52060 **Federal Register** / Vol. 90, No. 221 / Wednesday, November 19, 2025 / Notices

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8090–N]

RIN 0938–AV55

Medicare Program; CY 2026 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 notice announces Medicare's Hospital Insurance Program (Medicare Part A) premium for uninsured enrollees in calendar year (CY) 2026. This premium is paid by enrollees aged 65 and over who are not otherwise eligible for benefits under Medicare Part A (hereafter known as the ''uninsured aged'') and by certain individuals with disabilities who have exhausted other entitlement. The monthly Medicare Part A premium for the 12 months beginning January 1, 2026 for these individuals will be $565. The premium for certain other individuals as described in this notice will be $311.

DATES: The premium announced in this notice is effective on January 1, 2026.

FOR FURTHER INFORMATION CONTACT: Yaminee Thaker, (410) 786–7921.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in 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 individuals with disabilities 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 premium-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 for the aged under section 1818(d) through section 1818(f) of the Act will also apply to certain individuals with disabilities 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 (sections 1818 and 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 2026 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

Section 1818(g) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary), at the request of a State, to enter into a Medicare Part A buy-in agreement with a State to pay Medicare Part A premiums for Qualified Medicare Beneficiaries (QMBs). Under the QMB program, State Medicaid agencies must pay the Medicare Part A premium for those not eligible for premium-free Medicare Part A if those individuals meet all of the eligibility requirements for the QMB program under the State's Medicaid State plan. (Entering into a Medicare Part A buy-in agreement would permit a State to avoid any Medicare Part A late enrollment penalties that the individual may owe and would allow States to enroll persons in Medicare Part A at any time of the year, without regard to Medicare enrollment periods.) Other individuals may be eligible for the Qualified Disabled Working Individuals program, through which State Medicaid programs provide coverage of Medicare Part A premiums for individuals eligible to enroll in Medicare Part A by virtue of section 1818A of the Act who meet certain financial eligibility criteria.

II. Monthly Premium Amount for CY 2026

The monthly premium for the uninsured aged and certain individuals with disabilities who have exhausted other entitlement for the 12 months beginning January 1, 2026, is $565. 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 $311.

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 2026 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 2026 on—(1) current historical data; and (2) projection assumptions derived from current law and the Midsession Review of the President's Fiscal Year 2026 Budget.

For CY 2026, we estimate that 62,921,568 people aged 65 years and over will be entitled to (enrolled in) benefits (without premium payment) and that they will incur about $426.445 billion in benefits and related administrative costs. Thus, the estimated monthly average per capita amount is $564.78 and the monthly premium is $565. Subsequently, the full monthly premium reduced by 45 percent is $311.

IV. Costs to Beneficiaries

The CY 2026 monthly premium of $565 is approximately 9.1 percent higher than the CY 2025 premium of $518. We estimate that approximately 772,000 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 Medicare Part A premium paid by States, since they are enrolled in the QMB program. Furthermore, the CY 2026 reduced monthly premium of $311 is approximately 9.1 percent higher than the CY 2025 premium of $285. We estimate that an additional 103,000 enrollees will pay the reduced premium. Therefore, we estimate that the total aggregate cost to enrollees paying these premiums in CY 2026, compared to the amount that they paid in CY 2025, will be about $467 million.

V. Waiver of Proposed Rulemaking

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 1871 of the Act. Section 1871(a)(2) of the Act provides that no rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish . receive services or benefits under Medicare shall take effect unless it is promulgated through notice and comment rulemaking. Unless there is a statutory exception, section 1871(b)(1) of the Act generally requires the Secretary to provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute. Section 1871(b)(2)(C) of the Act also provides exceptions from the notice and 60-day comment period, under the good cause standard set forth in 5 U.S.C. 553(b)(B). Section 553(b)(B) authorizes an agency to dispense with notice and comment rulemaking for good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest.

