announcements. In doing so, we note that, under the Administrative Procedure Act, interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking.

We considered publishing a proposed notice to provide a period for public comment. However, we may waive that procedure if we find, for good cause, that prior notice and comment are impracticable, unnecessary, or contrary to the public interest. The statute establishes the time period for which the premium rates will apply, and delaying publication of the Part B premium rate such that it would not be published before that time would be contrary to the public interest. Moreover, we find that notice and comment are unnecessary because the formulas used to calculate the Part B premiums are statutorily directed. Therefore, we find good cause to waive publication of a proposed notice and solicitation of public comments.

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

Dated: November 15, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: November 15, 2012.

Kathleen Sebelius,

Secretary. Department of Health and Human Services.

[FR Doc. 2012–28275 Filed 11–16–12; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8047–N]

RIN 0938–AR15

Medicare Program; Part A Premiums for CY 2013 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) 2013. 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, 2013, for these individuals will be $441. The reduced premium for certain other individuals as described in this notice will be $243.

DATES: This notice is effective on January 1, 2013.

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 impending 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 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 2013 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for CY 2013

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 2013, is $441.

The monthly premium for those individuals subject to the 45 percent reduction in the monthly premium is $243.

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 2013 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 2013 on—(1) current historical data; and (2) projection assumptions derived from current law and the Mid-Session Review of the President's Fiscal Year 2013 Budget.

We estimate that in CY 2013, 42,352,324 people aged 65 years and over will be entitled to benefits (without premium payment) and that they will incur about $223.933 billion in benefits and related administrative costs. Thus, the estimated monthly average per capita amount is $440.62 and the monthly premium is $441. The full monthly premium reduced by 45 percent is $243.

IV. Costs to Beneficiaries

The CY 2013 premium of $441 is approximately 2.22 percent lower than the CY 2012 premium of $451. We estimate that approximately 604,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium. We estimate an additional 50,000 enrollees will pay the reduced premium. We estimate that the aggregate savings to enrollees paying these premiums in CY 2013, compared to the amount that they paid in CY 2012, will be about $75 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 2013 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., Part I, Ch. 8).

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 savings to voluntary enrollees (section 1818 and section 1818A of the Act) of about $75 million. Therefore, this notice is a not a major action as defined in Title 5, United States Code, Part I, Ch. 8 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 2012, that threshold is approximately $139 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: November 6, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: November 15, 2012.

Kathleen Sebelius,

Secretary.

[FR Doc. 2012–28274 Filed 11–16–12; 11:15 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Title: Parents and Children Together (PACT) Evaluation.

OMB No.: 0970–0403.

Description: The Office of Planning, Research, and Evaluation (OPRE), Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS), is proposing data collection activity as part of the Parents and Children Together (PACT) Evaluation.

The PACT project is a formative evaluation whose overall objective is to document and provide initial assessment of selected Responsible Fatherhood and Healthy Marriage grant programs that were authorized under the 2010 Claims Resolution Act. This information will be critical to informing decisions related to future investments in this kind of programming as well as the design and operation of such services.

To meet the objective of the study, PACT is utilizing three major, interrelated evaluation strategies:

(a) Impact evaluation;

(b) Implementation evaluation; and

(c) Qualitative evaluation.

Each of these strategies will be employed separately with (1) Responsible Fatherhood and (2) Healthy Marriage grantees. Specifically, we anticipate the following studies:

(a) Impact evaluation:

(1) Responsible Fatherhood grantee evaluation; and (2) Healthy Marriage grantee evaluation.

(b) Implementation evaluation:

(1) Responsible Fatherhood grantee evaluation;

(1—additional substudy) Responsible Fatherhood grantee evaluation with a focus on Hispanic populations; and

(2) Healthy Marriage grantee evaluation.

(c) Qualitative evaluation:

(1) Responsible Fatherhood grantee evaluation.

The following instruments have been approved for this study: Site selection: a discussion guide to assist in selecting sites was approved by OMB on April 20, 2012.

(a) Impact evaluation:

(1) Responsible Fatherhood grantee evaluation:

- Introductory script, approved October 31, 2012.
- Baseline survey, approved October 31, 2012.

(b) Implementation evaluation:

(1) Responsible Fatherhood grantee evaluation:

- Responsible Fatherhood Study MIS, approved October 31, 2012.

This 60-Day **Federal Register** Notice requests clearance of new instruments:

(a) Impact evaluation:

(1) Healthy Marriage grantee evaluation:

- Introductory script, which program staff will use to introduce the study to participants.
- Baseline survey, to capture participant characteristics and experiences prior to randomization.

(b) Implementation evaluation:

(1) and (2) Responsible Fatherhood and Healthy Marriage grantee evaluation:

- Semi-structured interview topic guide, to gather information on program implementation from program staff.
- On-line survey, to capture program staff experiences.
- Telephone interviews (with staff at referral organizations), to document linkages between the program and referral agencies.
- Working Alliance Inventory, to assess the strength of the participant-program staff working relationship.
- Focus group guide, to elicit participant experiences.
- Telephone interviews (with program dropouts), to determine reasons why those eligible for the program choose not to participate.

(1—additional substudy) Responsible Fatherhood grantee evaluation with a focus on Hispanic populations:

- Semi-structured interview topic guide, to examine how agencies adapt programs to address the needs of Hispanic populations.
- Focus group guide, to elicit participant experiences.
- Participant questionnaire, to capture participant characteristics and experiences.

(2) Healthy Marriage grantee evaluation:

- Study MIS (for use in HM programs), to track participation in the program.

(c) Qualitative evaluation:

(1) Responsible Fatherhood grantee evaluation:

- Guide for in-person, in-depth interviews, to understand the experiences, both in and out of the program, of a subset of men.
- Check-in call guide, to follow-up from the in-person, in-depth interviews, to ascertain new experiences by these men since last discussion.

This 60-Day **Federal Register** Notice also serves as a request for OMB to waive subsequent 60-day **Federal Register** notices pertaining to the PACT Evaluation.

Respondents:

Respondents include program applicants, program participants, program staff, and staff at referral agencies. Specific respondents per instrument are noted in the burden tables below.

Annual Burden Estimates

Some burden has already been approved for this study, and the following instruments are still in use. Approved burden is provided below:

Instrument respondent	Annual number of respondents	Number of responses per respondent	Average burden per response (minutes)	Total annual burden hours
Site Selection				
Selecting Study Grantees:				
Discussions/grantee and partner organization staff	50	1	60	50