

REG-ADOPT, MED-GUIDE 1992-1 MED-GUIDE-TB ¶39,503, **Final Regulations on Payment of Part A Premiums and State Buy-in Agreements.**, (Aug. 12, 1991)
Final Regulations on Payment of Part A Premiums and State Buy-in Agreements.

Final Regulation Amendments 56 F.R. 38074, Aug. 12, 1991.

Medicare and Medicaid: Part A Premiums and Buy-in Agreements

Part A premiums--Buy-in agreements for QMBs.--

Reproduced below are a summary, supplementary information, and final regulations concerning (1) Medicare Part A coverage, through payment of monthly premiums, for disabled individuals under age 65 who have lost Social Security and Medicare because of substantial gainful activity, and (2) state buy-in agreements and payment of Medicare Part A premiums for "Qualified Medicare Beneficiaries" (individuals who qualify for Medicare and whose poverty entitles them to have Medicaid pay their Medicare premiums, deductibles, and coinsurance).

See ¶1120, ¶14,231, ¶14,731, ¶14,745.

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 400, 406 and 407

Medicare and Medicaid; Eligibility for Premium Hospital Insurance; State Buy-in Agreements

[BDP-668-FC]

Agency: Health Care Financing Administration (HCFA), HHS.

Action: Final rule with comment period.

Summary: These rules--

1. Set forth the requirements and procedures for certain individuals under age 65 to enroll and become entitled to Medicare Part A benefits through payment of monthly premiums;

2. Revise the rules on State buy-in for Medicare benefits to provide that--

- After 1988, a State may, at any time, request a buy-in agreement or a modification of an existing agreement, including a modification under which the State may enroll and pay Part B premiums on behalf of a new buy-in coverage group--Qualified Medicare Beneficiaries (QMBs); and

- After 1989, a State may request and obtain a modification of an existing agreement, under which the State may also enroll QMB's in Part A and pay Part A premiums on their behalf.

These amendments are necessary to conform HCFA rules to changes made by section 9010 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), section 301 of the Medicare Catastrophic Coverage Act of 1988 (MCCA), and sections 6012 and 6013 of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89).

The purposes of the amendments are--

1. To make it possible for certain disabled individuals to become entitled to Medicare Part A benefits that require payment of a monthly premium. The provisions apply to an individual under age 65 who loses

entitlement to Medicare Part A without premiums because his or her earnings exceed the limit imposed for entitlement to social security disability benefits, on which Medicare Part A entitlement was based; and

2. To make available to States, for payment of premiums for QMBs, the administrative and cost efficiencies of the State buy-in procedures.

Effective Date: These regulations are effective September 11, 1991.

Comment Date: To be considered, comments must be mailed or delivered to the appropriate address, as provided below, and must be received by 5 p.m. on October 11, 1991.

Addresses: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-668-FC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

Due to staffing and resource limitations, we cannot accept facsimile (FAX) copies of comments.

In commenting, please refer to file code BPD-668-FC. Comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-245-7890).

For Further Information, Contact: Denis Garrison, (301) 966-5643.

Supplementary Information:

A. Entitlement to Premium Hospital Insurance

1. Statutory Provisions

Before enactment of OBRA '89, only an individual who had attained age 65 and who met other specified conditions was eligible to enroll for "premium" hospital insurance, that is, Part A benefits for which payment of monthly premiums is required.

Section 6012 of OBRA '89 adds to the Act a new section 1818A to provide that an individual who has not attained age 65 is also eligible to enroll for premium hospital insurance if he or she meets the following requirements:

- Has been entitled to Part A benefits under [section 226\(b\) of the Act](#) (entitlement based on entitlement to social security disability benefits);
- Continues to have the disabling physical or mental impairment on the basis of which the individual qualified for disability benefits; but
- Loses entitlement under section 226(b) due solely to having earnings that exceed the "substantial gainful activity" limit established by the social security regulations at 20 CFR 404.1574; and
- Is not otherwise entitled to Part A benefits.

