*Four-year Private Institutions:* Janet Dodson, Director of Financial Aid, Doane College.

Scott Fleming, Government Relations, Georgetown University.

Ellis Salim, Director of Financial Aid, Baker College.

*Alternates:* Bernard Pekala, Director of Financial Strategies, Boston College.

Thomas O'Neill, Jr., President, Association of Independent Colleges and Universities of Nebraska.

*Two-year Public Institutions:* Patrick Moore, Director of Financial Aid, Delaware Technical and Community College.

*For-Profit Institutions:* Marry Dorrell, Corporate Vice President of Student Finance, Career Education Corporation.

*Students:* Carmen Berkeley, United States Students Association.

*Alternate:* Cedric Lawson, United Council of University of Wisconsin Students.

*Associations:* Terry Hartle, Senior Vice President, American Council of Education.

*Alternate:* Cyndy Littlefield, Association of Jesuit Colleges and Universities.

*Department of Education:* Gail McLarnon.

We have scheduled a total of three negotiated rulemaking sessions, all of which will be held at our offices on 1990 K Street, NW., Washington, DC 20006. The following schedule is subject to change. We will announce any changes to this schedule on the Department's Web site at *http://www.ed.gov/policy/highered/reg/hearulemaking/2008/index2008.html*.

Session 1: January 8–January 10.

Session 2: January 22–January 24.

Session 3: February 6–February 8.

For the first negotiating session, the TEACH Grant committee is scheduled to meet from 9 a.m. to 5 p.m. each day.

For Session 2, the committee is scheduled to meet from 9 a.m. to 5 p.m. each day.

For Session 3, the committee is scheduled to meet from 1 p.m. to 5 p.m. on February 6 and from 9 a.m. to 5 p.m. on February 7 and 8.

**Student Loan Committee Topics, Members, and Meeting Schedule**

The topics the Student Loan Committee is likely to address are:

Income-based Repayment Plan (IBR).

Conforming the Economic Hardship Deferment with IBR.

Public Service Loan Forgiveness.

Definition of Not-for-Profit Holder.

Harmonizing HEROES Waivers with Other Benefits Provided to Returning and Active Duty Military.

Federal Preemption of State Laws Related to improper inducements and arrangements between schools, lenders and other entities in the student loan programs.

This list of topics is tentative. Topics may be added as the process continues.

The members of the Student Loan Committee and the interests they are representing are:

*Students:* Luke Swarthout, United States PIRG.

*Alternate:* Rebecca Thompson, United States Student Association.

*Graduate and Professional Students:* Carrie Steere-Salazar, American Association of Medical Colleges.

*Alternate:* Radhika Miller, National Lawyers Guild Partnership for Civil Justice.

*Legal Aid:* Deanne Loonin, National Consumer Law Center.

*Alternate:* Lauren Saunders, National Consumer Law Center.

*Four-year Public Institutions:* Allison Jones, California State University.

*Alternate:* Anna Griswold, Pennsylvania State University.

*Four-year Private Institutions:* Eileen O'Leary, Stonehill College.

*Alternate:* Kathleen Koch, Seattle University School of Law.

*Two and Four-year Public Institutions:* George Chin, City University of New York.

*For-profit Institutions:* Mark Pelesh, Corinthian Colleges.

*Alternate:* Tammy Halligan, Career College Association.

*Lenders—For-Profit:* Tom Levandowski, Wachovia Corporation.

*Alternate:* Walter Balmas, MyRichUncle.

*Lenders—Non-Profit:* Scott Giles, Vermont Student Assistance Corporation.

*Alternate:* Phil Van Horn, Wyoming Student Loan Corporation.

*Guaranty Agencies:* Gene Hutchins, New Jersey Higher Education Student Assistance Authority.

*Alternate:* Dick George, Great Lakes Higher Education Guaranty Cooperation.

*Servicers:* Wanda Hall, EDFinancial Services.

*Alternate:* Rob Sommers, Sallie Mae.

*Collection Agencies:* Martin Darnian, Windham Professionals.

*Alternate:* Carl Perry, Progressive Financial Services.

