Subpart H—Implementation of the Federal Asset Sales Program

§ 102–38.360 What must an executive agency do to implement the eFAS program?

(a) An executive agency must review the effectiveness of all sales solutions, and compare them to the effectiveness (*e.g.*, cost, level of service, and value added services) of the eFAS SCs. Agencies should give full consideration to sales solutions utilizing private sector entities, including small businesses, that are more effective than the solutions provided by any eFAS-approved SC. If the agency decides that there are more effective sales solutions than those solutions offered by the eFAS SCs, the agency must request a waiver from the milestones using the procedures and forms provided by the eFAS Planning Office. Waivers will be approved by the eFAS Planning Office upon presentation of a business case showing that complying with an eFAS milestone is either impracticable or inefficient. Waiver approval will be coordinated with GSA's Office of Travel, Transportation, and Asset Management. Contact the eFAS Planning Office at *FASPlanningOffice@gsa.gov* to obtain these procedures and forms.

(b) An approved waiver for meeting one of the eFAS milestones does not automatically waive all milestone requirements. For example, if an agency receives a waiver to the migration milestone, the agency must still (1) post asset information on the eFAS Web site and (2) provide post-sales data to the eFAS Planning Office in accordance with the content and format requirements developed by the eFAS ESC, unless waivers to these milestones are also requested and approved. Waivers to the eFAS milestones will not be permanent. Upon expiration of the waiver to the migration milestone, an agency must either migrate to an approved SC, or serve as a fully functioning SC, as soon as practicable. See the definition of a ''Sales Center'' at § 102–38.35 for an overview of how agency sales solutions become SCs.

(c) An agency which receives a waiver from the eFAS milestones must comply with subparts A through G of this part as if it were an SC.

(d) An executive agency must comply with all eFAS milestones approved by OMB including those regarding the completion of an agency-wide sales migration plan, the reporting of pre- and post-sales data, and the migration to approved SCs unless a waiver has been submitted by the agency and approved by the eFAS Planning Office. The eFAS milestones are available for viewing at *http://www.gsa.gov/govsalesmilestones.*

§ 102–38.365 Is a holding agency required to report property in ''scrap'' condition to its selected SC?

No. Property which has no value except for its basic material content (scrap material) may be disposed of by the holding agency by sale or as otherwise provided in § 102–38.70. However, the holding agency should consult the SC(s) selected by the holding agency as to the feasibility of selling the scrap material. Agencies selling scrap property under authority of this subpart are still required to report sales metrics in accordance with eFAS ESC-approved format and content.

§ 102–38.370 What does a holding agency do with property which cannot be sold by its SC?

All reasonable efforts must be afforded the SC to sell the property. If the property remains unsold after the time frame agreed to between the SC and the holding agency, the holding agency may dispose of the property by sale or as otherwise provided in § 102–38.70. The lack of public interest in buying the property is evidence that the sales proceeds would be minimal. Agencies selling property under authority of this subpart are still required to report sales metrics in accordance with eFAS ESC-approved format and content.

[FR Doc. E8–8314 Filed 4–16–08; 8:45 am]

BILLING CODE 6820–14–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 422 and 423

[CMS–4133–CN]

RIN 0938–AP25

Medicare Program; Modification to the Weighting Methodology Used To Calculate the Low-Income Benchmark Amount; Correction

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

ACTION: Correction of final.

SUMMARY: This document corrects mathematical errors that appeared in the impact analysis accompanying the final rule that appeared in the **Federal Register** on April 3, 2008 entitled, ''Modification to the Weighting Methodology Used to Calculate the Low-Income Benchmark Amount.''

DATES: *Effective Date:* May 31, 2008.

FOR FURTHER INFORMATION CONTACT: Paul Spitalnic, (410) 786–2328.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc.08–1088 of April 3, 2008 (73 FR 18176), there were a number of technical errors that are identified and corrected in the Correction of Errors section below. The provisions in this correction notice are effective as if they had been included in the document printed in the **Federal Register** on April 3, 2008. Accordingly, the corrections are effective May 31, 2008.

