Centers for Medicare & Medicaid Services, HHS

longer eligible for inclusion in the buy-in group, the individual—
(1) Is considered to have enrolled during his or her initial enrollment period; and
(2) Will be entitled to SMI on this basis and liable for SMI premiums beginning with the first month for which he or she is no longer covered under the buy-in agreement.
(b) Voluntary termination. (1) An individual may voluntarily terminate entitlement acquired under paragraph (a) of this section by filing, with SSA or CMS, a request for disenrollment.
(2) Voluntary disenrollment is effective as follows:
(i) If the individual files a request within 30 days after the date of CMS’s notice that buy-in coverage has ended, the individual’s entitlement ends on the last day of the last month for which the State paid the premium.
(ii) If the individual files the request more than 30 days but not more than 6 months after buy-in coverage ends, entitlement ends on the last day of the month in which the request is filed.
(iii) If the individual files the request later than the 6th month after buy-in coverage ends, entitlement ends at the end of the month after the month in which request is filed.1

1 For requests filed before July 1987, entitlement ended on the last day of the calendar quarter after the quarter in which the disenrollment request was filed.

[53 FR 47204, Nov. 22, 1988, as amended at 56 FR 38082, Aug. 12, 1991]

PART 408—PREMIUMS FOR SUPPLEMENTARY MEDICAL INSURANCE

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§ 408.1 Statutory basis

(a) This part implements certain provisions of sections 1837 through 1840 and 1881(d) of the Social Security Act (the Act) and conforms to other regulations that implement section 1843 of the Act. Section 1839(b) requires regulations to establish when an individual’s coverage ends because of nonpayment of premiums. It also specifies that those regulations may provide a grace period for payment of overdue premiums without loss of coverage. Section 1843 sets forth the specific procedures for determining the amount of the monthly premium and section 1840 establishes the rules for payment of premiums. Section 1843 provides that a State may enter into a buy-in agreement to secure SMI coverage for certain individuals by enrolling them in the SMI program and paying the premiums on their behalf. Section 1881(d) provides that Medicare payment, for the reasonable charges incurred in connection with a kidney donation, shall be made (without regard to deductible, premium, or coinsurance provisions of title XVIII) as prescribed in regulations.

(b) The Federal Claims Collection Act (31 U.S.C. 3711), as implemented by 4 CFR parts 101–105, provides the basic authority for recovery of debts owed the United States government and specifies the conditions for the suspension or termination of collection action. Departmental regulations at 45 CFR part 30, updated by a final rule published on January 5, 1987 (52 FR 269) set forth procedures for the exercise of the Department’s authority to collect and dispose of debts and were intended to complement rules applicable to particular programs. CMS rules are set forth at 42 CFR part 401, subpart F.


§ 408.2 Scope and purpose.

(a) This part sets forth the policies and procedures for determining the amount of monthly supplementary medical insurance (SMI) premiums, for the payment, collection, or refund of premiums, for termination of coverage because of nonpayment of premiums, and for reinstatement of coverage if certain conditions are met. It conforms to subpart C of part 407 of this chapter, which sets forth the requirements for State buy-in agreements. These policies are intended to protect enrollee coverage to the maximum degree compatible with maintaining the integrity of the SMI program.

(b) Policies that apply to premiums that certain individuals must pay in order to become entitled to Medicare Part A hospital insurance benefits, are set forth in part 406 of this chapter.


§ 408.3 Definitions.

As used in this part, unless the context indicates otherwise—

Enrollee means an individual who is enrolled in the SMI program under Medicare Part B.

Taxable year means the 12-month period (calendar or fiscal year) for which the individual files his or her income tax return.
§ 408.4 Payment obligations.

(a) Month for which payment is due. (1) A payment is due for each month, beginning with the first month of SMI coverage and continuing through the month of death or, if earlier, the month in which coverage terminates.

(2) A premium is due for the month of death, if SMI coverage is still in effect, even though the individual dies on the first day of the month.

(b) Overdue premiums. (1) Overdue premiums constitute an obligation enforceable against the enrollee or the enrollee’s estate.

(2) Overdue premiums are collected—

(i) By deduction from social security or railroad retirement benefits or Federal civil service annuities;

(ii) Directly from the enrollee or the enrollee’s estate; or

(iii) By offset against any SMI payments payable to the enrollee or the enrollee’s estate.

(3) Interest is not charged on overdue premiums, except under a State buy-in agreement, as provided in § 408.6(c)(4).

(c) Premiums not required for certain kidney donors.

(1) No premiums are required for SMI benefits related to the donation of a kidney if the donor is not an enrollee.

(2) A kidney donor who is an enrollee is not relieved of the obligation for premiums.

[52 FR 48115, Dec. 18, 1987; 53 FR 4159, Feb. 12, 1988]

§ 408.6 Methods and priorities for payment.

(a) Methods of payment—General rules. Premiums are paid by one of the following four methods:

(i) Payment by a State under a buy-in agreement.

(ii) Deduction from monthly railroad retirement benefits of social security cash benefits or Federal civil service annuities.

(iii) Direct remittance on an individual basis, by or on behalf of the enrollee.

(iv) Direct remittance on a group basis, by an employer, union, lodge or other organization, or by an entity of State or local government.

(b) Priorities for payment. (1) If an enrollee is enrolled under a State buy-in agreement—

(i) SMI premiums may not be deducted from monthly cash benefits or annuities; and

(ii) The enrollee may not be required to pay by direct remittance.

