(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

Subpart A—General Provisions

Sec.

Subpart B—Individual Enrollment and Entitlement for SMI

Subpart C—State Buy-in Agreements

Subpart D—Part B Immunosuppressive Drug Benefit

AUTHORITY: 42 U.S.C. 1302, 1395p, 1395q, and 1395hh.

SOURCE: 53 FR 47204, Nov. 22, 1988, unless otherwise noted.

Subpart A—General Provisions

§ 407.1 Basis and scope.

(a) *Statutory basis.* The supplementary medical insurance (SMI) program is authorized by Part B of title XVIII of the Social Security Act.

(1) Section 1831 of the Act establishes the program.

(2) Sections 1836 and 1837 set forth the eligibility and enrollment requirements.

(3) Section 1838 specifies the entitlement periods, which vary depending on the time and method of enrollment and on the basis for termination.

(4) Section 1843 sets forth the requirements for State buy-in agreements under which States may enroll, and pay the SMI premiums for, eligible individuals who are also eligible for cash assistance or Medicaid.

(5) Section 104(b) of the Social Security Amendments of 1965 (Pub. L. 89–87) specifies the limitations that apply to certain aliens and persons convicted of subversive activities.

(6) Sections 1836(b) and 1837(n) of the Act provide for coverage of immunosuppressive drugs as described in section 1861(s)(2)(J) of the Act under Part B beginning on or after January 1, 2023, for eligible individuals whose benefits under Medicare Part A and eligibility to enroll in Part B on the basis of ESRD would otherwise end with the 36th month after the month in which the individual receives a kidney transplant by reason of section 226A(b)(2) of the Act.

(b) *Scope.* This part sets forth the eligibility, enrollment, and entitlement requirements and procedures for the following:

(1) Supplementary medical insurance. (The rules about premiums are in part 408 of this chapter.)

(2) The immunosuppressive drug benefit provided for under sections 1836(b) and 1837(n) of the Act, hereinafter referred to as the Part B-Immunosuppressive Drug Benefit (Part B–ID).

[53 FR 47204, Nov. 22, 1988, as amended at 87 FR 66505, Nov. 3, 2022]

§ 407.2 General description of program.

Part B of Title XVIII of the Act provides for voluntary ''supplementary medical insurance'' available to most individuals age 65 or over and to disabled individuals who are under age 65 and entitled to hospital insurance. The SMI program is financed by premiums paid by (or for) each individual enrolled in the program, plus contributions from Federal funds. It covers certain physicians' services, outpatient services, home health services, services furnished by rural health clinics (RHCs), Federally qualified health centers (FQHCS), ambulatory surgical centers (ASCs), and comprehensive outpatient rehabilitation facilities (CORFs), and other medical and other health services.

[57 FR 24980, June 12, 1992]

§ 407.4 Basic requirements for entitlement.

(a) An individual must meet the following requirements to be entitled to SMI:

(1) *Eligibility.* The individual must meet the eligibility requirements specified in § 407.10(a).

(2) *Enrollment.* The individual must enroll for SMI, or must be enrolled by a State under a buy-in agreement as specified in § 407.40.

(b) SMI pays only for covered expenses incurred during an individual's period of entitlement.

Subpart B—Individual Enrollment and Entitlement for SMI

§ 407.10 Eligibility to enroll.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, an individual is eligible to enroll for SMI if he or she—

(1) Is entitled to hospital insurance under any of the rules set forth in §§ 406.10 through 406.15 of this chapter; or

(2) Meets the following requirements:

(i) Has attained age 65. (An individual is considered to have attained age 65 on the day before the 65th anniversary of his or her birth.)

(ii) Is a resident of the United States.

(iii) Is a citizen of the United States, or an alien lawfully admitted for permanent residence who has resided continuously in the United States during the 5 years preceding the month in which he or she applies for enrollment.

(b) *Exception.* An individual is not eligible to enroll for SMI if he or she has been convicted of—

(1) Spying, sabotage, treason, or subversive activities under chapter 37, 105, or 115 of title 18 of the United States Code; or

(2) Conspiracy to establish dictatorship under section 4 of the Internal Security Act of 1950.