*Associations:* Anne Gross, NACUBO.

*Department of Education:* Dan Madzelan.

We have scheduled a total of three negotiated rulemaking sessions, all of which will be held at our offices on 1990 K Street, NW., Washington, DC 20006. The following schedule is subject to change. We will announce any changes to this schedule on the Department's Web site at *http://www.ed.gov/policy/highered/reg/hearulemaking/2008/index2008.html.*

Session 1: January 14–January 16.

Session 2: February 4–February 6.

Session 3: March 4–March 6.

For the first negotiating session, the Student Loan Committee is scheduled to meet from 9 a.m. to 5 p.m. each day.

For Session 2, the committee is scheduled to meet from 9 a.m. to 5 p.m. on February 4th and 5th; and from 9 a.m. to 12 noon on February 6th.

For Session 3, the committee is scheduled to meet from 9 a.m. to 5 p.m. each day.

**Electronic Access to This Document**

You may view this document in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *http://www.ed.gov/news/fedregister*.

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office toll free at 1–888–293–6498; or in the Washington, DC area at (202) 512–1530.

**Note:** The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *http://www.gpoaccess.gov/nara/index.html*.

**Program Authority:** 20 U.S.C. 1098a.

Dated: January 3, 2008.

**Diane Auer Jones,**

*Assistant Secretary for Postsecondary Education.*

[FR Doc. E8–121 Filed 1–7–08; 8:45 am]

**BILLING CODE 4000–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

### 42 CFR Parts 422 and 423

**[CMS–4133–P]**

**RIN 0938–AP25**

## Medicare Program; Option for Prescription Drug Plans To Lower Their Premiums for Low-Income Subsidy Beneficiaries

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

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would provide for an option for Medicare

Prescription Drug Plan (PDP) Sponsors to offer a separate prescription drug premium amount for low-income subsidy (LIS) individuals subject to certain conditions. We are proposing to allow PDP Sponsors to offer a reduced premium amount for LIS-eligible individuals to ensure that at least five PDP Sponsors in every PDP region would have a PDP with a premium at or below the premium subsidy amount. This provision will help to ensure there are a sufficient number of organizations offering zero-premium plans in each region and reduce the number of LIS beneficiary reassignments to other organizations.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on March 10, 2008.

**ADDRESSES:** In commenting, please refer to file code CMS–4133–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–4133–P, P.O. Box 8010, Baltimore, MD 21244–8010.

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–4133–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) 786–9994 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.

**FOR FURTHER INFORMATION CONTACT:** Deondra Moseley, (410) 786–4577. Meghan Elrington, (410) 786–8675.

**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–4133–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

[If you choose to comment on issues in this section, please include the caption ''BACKGROUND'' at the beginning of your comments.]

The beneficiary premiums for Prescription Drug Plans (PDP) are based on an annual bidding process. Each year the beneficiary premium for a Part D plan can change as a result of this bidding process. In addition, each year, as required by statute, CMS recalculates the Federal Part D premium subsidy available to low-income beneficiaries based on the new premiums for plans in each region. As a result of these premium and subsidy changes, the premium for a Part D plan can be fully covered by the low-income subsidy (LIS) in one year and not the following year.

The amount of the premium subsidy available to LIS-eligible individuals cannot be calculated until after bids are submitted for the calendar year in question, because the subsidy amount is based on the bids that are submitted. Therefore, a PDP sponsor whose premium for LIS-eligible enrollees is currently zero does not know at the time its bid is submitted whether the premium that would result from its bid will be higher or lower than the premium subsidy amount.