II. Summary of Errors

This correction notice corrects the impact estimates shown in the preamble to the final rule, Medicare Program; Modification to the Weighting Methodology Used to Calculate the Low-Income Benchmark Amount (CMS–4133–F), which appeared in the **Federal Register** on April 3, 2008. That final rule introduced an improved weighting method in the calculation of the low-income benchmark premium amount under section 1860D–14(b)(2)(A)(ii) of the Social Security Act.

The impact estimates presented in the final rule were affected by a mathematical calculation error that resulted in an overestimate of the number of Medicare Part D enrollees affected by the final rule and a similar overestimate of the additional cost to Medicare under the new policy. This notice corrects the estimated reduction in the future number of low-income subsidy eligible beneficiaries who would have to be reassigned to a different Part D prescription drug benefit plan. The original estimate was 850,000, and the corrected number is 580,000. Further, the additional cost of the rule was originally estimated to total $1.68 billion for fiscal years 2009 through 2018, and the corrected estimated cost is $1.23 billion. The correction of these estimation errors has no effect on the policy adopted in the final rule, on the Part D low-income subsidy benchmarks previously determined for 2008, or on beneficiaries'' enrollment in Part D plans in 2008.

III. Correction of Errors

In FR Doc. 08–1088 of April 3, 2008 (73 FR 18176), make the following corrections:

1. On page 18178, in the second column, in the first full paragraph, in line 27, change the number ''850,000'' to ''580,000.''

2. On pages 18180 through 18182, section ''V. Regulatory Impact

Statement'' is deleted and is replaced in its entirety to read as follows:

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 allows CMS to calculate the low-income premium benchmark amounts by weighting the premium amounts by total LIS enrollment for each plan in order to reduce the number of reassignments compared to the current regulatory framework. We believe this final rule will lead to additional Federal costs of approximately $60 million for calendar year (CY) 2009. The CY 2009 cost of $60 million represents our best estimate of the cost of the final rule. Generally, our best estimates reflect an equal likelihood of being too high or too low. The estimated cost over the next 10 fiscal years (2009 through 2018) is $1.23 billion. The year-by-year impacts in millions of dollars are shown in Table 1 below. The $60 million estimate above is for CY 2009. The table below summarizes the fiscal year (FY) costs. Yearly growth is due to an estimated increase in the number of enrollees in future years and increasing drug trends that cause higher estimated bids in future years.

TABLE 1.—FEDERAL COSTS FOR FY 2009 THROUGH FY 2018

Fiscal year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2009–2018
Estimated Costs (in millions)	$50	$80	$90	$100	$110	$120	$140	$160	$180	$200	$1,230

This rule does reach the economic threshold of $100 million in the out-years and thus is considered a major rule, as outlined by Executive Order 12866.

This cost is due to increased Federal premium subsidy payments, which are the result of generally increasing the low-income benchmarks. The higher benchmarks allow a greater number of low-income beneficiaries to remain in their current plan, rather than reassigning them to a lower cost plan.

In each region, the low-income benchmark essentially functions as a ceiling for the Federal premium subsidy for low-income beneficiaries. That is, the Federal premium subsidy covers the full cost of the plan's basic Part D premium for a full-subsidy beneficiary, up to the low-income benchmark amount.

Weighting based on each plan's share of LIS enrollment generally is expected to increase the low-income benchmarks. We estimated that, in 2008, if the low-income benchmarks had been calculated based on LIS enrollment weighting (rather than based on total Part D enrollment weighting), the benchmarks would have been higher in 21 of the 34 PDP regions. Generally, the higher the low-income benchmarks, the lower the number of LIS reassignments. This is because, under the higher benchmarks, more PDPs are likely to have premiums that are equal to or less than the low-income benchmark and, as a result, will be fully covered by the premium subsidy. Low-income subsidy beneficiaries are able to remain in these PDPs and are not reassigned to other lower-premium PDPs.

We expect this rule will reduce the administrative costs for plan sponsors associated with the reassignment of LIS beneficiaries. These costs include the production of new member informational materials by the new plan, increased staffing of call centers to field beneficiary questions, and costs associated with implementing transition benefits for new enrollees.