§ 407.11 Forms used to apply for enrollment under Medicare Part B.

Forms used to apply for enrollment under the supplementary medical insurance program are available free of charge by mail from CMS, or at any Social Security branch or district office and online at the CMS and SSA websites. As an alternative, the individual may request enrollment by signing a simple statement of request, if he or she is eligible to enroll at that time.

[87 FR 66505, Nov. 3, 2022]

§ 407.12 General enrollment provisions.

(a) *Opportunity to enroll.* (1) An individual who is eligible to enroll for SMI may do so during an initial enrollment period or a general enrollment period as specified in §§ 407.14, and 407.15. An individual who meets the conditions specified in § 407.20 may enroll during a special enrollment period, as provided in that section.

(2) An individual who fails to enroll during his or her initial enrollment period or whose enrollment has been terminated may enroll or reenroll during a general enrollment period, or, if he or she meets the specified conditions, during a special enrollment period.

(b) *Enrollment periods ending on a nonworkday.* (1) If an enrollment period ends on a Federal nonworkday, that period is automatically extended to the next succeeding workday.

(2) A Federal nonworkday is any Saturday, Sunday, or Federal legal holiday or a day that is declared by statute or executive order to be a day on which Federal employees are not required to work.

§ 407.14 Initial enrollment period.

(a) *Duration.* (1) The initial enrollment period is the 7-month period that begins 3 months before the month an individual first meets the eligibility requirements of § 407.10 and ends 3 months after that first month of eligibility.

(2) In determining the initial enrollment period of an individual who is age 65 or over and eligible for enrollment solely because of entitlement to hospital insurance, the individual is considered as first meeting the eligibility requirements for SMI n the first day he or she becomes entitled to hospital insurance or would have been entitled if he or she filed an application for that program.

(b) *Deemed initial enrollment period.* (1) SSA or CMS will establish a deemed initial enrollment period for an individual who fails to enroll during the initial enrollment period because of a belief, based on erroneous documentary evidence, that he or she had not yet attained age 65. The period will be established as though the individual had attained age 65 on the date indicated by the incorrect information.

(2) A deemed initial enrollment period established under paragraph (b)(1) of this section is used to determine the individual's premium and right to enroll in a general enrollment period if that is advantageous to the individual.

§ 407.15 General enrollment period.

(a) Except as specified in paragraph (b) of this section, the general enrollment period is January through March of each calendar year.

(b) An unlimited general enrollment period existed between April 1 and September 30, 1981. Any eligible individual whose initial enrollment period had ended, or whose previous period of entitlement had terminated, could have enrolled or reenrolled during any month of that 6-month period.

§ 407.17 Automatic enrollment.

(a) *Who is automatically enrolled.* An individual is automatically enrolled for SMI if he or she:

(1) Resides in the United States, except in Puerto Rico;

(2) Becomes entitled to hospital insurance under any of the provisions set forth in §§ 406.10 through 406.15 of this chapter; and

(3) Does not decline SMI enrollment.

(b) *Opportunity to decline automatic enrollment.* (1) SSA will notify an individual that he or she is automatically enrolled under paragraph (a) of this section and grant the individual a specified period (at least 2 months after the month the notice is mailed) to decline enrollment.

(2) The individual may decline enrollment by submitting to SSA or CMS a signed statement that he or she does not wish SMI.

(3) The statement must be submitted before entitlement begins, or if later, within the time limits set in the notice of enrollment.

§ 407.18 Determining month of automatic enrollment.

(a) An individual who is automatically enrolled in SMI under § 407.17 will have the month of enrollment determined in accordance with paragraphs (b) through (f) of this section. The month of enrollment determines the month of entitlement.

(b) An individual is automatically enrolled in the third month of the initial enrollment period if he or she—

(1) Is entitled to social security benefits under section 202 of the Act on the first day of the initial enrollment period;

(2) Is entitled to hospital insurance based on end-stage renal disease; on entitlement to disability benefits as a social security or railroad retirement beneficiary; or on deemed entitlement to disability benefits on the basis of Medicare-qualified government employment; or

(3) Establishes entitlement to hospital insurance by filing an application and meeting all other requirements (as set forth in subpart B of part 406 of this chapter) during the first 3 months of the initial enrollment period.