(2) If an enrollee is not covered under a State buy-in agreement, but is receiving a monthly benefit or an annuity specified in paragraph (a)(1)(ii) of this section—

(i) The premiums are deducted from that benefit or annuity; or

(ii) If the monthly benefit or payment is less than the monthly premium, the rules of paragraph (a)(2) of this section apply.

(3) If an enrollee is neither covered under a State buy-in agreement, nor receiving monthly benefits or annuity payments, the premiums must be paid totally by direct remittance.

(c) Payment by a State under a buy-in agreement. (1) A buy-in agreement is an agreement under which a State, through enrollment and payment of SMI premiums, secures SMI benefits for individuals who are eligible for that program and also eligible for certain other cash or medical benefits. (Policies on enrollment under State buy-in agreements are contained in subpart C of part 407 of this chapter.)

(2) The State pays the premiums for each month for which an individual is covered under the agreement.

(3) If an individual’s coverage under a State buy-in agreement terminates, his coverage continues on an individual enrollment basis. The premiums are then deducted from benefits, as set forth in
§ 408.8 Grace period and termination date.

(a) Grace period. (1) For all initial premium payments (monthly or quarterly), and subsequent monthly or quarterly payments, the grace period ends with the last day of the third month after the billing month.

(2) For payments required because the monthly benefit is less than the monthly premium, the grace period ends on April 30 of the year following the calendar year which the premiums are due.

(b) Extension of grace period: Last day is nonwork day. If the last day of the grace period is a Saturday, Sunday, legal holiday, or a day that, by statute or executive order, is a nonwork day for Federal employees, the grace period is extended to the next succeeding work day.

(c) Termination date. The end of the grace period is the termination date for SMI coverage if overdue premiums have not been paid by that date in accordance with § 408.68.

(d) Extension of grace period for good cause. (1) CMS may reinstate entitlement, without interruption of coverage, if the individual shows good cause for failure to pay within the initial grace period, and pays all overdue premiums within three calendar months after the termination date.

(2) Good cause will be found if the individual establishes, by a credible statement, that failure to pay premiums within the initial grace period was due to conditions over which he or she had no control, or which he or she could not reasonably have been expected to foresee.

§ 408.10 Claim for monthly benefits pending concurrently with request for SMI enrollment.

(a) If it is clear that an individual who applies for social security or railroad retirement benefits and for SMI will be entitled to monthly benefits, the application for monthly benefits is processed simultaneously with the request for SMI enrollment.

(1) If monthly benefits are paid, the SMI premiums are deducted from those benefits.

(2) If monthly benefits are suspended (for instance, because the individual’s earnings exceed the maximum allowed by law), the enrollee is billed for direct remittance.

(b) If it is clear that an individual will be entitled to SMI, but there is substantial question as to eligibility for monthly benefits, the request for SMI enrollment is processed separately.

(1) When SMI enrollment is approved, the enrollee is billed for direct remittance.

(2) When the application for monthly benefits is adjudicated, the following rules apply:

(i) If monthly benefits are paid, the SMI premiums are deducted from those benefits, with appropriate adjustments for any premiums already paid by direct remittance.

(ii) If the application for monthly benefits is approved but the benefits are suspended, the grace period is as set forth in § 408.8(a).

(iii) If the application for monthly benefits is denied, the grace period is as set forth in § 408.8(a)(1).

thereafter, to be effective for the 12 months beginning with the following January.

(3) The standard monthly premium applies to individuals who enroll during their initial enrollment periods. In other situations, that premium may be increased or decreased as specified in this subpart.

(4) The law was further amended in 1984 to include a temporary “hold harmless” provision (set forth in paragraph (e) of this section), that was subsequently extended and finally made permanent in 1988.

(5) The law was further amended in 2003 to ensure that amounts payable from the Transitional Assistance Account described in §403.822 of this chapter shall not be taken into account in computing actuarial rates or premium amounts.

(b) Criteria and procedures for the period from July 1976 through December 1983, the period from January 1991 through December 1995, and for periods after December 1998. (1) For periods from July 1976 through December 1983 and after December 1998, the Secretary determines and promulgates as the standard monthly premium (for disabled as well as aged enrollees) the lower of the following:

(i) The actuarial rate for the aged.

(ii) The monthly premium promulgated the previous December for the year beginning July 1, increased by a percentage that is the same as the latest cost-of-living increase in old age insurance benefits that occurred before the current promulgation. (Because of the change in the effective dates of the premium amount (under paragraph (a)(2) of this section), there was no increase in the standard monthly premium for the period July 1983 through December 1983.)

(2) For periods after December 1998, the Secretary determines the standard monthly premium in the manner specified in paragraph (b)(1) of this section, but promulgates it in September for the following calendar year.

(3) The premiums for calendar years 1991 through 1995 are those amounts as specified by section 1839(e)(1)(B) of the Act as follows:

(i) In 1991, $29.90;

(ii) In 1992, $31.80;

(iii) In 1993, $36.60;

(iv) In 1994, $41.10; and

(v) In 1995, $46.10.

(4) In no case shall payment made for transitional assistance costs under part 403, subpart H of this chapter be included in the formula used to calculate actuarial rates or standard monthly premiums.

(c) Premiums for calendar years 1984 through 1990 and 1996 through 1998. For calendar years 1984 through 1990 and 1996 through 1998, the standard monthly premium for all enrollees—

(1) Is equal to 50 percent of the actuarial rate for enrollees age 65 or over, that is, is calculated on the basis of 25 percent of program costs without regard to any cost-of-living increase in old age insurance benefits; and

(2) Is promulgated in the preceding September.