Although there is no quantifiable monetary value to CMS to reducing reassignments, we feel this benefit is important as it will increase program stability and continuity of care. The rule supports pharmacy and formulary consistency for the beneficiary. Particularly in regions with high MA-PD penetration, this rule will reduce the year-to-year volatility in reassignments of LIS beneficiaries and will help avoid the disruption that is inherent any time a beneficiary is switched from one plan to another.

Based on the most recent bid results, we estimated that if the 2008 benchmarks had been calculated using LIS enrollment weighting, there would have been approximately 580,000 fewer reassignments than if the benchmarks had been calculated using total Part D enrollment weighting. Then we determined the impact of the revised benchmarks and reassignments on program payments throughout the projection period. We do not explicitly project reassignments in future years. The expectation is that the net effect of future reassignments will result in projected cost levels comparable to the results of the reassignments modeled on the most recent bid results.

The cost estimate assumes full enrollment weighting based on LIS enrollment 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 but does include the effect on the level of administrative costs plan sponsors will include in their bids to account for their expected number of LIS beneficiary reassignments.

The proposed rule estimated Federal savings of approximately $20 million per calendar year. However, the final rule estimates an additional $60 million in Federal costs for CY 2009. There are two reasons that the cost estimate has changed. First, the budget baseline has been updated since the issuance of the proposed rule. The Mid-Session Review baseline assumed the continuation of the $1 *de minimis* policy; the President's 2009 Budget baseline does not. Because of the change in assumptions about the *de minimis* policy, even if we had stayed with the five zero-premium organization policy in the proposed rule, the cost of the final rule would have changed from savings of approximately $20 million per year to costs of approximately $10 million per year. Second, this final rule changes the weighting methodology used to calculate the low-income

benchmark premium amount. As discussed in the rationale, CMS has changed the method for calculating the Federal premium subsidy for LIS beneficiaries so that the subsidy amount better reflects the premiums of plans in which LIS beneficiaries are enrolled. The final rule uses each plan's share of LIS enrollment, rather than each plan's share of total Part D enrollment, to weight each plan's premium. This change results in fewer reassignments than the proposed rule (approximately 400,000) and greater low-income premium subsidy costs. The relationship between reassignments and the premium subsidy is described above.

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 604 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 $130 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

We have estimated the effect this regulation will have on the number of reassignments, the number of zero-premium plans available to full-subsidy eligible individuals in each region, and bid incentives.

This rule will reduce the number of reassignments compared to the current regulatory framework. In 2008, under the provisions of the ''Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries,'' approximately 1.19 million LIS beneficiaries were reassigned to new Part D organizations. We estimated that if the 2008 benchmarks had been calculated under the current regulation (that is, full enrollment weighted using all enrollees), the number of LIS reassignments would have been 2.18 million. Under the policy in the proposed rule, the number of reassignments would have declined by approximately 200,000 (compared to the current regulation) to 2.0 million. We estimate that, if the 2008 benchmarks had been calculated using the LIS weighting methodology in this final rule, the benchmarks would have been higher in 21 of the 34 regions and the number of reassignments would have been 1.60 million—approximately 580,000 lower than under the current regulation. The amount of the benchmark increase averaged $2.22.

We estimate that this final rule, if implemented in 2008, would have reduced the benchmarks slightly in 13 regions as compared to the current regulation. These regions tend to have low MA–PD penetration and a concentration of LIS beneficiaries in PDPs with relatively low premiums. The amount of the benchmark reduction averaged $1.13. In 2008, these benchmark reductions would have increased reassignments in total by about 150,000. The 1.60 million estimate noted above is net of these increased reassignments.

We estimate that this final rule, if implemented in 2008, would have increased the number of zero premium organizations available to beneficiaries in 16 of the 34 PDP regions. This is somewhat lower than the number of regions where the benchmarks would have been higher (21), because some regions did not have any new plans that landed under the benchmark with the new calculation. In addition, in 2008, this regulation would have resulted in at least four zero-premium organizations in every Part D region with the exception of one region, which would have had three zero-premium organizations.