LIS-eligible individuals enrolled in a PDP that does not charge them a premium are faced with the possibility that the plan they are enrolled in will impose a premium during the next calendar year that would require them to make monthly payments. Section 1860D–1(b)(1)(C) of the Social Security Act (the Act) mandates the initial enrollment of full-benefit dual eligible individuals not choosing a plan into a PDP where they would not pay a premium. It does not, however, require that individuals be reassigned to a plan that would not charge them a premium, if they would be required to pay a premium in their plan the following calendar year. Using our authority under Section 1860D–1(b)(1)(A) of the Act to, ''establish a process for the enrollment, disenrollment, termination, and change of enrollment of Part D eligible individuals in prescription drug plans,'' we have specified that LIS-eligible individuals facing the above situation may ''elect'' a PDP with no premium (to which they would be randomly assigned) by taking no action. We have referred to this process as our reassignment process. Beneficiaries eligible for the full low-income premium subsidy, including beneficiaries dually eligible for benefits under Titles XVIII and XIX of the Social Security Act, are subject to reassignment. Beneficiaries eligible for a partial premium subsidy are not subject to reassignment.

For 2008, the number of beneficiaries reassigned to a different organization under this process varied widely by region, ranging from as few as 17

beneficiaries to approximately 402,322 beneficiaries. The average number of beneficiaries reassigned to an organization other than the one with which they were enrolled was 34,044 per region.

Alternatively, LIS beneficiaries can affirmatively elect to stay in their plan and begin paying a premium, or choose another plan with or without a premium. While this policy prevents an LIS-eligible individual who did not choose to elect a plan from being charged a premium, it disrupts continuity and stability in coverage.

Currently, under the demonstration project entitled, ''Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries'' (established in 2007 and extended to 2008), if the premium amount for a LIS-eligible individual in the above situation is lower than a specified de minimis amount, the individual would not be charged this de minimis amount, and could remain in his or her current plan without paying a premium. This demonstration also transitions the calculation of the low-income benchmark premium amount for a region from a method that weights the standardized Part D bids for PDPs equally to the statutory method, which calculates the benchmarks by weighting the bids for PDPs and MA–PD plans in that region based on plan enrollment. While the evaluation for this demonstration project is still underway, we believe the de minimis policy has demonstrated the advantages of the continuity of care and stability that result from permitting LIS-eligible individuals effectively to be charged a lower total premium than the total premium amount charged in the case of non-LIS-eligible individuals. Accordingly, we believe that PDP Sponsors should have this option on an ongoing basis under regular program rules, subject to limitations that ensure the integrity of the bid process, and retain incentives to submit competitive bids.

We believe that the statute could reasonably be interpreted to permit, consistent with limitations that would be set forth in regulations, PDP Sponsors to establish a separate premium for LIS-eligible individuals in the amount of the low-income premium subsidy. Section 1860D–13(a)(1)(F) of the Act ordinarily requires that a prescription drug premium be uniform. This rule applies, however, ''except as provided in subparagraphs (D) (which provides for the late enrollment penalty) and (E) (which governs LIS-eligible individuals) * * *''. In addition 1860D–13(a)(1)(E) of the Act provides that in the case of an LIS-eligible individual, the premium ''is subject to decrease * * *''. While we initially interpreted this language to refer only to the decrease in the amount paid by the LIS-eligible individual in the amount of the low-income premium subsidy, we believe that the statutory language would also permit an interpretation that would allow PDP Sponsors to charge a decreased premium amount in the case of such individuals. When subject to the limitations as proposed here, this reasonable interpretation of the statute supports our goal of ensuring continuity of care and stability, while ensuring the integrity of the bid process and retaining incentives for organizations to submit competitive bids. We believe that our earlier interpretation of the statute did not take into account the flexibility afforded by section 1860D–13(a)(1)(E) of the statute, which is broadly worded to provide that for a LIS eligible individual, ''[t]he monthly beneficiary premium is subject to decrease[.]''

## II. Provisions of the Proposed Regulations

[If you choose to comment on issues in this section, please include the caption ''PROVISIONS OF THE PROPOSED REGULATIONS'' at the beginning of your comments.]

We are proposing to make revisions to the regulations in order to implement an option for PDP Sponsors to reduce PDP beneficiary premiums for LIS-eligible individuals. This option would not be made available to plans that offer enhanced alternative coverage. Specifically, we are proposing to revise § 422.262 and § 423.286(e), to provide for an exception to the general rule for uniformity of premiums. We are also proposing to revise § 423.286(e), to state that the monthly beneficiary premium paid by the beneficiary may be eliminated as provided in § 423.780.