(d) Limitation on increase of standard premium: 1987 and 1988. If there is no cost-of-living increase in old age or disability benefits for December 1985 or December 1986, the standard monthly premiums for 1987 and 1988 (promulgated in September 1986 and September 1987, respectively) may not be increased.

(e) Nonstandard premiums for certain cases—(1) Basic rule. A nonstandard premium may be established in individual cases only if the individual is entitled to old age or disability benefits for the months of November and December, and actually receives the corresponding benefit checks in December and January.

(2) Special rules: Calendar years 1987 and 1988. For calendar years 1987 and 1988, the following rules apply:

(i) A nonstandard premium may be established if there is a cost-of-living increase in old age or disability benefits but, because the increase in the standard premium is greater than the cost-of-living increase, the beneficiary would receive a lower cash benefit in January than he or she received in December.

(ii) A nonstandard premium may not be established if the reduction in the individual’s benefit would result, in whole or in part, from any circumstance other than the circumstance described in paragraph (e)(2)(i) of this section.
§ 408.21  Reduction in Medicare Part B premium as an additional benefit under Medicare + Choice plans.

(a) Basis for reduction in Part B premium. Beginning January 1, 2003 an M + C organization may elect to receive a reduction in its payments under § 422.250(a)(1) of this chapter if—

(1) 80 percent of the payment reduction is applied to reduce the standard Medicare Part B premiums of its Medicare enrollees.

(2) The Medicare Part B premium is reduced monthly and is offered to all Medicare enrollees in a specific plan benefit package.

(b) Administrative requirements for the Part B premium reduction. (1) The Medicare Part B premium reduction cannot be greater than the standard premium amount determined for the year, under section 1839(a)(3) of the Act. However, it may be less.

(2) The Medicare Part B premium reduction must be a multiple of 10 cents.

(3) The Medicare Part B premium reduction is applied regardless of who pays or collects the Part B premium on behalf of the beneficiary.

(4) The Medicare Part B premium can never be less than zero and will never result in a payment to a beneficiary for a specific month.

(c) Beneficiary eligibility. In order for a beneficiary to be eligible for the Medicare Part B premium reduction, the beneficiary must be enrolled in an M + C plan that offers the Medicare Part B premium reduction as an additional benefit.

(d) Notifications. After determining the Medicare Part B premium reduction amount for each eligible beneficiary, CMS will—

(1) Transmit this information to the Social Security Administration, Railroad Retirement Board, or the Office of Personnel Management, as appropriate, which will adjust the benefit check amounts as appropriate and notify the beneficiaries of their new benefit amount.

(2) Notify states and formal groups and direct billed beneficiaries of their reduced premium amounts in the regular monthly billing process.

§ 408.22  Increased premiums for late enrollment and for reenrollment.

For an individual who enrolls after expiration of his or her initial enrollment period or reenrolls after termination of a coverage period, the standard monthly premium determined
under § 408.20 is increased by ten percent for each full twelve months in the periods specified in §§ 408.24 and 408.25.

§ 408.24 Individuals who enrolled or reenrolled before April 1, 1981 or after September 30, 1981.

(a) Enrollment. For an individual who first enrolled before April 1, 1981 or after September 30, 1981, the period includes the number of months elapsed between the close of the individual’s initial enrollment period and the close of the enrollment period in which he or she first enrolled, and excludes the following:

(1) The three months of January through March 1968, if the individual first enrolled before April 1968.

(2) Any months before January 1973 during which the individual was precluded from enrolling or reenrolling by the 3-year limitation on enrollment or reenrollment that was in effect before October 30, 1972.

(3) Any months in or before a period of coverage under a State buy-in agreement.

(4) For an individual under age 65, any month before his or her current continuous period of entitlement to hospital insurance.

(5) For an individual age 65 or older, any month before the month he or she attained age 65.

(6) For premiums due for months beginning with September 1984 and ending with May 1986, the following:

(i) Any months after December 1982 during which the individual was—

(A) Age 65 to 69;

(B) Entitled to hospital insurance (Medicare Part A); and

(C) Covered under a group health plan (GHP) by reason of current employment status.

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in § 407.20 of this chapter.

(b) Reenrollment. For an individual who reenrolled before April 1, 1981 or after September 30, 1981, the period:

(1) Includes the following:

(i) The number of months elapsed between the close of the individual’s initial enrollment period and the close of the enrollment period in which he or she first enrolled; plus

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in § 407.20 of this chapter.

(iii) Any months after December 1986 and before October 1998 during which the individual was:

(A) A disabled Medicare beneficiary under age 65;

(B) Not eligible for Medicare on the basis of end stage renal disease, under § 406.13 of this chapter; and

(C) Covered under an LGHP as described in § 407.20 of this chapter.

(iv) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in § 407.20 of this chapter.

(iv) For premiums due for months beginning with July 1990, the following:

(i) Any months after December 1986 during which the individual met the conditions of paragraphs (a)(8)(i)(A) and (a)(8)(i)(B) of this section, and was covered under a GHP by reason of the current employment status of the individual or the individual’s spouse.

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in § 407.20 of this chapter.

(v) For premiums due for months beginning with January 1, 2007, the following:

(i) Any months after December 2006 during which the individual met the conditions under § 407.21(a) of this chapter.

(ii) Any months of Part B (SMI) coverage for which the individual enrolled during a special enrollment period as provided in § 407.21(b) of this chapter.