Section 6408(d) of OBRA '89 amends the Medicaid statute as follows:

- Provides for Medicaid payment of Part A premiums on behalf of individuals who are eligible to enroll for Part A under [section 1818A of the Act](#) (identified as Qualified Disabled and Working Individuals or QDWIs), who meet specified income and resources tests, and who are not otherwise eligible for Medicaid.

- Excludes QDWIs from the definition of QMB.

The amendment does not authorize use of the State buy-in procedures to pay the premiums for QDWIs. The Medicaid provisions applicable to QDWIs are set forth in a separate proposed rule (MB-031-P).

2. Changes in the Regulations

Revised designation scheme.

In anticipation of changes likely to be made by future statutory amendments, we have revised the designation scheme of part 406 of our rules (Hospital Insurance Eligibility and Entitlement) to make room for adding new provisions in logical order. We have also made substantive changes, as discussed below.

a. In §406.1 (Statutory basis), we have added reference to the new [section 1818A of the law](#), and in §406.5 (Basis of eligibility and entitlement), we have stated that certain persons under age 65 may also obtain Part A benefits by paying a premium.

b. In §406.20 (Basic requirements), we have revised paragraphs (a) and (b) and added a new paragraph (c) to set forth the requirements for the new under age 65 group.

c. In §406.21 (now called “Individual enrollment”), we have--

- Expanded a cross-reference in paragraph (a)
- Revised paragraph (b) to specify the initial enrollment period for those under age 65;
- Revised paragraph (d) to make clear that the “deemed” initial enrollment period applies only to those age 65 or over; and

- Expanded paragraph (e)(1) to include a definition of “large group health plan” (LGHP), because the “special enrollment period” provisions of the paragraph apply with respect to LGHPs as well as to the “employer group health plan” (EGHP) that was already defined in the paragraph.

d. We have expanded the “effect of enrollment” provisions of current §406.21 to add the effect on the new under age 65 group, and redesignated all those provisions under a new §406.22-Effect of month of enrollment on entitlement.

e. We have redesignated §406.25 as §406.28 (End of entitlement), and made the following changes:

- Revised paragraph (c) to make clear that loss of SMI benefits ends entitlement only for those age 65 or over; and

- Added a new paragraph (f) to specify that, for those under age 65, entitlement ends with the end of the month after the month in which the individual receives notice of medical improvement.

f. We have redesignated §406.22 (Monthly premiums) as §406.32 and added new paragraphs (e) and (f) to specify--

- The months for which premiums are due; and

- The option for public or private organizations to pay Part A premiums on behalf of individuals.

g. Since Part A premiums for QDWIs may not be paid under a State buy-in agreement, the Medicare rules need only make clear that individuals who qualify as QDWIs may not qualify as QMBs. This is accomplished by defining QDWIs and QMBs in §400.200 of the HCFA rules.

B. Extension of Disability Reentitlement Period

1. Statutory Provision

Section 9010 of the Omnibus Budget Reconciliation Act of 1987 amended sections 223(a)(i) and sections 202(d), (e), and (f) of the Act to extend the disability reentitlement period from 15 months to 36 months, effective January 1, 1988. Section 9010 also amended [section 226\(b\) of the Act](#) to stipulate that Medicare must end as though the reentitlement period was still only 15 months long.

2. Changes in the Regulations

We have revised §406.12(e) to reflect the effect of the new provisions on Medicare entitlement.

C. Expansion of State Buy-in Options

1. Statutory Provisions

Prior to 1970 and again during 1981, States were permitted, under [section 1843 of the Act](#), to request a buy-in agreement with the Secretary, or to request a modification to broaden an existing agreement. Under the agreement (or modified agreement) States could elect to enroll in Medicare Part B and pay Part B premiums for certain Medicaid recipients who were also eligible for Part B coverage. The States had two basic options with respect to buy-in: They could limit buy-in to Medicaid recipients who were cash assistance recipients or they could elect a broad buy-in group consisting of all Medicaid recipients who were also eligible for Medicare Part B. Part B enrollment and premium payment under the section 1843 buy-in provisions is determined without regard to the enrollment and coverage period and the premium computation rules applicable to people who enroll for Part B on an individual basis. Some States have elected to buy-in only for their cash assistance recipients, while a number of others elected to buy-in for all Medicaid recipients who are eligible for Medicare Part B.