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 will happen in the absence of this rule, but we expect some organizations will be induced to bid even lower while other organizations will give up on this population and bid higher.

C. Alternatives Considered

As stated in the ''Background'' section of this final 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 (de minimis). 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 for full-subsidy eligibles, 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 also considered changing the regulation to calculate the benchmarks using MA–PD premiums before they have been reduced by Part C rebates. That approach, however, is not permitted under the statute.

Finally, we considered the policy in the proposed rule itself, which was an option for PDP Sponsors in regions with less than five zero-premium PDPs to offer a separate prescription drug premium amount for full subsidy eligible individuals subject to certain conditions. In response to comments received on the proposed rule, we determined that this approach did not address the reassignment issue as effectively as the LIS benchmark

weighting approach recommended by commenters.

D. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 2 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the cost associated due to increased Federal low-income premium subsidy payments, which are primarily the result of allowing a greater number of low-income beneficiaries to remain in their current plan, rather than reassigning them to a lower cost plan. All expenditures are classified as costs to the Federal Government.

TABLE 2.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE MODIFICATION TO THE WEIGHTING METHODOLOGY USED TO CALCULATE THE LOW-INCOME BENCHMARK AMOUNT, FINAL RULE

Category: Monetized costs	Costs ($ millions)
Single Year CY 2009	$60
Annualized Monetized Costs Using 7% Discount Rate FY 2009–FY 2018	114.6
Annualized Monetized Costs Using 3% Discount Rate FY 2009–FY 2018	119.3
Undiscounted Cumulative Costs—FY 2009–FY 2018	1,230

Costs reflect transfers from the Federal Government to Health Plans.

E. Conclusion

This rule is estimated to result in an increased Federal cost of $60 million in CY 2009 and $1.23 billion over the next 10 fiscal years (2009 through 2018). As explained above, these costs are primarily due to an increase in low-income premium subsidy payments. This rule will not have a significant economic impact on a substantial number of small entities, so we are not preparing an analysis for the RFA. In addition, the regulation will not have a significant impact on the operations of a substantial number of small rural hospitals, so we are not preparing an analysis for section 1102(b) of the Act. The analysis above, together with the preamble, provides a Regulatory Impact Analysis as it qualifies as a major rule under Executive Order 12866. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive this notice and comment procedure if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

This correction notice does not make any changes to the final rule printed in the **Federal Register** on April 3, 2008, which was the product of a public notice and comment process. Rather, this notice corrects an arithmetic error that was reflected in the impact analysis accompanying the final rule. Because this error does not affect the substance of the final rule or involve any exercise of policy discretion, we do not believe an additional comment period is necessary.

In addition, because MA organizations and PDP Sponsors have already begun the process of preparing their bids for 2009, and may take the erroneous impact analysis in the final rule into account in doing so, it is in the public interest to publish a corrected impact statement as soon as possible.

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

Dated: April 11, 2008.

Ashley Files Flory,

Deputy Executive Secretary.

[FR Doc. 08–1136 Filed 4–11–08; 3:55 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 65

[Docket No. FEMA–B–7772]

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Interim rule.

SUMMARY: This interim rule lists communities where modification of the Base (1% annual-chance) Flood Elevations (BFEs) is appropriate because of new scientific or technical data. New flood insurance premium rates will be calculated from the modified BFEs for new buildings and their contents.

DATES: These modified BFEs are currently in effect on the dates listed in the table below and revise the Flood Insurance Rate Maps (FIRMs) in effect prior to this determination for the listed communities.

From the date of the second publication of these changes in a newspaper of local circulation, any person has ninety (90) days in which to request through the community that the Mitigation Assistant Administrator of FEMA reconsider the changes. The modified BFEs may be changed during the 90-day period.

ADDRESSES: The modified BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: William R. Blanton, Jr., Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3151.

SUPPLEMENTARY INFORMATION: The modified BFEs are not listed for each community in this interim rule. However, the address of the Chief Executive Officer of the community where the modified BFE determinations are available for inspection is provided.

Any request for reconsideration must be based on knowledge of changed conditions or new scientific or technical data.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.*, and with 44 CFR part 65.