(b) Reenrollment. For an individual who reenrolled before April 1, 1981 or after September 30, 1981, the period:

(1) Includes the following:

(i) The number of months elapsed between the close of the individual’s initial enrollment period and the close of the enrollment period in which he or she first enrolled; plus

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in § 407.20 of this chapter.

(iii) Any months after December 1986 and before October 1998 during which the individual was:

(A) A disabled Medicare beneficiary under age 65;

(B) Not eligible for Medicare on the basis of end stage renal disease, under § 406.13 of this chapter; and

(C) Covered under an LGHP as described in § 407.20 of this chapter.

(iv) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in § 407.20 of this chapter.

(v) For premiums due for months beginning with July 1990, the following:

(i) Any months after December 1986 during which the individual met the conditions of paragraphs (a)(8)(i)(A) and (a)(8)(i)(B) of this section, and was covered under a GHP by reason of the current employment status of the individual or the individual’s spouse.

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in § 407.20 of this chapter.

(vi) For premiums due for months beginning with January 1, 2007, the following:

(i) Any months after December 2006 during which the individual met the conditions under § 407.21(a) of this chapter.

(ii) Any months of Part B (SMI) coverage for which the individual enrolled during a special enrollment period as provided in § 407.21(b) of this chapter.
§ 408.25

(iii) The number of months elapsed between each subsequent period of coverage and the close of the enrollment period in which he or she reenrolled.

(2) Excludes the following:

(i) Any of the periods specified in paragraph (a) of this section; and

(ii) Any month before April 1981 during which the individual was precluded from reenrolling by the two-enrollment limitation in effect before that date.


§ 408.25 Individuals who enrolled or reenrolled between April 1 and September 30, 1981.

(a) Basic rules. Except as specified in paragraph (b) of this section, the rules set forth in §408.24 apply to an individual who enrolled or reenrolled between April 1 and September 30, 1981.

(b) Exception. For an individual who enrolled or reenrolled between April 1 and September 30, 1981, the months to be counted ran through the month in which he or she reenrolled. (During those 6 months, continuous open enrollment was in effect and there was no 3-month “general enrollment period”.)

§ 408.26 Examples.

Example 1. Mr. J, who became age 65 and otherwise eligible for enrollment in November 1965, first enrolls in March 1968. The months to be included in determining the amount of the increase in Mr. J’s premiums begin with June 1966 (the first month after the close of his initial enrollment period) and extend through December 1967 (the period January through March of 1968 is excluded in determining the total months) for a total of 19 months. Since there is only one full 12-month period in 19 months, Mr. J’s premium will be 10 percent greater than if he had enrolled in his initial enrollment period.

Example 2. Mr. V, who enrolled in December 1965, voluntarily terminates his enrollment effective midnight December 31, 1967. He enrolls for a second time in January 1969. The months to be included in determining the amount of the increase in Mr. V’s premiums are January 1968 through March 1969, a total of 15 months. Since this totals one full 12-month period, Mr. V’s monthly premium will be increased by 10 percent.

Example 3. Ms. N becomes age 65 in July 1965 and first enrolls in December 1967. She pays premiums increased by 10 percent above the regular rate, beginning July 1968, the first month of her SMI coverage. Ms. N fails to pay the premiums for the calendar quarter ending June 30, 1970, and her coverage is terminated on that date, the end of her grace period. Ms. N enrolls for a second time in January 1971. The months to be included in determining the amount of the increase in Ms. N’s premiums are June 1966 through December 1967, a total of 19 months, and July 1970 through March 1971, a total of 9 months, for a grand total of 28 months. Since this totals two full 12-month periods, Ms. N’s monthly premium will be increased by 20 percent.

Example 4. Mr. X attained age 65 in August 1966 and enrolled during his initial enrollment period. His coverage was terminated effective June 30, 1968, for nonpayment of premiums. He reenrolls in March 1973. For purposes of computing any applicable premium increase, he will not be charged any months between March 1971 (the end of the last general enrollment period during which he was eligible to reenroll under the law in effect before October 30, 1972) and January 1973. Therefore, he will be charged 36 months (July 1968–March 1971 plus January 1973–March 1973) and his premiums for his second period of coverage will be increased 30 percent.

Example 5. Ms. C, who attained age 65 in August 1973, had two periods of supplementary medical insurance coverage, both of which were terminated because of nonpayment of premiums: August 1973 through April 1975 and July 1977 through August 1978. She reenrolls in July 1981. The months to be included in determining the amount of premium increase are May 1975 through March 1977 (23 months) and April 1981 through July 1981 (4 months) for a total of 27 months. The 31 months from September 1978 through March 1981 may not be counted because Ms. C was prevented from reenrolling by the two-enrollment limitation in effect before April 1, 1981. For Ms. C, the standard monthly premium would be increased by 20 percent.

[52 FR 48115, Dec. 18, 1987; 53 FR 4159, Feb. 12, 1988]

§ 408.27 Rounding the monthly premium.

Any monthly premium that is not a multiple of 10 cents is rounded to the nearest multiple of 10 cents, and any odd multiple of 5 cents is rounded to the next higher multiple of 10 cents.

[52 FR 48115, Dec. 18, 1987; 53 FR 4159, Feb. 12, 1988]
§ 408.28 Increased premiums due to the income-related monthly adjustment amount (IRMAA).

Beginning January 1, 2007, Medicare beneficiaries must pay an income-related monthly adjustment amount in addition to the Part B (SMI) standard monthly premium, plus any applicable increase for late enrollment or re-enrollment, if the beneficiary’s modified adjusted gross income exceeds the threshold amounts specified in 20 CFR 418.1115.