Section 301 of the MCCA amended [section 1843 of the Act](#) to--

- Provide that States may, at any time after 1988, request a buy-in agreement or a modification of an existing agreement; and

- Establish Qualified Medicare Beneficiaries (QMBs) ¹ as a group for which States may pay Part B premiums through buy-in. This means that a State that has a buy-in agreement covering only cash assistance recipients may broaden that agreement to include QMBs or all Medicaid recipients.

With respect to Part B buy-in for QMBs, unless a State indicated to us that it wished to use a different method, we considered that the State had requested and been granted a modification of its buy-in agreement to include Part B premiums for QMBs, effective January 1, 1989. All States currently have such a modification in effect.

Section 6013 of OBRA '89 added to [section 1818 of the Act](#) a new subsection (g) which requires the Secretary, at the request of a State after 1989, to enter into a modification of its buy-in agreement under which the State may enroll QMBs in Part A and pay the Part A premiums on their behalf.

Before enactment of section 6013, an individual who failed to enroll for premium Part A during his or

her initial enrollment period (generally the 7-month period surrounding the month of attainment of age 65) could enroll only during the annual 3-month (January-March) general enrollment period (GEP). Coverage based on a GEP enrollment is effective the following July 1. This meant that an individual who first met the QMB eligibility requirements (other than entitlement to Part A) shortly after March 31 could not enroll until the next GEP, with coverage beginning the following July, as many as 15 months after the individual met the income and resource standards for QMB status. In such cases, QMB status would be significantly delayed by the individual's inability to enroll in Part A outside a GEP.

Furthermore, if an individual enrolled in Part A more than one year after initial eligibility, the State [may] have been required to pay a premium increased because of late enrollment. In States that elect the buy-in method, individuals can become entitled to Part A benefits when they first meet all other QMB eligibility requirements, without regard to the enrollment period and premium increase rules that apply to individual enrollment. In order to make this possible, we will consider that an individual who, as determined by the State, meets the QMB requirements becomes a QMB at the instant in which the buy-in becomes effective with respect to that individual. This is necessary because the Medicaid statute provides that an individual must be entitled to Medicare Part A in order to be a QMB, but only QMBs can qualify for enrollment outside the established initial and general enrollment periods. By considering that the individual's QMB status becomes effective at the same instant that the buy-in becomes effective, we can honor the intent of section 6013--to avoid delay in qualifying for QMB status.

The State buy-in procedure is the most efficient way for a State to obtain coverage and pay Part A premiums for QMBs, and most closely fulfills the intent of Congress that State payment of Part A premium for QMBs begin without significant delays. Accordingly, we informed the States that we would consider all States to have requested modification of their buy-in agreements to cover Part A for QMBs, unless they notified us, by a specified date, that they did not wish to use the buy-in procedure. Following is a list of the 35 States that have buy-in agreement modifications to include payment of Part A premium for QMBs:

Alaska	Iowa	North Dakota
Arizona	Maine	Ohio
Arkansas	Maryland	Oklahoma
Connecticut	Massachusetts	Pennsylvania
Delaware	Michigan	Rhode Island
District of Columbia	Minnesota	South Dakota
Florida	Mississippi	Tennessee
Georgia	Montana	Vermont
Hawaii	Nevada	West Virginia
Idaho	New Hampshire	Washington
Indiana	New York	Wisconsin
	North Carolina	Wyoming

In general, for QMBs who meet the SMI or premium HI eligibility requirements, enrollment is effective with the month in which they are determined to have QMB status. However, if enrollment is under a State buy-in agreement, that enrollment cannot be effective until the effective month of the agreement modification that covers QMBs.

