that, beginning January 1, 2007, we would inform Medicare beneficiaries that they may be required to pay an income-related monthly adjustment amount in addition to the standard Part B premium, plus any applicable increase for late enrollment or reenrollment, if their modified adjusted gross income exceeds the threshold limits specified in 20 CFR 418.1115.

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 3506(c)(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.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements.

Special Enrollment Period for Volunteers Outside of the United States (§ 406.25)

Section 406.25 outlines the requirements that an individual volunteer must meet to qualify for a SEP. A qualifying individual can enroll or reenroll without incurring a surcharge for a late enrollment or reenrollment. Specifically, § 406.25(a)(3)(i) states that an individual volunteer must demonstrate that his or her period of service is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of the Internal Revenue Code.

The burden associated with this requirement is the time and effort associated with demonstrating the tax-exempt status of the organization sponsoring the individual. The estimated burden associated with this requirement is 15 minutes per individual. We estimate that 1500 individuals will be subject to this requirement on a yearly basis for a total annual burden of 375 burden hours.

In addition, § 406.25(a)(3)(ii) requires that an individual demonstrate that he or she has health insurance that covers medical services received outside of the United States during his or her period of service. The burden associated with this requirement is the time and effort associated with demonstrating possession of health insurance coverage that covers the medical services received outside of the United States. We estimate the burden for verifying coverage to be 15 minutes per individual; we also estimate that 1500 individuals will be subject to this requirement on a yearly basis. The total estimated burden is 375 annual burden hours.

Special Enrollment Period for Volunteers Outside the United States (§ 407.21)

Section 407.21 addresses the provision of a SEP for an individual who elects not to enroll or to be deemed enrolled in SMI when first eligible and an individual who terminates SMI enrollment. To be eligible for the SEP, the individual must meet the criteria outlined in the regulations text. As stated in § 407.21(a), the individual must: (1) Volunteer in a program for a 12-month or longer period of service outside of the United States; (2) volunteer in a program sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under 501(a) of such Code; and (3) demonstrate that he or she had health insurance coverage that covers medical services received outside of the United States during his or her period of service, respectively.

The burden associated with the introductory text to § 407.21(a), as well as § 407.21(a)(1) and (a)(2), is the time and effort associated with verifying the individual's volunteer period of service, verifying the tax-exempt status of the organization sponsoring the individual, and submitting the information to CMS. The estimated burden associated with these requirements is 15 minutes per individual. We estimate that 1500 individuals will be required to verify their volunteer service. The total annual burden associated with this requirement is 375 burden hours.

The burden associated with the § 407.21(a)(3) is the time and effort

associated with an individual demonstrating that he or she has health insurance that covers medical services received outside of the United States during his or her period of service. We estimate the burden for verifying coverage to be 15 minutes per individual; we also estimate that 1500 individuals will be subject to this requirement on a yearly basis. The total estimated burden is 375 annual burden hours.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements contained in this section. These requirements are not final until they are approved by OMB.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: William N. Parham III, CMS–4129–P, Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn Lovett, CMS Desk Officer, CMS–4129–P, *carolyn_lovett@omb.eop.gov.* Fax (202) 395–6974.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

We have examined the impact of this 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 1995 (Pub. L. 104–4), and Executive Order 13132.

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 1 year). We do not anticipate that there will be more than 1500 beneficiaries (international volunteers) at any one time who will qualify for a SEP. To qualify under this SEP, the Medicare beneficiary must have elected not to enroll in Part B or premium Part A during the initial enrollment period, or terminated enrollment, because the individual was serving as a volunteer outside the United States. In addition, the individual must have served as a volunteer outside of the United States through a program that covers at least a 12-month period, and that is sponsored by an organization described in section 501(C)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of that Code, and must have health care insurance coverage that covers medical services while serving overseas in the program. It is for this reason, that we anticipate that the overall expenditure for this provision of the Medicare program projected over a 5-year period would be negligible. In addition, this rule only codifies the income-related monthly adjustment amount provision of MMA. It is for these reasons that this rule does not reach the economic threshold and thus is not considered a major rule.

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 small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this rule 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 603 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 are not preparing an analysis for section 1102(b) of the Act, because we have determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 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. That threshold level is currently approximately $120 million. This rule will have no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have determined that this proposed rule does not impose any costs on State or local governments, therefore the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 406

Health facilities, Kidney diseases, Medicare.

42 CFR Part 407

Medicare.

42 CFR Part 408

Medicare.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 CFR Chapter IV as follows:

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

1. The authority citation for part 406 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart C—Premium Hospital Insurance

2. Section 406.25 is added to read as follows:

§ 406.25 Special enrollment period for volunteers outside the United States.