[73 FR 36469, June 27, 2008]

Subpart C—Deduction From Monthly Benefits

§ 408.40 Deduction from monthly benefits: Basic rules.

(a) Deduction from monthly benefits. (1) Enrollees who are receiving monthly benefits do not have the option of paying by direct remittance to avoid deduction.

(2) If the enrollee is entitled to more than one type of monthly benefit, the order of priority for deduction is as follows:

(i) Railroad retirement benefits.

(ii) Social security benefits.

(iii) Civil service annuities.

(b) Deduction from initial or reinstated benefits. When an enrollee receives a monthly benefit check after an initial award or after a period of suspension, that check is, if administratively feasible, reduced or increased to deduct unpaid premiums or refund premiums paid in advance by direct remittance.

(c) Ongoing deductions. The premium for each month is deducted from the cash benefit for the preceding month, e.g., the premium for March is deducted from the benefit for February, which is paid at the beginning of March.

§ 408.42 Deduction from railroad retirement benefits.

(a) Responsibility for deductions. If an enrollee is entitled to railroad retirement benefits, his or her SMI premiums are deducted from those benefits by the Railroad Retirement Board (RRB) even though he or she is also entitled to social security benefits or a civil service annuity, or both.

(b) Action when benefits are suspended. If the railroad retirement benefits are suspended, the RRB sends premium notices requesting direct remittance, to be made in accordance with the rules set forth in Subpart D of this part.

§ 408.43 Deduction from social security benefits.

SSA, acting as CMS’s agent, deducts the premiums from the monthly social security benefits if the enrollee is not entitled to railroad retirement benefits. (If the benefit is less than the monthly premium, the benefit is withheld and the enrollee is required to pay the balance through direct remittance.)

§ 408.44 Deduction from civil service annuities.

(a) Responsibility for deductions. If an enrollee is not entitled to railroad retirement benefits or social security benefits, and is receiving a civil service annuity, the premiums are deducted from that annuity by the Office of Personnel Management (OPM) on the basis of a notice from SSA indicating that the annuitant is entitled to SMI.

(b) Deduction of spouse’s premiums. If the annuitant’s spouse is also enrolled for SMI and is not entitled to a civil service annuity or to social security or railroad retirement benefits, and the annuitant gives written consent, OPM also deducts the spouse’s premium from the annuitant’s monthly check.

(c) Withdrawal of annuitant’s consent.

(1) If an annuitant wishes to withdraw consent for deduction of the spouse’s premium, he or she must send written notice of withdrawal to OPM.

(2) The withdrawal notice is effective with the third month after the month in which it is received, or with the month specified in the notice, whichever is later.

§ 408.45 Deduction from age 72 special payments.

(a) Deduction of premiums. SMI premiums are deducted from age 72 special payments made under section 228 of the Act or the payments are withheld under procedures that correspond to the rules set forth in §§408.40 and 408.43.

(b) Collection of premiums while age 72 special payments are suspended. If the
§ 408.46 Effect of suspension of social security benefits.

(a) Benefit payments to be resumed during the taxable year. (1) If social security benefit payments are resumed during the taxable year, the enrollee is not billed.

(2) The enrollee may, if he or she wishes, pay the premiums during suspension of benefits.

(b) Benefit payments not to be resumed during the enrollee’s current taxable year. (1) If social security and medicare payments are suspended for a period that will not permit collection of all premiums due from monthly benefits payable in the enrollee’s current taxable year, CMS or its agents bill the enrollee and require direct remittance in accordance with subpart D of this part.

(2) The first billing is for whatever premiums are necessary to place the enrollee in a quarterly cycle.

(3) Thereafter, the billing is on a quarterly basis. (Quarters for different enrollees are staggered throughout the year.)

(4) The enrollee has the option of paying premiums for more than one quarter at the same time.

§ 408.47 [Reserved]

§ 408.50 When premiums are considered paid.

(a) Actual deduction. A premium is considered paid if it is actually deducted from a monthly benefit check. Therefore—

(1) The premium is “paid” even if SSA later finds that the benefit was paid in error; but

(2) A finding that a premium was erroneously withheld does not constitute payment of the premium for that month. Since there was no payment, there was no deduction. The enrollee is billed and continuance of coverage depends on payment of premiums before the end of the grace period or extended grace period.

(b) Payment within the grace period. Overdue premiums are considered paid within the grace period in the following situations:

(1) Benefits are resumed during the grace period. (i) Monthly cash benefit payments are payable for the last month of the initial grace period or for earlier months on the basis of a notice filed by the enrollee before the initial grace period ends; and

(ii) Those payments are sufficient to permit deduction of all overdue premiums.

(2) Annual earnings report or other report submitted during the grace period shows a benefit is due. (i) Before the end of the grace period, the enrollee submits a report clearly showing that monthly cash benefits, previously withheld, are payable; and

(ii) Those benefits are sufficient to permit deduction of the full amount of the overdue premiums.

(3) Premium arrears are paid by direct remittance. The enrollee makes a direct remittance payment of all overdue premiums before the end of the grace period.


§ 408.52 Change from direct remittance to deduction.

If a direct remittance enrollee becomes entitled to monthly benefits—

(a) The SMI premiums are deducted from those benefits; and

(b) The enrollee is notified of the deduction and of any adjustment of the initial benefit check that is required to collect overdue premiums or refund premiums paid in advance.
§ 408.63 Billing procedures when monthly benefits are less than monthly premiums.