We are proposing to amend § 423.34(d), to clarify that PDPs that have a separate premium for LIS-eligible individuals under our proposed option would not be eligible to receive ''auto-enrollees'' under section 1860D–1(b)(1)(C) of the Act. However, PDP Sponsors that have separate premiums for LIS enrollees in their PDPs would keep their existing LIS enrollees. An auto-enrollment would continue to be available only to PDPs with a standard prescription drug premium that is equal to, or below, the LIS amount.

In addition, we are proposing to revise § 423.780, to permit a PDP sponsor, subject to the conditions discussed below, to establish a separate premium for LIS-eligible individuals in the amount of the low-income premium subsidy amount when the premium that would otherwise apply would exceed this amount.

Several options were considered as we developed this proposed rule. We considered allowing all PDP Sponsors to make a business judgment, after the LIS amount was established, whether to reduce their premium to the subsidy amount for LIS-eligible individuals without regard to the amount by which their premium would otherwise exceed the amount of the subsidy. We did not choose this approach for two reasons. First, if the difference between the two amounts were too great, this would produce a significant disparity between the revenue needs assumed in the bid, and the revenue that would be received under the reduced premium, and undermine the integrity of the bid process. More importantly, if a PDP sponsor knew that it could be assured of reducing its premium for LIS-eligible individuals to the LIS amount no matter how much the premium produced by its bid exceeded this amount, this would greatly reduce existing incentives to bid as low as possible.

Second, we considered changing our approach to re-assignment from allowing LIS-eligible individuals to be re-assigned if they take no action to an approach that would allow LIS-eligible individuals to be informed of zero-premium PDP options, but would remain in their current plan if they take no action. We consulted with beneficiary advocate groups about this approach, and many expressed concerns about LIS-eligible individuals being subjected to premium costs without them electing to pay them. We further considered only reassigning LIS individuals if the premium they would have to pay were above a certain level, on the assumption that a relatively low premium amount may not present a financial hardship. However, this would raise complicated issues regarding collection of these premium amounts.

We are proposing to retain the current reassignment policy and permit certain PDP Sponsors to reduce premiums for LIS-eligible individuals to the subsidy amount, while limiting the amount the premium produced by bids could be reduced to reach the LIS amount. We considered proposing a fixed dollar amount, as is employed under the current de minimis demonstration, and would be employed under the change in reassignment policy discussed above. However, we again were concerned about an approach that permanently would employ a fixed dollar figure, and decided that a methodology under which the number is not known in

advance would better preserve incentives to submit a low bid.

We are proposing to apply this rule to PDPs only, as current auto-assignment rules do not apply to beneficiaries enrolled in MA-PDs. For this same reason, we do not plan to apply this rule to partial subsidy eligible enrollees. Furthermore, partial subsidy eligible enrollees already pay a premium, as their subsidy is only a percentage of the subsidy amount. A change from the subsidy amount to a higher premium does not have the same impact on them that it does on a full-subsidy eligible beneficiary, who would go from a zero-premium to paying one.

We accordingly propose to set the amount at a region-specific level that would ensure LIS-eligible individuals in each region a robust choice among zero-premium PDPs. Specifically, we are proposing that the limit on the amount by which premiums could be reduced for LIS-eligible individuals be an amount that ensures that at least five PDP Sponsors (i.e., organizations offering PDPs) in every PDP region would have a PDP with a premium at or below the premium subsidy amount. We chose the minimum number of five PDP Sponsors per region because this represents the mid-range number of PDP Sponsors in key regions that qualified for assignment of low-income subsidy-eligible beneficiaries in 2008. Specifically, in 2008 the number of PDP Sponsors with zero-premium plans for LIS individuals ranges from a low of two to a high of eight organizations in key regions with significant MA enrollment. The option of five organizations as a minimum threshold was selected to maintain the average 2008 level of competitiveness. This proposed rule would not affect regions in which there would be at least five PDP Sponsors offering zero-premium plans without this rule in place. In order to achieve the goal of stability for beneficiaries and plans, and offer multiple provider options, this test will be applied at the organizational level (PDP sponsor), rather than the plan (PDP) level. We believe that capping the number of premium differential organizations at a number that would produce zero-premium plans from at least five PDP Sponsors would maintain or possibly improve upon the current competitiveness of bids. We invite public comments on our choice of the minimum number five as the minimum number of Sponsors offering zero-premium plans, as well as on the other options discussed above that we considered, and any additional options that we are not proposing in this proposed rule.

