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(a) *Death.* Entitlement to SMI ends on the last day of the month in which the individual dies.

(b) *Termination of hospital insurance benefits.* If an individual's entitlement to hospital insurance ends before the month in which he or she attains age 65, entitlement to SMI will end on the same day unless it has been previously terminated in accordance with paragraph (c) or (d) of this section.

(c) *Request by individual.* An individual may at any time give CMS or SSA written notice that he or she no longer wishes to participate in SMI, and request disenrollment.

(1) Before July 1987, entitlement ended at the end of the calendar quarter after the quarter in which the individual filed the disenrollment request.

(2) For disenrollment requests filed in or after July 1987, entitlement ends at the end of the month after the month in which the individual files the disenrollment request.

(d) *Nonpayment of premiums.* If an individual fails to pay the premiums, entitlement will end as provided in the rules for SMI premiums, set forth in part 408 of this chapter.

§ 407.30 Limitations on enrollment.

(a) *Initial enrollment periods*—(1) *Individual under age 65.* An individual who has not attained age 65 may have one or more periods of entitlement to hospital insurance, based on disability. Since each period of disability entitlement entitles the individual to hospital insurance and since entitlement to hospital insurance makes the individual eligible for SMI enrollment, an individual may have an SMI initial enrollment period for each continuous period of entitlement to hospital insurance.

(2) *Individuals who have attained age 65.* An individual who has attained age 65 may not have more than one initial enrollment period on the basis of age. However, if the individual develops ESRD after age 65, he or she may have another initial enrollment period based on meeting the requirements of § 406.13 of this chapter.

(b) *Number of enrollments.* There is no limitation on the number of enrollments.

(c) *Coverage under buy-in agreements.* For purposes of paragraph (a) of this

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section, the continued enrollment of an individual following the end of coverage under a State buy-in agreement is considered an initial enrollment.

§ 407.32 Prejudice to enrollment rights because of Federal Government misrepresentation, inaction, or error.

If an individual's enrollment or non-enrollment in SMI 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 in its behalf, the Social Security Administration or CMS may take whatever action it determines is necessary to provide appropriate relief. The action may include:

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

(b) Designation of an entitlement period based on that enrollment period;

(c) Adjustment of premiums;

(d) Any combination of actions under paragraphs (a) through (c) of this section; or

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

Subpart C—State Buy-In Agreements

§ 407.40 Enrollment under a State buy-in agreement.

(a) *Statutory basis.* (1) Section 1843 of the Act, as amended through 1969, permitted a State to enter into an agreement with the Secretary to enroll in the SMI program certain individuals who are eligible for SMI and who are members of the buy-in group specified in the agreement. A buy-in group could include certain individuals receiving Federally-aided State cash assistance (with the option of excluding individuals also entitled to social security benefits or railroad retirement benefits) or could include all individuals eligible for Medicaid. Before 1981, December 31, 1969 was the last day on which a State could request a buy-in agreement or a modification to include a coverage group broader than the one originally selected.

(2) Section 945(e) of the Omnibus Reconciliation Act of 1980 (Pub. L. 96-499) further amended section 1843 to provide that, during calendar year 1981, a State could request a buy-in agreement if it did not already have one, or request a broader coverage group for an existing agreement.

(3) Several laws enacted during 1980–1987 had the effect of requiring that the buy-in groups available under section 1843 of the Act be expanded to include certain individuals who lose eligibility for cash assistance payments but are treated as if they were cash assistance beneficiaries for Medicaid eligibility purposes.

(4) Section 301(e)(1) of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) amends section 1843 of the Act to restore the 1981 provisions on a permanent basis, effective “after 1988.”

(5) The same section 301, as amended by section 608(d)(14)(H) of the Family Support Act of 1988 (Pub. L. 100-485), further amended section 1843 of the Act, beginning January 1, 1989, to establish a new buy-in category consisting of Qualified Medicare Beneficiaries and to provide that a State may request a buy-in agreement if it does not already have one, or request a broader buy-in group for the existing agreement.

(6) Section 4501 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) established the Specified Low-Income Medicare Beneficiary or SLMB eligibility group effective January 1993.

(7) Section 4732 of the Balanced Budget Act of 1997 (Pub. L. 105-33) established the Qualifying Individual or QI eligibility group effective January 1998.

(8) Section 112 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-275) increased the resource standard for QMB, SLMB, and QI to 3 times the maximum resources available under the Supplemental Security Income program, adjusted annually by increases in the Consumer Price Index effective January 1, 2010.

(9) Title II, section 211, of the Medicare Access and CHIP Reauthorization Act (Pub. L. 114-10), effective April 16, 2015, permanently extended the QI eligibility group.