If monthly benefits are less than monthly premiums, the following procedures apply:

(a) Notice of amount due. At the beginning of SMI entitlement, and at the beginning of each succeeding calendar year, SSA—
   (1) Notifies the enrollee of the amount of benefits payable for the rest of the year and the total premiums due for those same months; and
   (2) Bills the enrollee for the difference.

(b) Notice of amount overdue. At the beginning of each succeeding calendar year, SSA—
   (1) Notifies the enrollee of any amounts overdue for premiums for the preceding calendar year; and
   (2) Indicates that if the amount still overdue on April 30 is equal to or greater than the premium for 3 months, SMI coverage will terminate on that date.

§ 408.65 Payment options.

(a) The enrollee is not asked to pay premiums at the time of enrollment but is instructed to pay them upon receipt of a premium bill from CMS or its agents.

(b) However, if the enrollee wishes, he or she may pay from one to 12 months or from one to four quarters at the time of enrollment.

§ 408.68 When premiums are considered paid.

(a) Payment by check. The premium is considered paid if the check is paid by the bank the first or second time it is presented for payment.

(b) Payment within the grace period. (1) A premium is considered paid within the grace period if it is delivered personally, or mailed on or before the last day of that period.

(2) A premium payment is considered to have been mailed 7 days before it is received by CMS.
§ 408.70 Change from quarterly to monthly payments.

If an enrollee requests change from quarterly to monthly payments—
(a) If the enrollee is paid up under the quarterly cycle, the first monthly bill is for one month.
(b) If the enrollee is not paid up under the quarter system, the first bill includes all premiums due.

§ 408.71 Change from deduction or State payment to direct remittance.

(a) Basis for change. An SMI enrollee is required to pay by direct remittance in any of the following circumstances:
(1) The enrollee’s entitlement to social security or railroad retirement benefits ends for any reason other than death.
(2) The premiums can no longer be deducted from the civil service annuity of the enrollee or the enrollee’s spouse.
(3) The enrollee no longer qualifies for coverage under a State buy-in agreement, and is not entitled to social security or railroad retirement monthly benefits.
(b) Billing. When any of the events specified in paragraph (a) of this section occurs (or as soon thereafter as possible), CMS or its agents bill the enrollee for direct remittance, in accordance with this subpart.

Subpart E—Direct Remittance: Group Payment

§ 408.80 Basic rules.

(a) Sources of group payment. An employer, a lodge, union, or other organization may pay SMI premiums on behalf of one or more enrollees.
(b) Informal arrangement. Enrollees may turn over their premium notices to their employer, union, lodge, or other organization and that organization may send a single payment (with the premium notices attached so that the payments can readily be identified with the appropriate enrollees) to the CMS Premium Collection Center. Prompt payment is essential since SMI coverage terminates if premiums are not paid by the end of the grace period.
(c) Group billing arrangement. CMS may send a single notice for the premiums due from a group of enrollees if the following conditions are met:
(1) The group payer—
(i) Uses funds other than the enrollees’ to pay all or a substantial part of the premiums; or
(ii) Deducts the premiums from periodic payments it makes to the enrollees in the group.
(2) The enrollee’s rights are protected and enrollees are not required to pay the costs of having their premiums paid on a group basis.

§ 408.82 Conditions for group billing.

CMS agrees to a group billing arrangement only if the following conditions are met:
(a) Conditions the group payer must meet. The group payer submits a written request for group billing—
(1) Showing that all or part of the payments are made from the payer’s funds or from funds due the enrollees and in the payer’s possession; and
(2) Agreeing not to charge the enrollees for the service of paying the premiums or for the administrative costs such as recordkeeping and postage.
(b) Enrollees eligible for group payment.
(1) Group payment may be made only on behalf of individuals who are already enrolled and are being billed for direct remittance.
(2) Group payment may not be made for enrollees whose premiums are being deducted from monthly benefits in accordance with Subpart C of this part or being paid by the State under a buy-in agreement.
(c) Protection of enrollee’s rights. The use of group billing must not jeopardize the enrollees’ right—
(1) To confidentiality of personal information;
(2) To terminate enrollment;
(3) To resume individual payment of premiums if he or she wishes; and
(4) To receive notice of any action that affects the SMI benefits.
(d) Authorization by the enrollee. (1) To ensure maximum feasible protection of the rights specified in paragraph (c) of this section, each enrollee must give written authorization as specified in § 408.84(a)(2).
(2) A group payer that is not an entity of State or local government must
submit all enrollee authorizations to CMS.
(3) A group payer that is an entity of State or local government may retain the authorizations and certify to CMS that it has on file an authorization for each enrollee included in the group.
(4) It is on the basis of the enrollee’s authorization that CMS sends the group payer information about each enrollee, as necessary to carry out the group payment function.
(e) Size of group. The number of enrollees must be at least 20, which is the minimum size sufficient to make group billing efficient. (Smaller groups may use the informal procedure described in §408.80(b).)

§ 408.84 Billing and payment procedures.
(a) Initial premium notice. (1) CMS or its agent always sends the initial premium notice to the enrollee.
(2) An enrollee who wishes to have the premiums paid on a group basis must give the notice to the group payer, along with written authorization for sending subsequent notices to the group payer and for release of the information required for the group payment process.
(b) Monthly billings. Group premiums are billed on a monthly basis. However, the group payer may pay up to 12 months in advance.
(c) Group payers must make their payments within 30 days after billing, to avoid infringing on the 90-day grace period during which the premiums may be paid by the enrollee if he or she is dropped from the group.
(d) Effect of group payment. Payment by a group payer is considered payment by the enrollee.