PDP Sponsors will be required to elect this option in their bids. CMS will add a checkbox to the current Bid Pricing Tool submitted by PDP Sponsors in June of each year for each PDP to be offered. Sponsors will use this checkbox to indicate that the PDP will have two premiums—one for enrollees not eligible for the full LIS subsidy and another for LIS-eligible enrollees if they qualify under this rule. This rule will not increase the amount of the low-income premium subsidy paid to plans to account for the difference between the low-income premium subsidy and the premium produced by the plan's bid.

We note that PDP Sponsors that elect this option would be obligated, under our proposed regulations, to charge all LIS-eligible enrollees in affected plans a premium amount that would be the premium subsidy amount if the prescription drug premium produced by their bid did not exceed the amount established to ensure at least five PDP Sponsors offer zero-premium plans in each region. This premium would be part of the benefit package they would be obligated under their contract to cover.

## III. Collection of Information Requirements

The information collection requirements contained in § 423.780(f)(i) of this proposed rule are subject to the Paperwork Reduction Act (PRA). However, the burden associated with the requirement for the PDP sponsor to elect the option of providing for a separate prescription drug premium amount for LIS individuals is included in the burden estimate associated with the Bid Pricing Tool for Prescription Drug Plans which is currently approved under OMB approval number 0938–0944.

## 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

### *A. Overall Impact*

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), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This rule permits Prescription Drug Plan (PDP) Sponsors, subject to conditions, to lower their premiums for low-income subsidy beneficiaries to ensure there are a sufficient number of organizations offering zero-premium plans in each region and reduce the number of reassignments compared to the current regulatory framework. We believe this proposed rule would lead to Federal savings of approximately $20 million per year. This assumes full enrollment weighting for the calculations of the low-income benchmark premium amounts. The estimate was developed by applying this rule against the 2008 bids and this impact was projected throughout the forecast period. The estimate does not anticipate any change in bidding strategies or outcomes. All organizations with existing LIS beneficiaries that could be assigned out of the organization are assumed to elect the option to retain their beneficiaries including receiving reduced premiums for such LIS members. LIS beneficiaries that are assigned out of organizations are assumed to be randomly assigned to organizations that have premiums below the low income premium subsidy benchmark. We invite public comment on the assumptions included in this assessment.

We also evaluated the potential for non-Federal costs and savings associated with this rule. A small number of Part D sponsors would forego revenue associated with the reduction in their beneficiary premium for low income beneficiaries. In addition, we anticipate a reduction in administrative costs for these sponsors, as well as for sponsors to which the beneficiaries would have been reassigned in the absence of this rule. However, we believe that these costs and savings would be relatively small. We invite public comment on this assessment of non-Federal costs and savings. 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 $6.5 million to $31.5 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, and the Secretary certifies, that this regulation 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 for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this regulation 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 $127 million. This rule will have no consequential effect on State, local, or tribal governments in the aggregate, or by 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. Since this regulation does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

