

notice will not have a significant economic impact on a substantial number of small entities. Therefore, we are not preparing an analysis under the RFA.

In addition, section 1102(b) of the Social Security 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. The Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis under section 1102(b) of the Act.

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. In 2011, that threshold is approximately \$136 million. This notice will have no consequential effect on State, local, or tribal governments or on the private sector. However, States may be required to pay the deductibles and coinsurance for dually-eligible beneficiaries.

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. This notice will not have a substantial effect on State or local governments.

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

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

Dated: September 22, 2011

Donald M. Berwick,
Administrator, Centers for Medicare & Medicaid Services.

Dated: October 25, 2011.

Kathleen Sebelius,
Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8044-N]

RIN 0938-AQ15

Medicare Program; Part A Premiums for CY 2012 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

ACTION: Notice.

SUMMARY: This annual notice announces Medicare's Hospital Insurance (Part A) premium for uninsured enrollees in calendar year (CY) 2012. This premium is paid by enrollees age 65 and over who are not otherwise eligible for benefits under Medicare Part A (hereafter known as the "uninsured aged") and by certain disabled individuals who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning January 1, 2012, for these individuals will be \$451. The reduced premium for certain other individuals as described in this notice will be \$248.

DATES: Effective Date: This notice is effective on January 1, 2012.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786-6390.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare Hospital Insurance Program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors, and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. These "uninsured aged" individuals are uninsured under the OASDI program or the Railroad Retirement Act, because they do not have 40 quarters of coverage under Title II of the Act (or are/were not married to someone who did). (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for Medicare Part A.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium for certain disabled individuals who have exhausted other

entitlement. These are individuals who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, but who are no longer entitled to disability benefits and free Medicare Part A coverage because they have gone back to work and their earnings exceed the statutorily defined "substantial gainful activity" amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through section 1818(f) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 1818(d) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the following calendar year (CY) (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine, during September of each year, the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of \$1, the premium is rounded to the nearest multiple of \$1 (or, if it is a multiple of 50 cents but not of \$1, it is rounded to the next highest \$1).

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary enrollees (section 1818 and section 1818A of the Act). The reduction applies to an individual who is eligible to buy into the Medicare Part A program and who, as of the last day of the previous month—

- Had at least 30 quarters of coverage under Title II of the Act;
- Was married, and had been married for the previous 1-year period, to a person who had at least 30 quarters of coverage;
- Had been married to a person for at least 1 year at the time of the person's death if, at the time of death, the person had at least 30 quarters of coverage; or
- Is divorced from a person and had been married to the person for at least 10 years at the time of the divorce if, at the time of the divorce, the person had at least 30 quarters of coverage.

Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for CY 2012 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for CY 2012

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 2012, is \$451.

The monthly premium for those individuals subject to the 45 percent reduction in the monthly premium is \$248.

III. Monthly Premium Rate Calculation

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for CY 2012 rounded to the nearest multiple of \$1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of Part A enrollees aged 65 years and over as well as the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are:

- Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;
- Projecting increases in payment amounts for each of the service types; and
- Projecting increases in administrative costs.

We base our projections for CY 2012 on—(1) Current historical data; and (2) projection assumptions derived from current law and the Mid-Session Review of the President's Fiscal Year 2012 Budget.

We estimate that in CY 2012, 40,787,939 people aged 65 years and over will be entitled to benefits (without premium payment) and that they will incur about \$220.656 billion in benefits and related administrative costs. Thus, the estimated monthly average per capita amount is \$450.82 and the monthly premium is \$451. The full monthly premium reduced by 45 percent is \$248.

IV. Costs to Beneficiaries

The CY 2012 premium of \$451 is approximately 0.22 percent higher than the CY 2011 premium of \$450.

We estimate that approximately 590,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium. We estimate an additional 45,000 enrollees will pay the reduced premium. We estimate that the aggregate cost to enrollees paying these premiums in CY 2012, compared to the amount that they paid in CY 2011, will be about \$7 million.

V. Waiver of Proposed Notice and Comment Period

We use general notices, rather than notice and comment rulemaking procedures, to make announcements such as this premium notice. In doing so, we acknowledge that, under the Administrative Procedure Act (APA), interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking. The agency may also waive notice and comment if there is "good cause," as defined by the statute. We considered publishing a proposed notice to provide a period for public comment. However, under the APA, we may waive that procedure if we find good cause that prior notice and comment are impracticable, unnecessary, or contrary to the public interest.

We are not using notice and comment rulemaking in this notification of Medicare Part A premiums for CY 2011 as that procedure is unnecessary because of the lack of discretion in the statutory formula that is used to calculate the premium and the solely ministerial function that this notice serves. The APA permits agencies to waive notice and comment rulemaking when notice and public comment thereon are unnecessary. On this basis, we waive publication of a proposed notice and a solicitation of public comments.

VI. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

VII. Regulatory Impact Statement

We have examined the impact of this notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct 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). As stated in section IV of this notice, we estimate that the overall effect of these changes in the Part A premium will be a cost to voluntary enrollees (section 1818 and section 1818A of the Act) of about \$7 million. Therefore, this notice is not a major action as defined in Title 5, United States Code, section 804(2) and is not an economically significant action under Executive Order 12866.