§ 408.86 Responsibilities under group billing arrangement.
(a) Enrollee responsibilities. (1) The enrollee is still responsible for premium payments; the group payer simply acts as his agent. If the agent fails to pay, or identifies the payment incorrectly, SSA notifies both the agent and the enrollee that the enrollee’s account is delinquent. If an enrollee fails to take action on that notice, entitlement is terminated for nonpayment of premiums.
(2) The enrollee must promptly notify both SSA and the group payer of any change of address.
(b) Group payer’s responsibilities. The group payer must—
(1) Make premium payments promptly upon receipt of notices;
(2) Promptly notify both CMS and the enrollee when it drops an enrollee from the group;
(3) Make payments in a way that facilitates efficient and economical processing; and
(4) Maintain the confidentiality of the personal information obtained from CMS for the group payment process.
(c) CMS responsibilities. CMS—
(1) Sends the bill to the group payer upon authorization from the enrollee;
(2) Notifies both the payer and the enrollee if the payer fails to make timely payments; and
(3) Refunds excess premiums in accordance with §408.88.

§ 408.88 Refund of group payments.
(a) Basis for refund. Group payments are refunded only in the following circumstances:
(1) The premium was for a month after the month in which the enrollee’s SMI coverage terminated or the enrollee died.
(2) The premium was for a month after the month in which the group payer gave notice (before the 26th day of that month) that the enrollee was no longer eligible for group payment and was being dropped from the group.
(b) Example. F is the wife of J who is a retiree of Corporation X. That corporation pays premiums on behalf of all of its retirees and their dependents. F obtains a divorce from J on October 20 and thus disqualifies herself for further premium payments by the corporation. The corporation gives notice on November 10 that a refund is due because F has been dropped from the list of persons for whom it has agreed to pay premiums. The premium paid for December would be refunded to the group payer.
(c) To whom refund is made. (1) CMS ordinarily refunds to the group payer the premiums specified in paragraph (a) of this section.
(2) However, if CMS has information that clearly shows those premiums
were paid from the enrollee’s funds, it sends the refund to the enrollee.

§ 408.90 Termination of group billing arrangement.
(a) A group billing arrangement may be terminated either by the group payer or by CMS upon 30 days’ notice.
(b) CMS may terminate the arrangement if it finds that the group payer is not acting in the best interest of the enrollees or that, for any other reason, the arrangement has proved inconvenient for CMS.

§ 408.92 Change from group payment to deduction or individual payment.
(a) Enrollee excluded from group payment arrangement because of entitlement to monthly benefits. (1) When an enrollee becomes entitled to monthly benefits from which premiums can be deducted as specified in subpart C of this part, CMS notifies the group payer to discontinue payment for that enrollee.
(2) In order to maintain confidentiality, CMS does not explain to the group payer the reason for excluding the enrollee from the group payment arrangement.
(3) The enrollee’s premiums are thereafter deducted from the monthly benefits, in accordance with subpart C of this part.
(b) Enrollee no longer eligible for the group. (1) When an enrollee is no longer eligible to be included in the group (for instance because he or she is no longer employed by the group payer or has terminated union or lodge membership), the group payer must promptly notify CMS and the enrollee.
(2) CMS or its agents resume sending individual bills to the enrollee, for direct remittance subject to the grace period and termination dates specified in §408.8.

Subpart F—Termination and Reinstatement of Coverage

§ 408.100 Termination of coverage for nonpayment of premiums.
(a) Effective date of termination. Termination is effective on the last day of the grace period. The determination is not made until 15 days after that day to allow for processing of remittances mailed late in the grace period, as provided in §408.68.
(b) Notice of termination. (1) SSA sends the enrollee notice of termination between 15 and 30 days after the end of the grace period and includes information regarding the enrollee’s right of appeal.
(2) CMS notifies any intermediary or carrier that had previously been informed that the enrollee had met the SMI deductible for the year in which the termination is effective.

§ 408.102 Reconsideration of termination.
(a) Basic rules. Coverage may be reinstated without interruption of benefits if the following conditions are met:
(1) The enrollee appeals the termination by the end of the month following the month in which SSA sent the notice of termination.
(2) The enrollee alleges and it is found that the enrollee did not receive timely and adequate notice that the premiums were overdue.
(3) The enrollee pays, within 30 days after SSA’s subsequent request for payment, all premiums due through the month in which he or she appealed the termination.
(b) Basis for reinstating coverage. Coverage may be reinstated if the evidence establishes one of the following:
(1) The enrollee acted diligently to pay the premiums or to request relief upon receiving a premium notice very late in the grace period or shortly after its end, and the delayed notice was not the enrollee’s fault. (For example, if the billing notice was misaddressed or lost in the mail, it would not be the enrollee’s fault; if the enrollee had moved and not notified SSA of the new address, he or she would be responsible for the delay.)
(2) On the basis of information given by SSA, the enrollee could reasonably have believed that the premiums were being paid by deduction from benefits or by some other means. (An example would be a notice indicating that premiums would be paid by a State Medicaid agency or a group payer or would be deducted from the spouse’s civil service annuity.)
Centers for Medicare & Medicaid Services, HHS

§ 408.112 Refund of excess premiums after the enrollee dies.