(c) If an individual establishes entitlement to hospital insurance on the basis of an application filed in the last 4 months of the SMI initial enrollment period, he or she is automatically enrolled for SMI in the month in which the application is filed.

(d) If an individual establishes entitlement to hospital insurance on the basis of an application filed after the SMI initial enrollment period but not during a general enrollment period in effect before April 1, 1981, or after September 30, 1981, he or she is automatically enrolled for SMI on the first day of the next general enrollment period.

(e) If the individual establishes entitlement to hospital insurance on the basis of an application filed during a SMI general enrollment period in effect before April 1, 1981 or after September 30, 1981, he or she is automatically enrolled on the first day of that period.

(f) If an individual established entitlement to hospital insurance on the basis of an application filed during the general enrollment period of April 1, 1981, through September 30, 1981, he or she was automatically enrolled for SMI on the first day of the month in which the application was filed.

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

(a) *Terminology*—(1) *Group health plan (GHP) and large group health plan (LGHP).* These terms have the meanings given them in § 411.101 of this chapter except that the ''former employee'' language of those definitions does not apply with respect to SEPs for the reasons specified in § 406.24(a)(3) of this chapter.

(2) *Special enrollment period (SEP).* This term has the meaning set forth in § 406.24(a)(4) of this chapter. In order to use a SEP, an individual must meet the conditions of paragraph (b) and of paragraph (c) or (d) of this section, as appropriate.

(b) *General rule.* All individuals must meet the following conditions:

(1) They are eligible to enroll for SMI on the basis of age or disability, but not on the basis of end-stage renal disease.

(2) When first eligible for SMI coverage (4th month of their initial enrollment period), they were covered under a GHP or LGHP on the basis of current employment status or, if not so covered, they enrolled in SMI during their initial enrollment period; and

(3) For all months thereafter, they maintained coverage under either SMI or a GHP or LGHP. (Generally, if an individual fails to enroll in SMI during any available SEP, he or she is not entitled to any additional SEPs. 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.)

(c) *Special rule: Individual age 65 or over.* For an individual who is or was covered under a GHP, coverage must be by reason of the current employment status of the individual or the individual's spouse.

(d) *Special rules: Disabled individual.*[4] Individuals entitled on the basis of disability (but not on the basis of end-stage renal disease) must meet conditions that vary depending on whether they were covered under a GHP or an LGHP.

(1) For a disabled individual who is or was covered under a GHP, coverage must be on the basis of the current employment status of the individual or the individual's spouse.

(2) For a disabled individual who is or was covered under an LGHP, coverage must be as follows:

(i) Before August 10, 1993, as an ''active individual'', that is, 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.

(ii) On or after August 10, 1993, by reason of current employment status of the individual or a member of the individual's family.

(e) *Effective date of coverage.* The rule set forth in § 406.24(d) for Medicare Part A applies equally to Medicare Part B.

[61 FR 40346, Aug. 2, 1996]

[4] Under the current statute, the SEP provision applicable to disabled individuals covered under an LGHP expires on September 1998. Unless Congress changes that date, the last SEP available under those provisions will begin with June 1998.

§ 407.21 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 who does not elect to enroll or to be deemed enrolled in SMI when first eligible, or who terminates SMI enrollment, if the individual 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 the Internal Revenue Code of 1986.

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

(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 satisfies the provisions 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]

§ 407.22 Request for individual enrollment.

(a) A request for enrollment is required of an individual who meets the eligibility requirements of § 407.10 and desires SMI, if the individual—

(1) Is not entitled to hospital insurance;

(2) Has previously declined enrollment in SMI;

(3) Has had a previous period of SMI entitlement which terminated;

(4) Resides in Puerto Rico or outside the United States; or

(5) Is enrolling or reenrolling during a special enrollment period under § 407.20.

(b) A request for enrollment under paragraph (a) of this section must:

(1) Be signed by the individual or someone acting in his or her behalf; and

(2) Be filed with SSA or CMS during the initial enrollment period, a general enrollment period, or a special enrollment period as provided in § 407.20.