(a) *General rule.* An individual described in paragraph (a)(2) may use a SEP as defined in § 406.24(a)(4) of this section if—

(1) At the time the individual first met the requirements of § 406.10 through 406.15 or § 406.20(b), the individual elected not to enroll in premium Part A during the individual's initial enrollment period; or

(2) The individual terminated enrollment in premium hospital insurance during a month in which the individual was described in paragraph (a)(2) of this section.

(3) For purposes of paragraphs (a)(1) and (a)(2) of this section, an individual—

(i) Is serving as a volunteer outside of the United States through a program that covers at least a 12-month period and that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code; and

(ii) Can demonstrate that he or she has health insurance that covers medical services that the individual receives outside the United States while serving in the program.

(b) *Duration of SEP.* The SEP is the 6-month period beginning on the first day of the month which includes the date that the individual no longer meets the description in paragraph (a)(2) of this section.

(c) *Effective date of coverage.* If the individual enrolls in premium hospital insurance in accordance with a SEP authorized by this section, coverage begins on the first day of the month following the month in which the individual enrolls.

3. Section 406.33 is amended by—

A. Revising paragraph (a)(3).

B. Adding paragraphs (a)(5) and (a)(6).

The revision and additions read as follows:

§ 406.33 Determination of months to be counted for premium increase: Enrollment.

* * * * *

(a) * * *

* * * * *

(3) Any months during the SEP under § 406.24 of this part, during which premium hospital insurance coverage is in effect.

* * * * *

(5) For premiums due for months after December 2006, any months during which the individual met the provisions of § 406.25(a) of this subpart.

(6) Any months during the 6-month SEP described in § 406.25(b) of this part during which premium hospital insurance coverage is in effect.

PART 407—SUPPLEMENTARY MEDICAL INSURANCE (SMI) ENROLLMENT AND ENTITLEMENT

4. The authority citation for part 407 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Individual Enrollment and Entitlement for SMI

5. Section 407.21 is added to read as follows:

§ 407.21 Special enrollment period for volunteers outside the United States.

(a) *General rule.* A SEP, as defined in § 406.24(a)(4) of this subchapter, is provided for an individual who does not elect to enroll or to be deemed enrolled in Part B (SMI) when first eligible, or who terminates SMI enrollment, if while serving as a volunteer outside of the United States—

(1) The individual is in a program that covers at least a 12-month period of service outside of the United States;

(2) The program is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code; and

(3) The individual demonstrates that he or she has health insurance that covers medical services that the individual receives outside of the United States during his or her period of service.

(b) *Duration of SEP.* The SEP is the 6-month period beginning on the first day of the month which includes the date that the individual no longer satisfies the provisions of paragraph (b) of this section.

(c) *Effective date of coverage.* For individuals enrolling in an SEP under this section, coverage begins on the first day of the month following the month in which the individual enrolls.

PART 408—PREMIUMS FOR SUPPLEMENTARY MEDICAL INSURANCE

6. The authority citation for part 408 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Amount of Monthly Premiums

7. Section 408.20 is amended by adding paragraph (e)(3)(iii) to read as follows:

§ 408.20 Monthly premiums.

* * * * *

(e) * * *

(3) * * *

(iii) Beginning with CY 2007, a nonstandard premium may not be applied to individuals who are required to pay an income-related monthly adjustment amount described in § 408.28 of this part.

* * * * *

8. Section 408.24 is amended by—

A. Adding paragraph (a)(10).

B. Revising paragraph (b)(2)(i).

The addition and revision read as follows:

§ 408.24 Individuals who enrolled or reenrolled before April 1, 1981 or after September 30, 1981.

(a) * * *

* * * * *

(10) For premiums due for months beginning with January 1, 2007, the following:

(i) Any months after December 2006 during which the individual met the conditions under § 407.21(a) of this chapter.

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in § 407.21(b) of this chapter.

(b) * * *

(2) * * *

(i) Any of the periods specified in paragraph (a); and

* * * * *

9. Section 408.28 is added to read as follows:

§ 408.28 Increased premiums due to the income-related monthly adjustment amount (IRMAA).

Beginning January 1, 2007, Medicare beneficiaries must pay an income-related monthly adjustment amount in addition to the Part B standard monthly premium plus any applicable increase for late enrollment or reenrollment if the beneficiary's modified adjusted gross income exceeds the threshold amounts specified in 20 CFR 418.1115.

(Authority: Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.)

Dated: March 1 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: June 4, 2007.

Michael O. Leavitt,

Secretary.

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