

Subpart C—Premium Hospital Insurance

§ 406.20 Basic requirements.

(a) *General provisions.* Hospital insurance benefits are available to most individuals age 65 or over and to certain individuals under age 65 who do not qualify for those benefits under subpart B of this part and are willing to pay a monthly premium. This is called premium hospital insurance.

(b) *Eligibility of individuals age 65 or over to enroll for premium hospital insurance.* Any individual is eligible to enroll for Medicare Part A if he or she—

- (1) Has attained age 65;
- (2) Is a resident of the United States and is either—
 - (i) A citizen of the United States; or
 - (ii) An alien lawfully admitted for permanent residence who has resided in the United States continuously for the 5-year period immediately preceding the month in which he or she meets all other requirements;
- (3) Is not eligible for Part A benefits under subpart B of this part; and
- (4) Is entitled to supplementary medical insurance (Part B of Medicare) or is eligible and has enrolled for it during an enrollment period.

(c) *Eligibility of individuals under age 65 to enroll for premium hospital insurance.* An individual who has not attained age 65 is eligible to enroll for Medicare Part A if he or she meets the following conditions:

- (1) Has been entitled to Medicare Part A (under § 406.12 or § 406.15) on the basis of entitlement or deemed entitlement to social security disability benefits, as provided under section 226(b) of the Act.
- (2) Continues to have a disabling physical or mental impairment.
- (3) Loses entitlement to disability benefits (and therefore also loses entitlement to Medicare Part A under § 406.12) solely because his or her earnings exceed the amount allowed under the social security regulations pertaining to “substantial gainful activity” (20 CFR 404.1571–404.1574); and
- (4) Is not otherwise entitled to Medicare Part A.

[56 FR 38078, Aug. 12, 1991; 56 FR 50058, Oct. 3, 1991]

§ 406.21 Individual enrollment.

(a) *Basic provision.* An individual who meets the requirements of § 406.20(b) or (c), except as provided in § 406.26(b)(2), may enroll for premium hospital insurance only during his or her—

- (1) Initial enrollment period as set forth in paragraph (b) of this section;
- (2) A general enrollment period as set forth in paragraph (c) of this section;
- (3) A special enrollment period as set forth in §§ 406.24, 406.25, and 406.27; or
- (4) For HMO/CMP enrollees, a transfer enrollment period as set forth in paragraph (f) of this section.

(b) *Initial enrollment periods*—(1) *Initial enrollment period for individual age 65 or over.* The initial enrollment period extends for 7 months, from the third month before the month the individual first meets the requirements of § 406.20 (b)(1) through (b)(3) through the third month after that first month of eligibility.

(2) *Initial enrollment period of individual under age 65.* The initial enrollment period begins with the month in which the individual receives notice that entitlement to Medicare Part A will end because he or she has lost entitlement to disability benefits solely because of earnings in excess of the amounts allowed under the social security regulations on substantial gainful activity (20 CFR 404.1571–404.1574). It continues for 7 full months after that month.

(c) *General enrollment period.* (1) Except as specified in paragraph (c)(4) of this section, the general enrollment period extends from January 1 to March 31 of each calendar year.

(2) General enrollment periods are for individuals who do not enroll during the special enrollment period, who failed to enroll during the initial enrollment period, or whose previous period of entitlement had terminated.

(3) If the individual enrolls or reenrolls during a general enrollment period—

- (i) Before January 1, 2023, his or her entitlement begins on July 1 of the calendar year; or
- (ii) On or after January 1, 2023, his or her entitlement begins on the first day of the month after the month of enrollment.

(4) During the period April 1 through September 30, 1981, the general enrollment period was any time after the end of the individual's initial enrollment period. Any eligible individual whose initial enrollment period has ended, or whose previous period of entitlement had terminated, could enroll or re-enroll during that 6-month period.

(d) “*Deemed*” initial enrollment period for individual age 65 or over. (1) If an individual who has attained age 65 fails to enroll during the initial enrollment period because of reliance on incorrect documentary information which led him or her to believe that he or she was not yet age 65, an initial enrollment period may be established for him or her as though he or she had attained age 65 on the date indicated by the incorrect documentary information.

(2) The deemed initial enrollment period will be used to determine the individual's premium and right to enroll in a general enrollment period if such use is advantageous to the individual.

(e) [Reserved]

(f) *Transfer enrollment period for HMO/CMP enrollees*—(1) *Terminology*. HMO or CMP means an eligible organization as defined in § 417.401 which has a contract with CMS under part 417, subpart L of this chapter.