(10) Title II, section 402 of the Consolidated Appropriations Act of 2021 (Pub. L. 116-260), effective January 1, 2023, expands QMB, SLMB, and QI to cover individuals who are enrolled in Medicare Part B for coverage of immunosuppressive drugs.

(b) *Definitions.* As used in this subpart, unless the context indicates otherwise—

Buy-in group means a coverage group described in section 1843 of the Act that is identified by the State and is composed of multiple Medicaid eligibility groups specified in the buy-in agreement.

Cash assistance means any of the following kinds of monthly cash benefits, authorized by specified titles of the Act and, for convenience, represented by initials, as follows:

AABD stands for aid to the aged, blind or disabled under the first title XVI of the Act in effect until December 31, 1973.

AB stands for aid to the blind under title X of the Act.

AFDC stands for aid to families with dependent children under Part A of title IV of the Act, as it was in effect on July 16, 1996.

APTD stands for aid to the permanently and totally disabled under title XIV of the Act.

OAA stands for old-age assistance under title I of the Act.

SSI stands for supplemental security income for the aged, blind, and disabled under the second title XVI of the Act, effective January 1, 1974.

SSP stands for State supplementary payments, whether mandatory or optional, to an aged, blind, or disabled individual under the second title XVI or the Act.

Railroad retirement beneficiary means an individual entitled to receive an annuity under the Railroad Retirement Act of 1974.

1634 State means a State that has an agreement with SSA, in accordance with section 1634 of the Act, for SSA to determine Medicaid eligibility on behalf of the State for individuals residing in the State whom the SSA has determined eligible for SSI.

State means one of the 50 States, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, American

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Samoa, or the Northern Mariana Islands, except when reference is made to “the 50 States”.

State buy-in agreement or buy-in agreement means an agreement authorized or modified by section 1843 or 1818(g) of the Act, under which a State secures Part B or premium Part A coverage for individuals who are members of the buy-in group specified in the agreement, by enrolling them and paying the premiums on their behalf. A State’s submission of a State plan amendment addressing its buy-in process, if approved by CMS, constitutes the “buy-in agreement” between the State and CMS for purposes of sections 1843 and 1818(g) of the Act.

(c) *Basic rules.* (1) A State that has a buy-in agreement in effect must enroll any individual who is eligible to enroll in SMI under § 407.10 and who is a member of the buy-in group, with the State paying the premiums on the individual’s behalf. Individuals enrolled in the buy-in group can enroll in Part B at any time of the year, without regard to Medicare enrollment periods.

(2) Any State that does not have a buy-in agreement in effect may request buy-in for any one of the groups specified in §§ 407.42 and 407.43.

(3) Any State that does have an agreement may request a modification to cover a broader buy-in group or cancel its current agreement and request a new agreement to cover a narrower group.

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

(5) In a 1634 State, CMS enrolls SSI beneficiaries in Medicare Part B, on behalf of the State, with the State paying the beneficiary’s Part B premiums.

(6) Premiums paid under a State buy-in agreement are not subject to increase because of late enrollment or re-enrollment.

[56 FR 38080, Aug. 12, 1991; 56 FR 50058, Oct. 3, 1991; as amended at 85 FR 25632, May 1, 2020; 87 FR 66507, Nov. 3, 2022]

§ 407.42 Buy-in groups available to the 50 States, the District of Columbia, and the Northern Mariana Islands.

(a) *Basic rule.* The 50 States, the District of Columbia, and the Northern

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Mariana Islands must select one of the buy-in groups described in paragraph (b) in their buy-in agreements.

(b) *Buy-in groups available—*(1) *Group 1.* Cash Assistance and Deemed Recipients of Cash Assistance: This buy-in group includes all of the following:

(i) Individuals who receive SSI or SSP or both and are covered under the State’s Medicaid state plan as categorically needy.

(ii) Individuals who under the Act or any other provision of Federal Law are treated, for Medicaid eligibility purposes, as though the individual was receiving SSI or SSP and are covered under the State’s Medicaid state plan as categorically needy.

(iii) At State option, individuals whom the State must consider to be recipients of AFDC. Individuals a State would be required to include in electing this option would be, but not limited to, individuals eligible for Medicaid on the basis of section 1931(b) of the Act or their receipt of adoption assistance, foster care or guardianship care under Part E of title IV of the Act, in accordance with § 435.145 of this chapter.

(2) *Group 2.* Cash Assistance and Deemed Recipients of Cash Assistance and three Medicare Savings Program eligibility groups. This buy-in group includes both of the following:

(i) Group 1.