*B. Anticipated Effects*

The number of PDP Sponsors offering PDPs that had low enough premiums to qualify for low-income assignments for 2008 ranged from two to eight organizations per region in key regions that had a relatively high proportion of beneficiaries enrolled in MA plans. Five is the average number of PDP Sponsors offering plans that qualified for low-income assignments in these regions; we selected the five PDP Sponsor option to maintain the 2008 level of competitiveness in the bidding process. The 5 plan requirement is an attempt to balance the two goals of introducing beneficiary stability, particularly in regions with very low LIS premium subsidy benchmarks, together with maintaining the incentives in the competitive bidding process. There may be negative consequences if the 5 organizational requirement is too high and the plans bid less competitively or if the 5 organizational requirement is too low and there are an even greater number of low-income beneficiary reassignments. In addition, based on analysis of the 2008 bids, and assuming no de minimis demonstration is in place, CMS anticipates that seven regions would be affected by having a minimum of five plans. CMS estimates that a three Sponsor minimum would have affected five regions, while a seven Sponsor minimum would have affected ten regions. Therefore, we anticipate that this regulation will increase the number of PDP Sponsors offering zero-premium PDPs that would be available to full low-income subsidy-eligible beneficiaries. This proposed regulation would also decrease the number of reassignments of LIS-eligible beneficiaries to other PDPs, compared to the level of reassignment under the current regulation absent a de minimis policy. This decrease in beneficiary movement across plans would boost program stability for both beneficiaries and plans. Based on an analysis of 2008 bids, the five-organization minimum requirement results in 0.2 million fewer beneficiary assignments as compared to the current regulatory framework. The five-organization minimum requirement results in 0.5 million more beneficiary reassignments than would occur under the de minimis policy.

Lastly, CMS expects the improved program continuity and stability that would be produced by this rule would help prevent an increase in costs and risks imposed on PDP Sponsors. The higher the threshold for the number of PDP Sponsors per region offering zero-premium PDPs, the greater the negative impact on competitive bidding. We are seeking to strike a balance between minimizing LIS reassignments and preserving the integrity of the competitive bidding process. The results of competitive bidding in 2008 generated an average of five PDP Sponsors per region eligible for reassignments in certain key regions with relatively high MA enrollment. Selecting five as the minimum organization threshold under this proposed rule is intended to achieve this balance.

This approach maintains a strong incentive to bid low to keep and possibly add LIS beneficiaries. Absent the rule, there may be a ''winner take all'' outcome in certain regions with one organization acquiring all of the LIS beneficiaries in the region. It is difficult to predict what would happen in the absence of this rule, but we would expect some organizations would be induced to bid even lower while other organizations would give up on this population and bid higher. From a cost perspective these factors may offset relative to the proposed rule, but the volatility issue would remain.

*C. Alternatives Considered*

As stated in the Background section of this proposed rule, we considered allowing PDP Sponsors to reduce their premium to the subsidy amount after it was established for LIS-eligible individuals without regard to the amount of their premium. We also considered allowing plans with premiums under a fixed dollar amount to reduce their low-income premiums to the premium subsidy amount. We determined, however, that these options would undermine the integrity and competitiveness of the bidding process.

We also considered changing our approach to reassignment to an approach that would allow LIS-eligible individuals to be informed of zero-premium PDP options, but would remain in their current plan, regardless of the premium, if they take no action. Beneficiary advocacy groups were concerned about beneficiaries being charged a premium without electing to pay it. We further considered only reassigning LIS individuals if the premium they would have to pay were above a certain relatively low premium amount; however, this would raise complicated issues regarding collection of these premium amounts.

We chose to propose to retain the current reassignment policy and, in regions that would not otherwise have at least five zero-premium plans for LIS enrollees, permit a sufficient number of PDPs to reduce their premiums for LIS individuals so that the region includes five zero-premium plans. We believe this option would both maintain or possibly improve upon the current competitiveness of bids and reduce reassignments for beneficiaries.

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 422*

Administrative practice and procedure, Grant programs—health, Health care, Health insurance, Health maintenance organizations (HMO), Loan programs—Health, Medicare, Reporting and recordkeeping requirements.

*42 CFR Part 423*

Administrative practice and procedure, Emergency medical services, Health facilities, Health maintenance organizations (HMO), Medicare, Penalties, Privacy, Reporting and recordkeeping.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

## PART 422—MEDICARE ADVANTAGE PROGRAM

1. The authority citation for part 422 continues to read as follows:

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

### Subpart F—Submission of Bids, Premiums, and Related Information and Plan Approval

2. Amend § 422.262 to revise paragraph (c)(1) to read as follows:

**§ 422.262 Beneficiary premiums.**

(c) * * *

(1) *General rule.* Except as permitted for supplemental premiums pursuant to § 422.106(d), for MA contracts with employers and labor organizations, the MA monthly bid amount submitted under § 422.254, the MA monthly basic beneficiary premium, the MA monthly supplemental beneficiary premium, the MA monthly prescription drug premium (except as provided in § 423.780), and the monthly MSA premium of an MA organization may not vary among individuals enrolled in an MA plan (or segment of the plan as provided for local MA plans under paragraph (c)(2) of this section). In addition, the MA organization cannot vary the level of cost-sharing charged for basic benefits or supplemental benefits (if any) among individuals enrolled in an MA plan (or segment of the plan).