(2) *Basic rule*. Effective February 1, 1991, individuals enrolled in an HMO or CMP under part 417, subpart K of this chapter who meet the requirements of § 406.20(b) may enroll in premium hospital insurance during a transfer enrollment period. This transfer enrollment period begins with any month or any part of a month in which the individual is enrolled in an HMO or CMP and ends with the last day of the 8th consecutive month in which the individual is no longer enrolled in the HMO or CMP.

(3) *Effective date of coverage*. (i) If the individual enrolls in premium hospital insurance while still enrolled in an HMO or CMP, or during the first month that he or she is no longer enrolled in the HMO or CMP, part A coverage will begin on the first day of the month of part A enrollment, or, at the option of the individual, on the first day of any of the following 3 months.

(ii) If the individual enrolls in premium hospital insurance during any of the last 7 months of the transfer enrollment period, coverage will begin on the first day of the month after the month of enrollment.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986, as amended at 53 FR 47203, Nov. 22, 1988; 56 FR 38079, Aug. 12, 1991; 57 FR 36014, Aug. 12, 1992; 61 FR 40345, Aug. 2, 1996; 87 FR 66503, Nov. 3, 2022]

EFFECTIVE DATE NOTE: At 88 FR 65269, Sept. 21, 2023, § 406.21 was amended by adding paragraph (c)(5), effective Nov. 17, 2023. For the convenience of the user, the added text is set forth as follows:

§ 406.21 Individual enrollment.

* * * * *

(c) * * *

(5) If an individual resides in a State that pays premium hospital insurance for Qualified Medicare Beneficiaries under § 406.32(g) and enrolls or reenrolls during a general enrollment period after January 1, 2023, QMB coverage is effective the month entitlement begins (if the individual is determined eligible for QMB before the month following the month of enrollment), or a month later than the month entitlement begins (if the individual is determined eligible for QMB the month entitlement begins or later).

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§ 406.22 Effect of month of enrollment on entitlement.

(a) *Individual age 65 or over*. For an individual who has attained age 65, before January 1, 2023, the following rules apply:

(1) If the individual enrolls during the 3 months before the first month of eligibility, entitlement begins with the first month of eligibility.

(2) If the individual enrolls in the first month of eligibility, entitlement begins with the following month.

(3) If the individual enrolls during the month after the first month of eligibility, entitlement begins with the second month after the month of enrollment.

(4) If the individual enrolls in either of the last 2 months of the enrollment period, entitlement begins with the third month after the month of enrollment.

(b) *Individual age 65 or over.* For an individual who has attained age 65 on or after January 1, 2023, the following rules apply:

(1) If the individual enrolls during the first 3 months of their initial enrollment period, entitlement begins with the first month of eligibility.

(2) If an individual enrolls during the last 4 months of their initial enrollment period, entitlement begins with the month following the month of enrollment.

(c) *Individual under age 65.* For an individual who has not attained age 65 and who satisfies the requirements of § 406.20(c) before January 1, 2023, the following rules apply:

(1) If the individual enrolls before the month in which he or she meets the requirements of § 406.20(c), entitlement begins with the month in which the individual meets those requirements.

(2) If the individual enrolls in the month in which he or she first meets the requirements of § 406.20(c), entitlement begins with the following month.

(3) If the individual enrolls in the month following the month in which he or she meets the requirements of § 406.20(c), entitlement begins with the second month after the month of enrollment.

(4) If the individual enrolls more than one month after the month in which he or she first meets the requirements of § 406.20(c), entitlement begins with the third month after the month of enrollment.

(d) *Individual under age 65.* For an individual who has not attained age 65 and who first satisfies the requirements of § 406.20(c) on or after January 1, 2023, the following rules apply:

(1) For individuals who enroll during the first 3 months of their IEP, entitlement begins with the first month of eligibility.

(2) If an individual enrolls during the month in which they first become eligible or any subsequent month of their IEP, entitlement begins with month following the month of enrollment.

[56 FR 38079, Aug. 12, 1991, as amended at 87 FR 66503, Nov. 3, 2022]

§ 406.24 Special enrollment period related to coverage under group health plans.

(a) *Terminology.* As used in this subpart, the following terms have the indicated meanings.

(1) *Current employment status* has the meaning given this term in § 411.104 of this chapter.

(2) *Family member* has the meaning given this term in § 411.201 of this chapter.