2. Changes in the Regulations

Changes required in the Medicaid rules for buy-in are included in a proposed rule (MB-024-P) that contains all of the Medicaid provisions applicable to QMBs. This document contains only the changes that affect the Medicare rules, specifically, part 406--Hospital Insurance Eligibility and Entitlement, and part 407--Supplementary Medical Insurance (SMI) Enrollment and Entitlement.

a. In §400.200, we have added a definition of “Qualified Medicare Beneficiary” or “QMB.”

b. In part 406, we have added a new §406.26 to set forth the rules that apply when a State enrolls QMBs in premium hospital insurance (Premium HI) under a State buy-in agreement. Section 406.26 makes clear the following:

- Premium HI buy-in for QMBs is effective beginning in 1990.
- Buy-in coverage begins when the individual has QMB status and the agreement modification Covering Part A premiums for QMBs is effective.
- Buy-in coverage ends when HCFA receives the State’s notice of loss of QMB status, the buy-in agreement is terminated, or the individual becomes entitled to premium-free hospital insurance.
- When buy-in coverage ends, the individual is deemed to have enrolled during his or her initial enrollment period, in premium HI, unless buy-in coverage ended because the individual had become eligible for premium-free hospital insurance; and
- The individual is free to terminate the deemed enrollment.

c. In §407.40, (Enrollment under a State buy-in agreement), we have--

- Expanded the “Statutory basis” paragraph to refer to section 301 of the MCCA and section 6013 of OBRA ’89; and
- Added a definition of “Qualified Medicare Beneficiary,” citing §400.200.

d. In §§407.42 and 407.43, we have added a new buy-in category:

Individuals who are Qualified Medicare Beneficiaries, and footnoted this new category to indicate that the rules for buy-in for Part A benefits for QMBs are set forth in §406.26 of the Medicare rules.

e. We have also taken advantage of this opportunity to simplify the terminology and the description of the buy-in groups.

Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposal. The notice identifies the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. The proposed rulemaking procedure can be waived when an agency finds that it is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding of good cause in a final rule.

These rules conform HCFA regulations to three self-executing amendments to the Medicare law (title XVIII of the Social Security Act). These amendments to the Act are so specific and detailed that they leave little or no room for alternative interpretations or implementation. Accordingly, we find that there is good cause to dispense with proposed rulemaking as unnecessary.

However, as indicated under “Dates” above, we will consider timely comments. Although we cannot acknowledge comments individually, if we revise these regulations as a result of comments, we will discuss all timely comments in the preamble to the revised rules.

Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any rule that meets one of the E.O. 12291 criteria for a “major rule”; that is, that is likely to result in--

- An annual effect on the economy of \$100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

This final rule specifies the requirements and procedures regarding premium hospital insurance for individuals under age 65. However, Medicare program costs will not increase since the individuals affected have been covered under premium free Part A and these rules permit Part A coverage to continue if certain conditions are met and premium payments are made.

This proposal also revises the rules on State buy-in for Qualified Medicare Beneficiaries (QMBs) under Medicare Parts A and B.

As a result of the Part A State buy-in, we expect that approximately 200,000 individuals will be added to the Medicare Part A rolls. It is estimated that, as a result of these new enrollees, Medicare Part A income and outlays will increase by \$425 million. However, we do not project any significant increase in net Medicare program costs since the monthly Part A premium covers the estimated monthly average Medicare Part A expenditure per entitled aged beneficiary. If these enrollees have higher utilization rates or use higher cost services (by being sicker or older, or for any other reason) than the average Medicare Part A entitled aged beneficiary, then their costs would exceed the premium payments made on their behalf, resulting in an increase in net Medicare program costs; however, data to substantiate or refute this possibility is not available at this time.