If CMS has received premiums for months after the enrollee’s death, CMS refunds those premiums as follows:

(a) To the person or persons who paid the premiums or, if the premiums were paid by the enrollee, to the representative of the enrollee’s estate, if any.
(b) If refund cannot be made under paragraph (a) of this section, CMS refunds the premiums to the enrollee’s survivors in the following order of priority:

(1) The surviving spouse, if he or she was either living in the same household with the deceased at the time of death, or was, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased beneficiary;

(2) The child or children who were, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one child, in equal parts to each child);

(3) The parent or parents who were, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one parent, in equal parts to each parent);

(4) The surviving spouse who was not living in the same household with the deceased at the time of death and was not, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased beneficiary;

(5) The child or children who were not entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one child, in equal parts to each child);

(6) The parent or parents who were not entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one parent, in equal parts to each parent).

If none of the listed relatives survives, no refund can be made.

Subpart H—Supplementary Medical Insurance Premium Surcharge Agreements

Source: 67 FR 69966, Sept. 27, 2002, unless otherwise noted.
Centers for Medicare & Medicaid Services, HHS § 408.207

(b) The State or local government agency must secure from each enrollee a signed, written statement authorizing CMS to send billing notices directly to the State or local government agency, and to release to the State or local government agency information required under the SMI premium surcharge agreement.

c) The authorization statement for each enrollee must be retained in the State or local government agency files for as long as the enrollee is covered by the agreement. These authorization statements need not be forwarded to CMS.

d) The State or local government agency must certify to CMS, in writing, that an authorization statement is on file for each enrollee covered under the SMI premium surcharge agreement. Only one certification is necessary for the entire group of covered enrollees.

e) A State or local government agency must establish an automated data exchange with CMS using the Third Party Premium Collection System, in order to transmit electronically an input file that will be used to add or remove enrollees from the billing system.

§ 408.205 Application procedures.

(a) A State or local government agency must contact its CMS regional office (RO) to request application materials.

(b) If interested in entering into an agreement, the State or local government agency must return to the RO two copies of the completed application materials.

(c) CMS reviews the application materials, and, when they are approved, notifies the State or local government agency, and the RO.

§ 408.207 Billing and payment procedures.

(a) Adding and removing enrollees. The State or local government agency must transmit an input file containing addition and removal records electronically to CMS as follows:

1. Input files must be transmitted at least once each calendar month, but may be transmitted as often as once a day.

2. CMS will not add or remove enrollees retroactively, except for removals upon the death of an enrollee.

3. The State or local government agency must pay the SMI premium surcharge for each eligible enrollee who is included in the agreement for the time period beginning with the month the enrollee is added and continuing through the month the State or local government agency informs CMS that the enrollee is to be removed, the month the enrollee's Part B coverage terminates, or the month of the enrollee's death, whichever comes first.

(b) Payment and grace period. Payment must be made to CMS as follows:

1. Payment to CMS must be received by CMS by the first day of each month.

2. There is a 10-day grace period for receipt of payment.

3. Payment must be made to CMS via electronic funds transfer.

(c) Late payment penalties. CMS may assess interest for any payment it does not receive by the first day of the month as follows:

1. Interest will be assessed at the SMI trust fund rate as computed for new investments in accordance with section 1841(c) of the Act.

2. Interest will be waived if the full payment is received by the 10th day of the month in which it is due.

3. Interest will be assessed and calculated in 30-day increments.

4. Interest will be assessed on the balance of the amount billed that remains unpaid at the expiration of the grace period and unpaid balances from prior periods.

5. Interest will continue to accrue on unpaid amounts until the balance is paid in full.

(d) Disagreement over billing amounts or interest. If the State or local government agency disagrees with the amount assessed in a billing statement or interest charge, it must notify CMS as follows:

1. The State or local government agency must provide evidence suitable to CMS to substantiate its claim.

2. The State or local government agency must continue to make full payment while CMS evaluates the evidence provided.

3. Credit for payment amounts or interest that CMS determines to be due
§ 408.210 Termination of SMI premium surcharge agreement.

(a) Termination by the State or local government agency. The State or local government agency may voluntarily terminate its agreement with CMS as follows:

(1) The State or local government agency must notify CMS, in writing, at least 30 days before the effective date of the termination.

(2) The State or local government agency must pay any unpaid premium surcharge amounts and interest due within 30 days after the effective date of the termination.

(3) Interest will continue to accrue until all amounts due are paid in full.

(b) Termination by CMS. CMS may terminate the agreement with a State or local government agency as follows:

(1) If a State or local government agency’s payments are delinquent 30 days or more, CMS may terminate the agreement with 30 days advance notice.

(2) If the State or local government agency fails to comply with the terms of the agreement or procedures promulgated by CMS, CMS may terminate the agreement with 30 days advance notice.

(3) If CMS finds that the State or local government agency is not acting in the best interest of the enrollees, or CMS, or for any reason other than those in paragraphs (b)(1) and (b)(2) of this section, CMS may terminate the agreement at any time.

(4) The State or local government agency must pay all outstanding premium surcharge and any interest amounts due within 30 days after the effective date of the termination.

(5) Interest will continue to accrue until all amounts due are paid in full.

(6) After the agreement is terminated, CMS will resume collection of the premium surcharge from the enrollees covered under the terminated agreement.

(7) If an agreement is terminated by CMS, the State or local government agency must wait 3 years from the effective date of the termination before it can request to enter into another SMI premium surcharge agreement.

PART 409—HOSPITAL INSURANCE BENEFITS

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