(3) *Group health plan (GHP)* and *large group health plan (LGHP)* have the meanings given those terms in § 411.101 of this chapter, except that the “former employee” language of those definitions does not apply with respect to SEPs because—

(i) Section 1837(i)(1)(A) of the Act explicitly requires that GHP coverage of an individual age 65 or older, be by reason of the individual’s (or the individual’s spouse’s) current employment status; and

(ii) The sentence following section 1837(i)(1)(B), of the Act refers to “large group health plan”. Under section 1862(b)(1)(B)(i), as amended by OBRA ’93, LGHP coverage of a disabled individual must be “by virtue of the individual’s or a family member’s current employment status with an employer”.

(4) *Special enrollment period (SEP)* is a period provided by statute to enable certain individuals to enroll in Medicare without having to wait for the general enrollment period.

(b) *Duration of SEP.*² (1) The SEP includes any month during any part of which—

(i) An individual over age 65 is enrolled in a GHP by reason of the current employment status of the individual or the individual’s spouse; or

(ii) An individual under age 65 and disabled—

(A) Is enrolled in a GHP by reason of the current employment status of the individual or the individual’s spouse; or

(B) Is enrolled in an LGHP by reason of the current employment status of the individual or a member of the individual’s family.

²Before March 1995, SEPs began on the first day of the first month the individual was no longer covered under a GHP or LGHP by reason of current employment status.

(2) The SEP ends on the last day of the eighth consecutive month during which the individual is at no time enrolled in a GHP or an LGHP by reason of current employment status.

(c) *Conditions for use of a SEP.*³ In order to use a SEP, the individual must meet the following conditions:

(1) When first eligible to enroll for premium hospital insurance under § 406.20(b) or (c), the individual was—

(i) Age 65 or over and covered under a GHP by reason of the current employment status of the individual or the individual's spouse;

(ii) Under age 65 and covered under an LGHP by reason of the current employment status of the individual or a member of the individual's family ; or

(iii) Under age 65 and covered under a GHP by reason of the current employment status of the individual or the individual's spouse.

(2) For all the months thereafter, the individual has maintained coverage either under hospital insurance or a GHP or LGHP.

(d) *Special rule: Additional SEPs.* (1) Generally, if an individual fails to enroll during any available SEP, he or she is not entitled to any additional SEPs.

(2) However, if an individual fails to enroll during a SEP, because coverage under the same or a different GHP or LGHP was restored before the end of that particular SEP, that failure to enroll does not preclude additional SEPs.

(e) *Effective date of coverage.* (1) If the individual enrolls in a month during any part of which he or she is covered under a GHP or LGHP on the basis of current employment status, or in the first full month when no longer so covered, coverage begins on the first day of the month of enrollment or, at the individual's option, on the first day of any of the three following months.

(2) If the individual enrolls in any month of the SEP other than the

months specified in paragraph (e)(1) of this section, coverage begins on the first day of the month following the month of enrollment.

[61 FR 40346, Aug. 2, 1996]

§ 406.25 Special enrollment period for volunteers outside the United States.

(a) *General rule.* A SEP, as defined in § 406.24(a)(4) of this subchapter, is provided for an individual that meets the following requirements:

(1) The individual is serving as a volunteer outside of the United States in a program that covers at least a 12-month period.

(2) The individual is in a program that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of Internal Revenue Code of 1986.

(3) The individual can demonstrate that he or she has health insurance that covers medical services that the individual receives outside the United States while serving in the program.

(4) The individual—

(i) At the time he or she first met the requirements of § 406.10 through 406.15 or § 406.20(b), elected not to enroll in premium hospital insurance during the individual's initial enrollment period; or

(ii) Terminated enrollment in premium hospital insurance during a month in which the individual met the requirements of this section for a SEP.

(b) *Duration of SEP.* The SEP is the 6-month period beginning on the first day of the month that includes the date that the individual no longer meets the requirements of paragraph (a) of this section.

(c) *Effective date of coverage.* Coverage under a SEP authorized by this section begins on the first day of the month following the month in which the individual enrolls.

[73 FR 36468, June 27, 2008]

§ 406.26 Enrollment under State buy-in.