We also do not have data to determine how the cost of the Part A premium compares to average Medicaid hospital costs per recipient for these new Part A enrollees. If these costs are comparable, then there will be no significant impact on Medicaid expenditures resulting from the Part A buy-in. To the extent these new enrollees have higher costs than the average Part A enrollee, Medicaid program costs will decrease; however, low Medicaid hospital reimbursement rates may result in an offsetting increase in program payments when Part A premium payments under the buy-in are substituted for direct provider reimbursement.

With regard to Medicare Part B, all States have buy-in agreements and will initially expend funds by paying premiums on behalf of QMBs. However, the States’ financial burden for QMBs will ease as claims for services are submitted to Medicare for payment. The effects of Part B QMBs on Medicare expenditures will be discussed in a separate proposed rule, “Medicaid Payment of Medicare Cost Sharing for QMBs.”

Since this rule does not meet any of the E.O. 12291 criteria listed above, this rule is not a major rule and a regulatory impact analysis is not required.

B. Regulatory Flexibility Act (RFA)

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (5 U.S.C. 601 through 612) unless the Secretary certifies that a rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. This rule affects only individuals and States. We have not prepared a regulatory flexibility analysis or rural impact statement because we have determined, and the Secretary certifies, that this rule will not have a significant impact on a substantial number of small entities or on the operations of a substantial number of small rural hospitals.

Paperwork Reduction Act

These regulations contain no new information collection requirements subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980.

List of Subjects

42 CFR Part 400

Grant programs--health, Health facilities, Health maintenance organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 406

Health facilities, Kidney diseases, Medicare.

42 CFR Part 407

Medicare Part B enrollment and entitlement, State buy-in agreements.

42 CFR chapter IV is amended as set forth below:

PART 400--INTRODUCTION; DEFINITIONS

1. The authority citation continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

§400.200 [Amended]

2. In 400.200, the following statements and definitions are added, in alphabetical order:

* * * * *

QDWI stands for Qualified Disabled and Working Individual.

QMB stands for Qualified Medicare Beneficiary.

Qualified Disabled and Working Individual means an individual who--

(1) Is eligible to enroll for Medicare Part A under [section 1818A of the Act](#) ;

(2) Has income, as determined in accordance with SSI methodologies, that does not exceed 200 percent of the Federal poverty guidelines (as defined and revised annually by the Office of Management and Budget) for a family of the size of the individual's family;

(3) Has resources, as determined in accordance with SSI methodologies, that do not exceed twice the relevant maximum amount established, for SSI eligibility, for an individual or for an individual and his or her spouse; and

(4) Is not otherwise eligible for Medicaid.

Qualified Medicare Beneficiary means an individual who--

(1) Is entitled to Medicare Part A, with or without payment of premiums, but is not entitled solely because he or she is eligible to enroll as a QDWI;

(2) Has resources, as determined in accordance with SSI methodologies, that do not exceed twice the maximum amount established for SSI eligibility; and

(3) Has income, as determined in accordance with SSI methodologies, that does not exceed 100 percent of the Federal poverty guidelines.

* * *

PART 406--HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

1. The table of contents is revised to read as follows:

Subpart A--General Provisions

Sec.

406.1 Statutory basis.

406.2 Scope.

406.3 Definitions.

406.5 Basis of eligibility and entitlement.

406.6 Application or enrollment.

406.7 Forms to apply for entitlement under Medicare Part A.

Subpart B--Hospital Insurance Without Premiums

406.10 Individual age 65 or over who is entitled to social security or railroad retirement benefits.

406.11 Individual age 65 or over who is eligible as a social security or railroad retirement beneficiary, or on the basis of government employment.

