

(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 collected 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.

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§ 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 Adminis-

tration 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

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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