(a) *Enrollment of QMBs under a State buy-in agreement—*(1) *Effective date.* Beginning with calendar year 1990, a State may request and be granted a modification of its buy-in agreement to

³Before August 10, 1993, an individual under age 65 could qualify for a SEP only if he or she had LGHP coverage as an "active individual", which the statute defined as "an employee, employer, self-employed individual (such as the employer), individual associated with the employer in a business relationship, or as a member of the family of any of those persons".

include enrollment and payment of Part A premiums for QMBs (as defined in section 1905(p)(1) of the Act) who can become entitled to Medicare Part A only by paying a premium.

(i) Any State that has a buy-in agreement in effect must participate in daily exchanges of enrollment data with CMS.

(ii) [Reserved]

(2) *Amount of premium.* Premiums paid under State buy-in are not subject to increase because of late enrollment or reenrollment.

(3) *Enrollment without discrimination.* A State that has a buy-in agreement in effect must enroll in premium health insurance any applicant who meets the eligibility requirement for the QMB eligibility group, with the State paying the premiums on the individual's behalf.

(b) *Beginning of coverage under buy-in.* The coverage period begins with the latest of the following:

(1) The third month following the month in which the agreement modification covering QMBs is effectuated.

(2) The first month in which the individual is entitled to premium hospital insurance under § 406.20(b) and has QMB status. Under a State buy-in agreement, as defined in § 407.40 of this subchapter, QMB-eligible individuals can enroll in premium hospital insurance at any time of the year, without regard to Medicare enrollment periods.

(3) The date specified in the agreement modification.

(c) *End of coverage under buy-in.* Buy-in coverage ends with the earlier of the following:

(1) *Death.* Coverage ends on the last day of the month in which the QMB dies.

(2) *Loss of QMB status.* If the individual loses eligibility for QMB status, coverage ends on the last day of the month in which CMS receives the State's notice of ineligibility.

(3) *Termination of buy-in agreement.* If the State's buy-in agreement is terminated, coverage ends on the last day of the last month for which the agreement is in effect.

(4) *Entitlement to premium-free Part A.* If the individual becomes entitled to premium-free Part A, buy-in coverage

ends on the last day of entitlement to premium Part A.

(d) *Continuation of coverage: Individual enrollment following termination of buy-in coverage—*(1) *Deemed enrollment.* If coverage under a buy-in agreement ends because the agreement is terminated or the individual loses QMB status, the individual—

(i) Is considered to have enrolled during his or her initial enrollment period; and

(ii) Is entitled to Part A benefits and liable for Part A premiums beginning with the first month for which he or she is no longer covered under the buy-in agreement.

(2) *Voluntary termination.* (i) An individual may voluntarily terminate entitlement acquired under paragraph (d)(1) of this section by filing, with SSA or CMS, a request for disenrollment.

(ii) Voluntary disenrollment is effective as follows:

(A) 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.

(B) 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.

(C) 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.

[56 FR 38080, Aug. 12, 1991, as amended at 85 FR 25632, May 1, 2020; 87 FR 66504, Nov. 3, 2022]

§ 406.27 Special enrollment periods for exceptional conditions.

(a) *General rule.* Beginning January 1, 2023, in accordance with the Secretary's authority in sections 1837(m) and 1838(g) of the Act, the following SEPs, as defined under § 406.24(a)(4), are provided for individuals that missed a Medicare enrollment period, (as specified in § 406.21, § 406.24, or § 406.25), due to exceptional conditions as determined by the Secretary and established under paragraphs (b) through (f) of this

section. SEPs are provided for exceptional conditions that took place on or after January 1, 2023 except as specified in paragraph (e) of this section.

(b) *Special enrollment period for individuals impacted by an emergency or disaster.* An SEP exists for individuals prevented from submitting a timely Medicare enrollment request by an emergency or disaster declared by a Federal, State, or local government entity.

(1) *SEP parameters.* An individual is eligible for the SEP if they (or their SSA-authorized representative as defined at 42 CFR 405.910), their legal guardian, or person who makes healthcare decisions on behalf of that individual reside (or resided) in an area for which a Federal, State or local government entity newly declared a disaster or other emergency. The individual (or the individual's authorized representative, legal guardian, or person who makes healthcare decisions on behalf of that individual) must demonstrate that they reside (or resided) in the area during the period covered by that declaration.

(2) *SEP duration.* The SEP begins on the earlier of the date an emergency or disaster is declared or, if different, the start date identified in such declaration. The SEP ends 6 months after the end date identified in the declaration, the end date of any extensions or the date when the declaration has been determined to have ended or has been revoked, if applicable.

(3) *Entitlement.* Entitlement begins the first day of the month following the month of enrollment, so long as the date is on or after January 1, 2023.

