

1. 1831 Bancorp, MHC and 1831 Bancorp, Inc., both of Dedham, Massachusetts; to acquire an indirect 20 percent ownership interest in Plimoth Trust Company LLC, Plymouth, Massachusetts, and thereby engage in trust company activities, financial and investment advisory activities and employee benefits consulting services pursuant to sections 225.28(b)(5), (6) and (9)(ii).

Board of Governors of the Federal Reserve System, November 15, 2017.

Ann E. Misback,

Secretary of the Board.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8066-N]

RIN 0938-AT06

Medicare Program; CY 2018 Part A Premiums 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) 2018. 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, 2018 for these individuals will be \$422. The premium for certain other individuals as described in this notice will be \$232.

DATES: *Effective Date:* This notice is effective on January 1, 2018.

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)(1) 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 upcoming 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 2018 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for CY 2018

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 2018, is \$422.

The monthly premium for the individuals eligible under section 1818(d)(4)(B) of the Act, and therefore, subject to the 45 percent reduction in the monthly premium, is \$232.

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 2018 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 Medicare 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 2018 on—(1) current historical data; and (2) projection assumptions derived from current law and the Mid-Session Review of the President's Fiscal Year 2018 Budget.

We estimate that in CY 2018, 50,295,843 people aged 65 years and over will be entitled to (enrolled in) benefits (without premium payment) and that they will incur about \$254.518 billion in benefits and related administrative costs. Thus, the estimated monthly average per capita

amount is \$421.70 and the monthly premium is \$422. Subsequently, the full monthly premium reduced by 45 percent is \$232.

IV. Costs to Beneficiaries

The CY 2018 premium of \$422 is approximately 2 percent higher than the CY 2017 premium of \$413. We estimate that approximately 668,000 enrollees will voluntarily enroll in Medicare Part A, by paying the full premium. We estimate that over 90 percent of these individuals will have their Part A premium paid for by states, since they are enrolled in the Qualified Medicare Beneficiary Program (a Medicaid program which helps certain low-income individuals with Medicare premium and cost-sharing liability). Furthermore, the CY 2018 reduced premium of \$232 is approximately 2 percent higher than the CY 2017 premium of \$227. We estimate an additional 71,000 enrollees will pay the reduced premium. Therefore, we estimate that the total aggregate cost to enrollees paying these premiums in CY 2018, compared to the amount that they paid in CY 2017, will be about \$76 million.

V. Waiver of Proposed Notice and Comment Period

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 553(b) of the Administrative Procedure Act (APA) and section 1871 of the Act. However, we believe that the policies being publicized in this document do not constitute agency rulemaking. Rather, the statute requires that the agency determine the applicable premium amount for each calendar year in accordance with the statutory formula, and we are simply notifying the public of the changes to the Medicare Part A premiums for CY 2018. To the extent any of the policies articulated in this document constitute interpretations of the statute's requirements or procedures that will be used to implement the statute's directive, they are interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice, which are not subject to notice and comment rulemaking under the APA.

To the extent that notice and comment rulemaking would otherwise apply, we find good cause to waive this requirement. Under the APA, we may waive notice and public procedure if we find good cause that prior notice and comment are impracticable, unnecessary, or contrary to the public

interest. We believe that notice and comment rulemaking for this notification of Medicare Part A premiums for CY 2018 is unnecessary because of the lack of CMS discretion in the statutory formula that is used to calculate the premium and the solely ministerial function that this notice serves. Therefore, we find good cause to waive notice and comment procedures, if such procedures are required at all.

VI. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VII. Regulatory Impact Statement

A. Statement of Need

Section 1818(d) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary) during September of each year to determine and publish the amount to be paid, on an average per capita basis, from the Federal Hospital Insurance Trust Fund for services incurred in the impending CY (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A.

B. Overall Impact

We have examined the impacts 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), the Congressional Review Act (5 U.S.C. 804(2)) and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order. As stated in section IV of this notice, we estimate that the overall effect of the changes in the Part A premium will be a cost to voluntary enrollees (section 1818 and section 1818A of the Act) of about \$76 million. As a result, this notice is non-economically significant under section 3(f)(1) of Executive Order 12866. In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number 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 less than \$7.5 million to \$38.5 million in any 1 year (for details, see the Small Business Administration’s Web site at http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf).

Individuals and states are not included in the definition of a small entity. As discussed above, this annual notice announces the Medicare Part A premiums for CY 2018. As a result, we are not preparing an analysis for the RFA because the Secretary has determined that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act (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 and has fewer than 100 beds. As discussed above, we are not preparing an analysis for section 1102(b) of the Act, because the Secretary has determined that this notice 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. In 2017, that threshold is approximately \$148 million. This notice does not impose mandates that will have a consequential effect of \$148 million or more on state, local, or tribal governments or on the private sector.

Executive Order 13771, titled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017 (82 FR 9339, February 3, 2017). It has been determined that this notice is a transfer notice that does not impose more than de minimis costs and thus is not a regulatory action for the purposes of E.O. 13771.

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 direct effect on state or local governments, preempt state law, or otherwise have Federalism implications.

Although this notice merely announces Medicare’s Part A premiums for CY 2018 and does not constitute a substantive rule, we nevertheless prepared this Impact Statement in the interest of ensuring that the impacts of this notice are fully understood.

Dated: October 27, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 1, 2017.

Eric D. Hargan,

Acting Secretary, Department of Health and Human Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8065–N]

RIN 0938–AT05

Medicare Program; CY 2018 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts

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

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year (CY) 2018 under Medicare’s Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2018, the inpatient hospital deductible will be \$1,340. The daily coinsurance amounts for CY 2018 will be: \$335 for the 61st through 90th day of hospitalization in a benefit period; \$670 for lifetime reserve days; and \$167.50 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: *Effective Date:* This notice is effective on January 1, 2018.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390 for general information. Gregory J. Savord, (410) 786–1521 for case-mix analysis.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary) to determine and publish each year the amount of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year (CY).

II. Computing the Inpatient Hospital Deductible for CY 2018

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding CY, adjusted by our best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding CY, and adjusted to reflect changes in real case-mix. The adjustment to reflect real case-mix is determined on the basis of the most recent case-mix data available. The amount determined under this formula is rounded to the nearest multiple of \$4 (or, if midway between two multiples of \$4, to the next higher multiple of \$4).

Under section 1886(b)(3)(B)(i)(XX) of the Act, the percentage increase used to update the payment rates for FY 2018 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update, reduced by 0.75 percentage points (see section 1886(b)(3)(B)(xii)(V) of the Act), and an adjustment based on changes in the economy-wide productivity (the multifactor productivity (MFP) adjustment) (see section 1886(b)(3)(B)(xi)(II) of the Act). Under section 1886(b)(3)(B)(viii) of the Act, for FY 2018, the applicable percentage increase for hospitals that do not submit quality data as specified by the Secretary is reduced by one quarter of the market basket update. We are estimating that after accounting for those hospitals receiving the lower market basket update in the payment-weighted average update, the calculated deductible will not be affected, since the majority of hospitals submit quality data and receive the full market basket update. Section 1886(b)(3)(B)(ix) of the Act requires that any hospital that is not a meaningful electronic health record (EHR) user (as defined in section 1886(n)(3) of the Act) will have three-quarters of the market basket update reduced by 100 percent for FY 2017 and each subsequent fiscal year. We are estimating that after accounting for these hospitals receiving the lower market basket update, the calculated deductible will not be affected, since the majority of hospitals are meaningful EHR users and are expected to receive the full market basket update.

Under section 1886 of the Act, the percentage increase used to update the