(ii) Individuals enrolled in the—

(A) Qualified Medicare Beneficiary eligibility group described in § 435.123 of this chapter;

(B) Specified Low-Income Beneficiary eligibility group described in § 435.124 of this chapter; and

(C) Qualifying Individual eligibility group described in § 435.125 of this chapter.

(3) *Group 3.* All Medicaid Eligibility Groups: This buy-in group includes all individuals eligible for Medicaid.

[87 FR 66507, Nov. 3, 2022]

§ 407.43 Buy-in groups available to Puerto Rico, Guam, the Virgin Islands, and American Samoa.

(a) *Categories included in buy-in groups.* The buy-in groups that are available to Puerto Rico, Guam, the Virgin Islands, and American Samoa,

which are not covered by the SSI program, are described in paragraph (b) of this section in terms of the following categories:

(1) *Category A*: Individuals receiving OAA, AB, APTD, or AFDC.

(2) *Category B*: Individuals who, under the Act or any other provision of Federal law, are treated, for Medicaid eligibility purposes, as though they were receiving AFDC.

(3) *Category C*: Individuals who, in accordance with § 436.112 of this chapter, are covered under the State's Medicaid plan despite the increase in social security benefits provided by Public Law 92-336.

(4) *Category D*: Individuals who are Qualified Medicare Beneficiaries.¹

(5) *Category E*: All other individuals who are eligible for Medicaid.

(b) *Buy-in groups available*. Puerto Rico, Guam, the Virgin Islands, and American Samoa may choose any of the following coverage groups:

(1) *Group 1*: Categories A through E.

(2) *Group 2*: Categories A through D.

(3) *Group 3*: Categories A through C.

(4) *Group 4*: Individuals in category D, and individuals in categories A and B who are not social security or railroad retirement beneficiaries.

(5) *Group 5*: Individuals in categories A and B who are not social security or railroad retirement beneficiaries.

(6) *Group 6*: Individuals in category D, individuals in category A who are receiving OAA, and individuals in category C who are included in that category (in accordance with § 436.112 of this chapter) because they received OAA for August 1972 or would have been eligible to receive OAA for that month if they had applied or had not been institutionalized.

(7) *Group 7*: Individuals in category A who are receiving OAA, and individuals in category C who are included in that category (in accordance with § 436.112 of this chapter) because they received OAA for August 1972 or would have been eligible to receive OAA for that month if they had applied or had not been institutionalized.

(8) *Group 8*: Individuals in category D and individuals in category A who are receiving OAA and are not social security or railroad retirement beneficiaries.

(9) *Group 9*: Individuals in category A who are receiving OAA and are not social security or railroad retirement beneficiaries.

[56 FR 38082, Aug. 12, 1991]

§ 407.47 Beginning of coverage under a State buy-in agreement.

(a) *General rule*. The beginning of an individual's coverage period depends on two factors:

(1) The individual's meeting the SMI eligibility requirements and the requirements for being a member of the buy-in group; and

(2) The effective date of the buy-in agreement or agreement modification that covers the buy-in group to which the individual belongs, and which may not be earlier than the third month after the month in which the agreement or modification is executed. The State must apply the earliest applicable start date for the applicable buy-in group.

(b) *Application of general rule: Medicaid eligibles who are, or are treated as, cash assistance beneficiaries*. For Medicaid eligibles who are, or are treated as, cash assistance beneficiaries, coverage begins with the later of the following:

(1) The first month in which the individual—

(i) Meets the SMI eligibility requirements specified in § 407.10; and

(ii) Is, or is treated as, a cash assistance beneficiary.

(2) The month in which the buy-in agreement is effective.

(c) *Application of general rule: Qualified Medicare Beneficiaries*. For individuals who are QMBs as defined under § 435.123 of this chapter, coverage begins with the later of the following:

(1) The first month in which the individual meets the SMI eligibility requirements specified in § 407.10, and has QMB status.

(2) The month in which the buy-in agreement or agreement modification covering QMBs is effective.

¹ Rules for buy-in for premium hospital insurance for QMBs are set forth in § 406.26 of this chapter.

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(d) *Application of general rule: Other individuals eligible for Medicaid.* For individuals who are not cash assistance beneficiaries, are not treated as cash assistance beneficiaries, and are not QMBs, coverage begins with the later of the following:

(1) The second month after the month in which the individual—

(i) Meets the SMI eligibility requirements specified in § 407.10; and

(ii) Is determined to be eligible for Medicaid.

(2) The month in which the buy-in agreement or agreement modification is effective.

(e) *Coverage based on erroneous report.* If the State erroneously reports to SSA that an individual is a member of its coverage group, the rules of paragraphs (a) through (d) of this section apply, and coverage begins as though the individual were in fact a member of the group. Coverage will end only as provided in § 407.48.