(c) *Special enrollment period for individuals affected by a health plan or employer misrepresentation.* An SEP exists for individuals whose non-enrollment in premium Part A is unintentional, inadvertent, or erroneous and results from misrepresentation or reliance on incorrect information provided by the individual's employer or GHP, agents or brokers of health plans, or any person authorized to act on behalf of such entity.

(1) *SEP parameters.* An individual is eligible for the SEP if they can demonstrate (by documentation or written attestation) both of the following:

(i) He or she did not enroll in premium Part A during another enrollment period in which they were eligible based on information received from an employer or GHP, agents or brokers of health plans, or any person authorized to act on such organization's behalf.

(ii) An employer, GHP, agent or broker of a health plan, or their representative materially misrepresented information or provided incorrect information relating to enrollment in premium Part A.

(2) *SEP duration.* This SEP begins the day the individual notifies SSA of the employer or GHP misrepresentation and ends 6 months later.

(3) *Entitlement.* Entitlement begins the first day of the month following the month of enrollment, so long as the date is on or after January 1, 2023.

(d) *SEP for formerly incarcerated individuals.* An SEP exists for Medicare eligible individuals who are released from the custody of penal authorities as described in §411.4(b) of this subchapter on or after January 1, 2023.

(1) *SEP parameters.* An individual is eligible for this SEP if they demonstrate that they are eligible for Medicare and failed to enroll or re-enroll in Medicare premium Part A due to being in custody of penal authorities and there is a record of release either through discharge documents or data available to SSA.

(2) *SEP duration.* The SEP starts the day of the individual's release from the custody of penal authorities and ends the last day of the 12th month after the month in which the individual is released from the custody of penal authorities.

(3) *Entitlement—(i) General rule.* Entitlement begins the first day of the month following the month of enrollment, so long as the date is on or after January 1, 2023.

(ii) *Special rule.* An individual has the option of requesting entitlement retroactive to the month of their release from incarceration provided the individual pays the monthly premiums for the period of coverage (as required under §406.31). The retroactive period cannot exceed 6 months.

(e) *Special enrollment period for termination of Medicaid coverage.* An SEP exists for individuals whose Medicaid eligibility is terminated.

(1) *SEP parameters.* An individual is eligible for this SEP if they can demonstrate that—

(i) They are eligible for premium Part A under § 406.5(b); and

(ii) Their Medicaid eligibility is terminated on or after January 1, 2023, or is terminated after the last day of the Coronavirus Disease 2019 public health emergency (COVID–19 PHE) as determined by the Secretary, whichever is earlier.

(2) *SEP duration.* If the termination of Medicaid eligibility occurs—

(i) After the last day of the COVID–19 PHE and before January 1, 2023, the SEP starts on January 1, 2023 and ends on June 30, 2023.

(ii) On or after January 1, 2023, the SEP starts when the individual is notified of termination of Medicaid eligibility and ends 6 months after the termination of eligibility.

(3) *Entitlement—(i) General rule.* Entitlement begins the first day of the month following the month of enrollment, so long as the date is after the last day of the COVID–19 PHE or on after January 1, 2023, whichever is earlier.

(ii) *Special COVID–19 PHE rule.* An individual whose Medicaid eligibility is terminated after the end of the COVID–19 PHE, but before January 1, 2023 (if applicable), has the option of requesting that entitlement begin back to the first of the month following termination of Medicaid eligibility provided the individual pays the monthly premiums for the period of coverage (as required under § 406.31).

(iii) *Other special rule.* After January 1, 2023, an individual has the option of requesting entitlement for a retroactive period back to the date of termination from Medicaid provided the individual pays the monthly premiums for the period of coverage (as required under § 406.31).

(4) *Effect on previously accrued late enrollment penalties.* Individuals who otherwise would be eligible for this SEP, but enrolled during the COVID–19 PHE prior to January 1, 2023, are eligible to have late enrollment penalties col-

lected under § 406.32(d) reimbursed and ongoing penalties removed.

(f) *Special enrollment period for other exceptional conditions.* An SEP exists for other exceptional conditions as CMS may provide.

(1) *SEP parameters.* An individual is eligible for the SEP if both of the following apply:

(i) The individual demonstrates that they missed an enrollment period in which they were eligible because of an event or circumstance outside of the individual's control which prevented them from enrolling in premium Part A.

(ii) It is determined that the conditions were exceptional in nature.