§ 407.23 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) of this subchapter, are provided for individuals who missed a Medicare enrollment period (as specified in § 407.21, § 407.15 or § 407.20 of this subchapter) 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 the 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 the 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 SMI 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) the both of the following:

(i) He or she did not enroll in SMI 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 SMI.

(2) *SEP duration.* This SEP begins the day the individual notifies SSA of the employer or GHP misrepresentation, or the incorrect information provided 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 reenroll in SMI 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 after January 1, 2023.

(ii) *Special rule.* An individual has the option of requesting entitlement for a retroactive period of up to 6 months provided the date does not precede release from incarceration and the individual pays the monthly premiums for the period of coverage (as required under § 406.31). If the application is filed within the first 6 months of the SEP, the effective date is retroactive to the date of their release from incarceration. If the application is filed in the last 6 months of the SEP, the coverage effective date is retroactive to 6 months after the date of release from incarceration.

(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 Part B under § 407.4(a); and

(ii) Their Medicaid eligibility is being terminated on or after January 1, 2023, or 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 the month following the last month of the COVID–19 PHE or on or 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 COVD–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 part 408 of this subchapter).

(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 of this subchapter).

(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 § 408.22 of this subchapter 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 SMI.

(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 66505, Nov. 3, 2022]

§ 407.25 Beginning of entitlement: Individual enrollment.

The following apply whether an individual is self-enrolled or automatically enrolled in SMI:

(a) *Enrollment during initial enrollment period.* For individuals who first meet the eligibility requirements of § 407.10 in a month beginning—

(1) Before January 1, 2023, the following entitlement dates apply:

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

(ii) If an individual enrolls during the fourth month of the initial enrollment period, entitlement begins with the following month.

(iii) If an individual enrolls during the fifth month of the initial enrollment period, entitlement begins with the second month after the month of enrollment.

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

(v) For example, if an individual first meets the eligibility requirements for enrollment in April, then the individual's initial enrollment period is January through July. The month in which the individual enrolls determines the month that begins the period of entitlement, as follows:

TABLE 1 TO PARAGRAPH (a)(1)(v)

Enrolls in initial enrollment period	Entitlement begins on—
January	April 1 (month eligibility requirements first met).
February	April 1.
March	April 1.
April	May 1 (month following month of enrollment).
May	July 1 (second month after month of enrollment).
June	September 1 (third month after month of enrollment).
July	October 1 (third month after month of enrollment).

(2) On or after January 1, 2023, the following entitlement dates apply:

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

(ii) If an individual enrolls during the last 4 months of the initial enrollment period, entitlement begins with the month following the month in which they enroll.

(b) *Enrollment on reenrollment during general enrollment period.* (1) If an individual enrolls or reenrolls during a general enrollment period before April 1, 1981, or after September 30, 1981 and before January 1, 2023, entitlement begins on July 1 of that calendar year.

(2) If an individual enrolled or reenrolled during the general enrollment period between April 1, 1981 and September 20, 1981, entitlement began with the third month after the month in which the enrollment request was filed.

(3) If an individual enrolls or reenrolls during a general enrollment period on or after January 1, 2023, entitlement begins on the first day of the month following the month in which they enroll.

(c) *Enrollment or reenrollment during a SEP.* The rules set forth in § 406.24(d) of this chapter apply.

[53 FR 47204, Nov. 22, 1988, as amended at 61 FR 40347, Aug. 2, 1996; 87 FR 66506, Nov. 3, 2022; 87 FR 80469, Dec. 30, 2022]

§ 407.27 Termination of entitlement: Individual enrollment.

An individual's entitlement will terminate for any of the following reasons:

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

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

If an individual's enrollment or nonenrollment in SMI is unintentional, inadvertent, or erroneous because of the error, misrepresentation, on 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 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 reenrollment.

[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 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.

(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

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

(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) *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.

(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]

§ 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]

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.

§ 407.57 Part B–ID benefit enrollment.