406.12 Individual under age 65 who is entitled to social security or railroad retirement disability benefits.

406.13 Individual who has end-stage renal disease.

406.15 Special provisions applicable to Medicare qualified government employment.

Subpart C--Premium Hospital Insurance

406.20 Basic requirements.

406.21 Individual enrollment.

406.22 Effect of month of enrollment on entitlement.

406.26 Enrollment under State buy-in.

406.28 End of entitlement.

406.32 Monthly premiums.

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

406.34 Determination of months to be counted for premium increase: Reenrollment.

406.38 Prejudice to enrollment rights because of Federal Government error.

Subpart D--Special Circumstances That Affect Entitlement to Hospital Insurance

406.50 Nonpayment of benefits on behalf of certain aliens.

406.52 Conviction of subversive activities.

Authority: Secs. 202(t), 202(u), 226, 226A, 1102, 1818, and 1871 of the Social Security Act (42 U.S.C. 402(t), 402(u), 426, 426-1, 1302, 1395i-2, and 1395hh) and 3103 of Pub. L. 89-97 (42 U.S.C. 426a) unless otherwise noted.

§406.1 [Amended]

2. In §406.1, in line one, “and 1818” is changed to “1818 and 1818A”.
3. Section 406.5 is amended by revising paragraph (b) to read as follows:

§406.5 Basis of eligibility and entitlement.

* * *

(b) *Premium hospital insurance.* Many individuals who are age 65 or over, but do not meet the requirements set forth in subpart B of this part, and certain individuals under age 65, may obtain the benefits by paying a premium. Section 406.20 of this part explains the requirements individuals must meet to obtain premium hospital insurance.

4. In §406.12, paragraph (e) is revised to read as follows:

§406.12 Individual under age 65 who is entitled to social security or railroad retirement disability benefits.

* * *

(e) *Continuation of Medicare entitlement when disability benefit entitlement ends because of substantial gainful activity (SGA).*--(1) *Definitions.* As used in this section--

Trial work period means the 9-month period provided under title II of the Act and as defined [in] 20 CFR 404.1592, during which the individual may test his or her ability to work and still receive disability cash benefits; and

Reentitlement period means a period as defined in 20 CFR 404.1592a that begins with the first month after the trial work period and ends with the 36th month after the trial work period or, if earlier, with the first month in which the impairment no longer exists or is no longer disabling. (During the reentitlement period, benefits may be discontinued because of SGA. However, if SGA is later discontinued, benefits may be restricted without a new application and a new disability determination.)

(2) *Duration of continued Medicare entitlement.* Effective January 1, 1988, if an individual's entitlement to disability benefits or status as a qualified disabled railroad retirement beneficiary ends because he or she

engaged in, or demonstrated the ability to engage in, substantial gainful activity after the 36 months following the end of the trial work period, Medicare entitlement continues until the earlier of the following:

(i) The last day of the 24th month following the first month of SGA occurring after the 15th month of the individual's reentitlement period or, if later, the end of the month following the month the individual's disability benefit entitlement ends.

(ii) The last day of the month following the month in which notice is mailed to the individual indicating that he or she is no longer entitled to hospital insurance because of an event or circumstance (for example, there has been medical improvement, or the disabled widow has remarried) that would terminate disability benefit entitlement if it had not already been terminated because of substantial gainful activity.

5. Section 406.20 is revised to read as follows:

§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--

(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.

6. Section 406.21 is amended to revise the heading and paragraphs (a), (b), (d), and (e), to read as follows:

§406.21 Individual enrollment.

(a) *Basic provision.* An individual who meets the requirements of §406.20 (b) or (c) may enroll for premium hospital insurance only during his or her “initial enrollment period”, a “general enrollment period”, or a “special enrollment period”, as set forth in paragraphs (b) through (e) 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.

* * * * *

(d) *“Deemed” initial enrollment period for individual age 65 or over.* 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) *Special enrollment period--(1) Terminology.* As used in this paragraph--

(i) *Active individual* means an employee, an employer, a self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a family member of any of these persons.

(ii) *Employer plan* has, to the extent not inconsistent with [section 1837 of the Act](#), either of the following meanings:

(A) *Employer group health plan (EGHP)*, as defined in section 5000(b)(1) of the Internal Revenue Code (IRC) of 1986 which reads: “* * * ‘group health plan’ means any plan of, or contributed to by, an employer, to provide medical care * * * to his employees, former employees, or the families of such current or former employees, directly, or through insurance, reimbursement or otherwise.”