(2) *SEP duration.* The SEP duration is determined on a case-by-case basis, but will be no less than 6 months.

(3) *Entitlement.* Entitlement begins the first day of the month following the month of enrollment, so long as the date is on or after January 1, 2023.

[87 FR 66504, Nov. 3, 2022]

§ 406.28 End of entitlement.

Any of the following actions or events ends entitlement to premium hospital insurance:

(a) *Filing of request for termination.* The beneficiary may at any time give CMS or the Social Security Administration written notice that he or she no longer wishes to participate in the premium hospital insurance program.

(1) If he or she files the notice before entitlement begins, he or she will be deemed not to have enrolled.

(2) If he or she files the notice after entitlement begins, that entitlement will end at the close of the month following the month in which he or she filed the notice.

(b) *Eligibility for hospital insurance without premiums.* (1) If an individual meets the eligibility requirements for hospital insurance specified in § 406.10, § 406.11, § 406.13 or § 406.15, entitlement to premium hospital insurance ends with the month before the month in which he or she meets those requirements.

(2) If an individual meets the requirements of § 406.10, § 406.11, § 406.13, or § 406.15, he or she will be deemed to have filed the required application for hospital insurance benefits in his or

her first month of eligibility under that section.

(c) *End of entitlement to supplementary medical insurance (SMI) for individual who has attained age 65.* In the case of an individual enrolled on the basis of § 406.20(b), entitlement to premium hospital insurance ends on the same date that entitlement to SMI ends.

(d) *Nonpayment of premium.* (1) If an individual fails to pay the premium bill, entitlement will end on the last day of the third month after the billing month.

(2) CMS may reinstate entitlement if the individual shows good cause for failure to pay on time, and pays all overdue premiums within 3 calendar months after the date specified in paragraph (d)(1) of this section.

(e) *Death.* Entitlement ends with the day of death. (A premium is due for the month of death.)

(f) *End of disabling impairment for individual under age 65.* In the case of an individual enrolled on the basis of § 406.20(c), entitlement to premium hospital insurance ends on the last day of the month after the month in which the individual is notified that he or she no longer has a disabling impairment.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986, as amended at 53 FR 47204, Nov. 22, 1988. Redesignated and amended at 56 FR 38080, Aug. 12, 1991]

§ 406.32 Monthly premiums.

(a) *Promulgation and effective date.* Beginning with 1984, premiums are promulgated each September, effective for the succeeding calendar year.

(b) *Monthly premiums: Determination of dollar amount.* (1) Effective for calendar years beginning January 1989, the dollar amount is determined based on an estimate of one-twelfth of the average per capita costs for benefits and administrative costs that will be payable with respect to individuals age 65 or over from the Federal Hospital Insurance Trust Fund during the succeeding calendar year.

(2) Before 1989, the dollar amount was determined by multiplying \$33 by the ratio of the next year's inpatient deductible to \$76, which was the inpatient deductible determined for 1973. (Because of cost controls, the deductible actually charged for that year was \$72.)

(3) Effective for months beginning January 1994, if an individual meets the requirements in paragraph (c) of this section, the monthly premium determined under paragraph (b)(1) of this section is reduced in each month in which the individual meets the requirements by 25 percent in 1994, 30 percent in 1995, 35 percent in 1996, 40 percent in 1997 and 45 percent in 1998 and thereafter.

(4) The amount determined under paragraphs (b) (1), (2), or (3) of this section is rounded to the next nearest multiple of \$1. (Fifty cents is rounded to the next higher dollar.)

(c) *Qualifying for a reduction in monthly premium.* An individual who qualifies for the reduction described in paragraph (b)(3) of this section must be an individual who—

(1) Has 30 or more quarters of coverage (QCs) as defined in 20 CFR 404.140 through 404.146;

(2) Has been married for at least the previous one year period to a worker who has 30 or more QCs;

(3) Had been married to a worker who had 30 or more QCs for a period of at least one year before the death of the worker;

(4) Is divorced from, after at least 10 years of marriage to, a worker who had 30 or more QCs at the time the divorce became final; or

(5) Is divorced from, after at least 10 years of marriage to, a worker who subsequently died and who had 30 or more QCs at the time the divorce became final.

(d) *Monthly premiums: Increase for late enrollment and for reenrollment.* For an individual who enrolls after the close of the initial enrollment period or reenrolls, the amount of the monthly premium, as determined under paragraph (b) of this section, is increased by 10 percent for each full 12 months in the periods described in §§ 406.33 and 406.34. Effective beginning with premiums due for July 1986, the premium increase is limited to 10 percent and is payable for twice the number of full 12-month periods determined under those sections.