* * * * *

## PART 423—VOLUNTARY MEDICARE PRESCRIPTION DRUG BENEFIT

3. The authority citation for part 423 continues to read as follows:

**Authority:** Secs 1102, 1860D–1 through 1860D–42, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, and 1395hh).

### Subpart B—Eligibility and Enrollment.

4. Amend § 423.34 by—

A. Revising paragraph (d)(1).

B. Adding a new paragraph (d)(3).

The revisions and additions read as follows:

**§ 423.34 Enrollment of full-benefit dual eligible individuals.**

* * * * *

(d) * * *

(1) *General rule.* Except as provided in paragraph (d)(3) of this section, CMS must automatically enroll full-benefit dual eligible individuals who fail to enroll in a Part D plan into a PDP offering basic prescription drug coverage in the area where the individual resides that has a monthly beneficiary premium that does not exceed the low-income premium subsidy amount (as defined in § 423.780(b)). In the event that there is more than one PDP in an area with a monthly beneficiary premium at or below the low-income premium subsidy amount, individuals must be enrolled in such PDPs on a random basis.

(2) * * *

(3) PDPs whose premiums were reduced for LIS beneficiaries under § 423.780(f) would not be entitled to automatic enrollment under paragraph (d)(1) of this section.

* * * * *

### Subpart F—Submission of Bids and Monthly Beneficiary Premiums; Plan Approval

5. Amend § 423.286 by revising paragraph (e) to read as follows:

**§ 423.286 Rules regarding premiums.**

* * * * *

(e) *Decrease in monthly beneficiary premium for low-income assistance.* The monthly beneficiary premium paid by the beneficiary may be eliminated as provided in § 423.780.

* * * * *

### Subpart P—Premiums and Cost-Sharing Subsidies for Low-Income Individuals

6. Amend § 423.780 by adding a new paragraph (f) to read as follows:

**§ 423.780 Premium subsidy.**

* * * * *

(f) *Option for a reduced premium amount for full subsidy eligible individuals.* PDP sponsors have the option of providing for a separate prescription drug premium amount for full subsidy eligible individuals for prescription drugs plans under § 423.104(d) or (e) subject to the following conditions—

(1) The PDP sponsor must elect this option at the time its bid is submitted, and agree to set its prescription drug premium for all full subsidy eligible individuals at the premium subsidy amount under paragraph (b) of this section for the entire coverage year if

(i) The PDP sponsor puts forward no other PDP in the PDP region that is offering a premium below the premium subsidy amount or closer to the premium subsidy amount; and

(ii) Its premium amount would otherwise equal or be below the amount established under paragraph (f)(ii) of this section.

(2) Following the establishment of the premium subsidy amount, CMS will review the bids of PDP sponsors that have elected the option under paragraph (f)(i) of this section, and determine an amount that, when added to the premium subsidy amount, would produce a premium amount that is no greater than the amount that would equal or exceed the prescription drug premium amount produced by bids for at least five PDP sponsors in every PDP region.

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

Dated: December 13, 2007.

**Kerry Weems,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

Approved: December 28, 2007.

**Michael O. Leavitt,**

*Secretary.*

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## FEDERAL COMMUNICATIONS COMMISSION

### 47 CFR Parts 61 and 69

**[WC Docket No. 07–135; DA 07–5082]**

### Establishing Just and Reasonable Rates for Local Exchange Carriers

**AGENCY:** Federal Communications Commission.

**ACTION:** Proposed rule; extension of comment period.