(B) *Large group health plan (LGHP)*, as defined in section 5000(b)(2) of the IRC of 1986, which reads: “* * * a plan of, or contributed to by an employer or employee organization * * * to provide health care * * * to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.”

(iii) *Family member* means any person who is enrolled in an LGHP because of a relationship to an active individual, including, for example, a divorced or common-law spouse, a step-child, step-brother, or step-sister, or a natural, adopted, or foster child.

(iv) The phrase “plan of” encompasses a plan that is under the auspices of an employer who makes no financial contribution--a so-called “employee-pay-all” plan. Since [section 1837\(i\)\(1\)\(B\) of the Act](#) (which is made applicable to premium hospital insurance by [section 1818 of the Act](#)) requires that the individual be covered under the plan “by reason of the individual’s or the individual’s spouse’s current employment”, the “former employee” language of the IRC definition does not apply.

(v) "Special enrollment period" (SEP) is a 7-month period that begins when any individual is no longer covered by an EGHP based on the individual's or the individual's spouse's current employment; or when an individual under age 65 is no longer covered by a LGHP as an active individual.

(2) *Basic rule.* Effective August 1, 1986, individuals may enroll in premium hospital insurance during SEPs that are available to them if they meet the following requirements:

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

(A) Covered under an EGHP, by reason of current employment of the individual or the individual's spouse; or

(B) Covered under an LGHP, as an active individual under age 65.

(ii) The EGHP and LGHP coverage has ended because of termination of the employment or for any other reason.

(3) *Beginning date of SEP.* If the individual enrolls during the month in which employer plan coverage ends, that month is considered the first month of the SEP. Otherwise, the SEP begins with the following month.

(4) *Effective date of coverage.* Enrollment during the first month of the SEP will result in coverage effective with the first day of that month; enrollment in the second through seventh months of the SEP will result in coverage effective with the month following the month of enrollment.

(5) *Limitation on right to subsequent SEPs.* Subsequent SEPs become available if the individual reacquires employer plan coverage based on current employment and later loses it. Generally, if an individual fails to enroll during any available SEP, no further SEPs become available. However, if an individual failed to enroll during a previous SEP because employer plan coverage (under the same or a different plan) was restored before the end of that SEP, that failure to enroll would not preclude another SEP now or in the future.

7. Section 406.22 is redesignated as §406.32 and a new [§]406.22 is added, to read as follows:

§406.22 Effect of month of enrollment on entitlement.

(a) *Individual age 65 or over.* For an individual who has attained age 65, 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 under age 65.* For an individual who has not attained age 65, 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.

8. Section 406.26 is redesignated as §406.38 and a new §406.26 is added, to read as follows:

§46.26 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 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.

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

(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.

(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 HCFA 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 HCFA, 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 HCFA'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.

9. Section 406.25 is redesignated as §406.28, and amended to revise the heading, the introductory text, and paragraph (c), and add a new paragraph (f), to read as follows:

§406.28 End of entitlement.

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

* * * * *

(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.

* * * * *

(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.

10. In redesignated §406.32, new paragraphs (e) and (f) are added, to read as follows:

§406.32 Monthly premiums.

* * * * *

(e) *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.

(f) *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 HCFA if HCFA 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.)

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

1. The authority citation continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) unless otherwise noted.

2. The table of contents of part 407, subpart C is amended by revising the headings of §§407.42 and 407.43 to read as follows:

* * * * *

Subpart C--State Buy-in Agreements

* * * * *

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

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

* * * * *

3. Section 407.40 is revised to read as follows:

§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 recipients 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 sections 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.

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

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.

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 *Qualified Medicare Beneficiary* or *QMB* means an individual who meets the definition in §400.200 of this chapter and, therefore, is eligible to have the State Medicaid agency pay Medicare cost sharing amounts on his or her behalf.