(e) *Collection of monthly premiums.* (1) CMS will bill the enrollee on a monthly basis and include an addressed return envelope with the bill.

(2) The enrollee must pay by check or money order that is payable to “CMS Medicare Insurance,” and shows his or her name and the claim number that appears on his or her Medicare card. He or she must return the bill with the check or money order.

(f) *Months for which payment is due.*

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

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

(g) *Option for group payments.* A public or private organization may pay the premiums on behalf of one or more enrollees under a contract or other arrangement with CMS if CMS determines that this method of payment is administratively feasible. (The rules set forth in subpart E of part 408 of this chapter, for SMI premiums, also apply to group payment of Part A premiums.)

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986, as amended at 53 FR 47203, Nov. 22, 1988; 56 FR 8839, Mar. 1, 1991. Redesignated and amended at 56 FR 38079, 38080, Aug. 12, 1991; 57 FR 36014, Aug. 12, 1992; 57 FR 58717, Dec. 11, 1992; 59 FR 26959, May 25, 1994]

§ 406.33 Determination of months to be counted for premium increase: Enrollment.

(a) *Enrollment before April 1, 1981 or after September 30, 1981 and before January 1, 2023.* The months to be counted for premium increase are the months from the end of the initial enrollment period through the end of the general enrollment period, the special enrollment period, or the transfer enrollment period in which the individual enrolls, excluding the following:

(1) Any months before September 1973.

(2) For premiums due for months after May 1986, any months beginning with January 1983 during which the individual was enrolled in an employer group health plan based on the current employment of the individual or the individual’s spouse.

(3) Any months during the SEP under § 406.24 of this subpart, during which

premium hospital insurance coverage is in effect.

(4) Any months that the individual was enrolled in an HMO or CMP under part 417, subpart K of this chapter as described in § 406.21(f).

(5) For premiums due for months after December 2006, any months during which the individual met the requirements for a SEP under § 406.25(a) of this subpart.

(6) Any months during the 6-month SEP described in § 406.25(b) of this subpart during which premium hospital insurance coverage is in effect.

(b) *Enrollment during the period April 1 through September 30, 1981.* The months to be counted for premium increase are the months from the end of the initial enrollment period through the month in which the individual enrolled, excluding any months before September 1973.

(c) *Enrollment on or after January 1, 2023.* The months to be counted for premium increase are the months from the end of the initial enrollment period through the end of the month in which the individual enrolls, excluding both of the following:

(1) The months described in paragraphs (a)(1) through (6) of this section.

(2) Any months of non-coverage in accordance with an individual’s use of an exceptional conditions SEP under § 406.27 provided the individual enrolls within the duration of the SEP.

(d) *Examples.* (1) John F’s initial enrollment period ended July 1979 but he did not enroll until January 1980. The months to be counted are August 1979 through March 1980. Since only 8 months elapsed, there is no premium increase.

(2) Mary T’s initial enrollment period ended in April 1980 but she did not enroll until May 1981. The months to be counted are May 1980 through May 1981. Since 13 months has elapsed, the premium would be increased by 10 percent.

(3) Effective with July 1986, Mary T, in Example 2, would no longer have to pay an increased premium because she had paid it for twice the number of full 12-month periods during which she could have been, but was not, enrolled in the program.

(4) Vincent C's initial enrollment period ended August 31, 1986. He was covered under his wife's employer group health plan until she retired on May 31, 1989. He enrolled during June 1989, the first month of the special enrollment period under § 406.21(e). No months are countable for premium increase purposes because the exclusions of paragraph (a) of this section apply to all months.

(5) Terry P enrolled in the 1987 general enrollment period, with coverage effective July 1987. There were 28 months after the end of his initial enrollment period through the end of the 1987 general enrollment period. His premium is increased by 10 percent. The increase will be eliminated after he has paid the additional 10 percent for 48 months.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986, as amended at 53 FR 47203, Nov. 22, 1988. Further redesignated and amended at 57 FR 36014, Aug. 12, 1992; 73 FR 36468, June 27, 2008; 87 FR 66505, Nov. 3, 2022]

§ 406.34 Determination of months to be counted for premium increase: Re-enrollment.