The annual Medicare Part A premium announcement set forth in this notice does not establish or change a substantive legal standard regarding the matters enumerated by the statute or constitute a substantive rule which would be subject to the notice requirements in section 1871(b) of the Act. However, to the extent that an opportunity for public notice and comment could be construed as required for this notice, we find good cause to waive this requirement. Section 1818(d) of the Act requires 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. Further, the statute requires that the agency determine the applicable premium amount for each CY in accordance with the statutory formula, and we are simply notifying the public of the changes to the Medicare Part A premiums for CY 2026. We have calculated the Medicare Part A premiums as directed by the statute; the statute establishes both when the premium amounts must be published and the information that the Secretary must factor into the premium amounts, so we do not have any discretion in that regard. We find notice and comment procedures to be unnecessary for this notice and we find good cause to waive such procedures under section 553(b)(B) and section 1871(b)(2)(C) of the Act, if such procedures may be construed to be required at all. Through this notice, we are simply notifying the public of the updates to the Medicare Part A premiums, in accordance with the statute, for CY 2026.

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 Analysis

We have prepared this Regulatory Impact Analysis (RIA) section in the interest of ensuring that the impacts of this notice are fully understood.

A. Statement of Need

This notice announces the CY 2026 Medicare Part A premiums for the uninsured aged and for certain disabled individuals who have exhausted other entitlement, as required by sections 1818 and 1818A of the Act. It also responds to section 1818(d) of the Act, which requires the Secretary to provide for publication of these amounts in the **Federal Register** during the September that precedes the start of each CY. As this statutory provision prescribes a detailed methodology for calculating these amounts, we do not have the discretion to adopt an alternative approach to these issues.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); 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 those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts.). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. As stated in section IV. of this notice, we estimate that the overall effect of the changes in the Medicare Part A premium will be a cost to voluntary enrollees (sections 1818 and 1818A of the Act) of about $467 million. Based on our estimates, OIRA has determined this notice is significant under section 3(f)(1). Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of this notice.

In accordance with subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has determined that this notice meets the criteria set forth in 5 U.S.C. 804(2). For the reasons given, however, we find for good cause that notice and public procedure are impracticable, unnecessary, and contrary to the public interest and have determined that this policy will take effect on January 1, 2026, pursuant to 5 U.S.C. 808(2).

C. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in the Table 1, we have prepared an accounting statement showing the total aggregate cost to enrollees paying premiums in CY 2026, compared to the amount that they paid in CY 2025. This amount is approximately $467 million. As stated in section IV. of this notice, the CY 2026 premium of $565 is approximately 9.1 percent higher than the CY 2025 premium of $518. We estimate that approximately 772,000 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 Medicare Part A premium paid by States, since they are enrolled in the QMB program. Furthermore, the CY 2026 reduced premium of $311 is approximately 9.1 percent higher than the CY 2025 premium of $285.

TABLE 1—ESTIMATED TRANSFERS FOR CY 2025 MEDICARE PART A PREMIUM

Category	Transfers	Period covered
Annualized Monetized Transfers.	$467 million	2026
From Whom to Whom.	Beneficiaries to Federal Government.	....

D. Regulatory Flexibility Act

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 being nonprofit organizations or by meeting the Small Business Administration's (SBA) definition of a small business (having revenues of less than $9.0 million to $47 million in any 1 year). Individuals and States are not included in the definition of a small entity. This annual notice announces the Medicare Part A premiums for CY 2026 and will have an impact on certain Medicare beneficiaries, but not on small entities as defined by the SBA. As a result, we are not preparing an analysis for the RFA because the Secretary has certified that this notice 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 an RIA 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. This annual notice announces the Medicare Part A premiums for CY 2026 and will have an impact on certain Medicare beneficiaries. As a result, we are not preparing an analysis for section 1102(b) of the Act, because the Secretary has certified that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform 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 2025, that threshold is approximately $187 million. This notice would not impose a mandate that will result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $187 million in any 1 year.

F. Federalism

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.

G. Congressional Review

This notice is subject to the Congressional Review Act and has been transmitted to the Congress and the Government Accountability Office's Comptroller General for review.

Mehemet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on October 31, 2025.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2025–20250 Filed 11–14–25; 4:45 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10391]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information (including each proposed extension or reinstatement of an existing collection of information) and to allow 60 days for public comment on the proposed action. Interested persons are