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

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 by [section 1843 of the Act](#), under which a State secures SMI or premium HI 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.

(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.

(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. Section 407.42 is revised to read as follows:

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

(a) *Categories included in the buy-in groups.* The buy-in groups that are available to the 50 States, the District of Columbia, and the Northern Mariana Islands are specified in paragraph (b) of this section in terms of the following categories:

(1) *Category A:* Individuals who--

(i) Receive SSI or SSP or both; and

(ii) Are covered under the State’s Medicaid plan as categorically needy.

(2) *Category B:* Individuals who--

(i) Under the Act or any other provision of Federal law are treated, for Medicaid eligibility purposes, as

though they were receiving SSI or SSP; and

(ii) Are covered under the State's Medicaid plan as categorically needy.

(3) *Category C*: Individuals who are receiving AFDC.

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

(5) *Category E*: Individuals who, in accordance with §435.114 or §435.134 of this chapter, are covered under the State's Medicaid plan despite the increase in social security benefits provided by Public Law 92-336.

(6) *Category F*: Individuals who are Qualified Medicare Beneficiaries. ¹

(7) *Category G*: All other individuals who are eligible for Medicaid.

(b) *Buy-in groups available*. Any of the 50 States, the District of Columbia, and the Northern Mariana Islands may buy-in for one of the following groups:

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

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

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

(4) *Group 4*: Categories A, B, and F, individuals in categories C and D who are not social security or railroad retirement beneficiaries, and individuals in category E who are included in that category (in accordance with §435.134 of this chapter) because they received OAA, AB, APTD, or AABD in August 1972 or would have been eligible to receive such cash assistance for that month if they had applied or had not been institutionalized;

(5) *Group 5*: Categories A and B, individuals in categories C and D who are not social security or railroad retirement beneficiaries, and individuals in category E who are included in that category (in accordance with §435.134 of this chapter) because they received OAA, AB, APTD, or AABD in August 1972 or would have been eligible to receive such cash assistance for that month if they had applied or had not been institutionalized.

(6) *Group 6*: Categories A, B, and F, and individuals in category E who are included in that category (in accordance with §435.134 of this chapter) because they received AABD in August 1972 or would have been eligible to receive AABD for that month if they had applied or had not been institutionalized. This option is available only to those States that had an AABD program as of December 31, 1973.

(7) *Group 7*: Categories A and B, and individuals in category E who are included in that category (in accordance with §435.134 of this chapter) because they received AABD in August 1972 or would have been eligible to receive AABD for that month if they had applied or had not been institutionalized. This option is available only to those States that had an AABD program as of December 31, 1973.

5. Section 407.43 is revised to read as follows:

§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.²

(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.

6. Section 407.47 is revised to read as follows:

§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 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.

(b) *Application of general rule: Medicaid eligibles who are, or are treated as, cash assistance recipients.* For Medicaid eligibles who are, or are treated as, cash assistance recipients (that is, are members of categories A through E of §407.42(a) or categories A through C of §407.43(a)), 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 a member of one of those categories.
- (2) The month in which the buy-in agreement is effective.

(c) *Application of general rule: Qualified Medicare Beneficiaries.* For individuals who are QMBs (that is, are members of category F of §407.42(a) or category D of §407.43(a)), 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 members of category G of §407.42(a) or category E of §407.43(a), 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.

7. Section 407.48 is amended by revising paragraphs (c) introductory text, and (d) to read as follows:

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

* * * * *

(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:

* * * * *

(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.

8. Section 407.50 is amended by revising the introductory text of paragraph (a) to read as follows:

§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--

* * * * *

Dated: October 8, 1990.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

¹ Section 9403 of the Omnibus Reconciliation Act of 1986 defined QMBs (in [section 1905\(p\) of the Act](#)) and gave States the option of paying Medicare cost-sharing on their behalf.

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

² Rules for buy-in for premium hospital insurance for QMBs are set forth in §406.26 of this chapter.