(a) *First reenrollment before April 1, 1981 or after September 30, 1981 and before January 1, 2023.* The months to be counted for premium increase are:

(1) The months specified in § 406.33(a) or (b); plus

(2) The months from the end of the first period of entitlement through the end of the general enrollment period in which the individual reenrolled.

(b) *First reenrollment during the period April 1, 1981 through September 30, 1981.* The months to be counted for premium increase are—

(1) The months specified in § 406.33(a); plus

(2) The months from the end of the first period of entitlement through the month in which the individual reenrolled.

(c) *Subsequent reenrollment during the period April 1, 1981 through September 30, 1981.* The months to be counted for premium increase are—

(1) The months specified in paragraph (a) of this section; plus

(2) The months from April 1981 through the month in which the individual reenrolled for the second time.

(Since only one reenrollment was permitted before April 1981, any months from the end of the individual's first enrollment period of entitlement through March 1981 are not counted.)

(d) *Subsequent reenrollment after September 30, 1981.* The months to be counted for premium increase are—

(1) The months specified in paragraph (a) or (b) of this section, for the first and second periods of coverage; plus

(2) The months from the end of each subsequent period of entitlement through the end of the general enrollment period in which the individual reenrolled, excluding any months before April 1981.

(e) *Reenrollments on or after January 1, 2023.* (1) The months to be counted for premium increase are as follows:

(i) The months specified in § 406.33(c).

(ii) The months specified in paragraphs (b) and (d) of this section (if applicable).

(iii) The months from the end of the first period of entitlement through the end of the month during the general enrollment period in which the individual reenrolled.

(2) The months excluded from premium increase are the months of non-coverage in accordance with an individual's use of an exceptional conditions SEP under § 406.27, provided the individual enrolls within the duration of the SEP.

(f) *Example.* Peter M enrolled during his initial enrollment period, terminated his first coverage period in August 1979 and reenrolled for the first time in January 1980. The 7 months to be counted (September 1979 through March, 1980) were not enough to require any increase in the premium. Peter terminated his second period of coverage in February 1981 and reenrolled for the second time in July 1981. Since the 4 months (April through July 1981), when added to the previous 7 months, bring the total to only 11 months, no premium increase is required.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986. Further redesignated and amended at 57 FR 58717, Dec. 11, 1992; 87 FR 66505, Nov. 3, 2022]

§ 406.38 Prejudice to enrollment rights because of Federal Government error.

(a) If an individual's enrollment or nonenrollment for premium hospital insurance is unintentional, inadvertent, or erroneous because of the error, misrepresentation, or inaction of a Federal employee, or any person authorized by the Federal Government to act on its behalf, the Social Security Administration or CMS may take whatever action it determines is necessary to provide appropriate relief.

(b) The action may include—

(1) Designation of a special initial or general enrollment period;

(2) Designation of an entitlement period;

(3) Adjustment of premiums;

(4) Any combination of the actions specified in paragraph (b) (1) through (3) of this section; or

(5) Any other remedial action which may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986. Further redesignated at 56 FR 38080, Aug. 12, 1991]

Subpart D—Special Circumstances That Affect Entitlement to Hospital Insurance

§ 406.50 Nonpayment of benefits on behalf of certain aliens.

(a) Hospital insurance benefit payments may not be made for services furnished to an alien in any month in which his or her monthly social security benefits are suspended (or would be suspended if he or she were entitled to those benefits) because the alien remains outside the United States for more than 6 months.

(b) Benefits will be payable beginning with services furnished in the first full calendar month the alien is back in the United States.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986. Further redesignated at 57 FR 58717, Dec. 11, 1992]

§ 406.52 Conviction of certain offenses.

(a) *Penalty that affects entitlement.* (1) If an individual is convicted of any of the crimes listed in § 406.11(c) (1) and

(2), the court may impose, in addition to all other penalties, a penalty that affects entitlement to hospital insurance, beginning with the month of conviction.

(2) The additional penalty is that the individual's income (or the income of the insured individual on whose earnings record he or she became or seeks to become entitled) for the year of conviction and any previous year may not be counted in determining the insured status necessary for entitlement to hospital insurance.

(b) *Effect of pardon.* If the President of the United States pardons the convicted individual, that individual regains (or may again seek) entitlement effective with the month following the month in which the pardon is granted.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986. Further redesignated at 57 FR 58717, Dec. 11, 1992]

PART 407—SUPPLEMENTARY MEDICAL INSURANCE (SMI) ENROLLMENT AND ENTITLEMENT

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