The RFA requires agencies to analyze options for regulatory relief of small entities. 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 \$7.0 million to \$34.5 million in any 1 year. Individuals and States are not included in the definition of a small entity. We have determined that this notice will not have a significant economic impact on a substantial number of small entities. Therefore, we are not preparing an analysis under the RFA.

In addition, section 1102(b) of the Social Security 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. The Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis under section 1102(b) of the Act.

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. In 2011, that threshold is approximately \$136 million. This notice will have no

consequential effect on State, local, or tribal governments or on the private sector. However, States are required to pay the premiums for dually-eligible beneficiaries.

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. This notice will not have a substantial effect on State or local governments.

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

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

Dated: September 22, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 25, 2011.

Kathleen Sebelius,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8045-N]

RIN 0938-AQ16

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2012

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

ACTION: Notice.

SUMMARY: This notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) beneficiaries enrolled in Part B of the Medicare Supplementary Medical Insurance (SMI) program beginning January 1, 2012. In addition, this notice announces the monthly premium for aged and disabled beneficiaries as well as the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts. The monthly actuarial rates for 2012 are \$199.80 for aged enrollees and \$192.50 for disabled enrollees. The standard monthly Part B premium rate for 2012 is \$99.90, which is equal to 50

percent of the monthly actuarial rate for aged enrollees or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees. (The 2011 standard premium rate was \$115.40) The Part B deductible for 2012 is \$140.00 for all Part B beneficiaries. If a beneficiary has to pay an income-related monthly adjustment, they may have to pay a total monthly premium of about 35, 50, 65, or 80 percent of the total cost of Part B coverage.

DATES: Effective Date: January 1, 2012.

FOR FURTHER INFORMATION CONTACT: M. Kent Clemens, (410) 786-6391.

SUPPLEMENTARY INFORMATION:

I. Background

Part B is the voluntary portion of the Medicare program that pays all or part of the costs for physicians' services, outpatient hospital services, certain home health services, services furnished by rural health clinics, ambulatory surgical centers, comprehensive outpatient rehabilitation facilities, and certain other medical and health services not covered by Medicare Part A, Hospital Insurance. Medicare Part B is available to individuals who are entitled to Medicare Part A, as well as to U.S. residents who have attained age 65 and are citizens, and aliens who were lawfully admitted for permanent residence and have resided in the United States for 5 consecutive years. Part B requires enrollment and payment of monthly premiums, as described in 42 CFR part 407, subpart B, and part 408, respectively. The difference between the premiums paid by all enrollees and total incurred costs is met by transfers from the general fund of the Treasury.

The Secretary of the Department of Health and Human Services (the Secretary) is required by section 1839 of the Social Security Act (the Act) to announce the Part B monthly actuarial rates for aged and disabled beneficiaries as well as the monthly Part B premium. The Part B annual deductible is included because its determination is directly linked to the aged actuarial rate.

The monthly actuarial rates for aged and disabled enrollees are used to determine the correct amount of general revenue financing per beneficiary each month. These amounts, according to actuarial estimates, will equal, respectively, one-half of the expected average monthly cost of Part B for each aged enrollee (age 65 or over) and one-half of the expected average monthly cost of Part B for each disabled enrollee (under age 65).

The Part B deductible to be paid by enrollees is also announced. Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), the Part B deductible was set in statute. After setting the 2005 deductible amount at \$110.00, section 629 of the MMA (amending section 1833(b) of the Act) requires that the Part B deductible be indexed beginning in 2006. The inflation factor to be used each year is the annual percentage increase in the Part B actuarial rate for enrollees age 65 and over. Specifically, the 2012 Part B deductible is calculated by multiplying the 2011 deductible by the ratio of the 2012 aged actuarial rate over the 2011 aged actuarial rate. The amount determined under this formula is then rounded to the nearest \$1.

The monthly Part B premium rate to be paid by aged and disabled enrollees is also announced. (Although the costs to the program per disabled enrollee are different than for the aged, the statute provides that they pay the same premium amount.) Beginning with the passage of section 203 of the Social Security Amendments of 1972 (Pub. L. 92-603), the premium rate, which was determined on a fiscal year basis, was limited to the lesser of the actuarial rate for aged enrollees, or the current monthly premium rate increased by the same percentage as the most recent general increase in monthly Title II social security benefits.

However, the passage of section 124 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97-248) suspended this premium determination process. Section 124 of TEFRA changed the premium basis to 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees). Section 606 of the Social Security Amendments of 1983 (Pub. L. 98-21), section 2302 of the Deficit Reduction Act of 1984 (DEFRA 84) (Pub. L. 98-369), section 9313 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85) (Pub. L. 99-272), section 4080 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) (Pub. L. 100-203), and section 6301 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) (Pub. L. 101-239) extended the provision that the premium be based on 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees). This extension expired at the end of 1990.

The premium rate for 1991 through 1995 was legislated by section 1839(e)(1)(B) of the Act, as added by section 4301 of the Omnibus Budget