(a) *Deemed enrollment.* An individual whose Part A entitlement ends in accordance with § 406.13(f)(2) of this subchapter on or after January 1, 2023, is deemed to have enrolled into the Part B–ID benefit effective the first day of the month in which the individual first satisfies § 407.55, provided he or she provides the attestation required under § 407.59 prior to the termination of their Part A benefits.

(b) *Individual enrollment.* An individual whose Part A entitlement ends in accordance with § 406.13(f)(2) of this subchapter, and who meets the requirements of § 407.55 and provides the attestation required under § 407.59, may enroll in the Part B–ID benefit under the following conditions:

(1) If the individual's entitlement ends prior to January 1, 2023, he or she may enroll in the Part B–ID benefit beginning on October 1, 2022.

(2) If individual's entitlement ends on or after January 1, 2023, the individual may enroll at any time after their entitlement ends.

(c) *Reenrollment.* An individual who had previously enrolled in the Part B–ID benefit, but terminated that benefit, can reenroll at any time, provided the individual meets the requirements of § 407.55 and provides the attestation required under § 407.59.

(d) *Attestation.* To enroll in the Part B–ID benefit, an individual must submit the required attestation as described in § 407.59.

[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.

(e) *Entitlement date.* The entitlement to the Part B–ID benefit will start as follows:

(1) For enrollments provided under paragraph (a) of this section, entitlement is effective the month Part A benefits are terminated.

(2) For enrollments provided under paragraphs (b) and (c) of this section, the Part B–ID benefit is effective the month following the month in which the individual provides the attestation required in §407.59.

(3) *Exception.* Enrollments submitted October 1, 2022 through December 31, 2022, are effective January 1, 2023.

§407.59 Attestation.

As a condition of enrollment, an individual must attest to SSA in either a verbal attestation, signed paper form provided by SSA, by electronic submission, or fax, using procedures determined by SSA, that—

(a) The individual is not enrolled and does not expect to enroll in other coverage described in §407.55(b); and

(b) If the individual does enroll in other coverage described in §407.55(b), the individual will notify SSA within 60 days of enrollment in such other coverage.

§407.62 Termination of coverage.

(a) *Other coverage.* An individual who enrolls in other coverage as described in §407.55(b) will have his or her enrollment in the Part B–ID benefit terminated on either of the following bases:

(1) If the individual notifies SSA of such coverage consistent with §407.59(b), their enrollment in the Part B–ID benefit will be terminated effective the first day of the month after the month of notification unless the individual requests a different, prospective termination date that is not after the effective date of enrollment in other health insurance coverage, as described in §407.55(b).

(2) If the individual does not notify SSA of this coverage consistent with §407.59(b), their enrollment in the Part B–ID benefit will be terminated effective the first day of the month after the month in which there is a determination of the individual's enrollment in coverage described in §407.55(b).

(b) *Death.* Enrollment in the Part B–ID benefit ends on the last day of the month in which the individual dies.

(c) *Nonpayment of premiums.* If an individual fails to pay the premiums, the Part B–ID benefit enrollment will end as provided in the rules for Part B premiums set forth in part 408 of this chapter.

(d) *Request by individual.* An individual may request disenrollment at any time by notifying SSA that he or she no longer wants to be enrolled in the Part B–ID benefit. Such individual's enrollment in the Part B–ID benefit ends with the last day of the month in which the individual provides the disenrollment request, except for an individual who loses coverage under a State buy-in agreement, as described in §407.50(b)(2)(i).

(e) *Entitlement to Hospital Insurance benefits.* Enrollment in the Part B–ID benefit ends effective the last day of the month prior to the month that the individual becomes entitled to benefits under §406.5, §406.12, or §406.13 of this subchapter.

(f) *Appeals.* An involuntary termination of the Part B–ID benefit for reasons described at §407.62(a)(2), (b), or (c) of this subsection, will be considered an initial determination that is appealable under §405.904(a)(1) of this subchapter. An individual can request to continue receiving Part B–ID benefits while waiting for an appeals decision.

PART 408—PREMIUMS FOR SUPPLEMENTARY MEDICAL INSURANCE

Subpart A—General Provisions

Sec.

Subpart B—Amount of Monthly Premium