(f) [Reserved]

(g) *Part B enrollment under a buy-in agreement.* Individuals in a buy-in group can enroll in Part B at any time of the year, without regard to Medicare enrollment periods.

[56 FR 38082, Aug. 12, 1991, as amended at 87 FR 66508, Nov. 3, 2022]

EFFECTIVE DATE NOTE: At 87 FR 66508, Nov. 3, 2022, § 407.47 was amended by adding paragraph (f), effective Jan. 1, 2024. For the convenience of the user, the added text is set forth as follows:

§ 407.47 Beginning of coverage under a State buy-in agreement.

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(f) *Exception to the general rule: Limitations on retroactive adjustments in the case of retroactive Medicare Part A entitlement.* (1) In cases in which a Medicaid beneficiary is retroactively entitled to Medicare Part A, beginning with retroactive determinations made on or after January 1, 2024, State liability for retroactive Medicare Part B premiums for Medicaid beneficiaries under a buy-in agreement is limited to a period of no greater than 36 months prior to the date of the Medicare eligibility determination.

(2) The Secretary may grant good cause exceptions for periods of greater or less than 36 months if application of paragraph (f)(1) of the section would result in harm to a beneficiary or if the State cannot benefit from

Medicare and further limiting State liability would not result in harm to the beneficiary.

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§ 407.48 Termination of coverage under a State buy-in agreement.

An individual's coverage under a buy-in agreement terminates with the earliest of the following events:

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

(b) *Loss of entitlement to hospital insurance benefits before age 65.* If an individual loses entitlement to hospital insurance benefits before attaining age 65, coverage ends on the last day of the last month for which he or she is entitled to hospital insurance.

(c) *Loss of eligibility for the buy-in group.* If an individual loses eligibility for inclusion in the buy-in group, buy-in coverage ends as follows:

(1) On the last day of the last month for which he or she is eligible for inclusion in the buy-in group, if CMS determines ineligibility or receives a State ineligibility notice by a processing cut-off date as described in paragraph (e) of this section, by the second month after the month in which the individual becomes ineligible for inclusion in the buy-in group.

(2) On the last day of the second month before the month in which CMS receives a State ineligibility notice later than the time specified in paragraph (c)(1) of this section. If CMS receives a notice after the processing cut-off date conveyed under paragraph (e) of this section, CMS considers it to have been received the following month.

(d) *Termination or modification of buy-in agreement.* If the State's buy-in agreement is terminated, or modified to substitute a narrower buy-in group, coverage ends on the last day of the last month for which the agreement was in effect, or covered the broader buy-in group.

(e) *Processing cut-off dates for each calendar month.* On a quarterly basis, CMS is to prospectively convey to States a

schedule of processing cut-off dates for each calendar month.

[53 FR 47204, Nov. 22, 1988, as amended at 56 FR 38082, Aug. 12, 1991; 87 FR 66508, Nov. 3, 2022]

§ 407.50 Continuation of coverage: Individual enrollment following end of coverage under a State buy-in agreement.

(a) *Deemed enrollment.* When coverage under a buy-in agreement ends because the agreement terminates, or is modified to substitute a narrower buy-in group, or because the individual is no 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

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

¹For 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.

**Subpart D—Part B
Immunosuppressive Drug Benefit**

SOURCE: 87 FR 66508, Nov. 3, 2022 unless otherwise noted.

§ 407.55 Eligibility to enroll.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, an individual is eligible to enroll, be deemed enrolled, or reenroll in the Part B-ID benefit if their Part A entitlement ends as described in § 406.13(f)(2) of this subchapter.

(b) *Exception.* An individual is not eligible for the Part B-ID benefit if the individual is enrolled in or for any of the following:

(1) A group health plan or group or individual health insurance coverage, as such terms are defined in section 2791 of the Public Health Service Act.

(2) Coverage under the TRICARE for Life program under section 1086(d) of title 10, United States Code.

(3) A State plan (or waiver of such plan) under title XIX and is eligible to receive benefits for immunosuppressive drugs described in section 1836(b) of the Act under such plan (or such waiver).

(4) A State child health plan (or waiver of such plan) under title XXI and is eligible to receive benefits for such drugs under such plan (or such waiver).

(5) The patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38, United States Code and is either of the following:

(i) Not required to enroll under section 1705 of title 38 to receive immunosuppressive drugs described in section 1836(b) of the Act.

(ii) Otherwise eligible under a provision of title 38, United States Code, other than section 1710 of such title, to receive immunosuppressive drugs described in section 1836(b) of the Act.

(c) *Appeals.* Denials for enrollment in the Part B-ID benefit will be considered an initial determination that is appealable under § 405.904(a)(1) of this subchapter.